HELPING EMPLOYEES AND PATIENTS NAVIGATE NEW WATERS: THE INTERACTION OF MARKETPLACE COVERAGE, COBRA AND MEDICARE

Howard D. Bye-Torre, Esq.
Kiran H. Griffith, Esq.
Stoel Rives, LLP
Seattle, WA

With the advent of the Patient Protection and Affordable Care Act ("PPACA"), which established "Exchanges," now known as "Marketplaces," health insurance coverage options for employees and patients have become even more complex than before. Through these Marketplaces, the federal government provides a new way to obtain health insurance coverage both for individuals who have historically looked to their employers for coverage and for those who have never had health insurance. However, this new opportunity requires individuals to take a more active role in selecting health insurance coverage and to make important decisions with consequences that may not be readily apparent to them.

Among the important decisions is the choice among employer-sponsored group health plan ("GHP") coverage, COBRA,[1] Medicare, and coverage through the Marketplaces. The Centers for Medicare & Medicaid Services ("CMS"), the Department of Health and Human Services ("HHS"), the Department of Labor ("DOL"), and the Internal Revenue Service ("IRS") (collectively, the "Departments") have each provided important guidance on these issues,[2] albeit in a piecemeal fashion across a series of notices.[3]

Employees, former employees, retirees and their dependents losing or looking for alternatives to employer-sponsored health coverage often first approach the employer that sponsors their group health plan coverage to understand their options under COBRA, the Marketplaces' health insurance coverage and Medicare. Patients may also raise these issues with their medical providers. This article summarizes the key points of the Departments' guidance that employers and medical providers can use to discuss available coverage options, the consequences of each choice, and when and how to enroll once a coverage decision has been made.

Timing is Everything: The Marketplace's Open and Special Enrollment Periods

Like enrolling in COBRA, Medicare, and employer-sponsored GHPs, access to coverage through the Marketplaces depends on timing. Marketplace coverage, like Medicare and most GHPs, has annual open enrollment periods. The initial open enrollment period for the Marketplaces was six months,[4] but the subsequent open enrollment periods for coverage through the Federally-Facilitated Marketplaces ("FFMs") and State-Based Marketplaces ("SBMs")[5] will be a three-month period running from November 15 through the following February (for example, November 15, 2014, to February 15, 2015).[6]

FFMs and SBMs also have special enrollment periods during which they must permit an individual who experiences certain triggering events to enroll in or change coverage through the Marketplace outside the open enrollment periods. The triggering events are listed below:

1. The individual loses minimum essential coverage ("MEC"), except in the cases of failure to timely pay premiums or rescission of coverage;[7]
2. The individual gains a dependent through marriage, birth, adoption, or placement for adoption;
3. The individual was not previously a U.S. citizen, U.S. national, or lawfully present in the United States, and now gains such status;
4. The individual unintentionally, inadvertently, or erroneously enrolled, or failed to enroll, in the Marketplace due to an error, misrepresentation, or inaction of the Marketplace or HHS;
5. The individual adequately demonstrates that the Marketplace qualified health plan ("Marketplace QHP") in which he or she is enrolled violated a material contractual provision;[8]
6. The individual is newly eligible, or newly ineligible, for a federal subsidy (such as the premium tax credit) through the Marketplace;[9]
7. The individual gains access to new Marketplace QHPs as a result of a permanent move;
8. An individual who is an American Indian may enroll or change coverage once per month;
9. The individual demonstrates that he or she meets other exceptional circumstances as the Marketplace may provide;
10. The individual enrolled, or failed to enroll, due to misconduct by a non-Marketplace entity providing enrollment assistance or conducting enrollment activities.[10]

An individual generally has 60 days from the date of the triggering event to enroll in coverage through the Marketplace.[11] However (and as discussed in greater detail later in the article), an individual losing MEC may select a Marketplace QHP up to 60 days before, as well as after, the date that MEC is lost.[12]

Some of these Marketplace special enrollment events are similar to the special enrollment events applicable

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to GHPs subject to HIPAA's portability rules.[13] The HIPAA rules allow otherwise eligible employees and dependents experiencing such events to join a GHP or change medical plan options at any time, including outside of the GHP's open enrollment period.[14] But there are important differences between HIPAA's and the Marketplace's special enrollment periods. Unlike the ten Marketplace special enrollment periods, HIPAA has only four such periods: (1) loss of other coverage; (2) acquisition of a new dependent through marriage, birth, adoption or placement for adoption; (3) loss of Medicaid or CHIP[15] coverage; and (4) becoming newly eligible for state premium assistance through Medicaid or CHIP.[16]

Another very important difference between the HIPAA special enrollment periods and the Marketplace special enrollment periods is that the length of the HIPAA special enrollment periods for loss of other coverage and the acquisition of a new dependent is only 30 days.[17] This means, for example, that if an employee has a baby and forgets to enroll the child in an employer's GHP in the first 30 days after the baby was born, the employee could still go to the Marketplace and enroll the child in a Marketplace QHP if not more than 60 days have passed since the birth. This difference in the length of the special enrollment periods could be very important, for example, for an employee who forgets to enroll a premature or other baby with significant medical expenses in the employer's GHP in the first 30 days after birth or adoption.

With the exception of coverage for a dependent gained by birth, adoption, or placement for adoption, which is effective as of the date of birth, adoption or placement for adoption, special enrollment in a Marketplace QHP is prospective only, becoming effective no earlier than the first day of the first month following the triggering event (or the first day of the second month, if the individual enrolls in the second half of the month).[18] As discussed in greater detail below, this means that individuals who are transitioning from other coverage into a Marketplace QHP due to a special enrollment event must take care if they wish to avoid a gap in coverage before the Marketplace QHP coverage begins.

The Departments have provided guidance on transitioning to the Marketplace, including new opportunities to drop GHP coverage and the Marketplace implications of having coverage under COBRA or Medicare.

Participants Voluntarily Dropping GHP Coverage to Move to Marketplace Coverage

Employees and their dependents currently enrolled in and remaining eligible for an employer's GHP may wish to move to a Marketplace QHP for a variety of reasons.[19] For example, they become eligible for federal tax subsidies (premium tax credits and reduced cost-sharing) that may make Marketplace coverage less expensive than their GHP coverage. Or an employee and/or the employee's dependents decide that they wish to purchase Marketplace coverage because it is better than the GHP coverage offered by the employer.[20] The techniques for making this move to the Marketplace, and avoiding potential gaps in coverage between the prior and new coverage, depend upon whether the GHP is operated on a calendar-year basis and whether the move is made during or at the end of the GHP's plan year.

Switching Coverage During Open Enrollment Periods: GHP Operated on Calendar-Year Basis

In order to make the change to Marketplace coverage, a participant in a GHP operating on a calendar-year basis could drop the employer-sponsored coverage during the GHP's open enrollment period (with such coverage ending December 31), and enroll in a Marketplace QHP during the Marketplace's open enrollment period. If the person enrolls in the first month of the Marketplace's open enrollment period (from November 15th to December 15th), the Marketplace QHP coverage would begin on the following January 1, the day after the person's GHP coverage ends, resulting in no gap in coverage for that individual between the end of the GHP and the beginning of the Marketplace QHP coverage.

Switching Coverage During Open Enrollment Periods: GHP Operated on Non-Calendar-Year Basis

In order to make the change to Marketplace coverage, a participant in a GHP operating on a non-calendar-year basis could drop the employer-sponsored coverage during the GHP open enrollment period (with such coverage ending on the last day of the plan year), and enroll in a QHP under the Marketplace's special enrollment period for loss of MEC. In order to avoid a gap in coverage between the GHP and the Marketplace QHP, HHS has clarified that an individual losing MEC can apply for a QHP up to 60 days prior to the date of the loss of MEC. Thus, for example, if the GHP's plan year ended on June 30, and the individual signs up for a QHP in May or early June (with the resulting Marketplace QHP effective July 1), there would be no gap in coverage for the individual between the end of the GHP and the beginning of the Marketplace QHP coverage.

Switching Coverage in the Middle of the GHP's Plan Year

Most employers provide GHP coverage through the use of a cafeteria plan under Internal Revenue Code

Section 125, which allows employees to pay the premiums for their health coverage on a pre-tax basis. However, the IRS cafeteria plan rules place restrictions on when a participant can drop GHP coverage in the middle of the GHP's plan year.[21] To drop GHP coverage during the plan year, the participant must experience an event that the IRS and the GHP recognize as a qualifying change in status, and the participant's election change must be consistent with that change in status.[22] Under these change-in-status rules, participants wishing to switch to Marketplace coverage in the middle of the GHP plan year were not always able to do so.[23]

However, in September 2014, the IRS issued Notice 2014-55 to provide two new cafeteria plan permitted election changes that would enable employees to prospectively revoke their elections of coverage under a GHP and move to Marketplace coverage. Under the Notice, a cafeteria plan may now allow an employee to prospectively revoke an election of GHP coverage (other than a health flexible spending arrangement) to purchase a Marketplace QHP if the employee either has a Marketplace special enrollment right or is enrolling during the Marketplace's annual open enrollment period. The Marketplace QHP coverage must be effective no later than the first day after the GHP coverage is revoked. In other words, the employee should first apply for Marketplace coverage during a special enrollment period or the annual open enrollment period, and then revoke his or her election for GHP coverage effective the day before the QHP goes into effect.

Second, under the prior cafeteria plan change-in-status rules, an employee could not revoke an election of GHP coverage if he or she experienced a change in employment status that did not cause the employee to become ineligible for the GHP. Under the second new permitted election change, an employee may be allowed to revoke his or her GHP coverage when the employee's work hours are expected to drop below 30 hours a week, even if this drop in average work hours does not result in a loss in eligibility for coverage under the GHP.[24] To qualify for this election change, (1) the employee must enroll in other coverage that is MEC (e.g., a Marketplace QHP, or the GHP of a spouse or parent); and (2) the other coverage must begin no later than the first day of the second month following the month that includes the date the original coverage is revoked.

Notice 2014-55 states that employers are not required to adopt either of these new permitted election changes. An employer that wants to immediately offer one or both of these new election changes must amend its cafeteria plan on or before the last day of the plan year that begins in 2015. For example, an employer with a calendar-year cafeteria plan must amend by December 31, 2015, although the amendment can be retroactive back to January 1, 2014. An employer that chooses to implement these election changes in a subsequent plan year must amend the cafeteria plan by the last day of that plan year (although the amendment can be retroactive to the first day of the plan year in which the amendment was adopted).

Employers that provide a new election change in their cafeteria plans should notify employees about when and how they can revoke an election under the GHP to enroll in Marketplace coverage.

Participants Involuntarily Losing GHP Coverage: COBRA or Marketplace Coverage?

In addition to GHP participants who wish to voluntarily move to a Marketplace QHP, participants who will involuntarily lose GHP coverage (e.g., due to such events as termination of employment, divorce, or a child reaching age 26) must decide whether to purchase a Marketplace QHP or to obtain health insurance in another manner.[25] In many instances, participants who are losing GHP coverage will also have the option of enrolling in COBRA continuation coverage.

When a COBRA qualifying event occurs (e.g., termination of employment) causing the employee and/or the employee's dependents to lose GHP coverage, the persons eligible for COBRA (called "qualified beneficiaries") are at a crossroads: The individuals may elect COBRA or may enroll in Marketplace coverage under a special enrollment right triggered by the loss of MEC.[26] There are many reasons why an individual might choose one or the other option, and it is important that qualified beneficiaries fully understand the consequences of choosing one over the other. Some of the issues for these individuals to consider are:

Cost Factors

- Age. In general, younger individuals are more likely to find Marketplace coverage less expensive than COBRA coverage, but older individuals may find COBRA to be the less expensive option.
- Eligibility for Federal Subsidies. Individuals who qualify for federal subsidies at the Marketplace will likely want to choose a Marketplace QHP over COBRA. It is important to note that a former employee is not disqualified from receiving federally-subsidized Marketplace coverage merely because he or she receives an *offer* of COBRA or is otherwise eligible to enroll in COBRA. Federal subsidies through the Marketplace are unavailable, however, during the months in which the individual is *enrolled* in COBRA (or other continuation coverage).[27]
- COBRA Subsidies by Employer. Some employers subsidize COBRA coverage, which may make COBRA

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more attractive to individuals losing GHP coverage sponsored by these employers.

- Ability to Pay Premiums on Pre-Tax Basis. In certain situations, COBRA coverage may be able to be paid on a pre-tax basis through a cafeteria plan. Marketplace coverage is almost always paid on an after-tax basis.
- Cost of COBRA During Disability Extension. In certain circumstances, individuals with 18 months of COBRA coverage may qualify for an additional 11 months of COBRA due to disability. However, during this extension the GHP can charge up to 150 percent of the cost of coverage.[28] For individuals who qualify for the disability extension under COBRA, Marketplace coverage would likely be less expensive.

Other Factors

COBRA Coverage is seamless. There is no gap between the end of GHP and the beginning of COBRA coverage. COBRA begins on the day after the individual's GHP coverage ends. In contrast, there might be a gap between GHP coverage and Marketplace coverage (discussed in more detail below).

Quality of Coverage. The individual may have to change provider networks when transitioning to Marketplace coverage, and thus may prefer to elect COBRA in order to keep his or her current medical providers. On the other hand, the individual may prefer a provider network offered by a Marketplace QHP. Additionally, benefits may be better in one option than the other. For example, COBRA coverage may be more comprehensive than a Marketplace QHP because the COBRA coverage includes benefits for vision and dental expenses.

Below are some of the key concepts in the interaction between COBRA and the Marketplace.

Choosing COBRA = Loss of Marketplace Special Enrollment Right

A COBRA-eligible individual ("qualified beneficiary") generally has 60 days from the date of the loss of GHP coverage to elect COBRA coverage.[29] COBRA coverage is effective retroactively to the date that GHP coverage was lost.[30] However, upon an individual's election of COBRA, the Marketplace special enrollment right due to loss of MEC expires and does not arise again until the end of the COBRA coverage period.[31] Additionally, while an employer may terminate COBRA due to the failure to pay premiums, a COBRA beneficiary does not obtain another Marketplace special enrollment right merely because he or she decides to stop paying COBRA premiums.[32] In other words, a COBRA-covered individual who does not otherwise experience a triggering event giving rise to a Marketplace special enrollment right must wait until either the end of the COBRA coverage period or the Marketplace's next annual enrollment period to purchase a QHP.[33]

Choosing another GHP = Loss of Marketplace Special Enrollment Right

A qualified beneficiary may also be eligible to enroll in other GHP coverage, for example a GHP sponsored by the employer of the individual's spouse or parent, under the HIPAA special enrollment right for loss of coverage. The individual has 30 days from the date of the loss of current GHP coverage to request enrollment in other GHP coverage for which the individual is eligible.[34] If an employee or qualified beneficiary elects other GHP coverage, the Marketplace special enrollment right expires and does not arise again until another special enrollment triggering event occurs.

Using COBRA to Close the Marketplace "Gap"

When enrolling in a Marketplace QHP due to loss of MEC, the Marketplace QHP coverage is prospective only, becoming effective no earlier than the first day of the first month following the loss of coverage.[35] If an individual does not apply to a FFM until the second half of the month, coverage does not begin until the first day of the second month following the date of application. Because of these rules, a gap in coverage could arise between the GHP coverage and the Marketplace QHP coverage. For many, a gap in coverage of a few days or weeks may not be a problem. For others, however, it is a very real problem to lack access to healthcare services for any period of time.

GHP participants who know in advance when their coverage will end (e.g., planned retirement or a child's 26th birthday) and whose GHP coverage ends on the last day of the month can avoid a gap in coverage because, as explained above, these participants can select a Marketplace QHP up to 60 days in advance of the loss of their GHP coverage. But many individuals do not have prior notice that they will lose GHP coverage (e.g., an employee suddenly dies or is terminated from employment with no advance notice) and even if they sign up for the QHP as soon as they possibly can, they may face a gap in coverage before their Marketplace QHP begins. Other individuals may face a gap in coverage because their GHP coverage ends in the middle, rather than the end, of a month, since Marketplace QHP coverage does not begin until the first of the next month. For example, if an

employee is laid off on June 5, some GHPs provide that the employee's GHP coverage ends on June 5, and this employee would not be able to enroll in a Marketplace QHP until July 1.

It may be possible, however, to use COBRA to fill in a gap in coverage in one of two ways. First, an individual could elect COBRA coverage and maintain such coverage until the individual enrolls in the Marketplace QHP at the next Marketplace open enrollment period. Once the Marketplace coverage begins on January 1, the individual could terminate COBRA coverage. Second, if the individual does not want to maintain COBRA coverage until the next Marketplace open enrollment period, the individual could eliminate the gap if, during the 60-day COBRA election period, the individual (1) first applies for Marketplace coverage (electing COBRA first will destroy the Marketplace special enrollment right); (2) after submitting the Marketplace application, electing COBRA (which coverage would be retroactive to the date of loss of GHP coverage); and (3) terminating COBRA coverage once the Marketplace QHP coverage begins.

Medicare and Marketplace Coverage

Individuals losing GHP coverage who are also enrolled in Medicare or are eligible for Medicare must consider the impact that Medicare has on their future health insurance coverage.

Medicare is not part of the Marketplace.[36] The Marketplaces do not sell Medicare supplemental coverage, such as Medigap policies, or Medicare Part D prescription drug plans.[37] In general, Marketplace QHPs are not appropriate for individuals with Medicare, and an individual covered under a Marketplace QHP can drop that coverage without penalty when his or her Medicare coverage begins.[38] In fact, it is illegal to sell or issue duplicate coverage (such as a Marketplace QHP) to "Medicare beneficiaries," defined as individuals who are (a) entitled to Medicare Part A; and/or (b) enrolled in Medicare Part B.[39] While certain individuals could purchase a Marketplace QHP despite their eligibility for Medicare, many employees lack the information required to make an informed decision between Medicare coverage, Marketplace coverage, or some combination of the two. However, CMS recently released special guidance, in the form of frequently asked questions, about the choice between Medicare and a Marketplace QHP.[40]

Restrictions on the Purchase of Marketplace Coverage by Medicare Beneficiaries

Individuals who have Medicare (Part A or Part B) cannot purchase new QHPs at the Marketplaces after they are enrolled in Medicare.[41] As pointed out in the Medicare FAQs, persons collecting Social Security benefits are automatically enrolled in Medicare Part A. However, a person who is eligible for Medicare, but does not yet have Medicare, can purchase a QHP. For example, the following individuals could purchase QHP coverage despite their eligibility for Medicare:

1. A person who is age 65 or older, who is *not* collecting Social Security benefits, and who has *not yet enrolled* in Medicare B.[42]
2. A person under age 65 who would be eligible for Medicare due to end stage renal disease or disability but who has *not yet enrolled* in Medicare.[43]

However, a Medicare-eligible person who delays enrollment in Medicare because he/she has coverage under a Marketplace QHP could later face enrollment and penalty issues under Medicare. Specifically, if a Medicare-eligible individual does not enroll in Medicare during his or her "initial enrollment period" (i.e., when he or she first becomes eligible), the individual cannot enroll in Medicare until the next general enrollment period, which runs from January 1 to March 31 for coverage that does not begin until July of that year.[44] On top of that, the individual may have to pay late enrollment penalties, which increase the premiums for Medicare coverage, due to the late enrollment in Medicare.[45]

It is important note that these rules are different if a Medicare-eligible person is enrolled in a GHP, rather than a Marketplace QHP, when the individual is first eligible for Medicare. Such Medicare-eligible persons have a special enrollment period in which to enroll in Medicare after their GHP coverage terminates, and, if they enroll during such special enrollment period, they will not incur later enrollment penalties.[46]

There are a couple of exceptions to these rules. A Medicare beneficiary can purchase stand-alone dental plans that may be available at the Marketplace. However, not every Marketplace offers stand-alone dental plans, and none of the FFMs do.[47] In addition, a person who already has Marketplace QHP coverage at the time that he or she becomes a Medicare beneficiary may continue to purchase the QHP coverage that he or she was enrolled in at the time the person acquired Medicare (a "preexisting QHP").[48] In fact, an insurer is prohibited from terminating a person's preexisting QHP coverage due to that person's becoming eligible for Medicare.[49]

Although a Medicare beneficiary is allowed to keep his or her preexisting QHP coverage, it may not always be in the person's best interest to do so. First, the federal subsidies the individual received under a preexisting QHP will end following his or her enrollment in Medicare if the individual's Medicare coverage is MEC.[50] Medicare Part A by itself is considered to be MEC, but Medicare Part B by itself is not.[51] Therefore, an individual who enrolls only in Medicare Part B could continue to receive the

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federal subsidies for a preexisting QHP. But an individual who has Medicare Part A (including one who enrolls in both Medicare Parts A and B) will no longer receive federal subsidies for his or her preexisting QHP. Second, preexisting QHP coverage may not be worthwhile because of Medicare rules coordinating payment of benefits. Specifically, Medicare pays primary to the QHP.[52] This means that it may be less expensive for some individuals to purchase a Medicare supplemental policy (like Medigap) instead of paying the premiums for their preexisting QHP.[53]

Finally, drug coverage under the preexisting QHP might not count as creditable coverage for purposes of Medicare Part D. There is no requirement that prescription drug coverage offered under a Marketplace QHP be creditable coverage (i.e., at least as good as Medicare's prescription drug coverage) for purposes of Medicare Part D.[54] Individuals with a preexisting QHP that is not creditable coverage would be subject to late enrollment penalties if they do not enroll in Medicare Part D when they first become eligible.[55]

Conclusion

The interplay among the complex federal rules for Marketplace QHPs, COBRA and Medicare will continue to pose challenges for individuals transitioning from GHP coverage to the Marketplace, and for the employers and medical providers seeking to help them with these important coverage decisions. The increasing number of choices available to Americans will force employees and patients to increase their understanding of the differences among these options and to become better consumers when purchasing health insurance for themselves and their families.

Howard D. Bye-Torre is an attorney in the Seattle office of Stoel Rives LLP whose practice centers on compliance issues for group health and other welfare plans. Mr. Bye-Torre has written and spoken on healthcare reform, Medicare, COBRA, HIPAA, wellness programs, domestic partnership and same-sex marriage benefits issues and other state and federal law benefit topics. He serves on the Editorial Board of the Health Lawyer and is a contributing author to two publications of the Employee Benefits Institute of America ("EBIA"): "Employee Benefits for Domestic Partners: Design, Taxation, and Administration," and "Group Health Plans: Federal Mandates Other Than COBRA & HIPAA." He can be reached at 206-386-7631 or *howard.bye-torre@stoel.com*.

Kiran H. Griffith (nee Kiran Hashmi) is an attorney in the Seattle office of Stoel Rives LLP. She assists clients on employee benefit matters including health, cafeteria, and other welfare plans. In addition to her work in health and welfare, Ms. Griffith advises clients on qualified retirement plans. She can be reached at 206-386-7583 or *kiran.griffith@stoel.com*.

Endnotes

1 COBRA, a federal law, requires most group health plans to offer 18 to 36 months of continuation coverage when a "qualified beneficiary" loses GHP coverage due to a "qualifying event." 26 U.S.C. § 4980B(f).

2 *See, e.g.*, IRS Notice 2014-55, Cafeteria Plans — additional permitted election changes (Sept. 2014) [hereinafter "IRS Notice 2014-55"]; Dep't of Health & Human Svcs., "Special Enrollment Periods and Hardship Exemptions for Persons Meeting Certain Criteria," at 2 (May 2, 2014); Dep't of Labor, "Model COBRA Continuation Coverage Election Notice" (May 2, 2014); Ctrs. For Medicare & Medicaid Svcs., Frequently Asked Question, FAQ ID 1496 (April 21, 2014), available at https://regtap.info/faq_printe.php?id=1496.

3 HHS readily concedes that the former Model COBRA Continuation Coverage Election Notice did not address, or perhaps did not sufficiently address, the Marketplace options available to persons eligible for COBRA coverage. Dep't of Health & Human Svcs., "Special Enrollment Periods and Hardship Exemptions for Persons Meeting Certain Criteria," at 2 (May 2, 2014) [hereinafter "HHS May 2014 Notice"] (providing additional special enrollment period through July 1, 2014, for COBRA-eligible individuals to enroll in the Marketplace).

4 October 1, 2013, through March 31, 2014. 45 C.F.R. § 155.410(b).

5 If a state chose not to establish and operate a Marketplace, the federal government established and operates the Marketplace in that state. 45 C.F.R. § 155.105(f). Only 13 states and the District of Columbia have SBMs; the remaining states have a FFM. According to HHS, as of May 1, 2014, over 8 million people purchased Marketplace coverage for 2014 — nearly 2.6 million in the SBMs, and 5.4 million in the FFMs. Dep't of Health & Human Svcs., Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period, at 12 (May 1, 2014). Approximately 6.7 million individuals who went to a Marketplace were determined to be eligible for Medicaid or CHIP. *Id.* at 8. More information about the first annual open enrollment statistics can be found at www.aspe.hhs.gov/health/reports/2012/ACA-Research/index.cfm.

6 Coverage will be effective as early as January 1 for applications submitted by December 15, 2014. Coverage will be effective February 1 for applications submitted from December 16, 2014, to January 15, 2015, and effective March 1 for applications submitted after January 15, 2015. 45 C.F.R. § 155.410(e), (f). CMS has proposed to change the Marketplace open enrollment period for 2016 (and years thereafter) to October 1 to December 15. Thus, if adopted, the open enrollment period for 2016 would be October 1, 2015 to December 15, 2015. 79 Fed. Reg. 70673, 70752 (November 26, 2014).

7 The following coverage qualifies as "minimum essential coverage" under IRC § 5000A(f)(1): government-sponsored coverage such as Medicare Part A, Medicaid, CHIP, and TRICARE; eligible employer-sponsored coverage such as GHP; health coverage provided in the individual market, including through a Marketplace; grandfathered health plans; and other health coverage that HHS recognizes, such as refugee medical assistance and Medicare Advantage plans. Minimum essential coverage does *not* include certain excepted benefits, such as limited-scope vision plans or limited-scope dental plans.

8 A "qualified health plan" is a health insurance plan that provides a package of "essential health benefits," like inpatient hospital care, preventive services, emergency benefits, prenatal and postnatal care, treatment for mental health and substance abuse, and prescription drugs. To constitute a QHP, the health insurance plan must comply with certain accreditation requirements and be certified by the Marketplace. PPACA, Pub. L. No. 111-148, § 1301(a) (2010).

[9] *See* IRC § 36B (outlining the conditions to receive a premium tax credit to help pay for Marketplace coverage).

[10] 45 C.F.R. § 155.420.

[11] 45 C.F.R. § 155.420(c).

[12] 45 C.F.R. § 155.420(c)(2).

[13] HIPAA is the federal Health Insurance Portability and Accountability Act, Pub. L. No. 104-191 (Aug. 21, 1996). HIPAA's portability rules, aimed at helping employees maintain health coverage and benefits as they move from job to job, are found in ERISA §§ 701–734, IRC §§ 9801–9833 and 4980D, and in the Public Health Service Act ("PHSA") §§ 2704–2705, 2722–2724 and 2791–2792. HIPAA also addresses a number of other topics, such as the privacy and security of protected health information.

[14] *See* 26 U.S.C. § 9801(f), ERISA § 701(f) and PHSA § 2704(f).

[15] Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3 §311 (2009). For more information about CHIP, see www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/Childrens-Health-Insurance-Program-CHIP.html.

[16] *Id*. States have the option of adopting a program under which Medicaid or CHIP will pay all or part of the premium for employer-sponsored GHP coverage.

[17] 26 U.S.C. § 9801(f), ERISA § 701(f) and PHSA § 2704(f); *see also* 26 C.F.R. § 54.9801-6; 29 C.F.R. § 2590.701-6; 45 C.F.R. § 146.117. The special enrollment period for the loss of Medicare or CHIP coverage and new eligibility for premium assistance from Medicare and/or CHIP is 60 days. 26 U.S.C. § 9801(f), ERISA § 701(f) and PHSA § 2704(f).

[18] The cutoff date for when coverage can be available the first day of the first month following the triggering event varies by Marketplace. For FFMs, an application must be received by the fifteenth day of the month for coverage to be effective the first day of the first month. 45 C.F.R. § 155.420(b). The effective date of coverage under the HIPAA special enrollment rights is the first day of the month following the request for enrollment, except that enrollment due to birth, adoption or placement for adoption must be effective as of the date of birth, adoption or placement for adoption. 26 U.S.C. § 9801(f), ERISA § 701(f) and PHSA § 2704(f).

[19] As long as the employer offers GHP coverage to its full-time employees (and their children) that provides minimum value and for which the employee-only premium is affordable, the employer will not incur a pay-or-play penalty, even if the employee decides to purchase insurance at a Marketplace. Code § 4980H.

[20] Part-time employees whose employers offer inferior health insurance to part-timers may often find that the Marketplace coverage is better for them and their families.

[21] Treas. Reg. § 1.125-2.

[22] Treas. Reg. § 1.125-4.

[23] IRS Notice 2014-55.

[24] This rule is of special interest to employers using the look-back measurement periods and stability periods allowed under the employer shared responsibility ("pay-or-play") regulations. Treas. Reg. § 54.4980H-3(d). To avoid a possible pay-or-play penalty, the employer must continue to offer GHP coverage to an employee during a stability period, even if that employee's hours dropped to only a few hours a week. Treas. Reg. § 54.4980H-3(d)(1)(i). However, if an employee's work hours are reduced during the stability period, the employee may wish to move to a Marketplace QHP, and this second exception allows the employee to do so.

[25] Under PPACA's individual mandate, most Americans are required to have health insurance to avoid a tax penalty. 26 U.S.C. § 5000A(a).

[26] The loss of GHP coverage could also trigger a Marketplace special enrollment right due to new eligibility for federal Marketplace subsidies. Loss of GHP coverage might also trigger a HIPAA special enrollment right to enroll in a GHP sponsored by the employer of the employee's spouse or parent.

[27] 26 C.F.R. § 1.36B-2(c)(3)(iv). Other types of continuation coverage include, for example, continuation coverage available to employees who go on military leave and their dependents under the federal Uniformed Services Employment and Reemployment Rights Act, 38 U.S.C. §4301 *et seq*.

[28] 26 U.S.C. § 4980B(f)(2)(C).

[29] 26 U.S.C. § 4980B(f)(5).

[30] Treas. Reg. § 54.4980B-6, Q/A-3(a).

[31] 45 C.F.R. § 155.420(d)(1).

[32] 45 C.F.R. § 155.420(e)(1).

[33] Some analysts have suggested that the Marketplace special enrollment right following an individual's becoming newly eligible or ineligible for federal subsidies could be one way a COBRA-covered individual could get to the Marketplace sooner. This possibility is discussed at the end of this section.

[34] 45 C.F.R. § 146.117(a)(4)(i).

[35] 45 C.F.R. § 155.420(b)(2)(iv).

[36] Frequently Asked Questions Regarding Medicare and the Marketplace, at C.1 (Aug. 1, 2014), available at http://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Downloads/Medicare-Marketplace_Master_FAQ_8-28-14_v21.pdf [hereinafter "Medicare FAQs"] (last visited November 7, 2014).

[37] Medicare FAQs, at C.3.

[38] Medicare FAQs, at C.2 & C.10.

[39] SSA, § 1882(d); Medicare FAQs, at A.1 & A.3. Persons become entitled to Medicare Part A either by (1) paying a Part A premium, or (2) automatically collecting Social Security benefits.

[40] *See* Medicare FAQs, *supra* note 36.

[41] Medicare FAQs, at A.1.

[42] Medicare FAQs, at A.14.

[43] Medicare FAQs, at B.2.

[44] Medicare FAQs, at A.6.

[45] *Id*.

[46] Medicare FAQs, at A.10.

[47] Medicare FAQs, at A.7. In the FFMs, standalone dental plan coverage is available only as an add-on to comprehensive QHP coverage.

[48] Medicare FAQs, at A.8.

[49] Medicare FAQs, at C.7.

[50] Medicare FAQs, at A.8.

[51] Medicare FAQs, at A.5 & A.8.

[52] Medicare FAQ, at D.1.

[53] Remember, however, that Medigap policies are not sold in the Marketplaces.

[54] Medicare FAQs, at A.11.

[55] Medicare FAQs, at A.12.