access health CT

Connecticut's Health Insurance Marketplace

EMPLOYER MANDATE APPEAL REQUEST FORM

Employer Mandate and Appeal Process

Should an employer wish to appeal an employee's eligibility for tax credits, AHCT requires that the company complete this appeals request form and submit it, by email, to Access Health at ExemptionsAndAppeals.ahct@ct.gov. A valid appeal must contain a complete appeal form and sufficient, up-to-date proof of the existence of the employer's Affordable, Minimum Value plan and proof that the employee and their dependents under age 26, if applicable, were offered enrollment in such plan. The specific documents that will be accepted are listed below. Other documents may qualify, but only with prior approval.

A complete and valid appeal must be received within 90 days from the date on the letter Access Health sent you regarding your employee's enrollment with Access Health. Once a valid appeals package has been received by Access Health, we will send the employer and your employee who enrolled with tax credits notice of the active appeal and more information about the appeals process.

If no valid appeal is submitted during this period or if the appeal is not granted, the employer may also have an opportunity to defend against any potential tax penalties through the tax filing process or through the process outlined in subtitle F of the Internal Revenue Service (IRS) Code.

If Access Health determines that, based on the information provided, your company does and did offer Affordable, Minimum Value health insurance coverage to the employee and their child dependents under the age of 26, your company's Employer Mandate tax penalties, if any, may be diminished or eliminated.

Regardless of the decision rendered in this Appeal, should the IRS determine that your business is not and/or did not offer Affordable, Minimum Value health insurance coverage to your employee(s) and their child dependents under the age of 26, the IRS may levy Employer Mandate tax penalties under Chapter 26, Section § 54.4980H of the U.S. Code. This Appeal does not remove any IRS tax filing requirements or liability that may exist for your business.

Employer Information

Please fill out all information fields below. Fields marked with an asterisk (*) are required.

Employer name*		Employer Identification Num. (EIN)*
Employer Address*		Phone Number (inc. area code)* ( )
City*	State*	Zip Code*
Who can we contact about employee health coverage at this job?		
Phone number (if different from above) ( )	Email address*	
Employee Application ID (located in the upper right corner of the "Notice of Employee Eligibility for Premium Assistance" letter your business received)*		

Number of Full-Time Equivalent Employees: (See http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers)

Appeal Reason

☐ 1. The employee listed on the "Notice of Employee Eligibility for Premium Assistance" I received is not and was not for any part of the current coverage year a full-time employee employed by the above listed business

☐ 2. The business listed above sponsors and timely offered Affordable and Minimum Value health insurance coverage to the employee listed on the "Notice of Employee Eligibility for Premium Assistance" I received.

☐ 3. The business listed above sponsors and timely offered Affordable and Minimum Value health insurance coverage to the child dependents of the employee listed on the "Notice of Employee Eligibility for Premium Assistance" I received.

If you would like to provide us with additional information, you may (but are not required to) do so in the space provided below:

I am requesting an appeal because:

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(Please use the back of this form if you need more room to write.)

Information about Coverage Offered

1. Are the employee and their child dependents currently eligible for coverage offered by this employer?
   - ☐ Yes, employee is currently eligible to join employer-sponsored health insurance plan
   - ☐ No, employee is not currently eligible to join employer-sponsored health insurance plan

   1a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee next eligible for coverage? ________________________(mm/dd/yyyy)

2. What is the premium cost of the least expensive employee-only plan (don't include family coverage price) offered by the employer to the employee that meets the Minimum Value standard
   a. How much would the employee have to pay in premiums for this plan? $________________

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the current plan year for the employer-sponsored coverage referenced above will end before the end of the current calendar year (prior to Dec. 31st of the current year) and you know that the health plans offered or to whom they will be offered will change, please answer the following questions.

3. What change will the employer make for the new plan year?
   - ☐ Employer won't offer health coverage
   - ☐ Employer will start offering health coverage to employees and their child dependents or will change the premium for the lowest-cost plan available only to the employee that meets the Minimum Value standard

   a. How much would the employee have to pay in premiums for this new plan? $_____________
   b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Eligible Supporting Documents

Documents from both sections 1 and 2 below must be provided along with this Appeal

1. **Proof of Minimum Value Offering**

- A copy of the Coverage Options Letter (OMB No. 1210-0149, see http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf) or similar letter with proof that the letter was given to the employee.

OR

- Proof of active employer provided coverage and a history showing the months that coverage was active (history should show plan existence for last 12 months, or for the entire duration of the plan if it has been active for shorter than 12 months).
  - Must include proof that plan was offered to employee and their child dependents
  - History can be shown by plan documents or by a bank/credit account history showing qualifying payments from/on behalf of the employer with carrier name clearly shown

OR

- Minimum Value Calculator output showing that the plan details meet Minimum Value along with a copy of the plan documents in order to corroborate such inputs and proof that the plan was offered to the employee and any dependents under age 26. See this link for the Minimum Value Calculator.

OR

- ○ Statement from carrier which states the plan was offered and that the plan has an actuarial value of at least 60% (Bronze plan level), and, if applicable, proof that plan was offered to employee(s) and any dependent(s) under age 26.

2. **Proof of Affordable Offering**

- A monthly accounting of the W-2 wages for the employee for each month of the prior plan year. (Form W-2 wages are the amount of wages paid to the employee that are reported in Box 1 of that employee's Form W-2.) (Box 1 amount should be the value prior to any elective deferrals to a 401(k), 403(b) or cafeteria plan (such as a health plan)).

AND

- For the prior plan year, a monthly accounting of what the employee's share of the premium cost of the plan would be for self-only coverage (that is, not including any cost for coverage of dependents). If the employer offered more than one plan in 2014, the employer must provide what the employee's share of the premiums of the lowest-cost plan would be for self-only coverage

I attest that the information I provided in this Employer Mandate Appeal Request Form is true and accurate:

Employer Name: ________________________________

Attested By: __________________________________ Date: ______________________
Name:
Title:

Where Do I Send This Form?

You may send a completed Form to us in one of the following ways:

1. By email: ExemptionsAndAppeals.ahct@ct.gov

How Can I Contact Access Health CT?

Contact us if you have any questions about this Form or if you need assistance in filling out this Form. You can contact us in any of the following ways:

- By calling Access Health CT Appeals at 1-860-757-6841. For those individuals who are deaf or hard of hearing, the TTY number 1-855-789-2428.
- By email, exemptionsandappeals.ahct@ct.gov.