

# PPACA Update – Local Ed & Local Government

- Federal Marketplace Notice
- Marketplace Letter from Feds
- New Hire Notifications
- FT Rehire
- Marketplace Appeal Letter
- Edison Reporting

# Federal Marketplace Notice

## Local Education:

[https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/marketplace\\_le.docx](https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/marketplace_le.docx)

## Local Government:

[https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/marketplace\\_lg.docx](https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/marketplace_lg.docx)

# Marketplace Letter from Feds

 Health Insurance Marketplace  
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
465 INDUSTRIAL BOULEVARD  
LONDON, KY 40750-0001

B8373-5L P-01006 T-0267 00058261 1 AT 300  
STATE OF TENNESSEE  
BENEFITS MANAGER  
500 JAMES ROBERTSON PKWY  
NASHVILLE, TN 37243-1204



# New Hire Notifications

All benefits-eligible new hires must be offered insurance

**Pre-Enrollment Benefits Information letter (State)**

[https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/abc\\_pre\\_employment\\_document.docx](https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/abc_pre_employment_document.docx)

**Orientation Presentation -**

[https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/new\\_employee\\_presentation\\_le\\_lg\\_notes\\_2018.pdf](https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/new_employee_presentation_le_lg_notes_2018.pdf)

**Checklist-**

[https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/abc\\_checklist\\_le.pdf](https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/abc_checklist_le.pdf)

[https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/abc\\_checklist\\_lg.pdf](https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/abc_checklist_lg.pdf)



# Full-Time Rehires

- If an employee terminates employment and is rehired within 13 weeks, you are required to begin their insurance no later than the first of the month following their reinstatement of employment.

# Marketplace Appeal Letter



Health Insurance Marketplace



4/2016

Form Approved  
OMB No. 0938-1213

## Instructions to help you complete the Employer Appeal Request Form



### Using this form

- If you received a Marketplace notice stating that you may be subject to the Employer Shared Responsibility Payment, you can request an appeal by submitting this form or mailing in a letter that includes the information requested on this form.

Use this form if you're appealing a notice you received from:

- The federally-facilitated Health Insurance Marketplace
- A state-based Marketplace operating in:

California	Maryland
Colorado	Massachusetts
District of Columbia	New York
Kentucky	Vermont

This appeal may determine if an employee was eligible for help with the costs of coverage through the Marketplace at the same time that you may have offered them affordable health coverage that met the minimum value standard. **This appeal will NOT determine if your organization has to pay the Employer Shared Responsibility Payment.** Only the Internal Revenue Service (IRS), not the Health Insurance Marketplace or the Marketplace Appeals Center, can determine which employers are subject to the Employer Shared Responsibility Payment as stated under section 4980H of the Internal Revenue Code.

**IMPORTANT:** For 2015, the Employer Shared Responsibility Payment will generally apply to employers with 100 or more full-time equivalent (FTE) employees, and may apply to certain employers with 50 or more FTE employees. **Starting in 2016**, the Employer Shared Responsibility Payment will apply to employers with 50 or more FTE employees.

- If you want to appeal a Small Business Health Options Program (SHOP) eligibility decision, visit [HealthCare.gov/small-businesses/provide-shop-coverage/appeal-a-shop-decision/](http://HealthCare.gov/small-businesses/provide-shop-coverage/appeal-a-shop-decision/) for more information.



# Marketplace Appeal Letter



## Timeframe to request an appeal

You must submit your appeal request form **within 90 days** of the date of your Marketplace notice.



## Designating a secondary contact

You may authorize a secondary contact to help with your appeal. The secondary contact may act on your behalf, talk with the Marketplace Appeals Center, view your case file, and receive all correspondence regarding your appeal. To authorize a secondary contact complete **Section 2: Designate a secondary contact**.



## How to submit this form

Complete and sign this form, and mail it with copies of any supporting documents to the address shown below.

**Health Insurance Marketplace  
Dept. of Health and Human Services  
465 Industrial Blvd.  
London, KY 40750-0061**

You may also fax the form to a secure fax line: 1-877-369-0129.

You'll receive all future correspondence about this appeal from the Marketplace Appeals Center. The Marketplace Appeals Center is different from the Health Insurance Marketplace.

# Marketplace Appeal Letter



## What happens next?

1. We'll send you a notice letting you know that that we received your appeal request. If there's a problem with the appeal request, we'll tell you how to correct the issue. We'll also send a notice to the employee listed on the notice you received from the Marketplace.
2. We'll review your appeal including any additional documentation provided by you and/or the associated employee. We may request additional information.
3. We'll send appeal decision notices explaining the outcome of our review to you and to the associated employee.



## Additional help

### Language assistance services

If you need language assistance in a language other than English, you have the right to get help and information in your language at no cost. Call the Marketplace Call Center at 1-800-318-2596.

### Accessibility

To request an auxiliary aid or service, you can:

- Call 1-844-ALT-FORM (1-844-258-3676). TTY users should call 1-844-716-3676.
- Send a fax to 1-844-530-3676.
- Send an email to: [AltFormatRequest@cms.hhs.gov](mailto:AltFormatRequest@cms.hhs.gov)
- Use this address only to send a letter requesting an auxiliary aid or service:  
Centers for Medicare and Medicaid Services  
Office of Equal Employment Opportunity & Civil Rights (OEOCR)  
7500 Security Boulevard, Room N2-22-16  
Baltimore, MD 21244-1850  
Attn: CMS Alternate Format Team



To submit your appeal request, see **How to submit this form** on page 1 of these instructions. Don't use **Accessibility** contact information to submit an appeal request.

## Questions

Contact the Marketplace Appeals Center at 1-855-231-1751. TTY users should call 1-855-739-2231. Hours of operation are Monday through Friday, 7:30 a.m. to 8:30 p.m. Eastern Time (ET); and Saturday, 10:00 a.m. to 5:30 p.m. ET.

# Marketplace Appeal Letter



Health Insurance Marketplace



Page 1 of 2

## Employer Appeal Request Form

Form Approved  
OMB No. 0938-1213  
Appeal Request Form – Employer

Use this form to appeal a Marketplace determination that an employee was eligible for advance payments of the premium tax credit and cost-sharing reductions (if applicable) in part because your business didn't offer health coverage that met minimum value requirements and was affordable with respect to this employee.

Please print in capital letters using black or dark blue ink only.

### SECTION 1: Tell us about the employer who's requesting this appeal.

1. Business Name			Federal Employer ID Number (EIN)	
Primary business mailing address			Suite #	
City	State	ZIP code		
Name of the primary contact (First name, Middle initial, Last name)			Phone number	
Title of primary contact				
Primary business mailing address			Suite #	
City	State	ZIP code	Phone number	

# Marketplace Appeal Letter

## SECTION 2: Designate a secondary contact. (optional)

This is someone who may act on your organization's behalf regarding this appeal request.

Name of the secondary contact (First name, Middle initial, Last name)			Phone number
<input type="text"/>			<input type="text"/>
Organization name (if applicable)			Title
<input type="text"/>			<input type="text"/>
Secondary contact mailing address			Suite #
<input type="text"/>			<input type="text"/>
City	State	ZIP code	Phone number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

# Marketplace Appeal Letter

## SECTION 3: Tell us why you're appealing the Marketplace determination of this employee's eligibility for help with the costs of Marketplace coverage.

What's the date on the Marketplace notice? (mm/dd/yyyy)

 /  / 

What's the employer's first and last name?

What's the employer's date of birth (if available)?

 /  / 

What's the employer's Application ID # (if available on your notice)?

An individual may qualify for help with the costs of Marketplace coverage if the coverage that's offered by an employer doesn't meet minimum value requirements or isn't affordable with respect to the employee.

Use the space below to explain why this employee shouldn't have been eligible for advance payments of the premium tax credit and cost-sharing reductions (if applicable). Use extra paper, if necessary. If you're including documents to support your request, send us copies. Keep all original documents.

## SECTION 4: Signature

By completing, signing, and dating below, I authorize the Marketplace Appeals Center to perform a review of whether the employer named on this form offered minimum essential coverage through an employer-sponsored plan that's considered affordable with respect to the relevant employee, and meets the minimum value standard.

I understand I may request a copy of my Marketplace appeal record and that certain information about the relevant employee's eligibility determination may or may not be made available to me as described in 45 CFR §155.555(g)(2) and 45 CFR §155.555(h).

By signing this form under penalty of perjury, I declare that I've provided true answers to all the questions that I've answered to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false information.

### Signature

1. Printed name of primary contact (First name, Middle name, Last name)

Title

Signature

Date (mm/dd/yyyy)

 /  /

# Marketplace Appeal Letter

[REDACTED] is a full-time benefit eligible State of Tennessee employee. She was covered by the State's health insurance in CY 2015 but waived coverage for CY2016 using Employee Self Service during Annual Enrollment on 9/25/2015 at 8:22 am (see attached audit copy). The State's health insurance meets the minimum essential coverage requirement and affordability test. [REDACTED] monthly salary in 2016 was \$1,856 and as of June 1st is \$1,975. The State offers a CDHP/HSA product for \$81 a month premium for employee only coverage. The State is using the Rate of Pay Safe Harbor for the Affordability test and it is calculated based on the salary at the beginning of the plan year. The premium of \$81 using \$1856 is 4.3% [REDACTED] salary and is below the 9.5% requirement. The State is appealing the decision because [REDACTED] is eligible for the state's health insurance and chose to waive it and is not eligible for advance payments or cost-sharing reductions.

# Marketplace Appeal Letter

Health Insurance Marketplace  
Dept. of Health & Human Services  
P. O. Box 311  
Pittston, PA 18640  
Fax: 877-369-0129

Appeal Case ID: **APL-XXXXXX**

Dear Appeals Department:

The State should not be liable for a penalty because Ms. XXX XXX, a State of Tennessee employee had access to affordable health care coverage from the State of Tennessee that met the minimum value standard in 2016.

As proof of this, we are providing:

Documents showing that employer-sponsored coverage was offered to the employee in 2016

- Employee's Health Enrollment record showing an effective date of coverage of 11/1/2014
- Employee's Health Enrollment record showing coverage was waived effective 1/1/2016
- The Audit report showing the employee waived coverage using Employee Self Service on 9/25/2015 at 8:22 AM
- Confirmation Statement issued 12/14/2015 confirming no elections of health insurance with an effective date of 1/1/2016

Documents showing the employee's job-based income and frequency of payment

- Copy of employee's pay stubs

Documents showing the employee's required share of the premium amount for the lowest cost self-only plan offered to the employee for 2016

- Rate sheet of employer-sponsored coverage offered to employee

Document showing that the lowest cost self-only plan being offered to the employee for 2016 meets the minimum value standard

- Report of Minimum Value certification from an actuary accredited by the AAA

# Marketplace Appeal Letter

Documents showing that employer-sponsored coverage was offered to the employee in the year in question - Edison Health Benefits Page



Health Benefits

Employee ID: Benefit Record: 0

**Plan Type** Find | View All First 1 of 4 Last

Plan Type: 10 Medical

**Coverage** Find | View All First 2 of 2 Last

\*Coverage Begin Date: 11/01/2014 \*Deduction Begin Date: 10/01/2014

**Coverage Election**

Elect  Waive  Terminate \*Election Date: 11/15/2014

Benefit Program:

Benefit Plan: PPPV3M Option Code:

Coverage Code: A Single

Health Provider ID:   Previously Seen

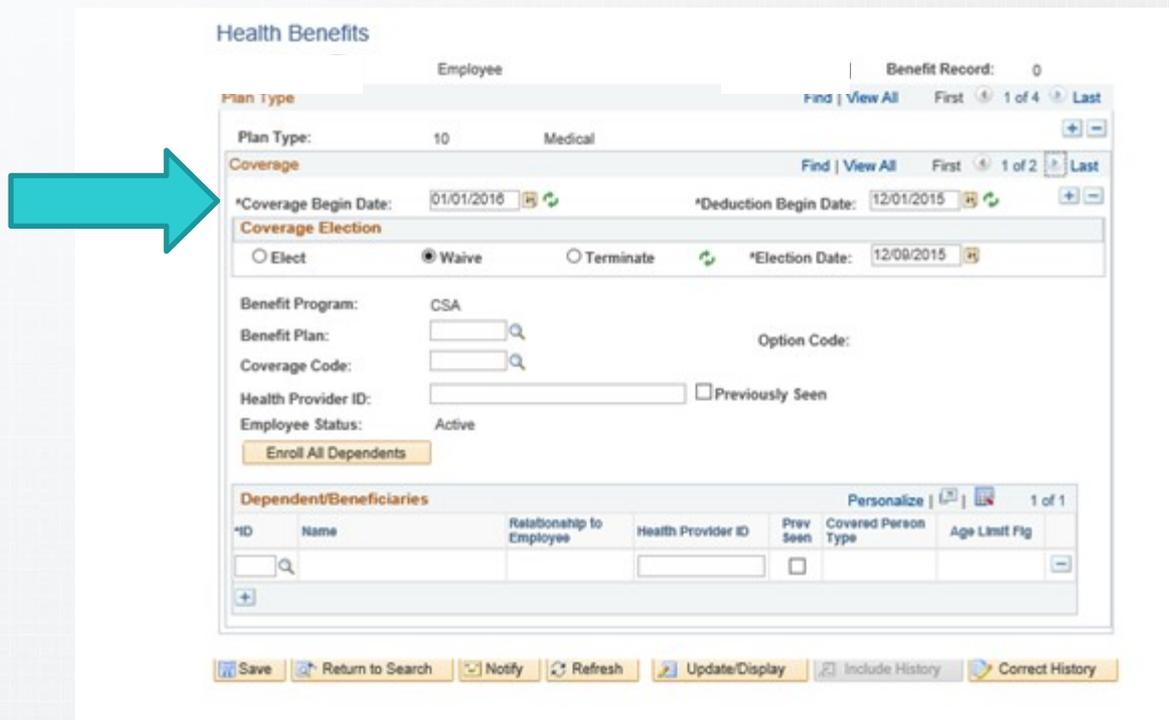
Employee Status:

**Dependent/Beneficiaries** Personalize 1 of 1

ID	Name	Relationship to Employee	Health Provider ID	Prev Seen	Covered Person Type	Age Limit Flg
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

# Marketplace Appeal Letter

Documents showing that employer-sponsored coverage was offered to the employee in the year in question - Edison Health Benefits Page



The screenshot displays the 'Health Benefits' page for an employee. The page is titled 'Health Benefits' and shows the employee's name as 'Employee'. The 'Benefit Record' is 0. The 'Plan Type' is 10 Medical. The 'Coverage' section shows a 'Coverage Begin Date' of 01/01/2016 and a 'Deduction Begin Date' of 12/01/2015. The 'Coverage Election' section shows the 'Elect' option selected, with an 'Election Date' of 12/09/2015. The 'Benefit Program' is CSA. The 'Benefit Plan' and 'Coverage Code' fields are empty. The 'Health Provider ID' field is empty, and the 'Previously Seen' checkbox is unchecked. The 'Employee Status' is Active. There is an 'Enroll All Dependents' button. The 'Dependent/Beneficiaries' section shows a table with columns for ID, Name, Relationship to Employee, Health Provider ID, Prev Seen, Covered Person Type, and Age Limit Flg. The table is currently empty. At the bottom of the page, there are buttons for Save, Return to Search, Notify, Refresh, Update/Display, Include History, and Correct History.

Health Benefits

Employee | Benefit Record: 0

Plan Type: 10 Medical

Coverage: 1 of 2

\*Coverage Begin Date: 01/01/2016 \*Deduction Begin Date: 12/01/2015

Coverage Election

Elect  Waive  Terminate \*Election Date: 12/09/2015

Benefit Program: CSA

Benefit Plan: [Search]

Coverage Code: [Search]

Health Provider ID: [Search]  Previously Seen

Employee Status: Active

Enroll All Dependents

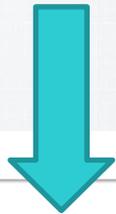
Dependent/Beneficiaries

ID	Name	Relationship to Employee	Health Provider ID	Prev Seen	Covered Person Type	Age Limit Flg
[Search]			[Search]	<input type="checkbox"/>		[Search]

Save Return to Search Notify Refresh Update/Display Include History Correct History

# Marketplace Appeal Letter

Documents showing that employer-sponsored coverage was offered to the employee in the year in question - Edison ESS Audit Query TN\_BA133\_AUDIT\_OPEN\_ENRL\_ESS



TN\_BA133\_AUDIT\_OPEN\_ENRL\_ESS - Audit OE Self-Service Changes

Empl ID:

[View Results](#)

Download results in: [Excel Spreadsheet](#) [CSV Text File](#) [XML File \(2 kb\)](#)

View All First 1-6 of 6 Last

ID	Empl Record	Dep/Benefit	Empl or Dep Name	Plan Typ	Action	Plan	Descr	Covg Cd	Ann Pkdg	Sched ID	Date/Time	Elect After Submit
1		0.00		10	Waive					0.00 OES15	09/25/2015 8:22:18AM	
2		0.00		11	Waive					0.00 OES15	09/25/2015 8:22:18AM	
3		0.00		14	Elect	VSEXP	Vision Expanded	D		0.00 OES15	09/25/2015 8:22:18AM	
4		0.00		20	Elect	FB04DU	EE + CH Basic Life and ADD			0.00 OES15	09/25/2015 8:22:18AM	
5		0.00		60	Waive					0.00 OES15	09/25/2015 8:22:18AM	
6		0.00		61	Waive					0.00 OES15	09/25/2015 8:22:18AM	

# Marketplace Appeal Letter

## Documents showing that employer-sponsored coverage was offered to the employee in the year in question - Confirmation Statement

12/14/2015

Employee 1  
Agency:

**RE: BENEFITS ENROLLMENT INFORMATION**

This letter is to let you know that your benefits enrollment/change request has been processed. Below you will find a summary of the benefits selections you made. It shows each benefit you have been enrolled in, the coverage tier for those benefits, and the date each benefit takes effect.

**Please look at this summary and make sure that all the information is correct and complete.**

If you have any questions about the information below, please contact Benefits Administration at **615-741-3590** or **1-800-253-9981** Monday through Friday from 8 a.m. to 4:30 p.m. Central time within 31 days of the date of this letter.

If you are Medicare eligible active employee, you receive prescription benefits through the State plan. If you retire and choose to elect Medicare Part D, you can find the letter to provide as proof of prescription coverage at [http://www.tn.gov/assets/entities/finance/benefits/attachments/medicare\\_part\\_d\\_notice.pdf](http://www.tn.gov/assets/entities/finance/benefits/attachments/medicare_part_d_notice.pdf).

*Please note: If you are a state employee who chose to participate in the 401(k) or 457 savings plan, you will need to login to the Great West Retirement Services website at [www.gwrs.com](http://www.gwrs.com) to set up your investment allocations and beneficiaries. In addition, to view the coverage value of your life insurance policies, please see your member handbook at [http://www.tn.gov/finance/ins/pdf/life\\_handbook.pdf](http://www.tn.gov/finance/ins/pdf/life_handbook.pdf).*

**ENROLLMENT INFORMATION**

<u>HEAD OF CONTRACT</u>		<u>EDISON II</u>	
<u>PLAN TYPE</u>	<u>BENEFIT PLAN</u>	<u>COVERAGE TIER</u>	<u>EFFECTIVE DATE</u>
Vision	Vision Expanded	Employee + Child(ren)	01/01/2016
EAP	Magellan Behavioral Health		10/06/2014
Basic Life	Minnesota Life Insurance Company Single		01/01/2016



# Marketplace Appeal Letter

Documents showing the employee's job-based income and frequency of payment - Copy of employee's pay stubs



<b>State of Tennessee</b> 21st Floor William Snodgrass Tower, 312 Rosa L Parks Avenue Nashville, TN 37243		<b>Pay Group:</b> 7SS-Semi Monthly 7 Day Sunday-Satu <b>Pay Begin Date:</b> 08/01/2016 <b>Pay End Date:</b> 08/15/2016	<b>Business Unit:</b> <b>Advice #:</b> <b>Advice Date:</b> 08/31/2016
Nashville, TN !	<b>Employee ID:</b> <b>Department:</b> <b>Location:</b> Davidson County <b>Job Title:</b> <b>Pay Rate:</b> \$1,975.00 Monthly	<b>TAX DATA:</b>	<b>Federal</b> <b>TN State</b>
		<b>Marital Status:</b> Single <b>Allowances:</b> 2 <b>Addl. Percent:</b> <b>Addl. Amount:</b>	n/a 0



# Marketplace Appeal Letter

Documents showing the employee's required share of the premium amount for the lowest cost self-only plan offered to the employee for the year in question- Rate sheet of employer-sponsored coverage

- Current and previous year premium rates can be found on the ABC website:

<https://www.tn.gov/finance/fa-benefits/premiums.html>

# Marketplace Appeal Letter

Document showing that the lowest cost self-only plan being offered to the employee for the year in question meets the minimum value standard - Report of Minimum Value certification from an actuary accredited by the AAA

## Minimum Actuarial Value Certification

State of Tennessee  
2016 Plan Year

Risk. Reinsurance. Human Resources.

**AON**  
Empower Results®

TN

# PPACA Documents on ABC website

PPACA Documents:

[https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/marketplace\\_st.pdf](https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/marketplace_st.pdf)

[https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/marketplace\\_he.pdf](https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/marketplace_he.pdf)

[https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/marketplace\\_le.docx](https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/marketplace_le.docx)

[https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/marketplace\\_lg.docx](https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/marketplace_lg.docx)

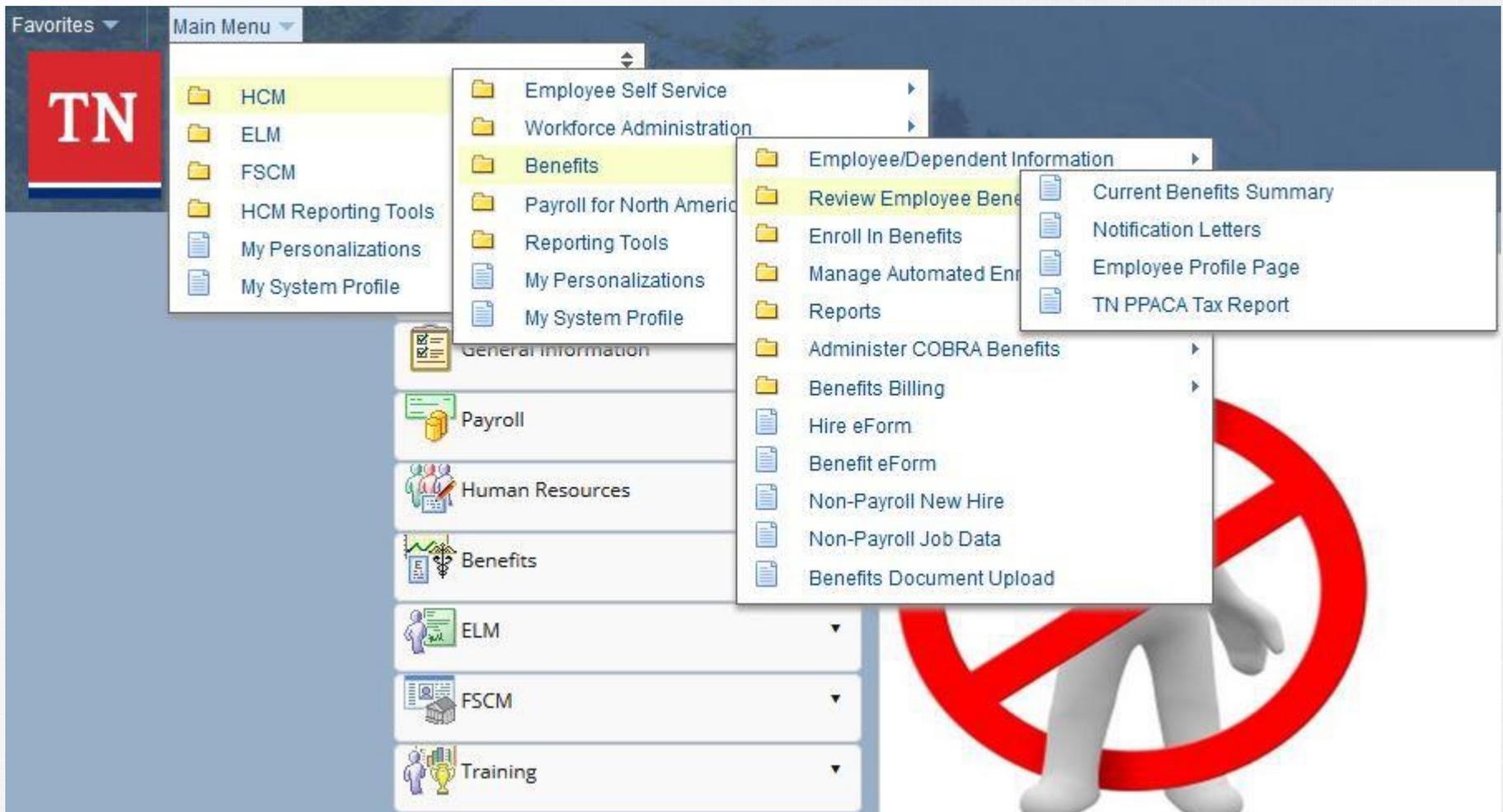
[https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/ppaca\\_full\\_to\\_part\\_time.pdf](https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/ppaca_full_to_part_time.pdf)

[https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/ppaca\\_info\\_sheet.pdf](https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/ppaca_info_sheet.pdf)

[https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/ppaca\\_minimum\\_value\\_cert.pdf](https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/ppaca_minimum_value_cert.pdf)

<http://www.tn.gov/finance/article/fa-benefits-abc>

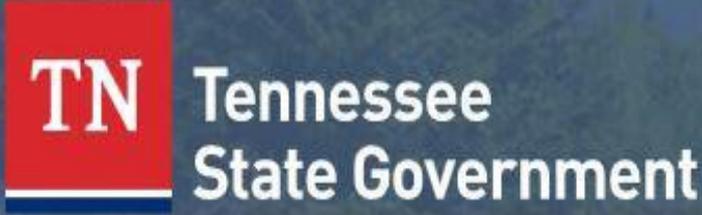
# Edison Reporting



**Main Menu > HCM > Benefits > Review Employee Benefits > TN PPACA Tax Report**

# Edison Reporting

Favorites ▾ Main Menu ▾ > HCM ▾ > Benefits ▾ > Review Employee Benefits ▾ > TN PPACA Tax Report



## TN PPACA Tax Report

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Run Control ID:  ←

**Create a new Run Control or use an existing one**

# Edison Reporting

The screenshot shows the Edison Reporting interface for the Tennessee State Government. The breadcrumb navigation at the top reads: Favorites > Main Menu > HCM > Benefits > Review Employee Benefits > TN PPACA Tax Report. The header features the TN logo and the text "Tennessee State Government". Below the header, a tab labeled "PPACA Report" is active. The main content area displays "Run Control ID: PPACA" and three buttons: "Report Manager", "Process Monitor", and "Run". A section titled "Report Request Parameters" contains a "Year" field with the value "2016". At the bottom, there are four buttons: "Save", "Notify", "Add", and "Update/Display".

Run Control ID: PPACA      Report Manager      Process Monitor      Run

Report Request Parameters

Year 2016

Save      Notify      Add      Update/Display

**Use the year for which you want to pull information**

# Edison Reporting

- The report will include active employees AND retirees
- COBRA participants will still be emailed to you in December

- **Questions?**