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The Individual Mandate

The Affordable Care Act (ACA) requires most individuals to obtain acceptable health insurance coverage for themselves and their family members or pay a penalty. This rule, which took effect in 2014, is often referred to as the "individual mandate." Individuals may be eligible for an exemption from the penalty in certain circumstances.

On July 1, 2013, the Department of Health and Human Services (HHS) released a final rule on the individual mandate, which finalized provisions in a proposed rule issued on Feb. 1, 2013. Also, on Aug. 30, 2013, the Internal Revenue Service (IRS) issued a separate final rule on the individual mandate, finalizing provisions in their proposed rule issued on Feb. 1, 2013. These final rules generally adopt the proposed standards without significant change, including:

- Exemptions from the individual mandate;
- The method for calculating the penalty; and
- Standards for designating certain coverage as constituting "minimum essential coverage."

In conjunction with the final rules, HHS issued additional guidance specifically on the hardship exemption. The IRS issued Notice 2013-42 to provide transition relief for individuals who are eligible to enroll in employer-sponsored health plans with non-calendar year plan years, as well as related questions and answers for individuals.

Finally, on Jan. 27, 2014, the IRS published another set of proposed rules that supplement and clarify the earlier final rules, as well as Notice 2014-10 to provide transition relief from the individual mandate for months in 2014 in which individuals have certain limited-benefit health coverage that is not minimum essential coverage.

HOW MUCH IS THE PENALTY?

The penalty for not obtaining acceptable health insurance coverage will be phased in over a three-year period, and is the *greater of two amounts*—the "flat dollar amount" and "percentage of income amount." For purposes of calculating the penalty, income is the taxpayer's household income minus the taxpayer's exemption (or exemptions for a married couple) and standard deductions.

The penalty starts at the greater of $95 per person or 1 percent of income for 2014. The penalty increases to $325 or 2 percent of income in 2015. In 2016 and thereafter, the penalty increases to $695 or up to 2.5 percent of income.

2014	$95 per person/1 percent of income
2015	$325 per person/2 percent of income
2016 and later	$695 per person/2.5 percent of income

Families will pay half the penalty amount for children, up to a family cap of three times the annual flat dollar amount.

Also, the penalty is **capped at the national average of the annual bronze plan premium**. IRS Rev. Proc. 2014-46 provides the 2014 national average of bronze plan premiums to be used when calculating the cap. The monthly

national average bronze plan premium for 2014 is **$204** per individual, and **$1,020** for a family with five or more members (or, annually, **$2,448** for individuals and **$12,240** for a family with five or more members).

IRS Rev Proc. 2015-15 provides the 2015 national average of bronze plan premiums to be used when calculating the cap. The monthly national average bronze plan premium for 2015 is **$207** per individual, and **$1,035** for a family with five or more members (or, annually, **$2,484** for individuals and **$12,420** for a family with five or more members).

WHO IS LIABLE FOR A PENALTY?

The penalty will be assessed against an individual for any month during which he or she does not maintain "minimum essential coverage" (MEC) beginning in 2014 (unless an exemption applies). The requirement to maintain MEC applies to all individuals of all ages (including children), unless that individual falls within a specific exception or is exempt. An individual is treated as having coverage for a month if he or she has coverage for **any one day** of that month.

Exception for Certain U.S. Citizens Living Abroad

All U.S. citizens who do not qualify for an exemption are subject to the individual mandate, regardless of whether they live in the U.S. or abroad. However, U.S. citizens who are not physically present in the United States for **at least 330 full days within a 12-month period** are treated as having minimum essential coverage for that 12-month period. In addition, U.S. citizens who are **bona fide residents of a foreign country** (or countries) for an entire taxable year are treated as having minimum essential coverage for that year.

In general, these are individuals who qualify for a foreign earned income exclusion under section 911 of the Internal Revenue Code. Individuals may qualify for this rule even if they cannot use the exclusion for all of their foreign earned income because, for example, they are employees of the United States. Individuals that qualify for this rule will not need to take any further action to comply with the individual mandate during the months when they qualify. See Pub. 54, Tax Guide for U.S. Citizens and Resident Aliens Abroad, for information on the foreign earned income exclusion.

U.S. citizens who meet neither the physical presence nor residency requirements will need to maintain minimum essential coverage, qualify for an exemption or pay a penalty for each month of the year. One exemption that may be particularly relevant to U.S. citizens living abroad for a small part of a year is the exemption for a short coverage gap, which provides that no penalty will be due for a once-per-year gap in coverage that lasts less than three months.

Minimum Essential Coverage

MEC includes coverage under:

- A **government-sponsored program**, such as coverage under the Medicare or Medicaid programs, CHIP, TRICARE and certain types of Veterans health coverage;
- An **eligible employer-sponsored plan** (including COBRA and retiree coverage), defined as any plan offered by an employer to an employee which is a governmental plan or a plan or coverage offered in the small or large group market within a state (a self-funded plan can also qualify as an eligible employer-sponsored plan);
- A **health plan purchased in the individual market**; or
- A **grandfathered health plan**.

MEC also includes any additional types of coverage that are designated by HHS or when the sponsor of the coverage follows a process to be recognized as MEC. HHS has designated the following other types of coverage as MEC:

- Self-funded student health coverage and state high risk pools for plan or policy years that begin on or before Dec. 31, 2014 (for plan or policy years that begin after Dec. 31, 2014, sponsors of self-funded student health plans and state high risk pools may apply to be recognized as MEC);

2/13; EM 1/15

- Refugee Medical Assistance supported by the Administration for Children and Families; and
- Medicare Advantage plans.

MEC excludes any coverage, whether insurance or otherwise, that consists solely of excepted benefits (as defined by HIPAA). MEC does not include specialized coverage, such as coverage only for vision or dental care, workers' compensation, disability policies or coverage only for a specific disease or condition.

Government Programs with Limited Benefits

A number of government programs do not provide full coverage for medical expenses, and thus do not qualify as MEC (for example, Medicaid coverage for pregnant women or Medicaid programs that only cover family planning services, tuberculosis-related services or emergency medical conditions). The following additional types of Medicaid coverage do not qualify as MEC because they are not required to offer comprehensive coverage under the Medicaid rules:

- Coverage for the medically needy (individuals with high medical expenses who would be eligible for Medicaid but for their income level); and
- Coverage under Section 1115 demonstration projects (experimental, pilot or demonstration projects that promote the objectives of the Medicaid program).

However, HHS and the Treasury may recognize certain medically-needy or Section 1115 demonstration project coverage to qualify as MEC, if the coverage is comprehensive.

TRICARE "space available care" and "line-of-duty-care" also would not qualify as MEC. Space available care is provided for certain individuals who are excluded from TRICARE coverage for health care services from private sector providers and only eligible for care if space is available in a facility for the uniformed services. Line-of-duty care is provided for certain individuals who are not on active duty and are entitled to episodic care for an injury, illness or disease incurred or aggravated in the line of duty.

However, because individuals enrolled in these types of coverage may not know at open enrollment for the 2014 plan year that they are not MEC, IRS Notice 2014-10 provides **transition relief from the individual mandate in 2014** for these individuals. Notice 2014-10 provides that a taxpayer is not liable for the individual mandate penalty for months in 2014 when he or she is enrolled in:

- Family planning services Medicaid;
- Tuberculosis-related services Medicaid;
- Pregnancy-related Medicaid;
- Emergency medical conditions Medicaid;
- Certain Section 1115 demonstration projects;
- Coverage for medically needy individuals;
- Space available care; or
- Line-of-duty care.

When determining whether a period without coverage qualifies as a short coverage gap, an individual will be treated as having MEC for any month in 2014 when that individual is eligible for the transition relief in Notice 2014-10.

Foreign Group Health Coverage

In addition, a proposed rule from March 17, 2014, addresses when foreign group health coverage would qualify as MEC. The proposed rule would clarify that foreign group health coverage is group health coverage that is not insured by an issuer regulated by a state and is for expatriates who are U.S. citizens or nationals residing abroad, or is for expatriates who are not U.S. citizens or nationals residing in the United States. Under the proposed rule:

- If coverage for expatriates who are U.S. citizens or nationals who reside abroad is provided by a self-insured group health plan, or is provided by group health insurance not regulated by a state or group health coverage

2/13; EM 1/15

provided by a foreign national health plan, the coverage is MEC for any month that the U.S. citizen or national is physically absent from the U.S. for at least one day of the month.

- If an expatriate is a U.S. citizen or national and is physically present in the U.S. for an entire month, the foreign group health coverage is MEC if the coverage provides health benefits within the U.S., and is provided by a self-insured group health plan, group health insurance regulated by a foreign government (and not by a state), or group health coverage provided by a foreign national health plan.
- If the foreign group health coverage is for expatriates residing in the U.S. who are not citizens or nationals of the U.S, the coverage is designated as MEC if the coverage provides health benefits within the U.S., and is provided by a self-insured group health plan, group health insurance regulated by a foreign government (and not regulated by a state), or group health coverage provided by a foreign national health plan.

Liability for Dependents

Liability for a dependent's lack of MEC falls on the taxpayer who may claim the individual as a dependent, regardless of whether the taxpayer actually claims the individual as a dependent for the taxable year. For this purpose, a dependent includes a taxpayer's qualifying children and qualifying relatives (such as parents or siblings who are supported by the taxpayer).

This liability may not be assigned to another taxpayer, even if the other taxpayer has a legal obligation to provide the child's health care. However, Exchanges may grant a hardship exemption to the custodial parent for a child in this situation, if the child is ineligible for coverage under Medicaid or CHIP.

Special rules apply for adopted and foster children. If a taxpayer legally adopts a child and is entitled to claim the child as a dependent for the taxable year when the adoption occurs, the taxpayer is not liable for a penalty with respect to that child for the month of the adoption and any preceding month. Conversely, if a taxpayer who is entitled to claim a child as a dependent for the taxable year places the child for adoption during the year, the taxpayer is not liable for a penalty with respect to that child for the month of the adoption and any following month.

EXCEPTIONS TO THE INDIVIDUAL MANDATE

The ACA provides nine categories of individuals who are **exempt from the penalty**. An individual who is eligible for an exemption for **any one day** of a month is treated as exempt for the entire month.

EXEMPTIONS FROM THE INDIVIDUAL MANDATE		
Individuals who cannot afford coverage	Taxpayers with income below the filing threshold	Members of federally recognized Indian tribes
Individuals who experience a hardship	Individuals who experience a short gap in coverage	Religious conscience objectors
Members of a health care sharing ministry	Incarcerated individuals	Individuals not lawfully present in the U.S.

The religious conscience exemption and most categories of the hardship exemption are available **exclusively through an Exchange**. Individuals must apply for these exemptions by filing an application with the Exchange.

Four categories of exemptions will be available **exclusively through the tax filing process**—for individuals who are not lawfully present, individuals with household income below the filing threshold, individuals who cannot afford coverage and individuals who experience a short coverage gap. In addition, certain subcategories of the hardship exemption will be available exclusively through the tax filing process.

2/13; EM 1/15

The exemptions for members of a health care sharing ministry, individuals who are incarcerated and members of federally recognized Indian tribes can be provided either through an Exchange or through the tax filing process.

Individuals who are denied an exemption will have the right to appeal. In addition, an applicant that no longer qualifies for an exemption but is otherwise eligible to enroll in a QHP will be eligible for a special enrollment period.

Exemption for Exchange Plan Enrollment during Initial Enrollment Period

On Oct. 28, 2013, HHS issued an FAQ to create a hardship exemption for individuals who purchased Exchange coverage during the initial enrollment period (Oct. 1, 2013, through March 31, 2014). Without the exemption, individuals who purchased insurance towards the end of the initial enrollment period could be required to pay a penalty based on a gap in coverage that lasts for three months or longer.

Under the new hardship exemption, if an individual enrolled in an Exchange plan during the initial open enrollment period, he or she will be able to claim a hardship exemption from the penalty for the months prior to the effective date of the individual's coverage, without the need to request an exemption from the Exchange. The hardship exemption is claimed when the individual files his or her federal income tax return in 2015. According to CMS, additional detail on how to claim this exemption will be provided in 2014.

Transition Relief for Coverage under Non-Calendar Year Plans

Many employer-sponsored plans have a non-calendar plan year. In general, most employer-sponsored plans do not permit employees to enroll after the beginning of a plan year unless certain triggering events occur, such as a change in employment status. According to the IRS in Notice 2013-42, without transition relief, many individuals eligible to enroll in non-calendar year plans would need to enroll in 2013 (before the individual mandate becomes effective) in order to maintain MEC for months in 2014.

Under the IRS' transition relief, an employee (or an individual having a relationship to the employee) who is eligible to enroll in a non-calendar year eligible employer-sponsored plan with a plan year beginning in 2013 and ending in 2014 (the 2013-2014 plan year) **will not be liable for the individual mandate penalty for certain months in 2014**.

The transition relief begins in January 2014 and continues through the month in which the 2013-2014 plan year ends. Also, any month in 2014 for which an individual is eligible for this transition relief will not be counted in determining a continuous period of less than three months for purposes of the short coverage gap exemption.

HOW IS THE PENALTY ENFORCED?

Starting in 2015, individuals filing a tax return for the previous tax year will indicate which members of their family (including themselves) are exempt from the individual mandate. For family members who are not exempt, the taxpayer will indicate whether they had insurance coverage. **For each non-exempt family member who doesn't have coverage, the taxpayer will owe a payment**. Spouses who file a joint return are jointly liable for the penalties that apply to either or both of them. Any individual who is eligible to claim a dependent will be responsible for reporting and paying the penalty applicable to that dependent.

The IRS will generally assess and collect individual mandate penalties **in the same manner as taxes**. However, the ACA imposes certain limitations on the IRS' ability to collect the penalty. As a result, it is likely that any assessable penalty under the individual mandate will be subtracted from the tax refund that the individual is owed, if any.

PREMIUM TAX CREDITS FOR LOW-INCOME INDIVIDUALS

The ACA created a premium tax credit to help eligible individuals and families purchase health insurance through an Exchange. By reducing a taxpayer's out-of-pocket premium costs, the credit is designed to make coverage through an Exchange more affordable. To be eligible for the premium tax credit, a taxpayer:

2/13; EM 1/15

- Must have household income for the year between 100 percent and 400 percent of the federal poverty line (FPL) for the taxpayer's family size;
- May not be claimed as a tax dependent of another taxpayer; and
- Must file a joint return, if married.

In addition, to receive the credit, a taxpayer must enroll in one or more qualified health plans through an Exchange.

Eligibility for Minimum Essential Coverage for Purposes of the Premium Tax Credit

In general, an individual is not eligible for a premium tax credit if he or she is eligible for MEC (such as coverage under a government-sponsored program or an eligible employer-sponsored plan). However, eligibility for employer-sponsored coverage that is unaffordable will not disqualify a taxpayer from receiving a premium tax credit. Employer-sponsored coverage is unaffordable if the employee's cost for self-only coverage exceeds **9.5 percent** of the employee's household income for the tax year (**adjusted to 9.56 percent for plan years beginning in 2015** under Rev. Proc. 2014-37).

On Feb. 1, 2013, the IRS published additional final regulations to confirm that an employer-sponsored plan is affordable for related individuals (that is, family members) if the portion of the annual premium the employee must pay for self-only coverage does not exceed 9.5 percent of the taxpayer's household income (adjusted to 9.56 percent for plan years beginning in 2015). Thus, the affordability determination for families is based on the cost of self-only coverage, not family coverage.

On June 26, 2013, the IRS released Notice 2013-41, which provides guidance for when an individual is treated as eligible for certain types of MEC where special circumstances exist.

- **CHIP Waiting Period**—An individual subject to a waiting period before he or she can enroll in CHIP is not treated as eligible for CHIP and therefore may receive a premium tax credit during that waiting period.
- **Coverage Tied to a Certain Condition**—An individual eligible for either:
    - Medicaid coverage as a result of disability or blindness; or
    - Medicare coverage as a result of disability or illness, is considered eligible for MEC under Medicaid or Medicare only upon a favorable determination of eligibility by the responsible agency. As a result, an individual with a condition that may make him or her eligible for Medicaid or Medicare may still be eligible for a premium tax credit unless and until the individual is determined to be eligible for Medicaid or Medicare.
- **Other Coverage, Including Coverage that may have a Substantial Premium**—Individuals are considered eligible for certain types of MEC only if they are actually enrolled. These include:
    - Medicare part A coverage requiring payment of premiums;
    - State high risk pools;
    - Student health plans; and
    - Certain TRICARE programs, such as Young Adult and Reserve Select.

MORE INFORMATION

Please contact Rose Street Advisors for more information on the health care reform law or the individual mandate.

2/13; EM 1/15