The ACA and the Individual Shared Responsibility Requirement, Including an Update on Proposed Regulations Issued on July 8, 2016

Updated July 2016

General Information

The individual responsibility requirement (also known as the individual mandate) became effective for most people as of January 1, 2014. Under the individual mandate, most people residing in the U.S. are required to have minimum essential coverage or they must pay a penalty. Many individuals will be eligible for financial assistance through premium tax credits (also known as premium subsidies) to help them purchase coverage if they buy coverage through the health insurance Marketplace (also known as the Exchange).

Employers are not required to educate employees about their individual responsibilities under the Patient Protection and Affordable Care Act (ACA). This Advisor simply provides information that employers may find helpful to know.

For 2014, the penalty for an adult was the greater of $95 or 1 percent of household income above the tax filing threshold. For 2015, the penalty was the greater of $325 and 2two percent of income above the tax filing threshold. For 2016, the penalty is the greater of $695 and 2.5 percent of income above the tax filing threshold.

The penalty for a child under age 18 is 50 percent of the adult penalty. The maximum penalty per family is three times the individual penalty. The penalty is calculated and paid as part of the employee's federal income tax filing.

Minimum Essential Coverage

A person must have "minimum essential coverage" to avoid a penalty. Minimum essential coverage is basic medical coverage and may be provided through an employer, Medicare, Medicaid, CHIP, TRICARE, some VA programs, or an individual policy (through or outside the Marketplace). Acceptable employer coverage includes both insured and self-funded PPO, HMO, HDHP and fee-for-service plans, as well as grandfathered coverage, COBRA, retiree medical, and health reimbursement arrangements HRAs). It does not matter whether the coverage is provided directly by the employer or through another party, such as a multiemployer plan, a collectively bargained plan, a PEO, or a staffing agency.

Exempt Individuals

While most people must obtain coverage or pay penalties, individuals will not be penalized if they do not obtain coverage and:

- They do not have access to affordable coverage (cost exceeds 8 percent of modified adjusted gross household income)
- Their household income is below the tax filing threshold
- They meet hardship criteria (such as recent bankruptcy, homelessness, unreimbursed expenses from natural disasters)
- Their period without coverage is less than three consecutive months
- They live outside the U.S. long enough to qualify for the foreign earned income exclusion
- They reside in a U.S. territory for at least 183 days during the year
- They are a member of a Native American Tribe
- They belong to a religious group that objects to having insurance, including Medicare and Social Security, on religious grounds (e.g., Amish)
- They belong to a health sharing ministry that has been in existence since 1999
- They are incarcerated (unless awaiting trial or sentencing)
- They are illegal aliens

If the person has access to employer-provided coverage as either the employee or an eligible dependent, affordability of the employer-provided coverage is the only factor considered for purposes of the individual mandate.

- For the employee, coverage is unaffordable (so no penalty applies for failure to have coverage) if the cost of single coverage is more than 8 percent of household income
- For a dependent, coverage is unaffordable (so no penalty applies for failure to have coverage) if the cost of the least expensive employer-provided dependent coverage is more than 8 percent of household income
- If the employee and spouse both have access to coverage through their own employer, the cost for each person's coverage is based on the cost of their own single coverage, but the totals are then combined to see if the total cost exceeds 8 percent of household income

This means that there will be situations in which the employee has to pay a penalty, but family members do not. It also means that a while a low-income person could choose not to purchase coverage (and pay no penalty), he or she also has the option to purchase through the Marketplace and receive a premium subsidy.

An individual who is exempt from the individual mandate because he or she does not have affordable coverage available also has the option to purchase catastrophic coverage. Premium subsidies are not available for catastrophic coverage.

If the person does not have access to employer (or other non-Marketplace) coverage, the measure of unaffordability is the person's premium after the premium subsidy is applied to the lowest cost bronze plan available through the Marketplace.

Eligibility for Premium Subsidies

To help lower-income people meet the requirement to have insurance, a premium subsidy will be available to a person who:

- Purchases coverage through a public Marketplace; and
- Has a household modified adjusted gross income between 100 percent or 133 percent (depending on the person's state) and 400 percent of Federal Poverty Level (FPL); and
- Is not eligible for minimum essential medical coverage through a government program such as Medicare, Medicaid, or CHIP; and
- Is not eligible for employer-provided coverage that both is minimum value (is expected to cover at least 60 percent of claims) and affordable (the cost of **single** coverage is not more than 9.5 percent of household income; this means that dependents are not eligible for a premium subsidy if the cost of employee-only coverage is affordable and they are eligible for the employer-provided coverage, even if the cost of family coverage exceeds 9.5 percent of income).

Additional requirements to be eligible for the premium subsidy are that the person:

- Is a U.S. citizen, national or alien lawfully present in the U.S. (e.g., on a visa)
- Is not eligible to be claimed as another person's tax dependent
- Files a tax return (if married, a joint return must be filed)
- Does not have employer-provided minimum essential coverage, including an HRA with a balance (regardless of whether it is affordable and minimum value)

The amount of available premium subsidy depends on the person's household income. The percentage of income a person will be expected to pay for coverage ranges from 2 percent for someone whose income is 100 percent to 133 percent of FPL to 9.5 percent for someone whose income is 300 percent to 400 percent of FPL. Basically, the Marketplace will look at how much a specific silver (70 percent value) plan costs in the Marketplace and determine how much of that cost the person should pay based on their income. The person will directly pay his or her share to the insurer and the government will pay the rest directly to the insurer.

The government payment of the premium subsidies is considered an advance tax credit, so when the person files his or her federal income tax return after the end of the year there will be a true-up using IRS Form 8962, and the employee will pay extra tax (to a maximum) or get money back if the monthly subsidies/credits were too large or too small.

Individuals with incomes below 250 percent of FPL will also be eligible for help with deductibles, coinsurance and co-pays.

A person who applies for a premium subsidy will be required to provide information about coverage available through sources other than the Marketplace as part of the application process. If the person says that coverage is available through the person's employer (or his or her spouse's employer), the Marketplace will contact the employer to verify that the employee's information is accurate. Employers will be encouraged, but not required, to respond to these verification requests. Income will be verified through tax filings. Equifax will be used to obtain current income information if that is needed. The IRS has the right to audit both the employer and individual.

Note: The ACA defines "affordability" differently based on the situation. Affordability for purposes of the individual responsibility requirement is based on 8 percent of household income; affordability for purposes of the premium subsidy is based on 9.5 percent of household income; and affordability for purposes of the employer shared responsibility requirement is based on 9.5 percent of the employee's safe harbor income for self-only coverage.

The IRS has issued an FAQ about the individual mandate: Questions and Answers on the Individual Shared Responsibility Provision

A Fact Sheet is also available: The Individual Shared Responsibility Provision

Noteworthy Numbers and Other Details

For 2015, the tax filing threshold is $10,300 if filing single (under 65) and $20,600 if married and filing jointly (both spouses under 65).

For 2016, the Federal Poverty Level (FPL) in the 48 contiguous states is $11,880 for a household size of one and $24,300 for a household of four. It is $14,840/$30,380 in Alaska and $13,670/$27,950 in Hawaii.

The subsidy is based on the following table (a sliding scale applies in a linear manner, rounded to the nearest one-hundredth of one percent between the minimum and maximum percentage).

Household income as a percent of FPL	Applicable Percentage	
	Minimum	Maximum
Up to 133%	2.0	2.0
133% - 150%	3.0	4.0
150% - 200%	4.0	6.3
200% - 250%	6.3	8.05
250% - 300%	8.05	9.5
300% - 400%	9.5	9.5

The applicable percentage multiplied by the person's household income determines the person's required share of premiums for the second least expensive silver plan in the Marketplace.

Household income generally includes the income of all individuals in the tax household (e.g., the income of employed children is considered unless the child files his or her own tax return).

Proposed Regulations

On July 8, 2016, the Department of the Treasury issued proposed regulations relating to the health insurance premium tax credit (premium tax credit) and the individual shared responsibility provision.

The proposed regulations affect:

- Individuals who enroll in qualified health plans through the health insurance exchanges and claim the premium tax credit;
- The exchanges that make qualified health plans available to individuals and employers;

- Individuals who are eligible for employer-sponsored health coverage; and
- Individuals who seek to claim an exemption from the individual shared responsibility provision because of unaffordable coverage.

The proposed regulations are proposed to apply for taxable years beginning after December 31, 2016, unless otherwise indicated. Taxpayers may rely on certain provisions of the proposed regulations for taxable years ending after December 31, 2013. Rules related to the benchmark plan are proposed to apply for taxable years beginning after December 31, 2018.

Although employers are not directly affected by the rules governing the premium tax credit, these proposed regulations may indirectly affect employers through the employer shared responsibility provisions and the related information reporting provisions.

How the Proposed Regulations Affect Individuals

The proposed regulations aim to reduce the likelihood that individuals who recklessly or intentionally provide inaccurate information to an Exchange will benefit from an Exchange determination, specifically the determination that the taxpayer's household income will be between 100 percent and 400 percent of the applicable FPL for the year, or the determination that the taxpayer or a member of the taxpayer's family is not eligible for certain government-sponsored programs.

The proposed regulations provide that, where these determinations are made, a taxpayer will not be treated as an applicable taxpayer or a taxpayer may be treated as eligible for coverage under the government-sponsored program if the taxpayer provided incorrect information to the Exchange with intentional or reckless disregard for the facts. Essentially, individuals who intentionally or recklessly disregard the facts will be unable to benefit from the regulations that do not require a repayment of advance credit payments (for taxpayers who experience an unforeseen decline in income, or for taxpayers with household income within the range for eligibility for certain government-sponsored programs.)

The proposed regulations provide that the Nonappropriated Fund Health Benefits Program offered by the Department of Defense is treated as an eligible employer-sponsored plan for purposes of determining if an individual is eligible for minimum essential coverage.

Employer Sponsored Plan Considerations

The proposed regulations clarify that, if an individual declined to enroll in employer-sponsored coverage for a plan year and did not have the opportunity to enroll in that coverage for one or more succeeding plan years, the individual is treated as ineligible for that coverage for the succeeding plan year or years for which there is no enrollment opportunity.

The proposed regulations also clarify that an individual is considered eligible for coverage under an eligible employer-sponsored plan only if that plan is minimum essential coverage; further, an individual enrolled or offered a plan consisting solely of excepted benefits is not denied the premium tax credit because of that excepted benefits offer or coverage.

Change in Individual's Status

The proposed regulations provide that, if an individual who is enrolled in a qualified health plan for which advance credit payments are made informs the Exchange that the individual is or will soon be eligible for other minimum essential coverage and that the advance credit payments should be discontinued, but the

Exchange does not discontinue advance credit payments for the first calendar month after the individual notifies the Exchange, the individual is treated as eligible for the other minimum essential coverage no earlier than the first day of the second calendar month beginning after the first month the individual may enroll in the other minimum essential coverage. Similarly, if an individual is determined to be eligible for Medicaid or CHIP, but advance credit payments are not discontinued for the first calendar month after the eligibility determination, the individual is treated as eligible for Medicaid or CHIP no earlier than the first day of the second calendar month beginning after the determination. According to the proposed regulations, taxpayers may rely on these two rules for all taxable years beginning after December 31, 2013.

Partial Month Considerations

The proposed regulations provide that a taxpayer who is eligible for advance credit payments pursuant to an eligibility appeal for a member of the taxpayer's coverage family who, based on the appeals decision, retroactively enrolls in a qualified health plan, is considered to have met the requirement for enrollment in a qualified health plan for a month if the taxpayer pays the taxpayer's share of the premium for coverage under the plan for the month on or before the 120th day following the date of the appeals decision. According to the proposed regulations, taxpayers may rely on this rule for all taxable years beginning after December 31, 2013.

The proposed regulations clarify that, for purposes of the premium tax credit, the premium assistance amount for an individual who is not enrolled for an entire month is the same as for those whose qualified health plan is terminated before the last day of the month. As long as the individual was enrolled or is treated as enrolled as of the first day of the month, the premium assistance amount for a month is the lesser of the enrollment premium for the month (reduced by any amounts that were refunded), or the excess of the benchmark plan premium over the contribution amount for the month. According to the proposed regulations, taxpayers may rely on this rule for all taxable years beginning after December 31, 2013.

To ensure consistency with the rule above for calculation of premium assistance amounts for partial months of coverage, the proposed regulations provide that, if an individual is enrolled in a qualified health plan after the first day of the month, no value should be reported for the individual's enrollment premium or benchmark plan premium for that month. If an individual's coverage in a qualified health plan is terminated before the last day of a month, or an individual is enrolled in coverage after the first day of a month and the coverage is effective on the date of the individual's birth, adoption, or placement for adoption or foster care, or on the effective date of a court order, an Exchange must report the premium for the application benchmark plan for a full month of coverage (excluding the premium allocated to benefits in excess of essential health benefits.) Further, the Exchange must report the enrollment premiums for the month (excluding the premium allocated to benefits in excess of essential health benefits), reduced by any amount that was refunded due to the plan's termination.

Other Considerations

The proposed regulations clarify that if advance credit payments are made for coverage of an individual for whom no taxpayer claims a personal exemption deduction, the taxpayer who attests to the Exchange to the intention to claim a personal exemption deduction for the individual – not the individual for whose coverage the advance credit payments were made – must file a tax return and reconcile the advance credit payments.

The proposed regulations also clarify that when multiple families enroll in a single qualified health plan and advance credit payments are made for the coverage, the enrollment premiums reported by the

Exchange for each family is the family's allocable share of the enrollment premiums, which is based on the proportion of each family's applicable benchmark premium.

The proposed regulations also provide changes to benchmark plans that are proposed to apply for taxable years beginning after December 31, 2018.

Opt-Out Arrangements and an Employee's Required Contribution

The current regulations provide that, in determining whether employer-sponsored coverage is affordable to an employee, an employee's required contribution for the coverage includes the amount by which the employee's salary would be reduced to enroll in the coverage. The proposed regulations provide that if an employer makes an opt-out payment available to an employee, then the amount of the payment made under an unconditional opt-out arrangement increases the employee's required contribution.

Further, the proposed regulations clarify that an unconditional opt-out arrangement that is required under a collective bargaining agreement's terms in effect before December 16, 2015, will be treated as having been adopted prior to December 16, 2015. The proposed regulations also clarify that employers participating in the collective bargaining agreement are not required to increase the amount of an employee's required contribution until the later of:

1. the beginning of the first plan year that begins after the expiration of the collection bargaining agreement that was in effect before December 16, 2015, (disregarding any extensions on or after December 16, 2015), or
2. the applicability date of these regulations with respect to sections 4980H and 6056.

This proposed regulation applies to any successor employer adopting the opt-out arrangement before the expiration of the collective bargaining agreement in effect before December 16, 2015 (disregarding any extensions on or after December 16, 2015).

The proposed regulations create a different rule for conditional opt-out arrangements. Amounts made available under conditional opt-out arrangements are disregarded in determining the required contribution if the arrangement satisfies certain conditions (eligible opt-out arrangement). If the arrangement does not satisfy the following conditions, then the amounts are taken into account in determining the employee's required contribution.

An eligible opt-out arrangement is an arrangement under which the employee's right to receive the opt-out payment is conditioned on:

1. The employee declining to enroll in the employer-sponsored coverage;
2. The employee providing reasonable evidence that the employee and the employee's expected tax family have or will have minimum essential coverage (other than coverage in the individual market, whether or not obtained through the Marketplace) during the period of coverage to which the opt-out arrangement applies; and
3. The employer having no knowledge or no reason to know that the employee or any other member of the employee's expected tax family does not have or will not have the required alternative coverage.

Reasonable evidence of alternative coverage includes the employee's attestation that the employee and all other members of the employee's expected tax family have or will have minimum essential coverage (other than coverage in the individual market, whether or not obtained through the Marketplace) or other

reasonable coverage. Evidence of coverage must be provided at least every plan year to which the eligible opt-out arrangement applies.

As a best practice, employers should consider phasing out their use of opt-out arrangements because it appears that government agencies are continuing to limit the permissible use of opt-out arrangements. Employers who continue to use opt-out arrangements should consult with their legal counsel to ensure that their arrangements comply with current regulations.

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