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Guidance Released on Individual Mandate, MEC and Subsidy Eligibility

By Rich Gisonny and Kathleen Rosenow

The Internal Revenue Service (IRS) and the Department of Health and Human Services (HHS) have proposed guidance on the individual mandate under the Patient Protection and Affordable Care Act (PPACA), including the requirements for minimum essential coverage (MEC). The IRS also issued final guidance about family members' eligibility for the federal premium tax credit.

Under the individual mandate, everyone must maintain MEC for themselves and family members (unless they are exempt) beginning in 2014 or pay a penalty with their federal income tax return. Taxpayers are responsible for their claimed dependents, and married taxpayers filing a joint return are jointly liable for penalties.

The multiple exemptions from the individual mandate — combined with fairly low penalties — suggest that many people will remain uninsured, which poses potential uncompensated care concerns for hospitals and other health care providers, at least in the near term.

Comments on the IRS proposed regulations are due by May 2, 2013, and there will be a public hearing May 29, 2013.

Family members' eligibility for premium tax credits based on affordability of self-only coverage

Under the IRS final regulation, an employer-sponsored plan will be deemed affordable if the employee's portion of the annual premium for *self-only* coverage does not exceed 9.5% of the employee's household income (even if family coverage costs more than 9.5% of household income). Those with access to affordable employer plans offering MEC cannot obtain federal subsidies in an exchange-based plan.

This interpretation is consistent with the PPACA, the regulations the IRS proposed in 2012 and the fact that employer liability for the $3,000 annual penalty under the play-or-pay mandate is partly based on whether the employer offers affordable *self-only* MEC.

Under the IRS proposed regulations, however, family coverage that costs more than 8% of household income is considered unaffordable, thus making family members eligible for the affordability exemption (see below).

Minimum essential coverage

The HHS proposed regulation expands the types of health coverage that meet the MEC standard and confirms that insured and self-insured employer-sponsored coverage (including COBRA coverage and retiree medical coverage) qualifies. There are no minimum standards for employer coverage. It is not clear whether such standards will be developed eventually, enabling employers to avoid the $2,000 "pay" penalty by offering a low-value plan that covers a narrow range of medical services. Other MEC includes the following:

- Medicaid and Medicare coverage (including Medicare Advantage plans)
- Coverage bought through an exchange or elsewhere
- Coverage under the Children's Health Insurance Program
- TRICARE and certain types of veterans coverage
- Foreign health coverage
- Self-funded student health insurance plans
- Refugee medical assistance and AmeriCorps coverage

The proposed regulations would designate state high-risk pools as MEC; however, HHS intends to reassess this designation in the future. HHS also spells out criteria and a process by which other

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coverage may be designated as MEC. This does not apply to employer coverage, which is addressed in a separate statutory category of MEC under the Department of Treasury's authority. The regulations confirm that MEC includes any eligible employer-sponsored plan. Health coverage for "excepted benefits" does not qualify.

An individual is considered to have MEC for any calendar month in which he or she has acceptable coverage for at least one day during the month.

Exemptions from individual mandate

The Internal Revenue Code provides nine exemptions from the individual mandate:

1. Hardship or domestic circumstances
2. Religious conscience
3. Membership in a health care ministry
4. Incarceration
5. Member of an Indian tribe
6. Not being lawfully present in the U.S.
7. Short coverage gaps
8. Household income below the filing threshold
9. Inability to afford coverage

HHS has proposed processes for exchanges to use in determining eligibility exemptions and granting certificates of exemption for the first five exemptions. The IRS will determine eligibility for the other four through the tax filing process.

For most exemptions (other than religious conscience or Indian tribe membership), people must apply for the exemption annually. After an exchange grants an exemption, it will transmit the individual's name, Social Security number, exemption certificate number and any other required information to the IRS. Generally, an individual who is exempt for one day is considered exempt for the month.

Affordability exemption

The affordability exemption is available to anyone who lacked access to affordable MEC for any month. Affordable coverage may not exceed 8% of the taxpayer's household annual income in 2014 (HHS will adjust the percentage after that). To ascertain affordability, the taxpayer's household income will be increased by the portion of the required contribution made through a salary reduction arrangement and excluded from gross income.

For those eligible for an employer-sponsored plan — whether as an employee or as a family member — affordability is based on the cost of enrollment. For this purpose, related individuals are those whose eligibility for coverage arises from their relationship to the employee and who are claimed as dependents on the employee's federal income tax return. For example, an employee's spouse is a related individual if the employee and spouse file a joint return.

The required contribution for a spouse and dependents is the employee's premium for the lowest-cost coverage, covering the employee as well as the spouse and dependents, available. For example, if the required contribution for self-only coverage is less than 8% of household income, but family coverage under the same plan is more than 8% of household income, the spouse and dependents — but not the employee — would be exempt.

If two or more family members are employed and their employers offer self-only and family coverage, both employees determine affordability using the premium for the lowest-cost self-only coverage offered by their respective employers. In these cases, both individuals' self-only coverage may be considered affordable even though family coverage costs more than 8% of household income.

Short coverage gap exemption
The short coverage gap exemption is available to those whose continuous period without MEC is less than three months and is the first short coverage gap in that year. If a coverage gap straddles two years, and the first-year gap is less than three months, there is no penalty for the first-year gap, regardless of its eventual duration. If the gap were from November to February, for example, there would be no penalty for November and December.

Deemed MEC for U.S. citizens living abroad and residents of U.S. territories
While U.S. citizens living abroad are subject to the individual mandate, those who live abroad for at least 330 days within a 12-month period are treated as having MEC. Residents of U.S. territories are also considered to have MEC.

Exemption for nonresident aliens and those not lawfully present in the U.S.
All U.S. citizens are subject to the mandate, as are permanent residents and foreign nationals in the U.S. long enough to qualify as resident aliens for tax purposes. The proposed regulation clarifies that noncitizens who are not foreign nationals and who are not lawfully present in the U.S. are exempt for a month. In addition, nonresident aliens are exempt from the individual mandate.

Hardship exemption
The PPACA authorizes HHS to exempt people for whom obtaining coverage is a hardship. The proposed regulation describes circumstances that constitute a hardship for this purpose:

- Financial or domestic circumstances, including unexpected natural or human-caused events, that create a significant, unexpected increase in essential expenses, such that buying health insurance would have deprived the individual of food, shelter, clothing or other necessities
- Individuals that an exchange determines, based on projected household income, will not be offered affordable coverage (even if, due to a change in circumstance, it turns out that the coverage would have been affordable)
- Certain individuals who were not required to file an income tax return but who nevertheless filed to receive a tax benefit, who claimed a dependent who was required to file a tax return and whose household income exceeded the applicable return filing threshold
- Individuals who would be eligible for Medicaid had the state chosen to expand Medicaid eligibility

The hardship exemption also will be available on a case-by-case basis for people whose unexpected personal or financial circumstances prevented them from obtaining coverage.

Computation of individual mandate penalty

Taxpayers are liable for the penalty for themselves as well as for those eligible for dependent status for the year; whether the taxpayer actually claims the individual as a dependent is irrelevant.

The penalty amount is generally the sum of the monthly amounts for the period without MEC. The monthly penalty is 1/12 of the greater of a flat-dollar amount or percentage of income. The flat-dollar amount is the lesser of (a) the sum of the applicable dollar amounts ($95 in 2014, $325 in 2015, $695 in 2016 and indexed thereafter) or (b) 300% of the applicable dollar amount. (If a nonexempt individual is under age 18 at the beginning of a month, the applicable dollar amount is one-half of the regular dollar amount.) The percentage of income is calculated as the excess of household income over the taxpayer's federal income tax return filing threshold, multiplied by a percentage — 1% in 2014, 2% in 2015, and 2.5% in 2016 and beyond.

[Minimum Essential Coverage]

However, the penalty amount for any tax year may not exceed the national average premium for bronze-level qualified health plans offered through exchanges for the applicable family size. Under the proposed regulation, the applicable national average bronze plan premium must be determined for each month and then aggregated for comparison with the sum of the monthly penalty amounts. Consequently, the applicable national average bronze plan premium may vary from month to month to account for changes in the taxpayer's family.

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"The hardship exemption also will be available on a case-by-case basis."

DOL Finalizes FMLA Regulations on Military Caregivers and Airline Flight Crews

By Stephen Douglas and Rich Gisonny

The Department of Labor (DOL) has issued final regulations implementing amendments to military family leave provisions under the Family and Medical Leave Act (FMLA). The amendments, which were enacted as part of the National Defense Authorization Act (NDAA) for fiscal year 2010, broaden eligibility for caregiver leave and expand the definition of a serious injury.

"The amendments broaden eligibility for caregiver leave and expand the definition of a serious injury."

The DOL final rules also implement amendments made by the Airline Flight Crew Technical Corrections Act (AFCTCA), which established a service eligibility requirement for airline flight crew members and special recordkeeping requirements. The final rules took effect March 8, 2013, although many of the statutory amendments became effective earlier.

Highlights

The FMLA entitles eligible employees of covered employers to unpaid, job-protected leave for family and medical reasons. An eligible employee may take up to 12 workweeks of FMLA leave in a 12-month period for the birth of a child or the placement of a child for adoption or foster care; to care for a spouse, child or parent with a serious health condition; or for the employee's own serious health condition.

In 2008, an amendment to the FMLA added two military family leave entitlements allowing: (1) a spouse, child, parent or next of kin of a current service member with a serious injury or illness incurred in the line of active duty to take up to 26 workweeks of military caregiver leave during a single 12-month period; and (2) an eligible employee whose spouse, child or parent is a member of the National Guard or Reserves to take up to 12 workweeks of qualifying exigency leave arising out of the military member's active duty or call to active duty for a contingency operation.

The fiscal 2010 NDAA expanded FMLA military caregiver leave to certain veterans with a serious injury or illness incurred or aggravated in the line of active duty, regardless of whether the condition manifested before or after the veteran left active duty. It also allows military caregiver leave for current

News in Brief

IRS Requires Complete Restatements for Determination Letter Requests

By Stephen Douglas and Russ Hall

The Internal Revenue Service (IRS) has issued its annual revenue procedures for requesting determination letters for qualified retirement plans. As of February 1, 2013, plan sponsors must submit a restated plan rather than a "working copy" with their determination letter request. As in the past, submissions must also include copies of all amendments adopted since the most recent determination letter.

The restatement requirement means that sponsors of individually designed plans will need to prepare formal restated plan documents at least every five years. All applicants will have to formally adopt the restated document no later than 91 days after the issuance of a favorable determination letter. Sponsors may want to submit the restatement on a proposed basis so any changes requested by the IRS as part of the determination letter process can be incorporated into the final document before its formal adoption. Plan sponsors will want to review their procedures for adopting plan amendments to be sure they can accomplish formal approval and, if required under the plan, execution in a timely manner.

The fees for requesting determination letters have not changed since last year. The guidance also notes that, in certain situations, sponsors must include Form 8821 (authorization for a third party to inspect and/or receive confidential information) with their determination letter request.

service members with preexisting serious injuries or illnesses that were aggravated by service in the line of active duty. The amendments expanded qualifying exigency leave to eligible employees with family members serving in the regular Armed Forces and added a requirement that, for all qualifying exigency leave, the military member must be deployed to a foreign country.

To meet the FMLA hours-of-service eligibility requirement under the AFCTCA, an airline flight crew employee must have worked or been paid for at least 60% of the "applicable monthly guarantee" and worked or been paid for at least 504 hours during the previous 12 months.

The final rules include the following major provisions:

- Limiting covered veterans to those discharged or released under conditions other than dishonorable up to five years before the military caregiver leave begins
- Creating a flexible definition for serious injury or illness of a covered veteran that includes four alternatives, of which only one must be met
- Permitting eligible employees to obtain certification of a service member's serious injury or illness from any health care provider allowed under the FMLA, not only those affiliated with the Department of Defense, Veterans Administration or TRICARE
- Extending qualifying exigency leave to relatives of members of the regular Armed Forces and requiring all military members to be deployed to a foreign country to be considered on "covered active duty" under the FMLA
- Increasing the amount of time an employee may take for qualifying exigency leave related to the military member's rest and recuperation leave from five to 15 days
- Creating an additional qualifying exigency leave category for parental care leave necessitated by the covered active duty of a military member who had been caring for a parent incapable of self-care
- Incorporating the statutory hours of service eligibility requirements for airline flight crew employees for FMLA leave
- Creating a unique leave calculation method for airline flight crew, and establishing that FMLA leave used by flight crew on an intermittent or reduced schedule basis must be accounted for using an increment no greater than one day
- Requiring employers of airline flight crew employees to maintain records of the applicable monthly guarantee for each category of employee, including any relevant collective bargaining agreements or employer policy documents, and also requiring employers to maintain records of the airline flight crew hours worked and hours paid

Employers will need to update their FMLA policies and procedures to reflect these latest regulations.

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"For all qualifying exigency leave, the military member must be deployed to a foreign country."

News in Brief

Proposed Guidance on Contraceptive Coverage and Religious Employers

By Rich Gisonny and Kathleen Rosenow

The departments of Treasury, Labor and Health and Human Services have proposed a regulation to address contraceptive coverage without cost sharing under health care reform. The proposed rules amend the exemptions for group health plans sponsored by religious employers and establish accommodations for group health plans sponsored by religiously affiliated universities, hospitals and social service agencies. The rules effectively require insurance companies — rather than churches or other religious organizations — to cover and bear the cost of contraceptive services to employees.

The proposed rules make two significant changes to provide coverage for contraceptives without cost sharing while accommodating religious objections to contraceptive services:

1. Amend the criteria for the religious exemption to ensure that an otherwise exempt employer plan is not disqualified because the employer's purposes extend beyond inculcating religious values or because the employer serves or hires people of different religious faiths.
2. Establish accommodations for health coverage established or maintained by eligible organizations (e.g., nonprofit religious institutional health providers and charities), or arranged by eligible religious institutions of higher education with religious objections to contraceptive coverage. Women employed by these organizations could get free contraceptive coverage through a separate plan provided by a health insurer that covers the cost.

The regulation also solicits comments on three possible approaches for self-insured religious employer-sponsored group health plans whose sponsors do not wish to provide contraceptive coverage.

The proposal constitutes a temporary safe harbor, which will remain in effect until the first plan year beginning on or after August 1, 2013. The departments plan to finalize the proposed amendments before the safe harbor ends.

HHS Guidance on Verification of Available Employer-Sponsored Health Coverage

By Rich Gisonny and Kathleen Rosenow

A regulation proposed by the Department of Health and Human Services (HHS) addresses verification of employer-sponsored health coverage for the state health care exchanges. The verification is important for applicants trying to obtain subsidies in the exchanges and for employers trying to avoid penalties for not providing affordable minimum essential coverage (MEC). The guidance also establishes procedures for employers to appeal an unfavorable determination.

"In implementing the play-or-pay provisions under health care reform, employers should review these procedures."

Plan enrollment will begin October 1, 2013, and the exchanges should be open for business in 2014. In implementing the play-or-pay provisions under health care reform, employers should review these procedures, which are separate from the IRS procedures for determining employer penalties under the employer play-or-pay mandate.

Verification of enrollment and eligibility for coverage

To establish eligibility for advance payment of the premium tax credit, an individual must provide the exchange with the following information:

- The employer's contact information and employer identification number
- Whether the individual is employed full time
- Whether the employer provides MEC and, if so, the required employee contribution for the lowest-cost plan

A comprehensive data set for the verification process will not be available from a single source by October 1. So the proposed regulation sets out an interim process for determining whether someone reasonably expects to be enrolled in or be eligible for employer coverage for 2014 and 2015. The process could change for 2016 and beyond if HHS identifies or develops one or more data sources for an automated pre-enrollment verification process.

To help consumers provide the necessary information on an exchange coverage application, HHS is considering using a pre-enrollment one-page template, which applicants would download from the exchange website and give to the employer. The employer could also download and populate the template with coverage options and distribute to employees at hiring.

The proposed regulation identifies a series of data sources that exchanges may to use to verify employer-plan access:

1. Electronic data sources regarding enrollment in or eligibility for an employer-sponsored plan that have been approved by HHS, are based on evidence showing the data are current and accurate, and minimize the employer's administrative burden
2. HHS-specified data that may be transmitted to HHS to verify a federal employee's enrollment or eligibility for employer-sponsored health coverage
3. Data from the Small Business Health Options Program in the exchange state
4. Any available data from any HHS-approved electronic data sources regarding an applicant's employment and that of family members, based on evidence showing the data are current and accurate, and minimize the employer's administrative burden

Verification process

Exchanges generally must accept applicants' attestation of eligibility and coverage without requiring further verification, with two exceptions:

- If the attestation conflicts with other information submitted to the exchange (as described in the first three data sources listed above), other information from the applicant or the exchange's records, the exchange must contact the applicant to resolve the inconsistency. If that fails to resolve the issue, the exchange must again notify the applicant of the inconsistency and give him or her 90 days from the notice date to provide documentary evidence to resolve it.
- If the exchange has no information from the first three data sources described above and either does not have information described in the fourth data source or the applicant's attestation conflicts with that information, the exchange must select a statistically significant random sample of such applicants and:

1. Notify the applicant that the exchange will contact the employer to verify enrollment in or eligibility for an employer plan
2. Proceed with the eligibility determination using the applicant's attestation and establish eligibility for enrollment in a qualified health plan to the extent the applicant is otherwise qualified
3. Ensure that advance payments of the premium tax credit and cost-sharing reductions are provided to an applicant who is otherwise qualified for them as long as the applicant acknowledges that any advance payments are subject to later reconciliation
4. Make reasonable attempts to contact identified employers and household members to verify enrollment or eligibility
5. Determine the applicant's eligibility based on all information received and notify the applicant and employer(s) of any change in an eligibility determination
6. If the exchange is unable to obtain necessary information from an employer within 90 days of the initial notice date, eligibility must be based on the applicant's attestation

Information about an applicant may be disclosed to the employer only as necessary for the employer to identify the employee. The exchange may also turn the verification process over to HHS as long as certain requirements are met.

Employer appeals process

The exchange must notify employers when one of their employees qualifies for advance payments of the premium tax credit or cost-sharing reductions. The proposed regulation outlines an appeals process employers may use to dispute a determination that the employer does not provide affordable MEC.

Employers may request an appeal within 90 days after the exchange sends notice of an employee's eligibility for advance payment of the premium tax credit or cost-sharing reductions. Employers also may submit evidence to support an appeal request, such as verification of MEC, the employee's enrollment status and the required employee contribution for the lowest-cost plan. Employers may submit their appeal by telephone, mail, in person or by Internet, and an impartial appeals officer may help the employer with the appeal and may not interfere with the employer's right to an appeal.

The appeals procedure gives employers an opportunity to correct any erroneous information in an employee's application about employer coverage. An appeals officer must conduct a *de novo* review (a review without deference to earlier decisions in the case) of whether the employer's coverage entitles the employee to subsidies. This appeals process is separate from the IRS process for determining employer liability for a tax penalty for not providing affordable MEC.

Employers submit their appeals to the state-based exchange, although if the exchange has not established an appeals process, they may submit them to HHS.

The appeals officer must notify the employer, employee and exchange of the decision in writing — electronically or in hard copy — within 90 days of receiving the appeal, as administratively feasible. The decision must be in plain language and describe the decision's effect on the employee's eligibility. If the decision affects the employee's eligibility, the exchange must promptly redetermine it.

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