

# **A Primer to the Affordable Care Act's Individual Mandate**

## Table of Contents – Outline with quick links

- A. Introduction
- B. Enrollment specifics
- C. Minimum health insurance coverage
  - 1. What does minimum essential health insurance coverage include
    - a. Government sponsored health programs
    - b. Eligible employer-sponsored programs
    - c. Plans in the individual (non-group) market, and plans offered by an exchange
    - d. Grandfathered group health plans
    - e. Other coverage
  - 2. The ACA requires certain benefit categories be included in minimum essential health insurance coverage
  - 3. Minimum essential health insurance coverage does not include coverage providing limited benefits
  - 4. Commentary by Russell Paskett and Theresa Niland
- D. The insurance exchanges
  - 1. Purpose
  - 2. Individuals and small businesses are entitled to use the insurance exchanges
  - 3. Four different levels of coverage are available on the Insurance Exchanges
  - 4. Tax credits and cost sharing subsidies
  - 5. Medicaid and CHIP eligibility is determined at the Insurance Exchanges
  - 6. The Insurance Exchanges will assist with penalty calculations and exemptions
  - 7. Cost-sharing subsidies are available at the Insurance Exchanges
  - 8. Individuals don't have to use the Insurance Exchanges for ACA qualifying insurance
  - 9. An employer who fails to offer "affordable" health coverage, whose employee then receives tax credits via the Insurance Exchange may face tax penalties
  - 10. Commentary
- E. Exemptions
  - 1. Religious conscience exemption
  - 2. Members of health care sharing ministries
  - 3. Individuals not lawfully present
  - 4. Incarcerated individuals
  
  - 1. Individuals who cannot afford coverage
  - 2. Taxpayers with household income below income tax filing threshold
  - 3. Coverage gap of less than 3 months
  - 4. Hardships
  - 5. Members of Native American Tribes
  - 6. Individuals residing outside of the U.S.

7. Dependents

F. Annual penalty for failing to comply with the individual mandate

*By Terri L. Ackerman, Esquire  
Moffatt Thomas Barrett Rock & Fields, Chtd, Idaho Falls  
with commentary by Financial Advisor and Licensed Insurance Broker Russell Paskett,  
Keystone Financial Strategies,  
and Theresa Niland,  
Senior Associate General Counsel and Privacy Officer for Blue Cross of Idaho*

**A. Introduction**

The aim of the Patient Protection and Affordable Care Act (“ACA” or “ObamaCare”) is to increase the number of individuals who have health insurance. In order to achieve this, the ACA, beginning January 1, 2014, imposes an “Individual Mandate,” which requires that all individuals must maintain “Minimum Essential Health Insurance Coverage.” Some exemptions are available.

Those who do not qualify for an exemption, and who fail to maintain Minimum Essential Health Insurance Coverage, must make a “Shared Responsibility Payment” when they file their 2014 Federal Income Tax return in 2015. The Shared Responsibility Payment is described in Section 5000 of the Internal Revenue Code. *See* 26 U.S.C. § 5000A (a)-(b); <http://www.gpo.gov/fdsys/pkg/USCODE-2011-title26/pdf/USCODE-2011-title26-subtitleD-chap48-sec5000A.pdf>. *See also* <http://www.gpo.gov/fdsys/pkg/FR-2013-08-30/pdf/2013-21157.pdf>

The Individual Mandate also requires all children to have Minimum Essential Health Insurance Coverage or qualify for an exemption. (The individual who may claim a child as a dependent for Federal Income Tax purposes is responsible for paying the penalty if the child does not have Minimum Essential Health Insurance Coverage or qualify for an exemption.) Insurance plans and insurance companies that offer dependent coverage are required to make that coverage available until an adult child reaches the age of 26. Both married and unmarried children qualify for this coverage. There is no requirement to provide coverage for children of children receiving extended coverage. There is also no requirement to provide coverage to the spouses of children receiving extended coverage.

Under the ACA, insurance carriers can now only vary premiums on three factors: age, tobacco use, and geographic rating within a state. No other factors can be used to increase premiums, including, pre-existing conditions, health status, claims history, duration of coverage, gender, occupation, and employer size. (Note, that of course, the size of your family will affect the amount of money that you pay for health insurance.) Individuals cannot be denied coverage because of pre-existing conditions, and insurance carriers cannot drop individuals if they get sick. There are no annual or lifetime coverage maximums on essential health benefits. Additionally, older Americans never have to pay more than three times the cost to younger citizens.

Individual Americans, per the ACA, may comparison shop for and purchase Minimum Essential Health Insurance Coverage at the Health Insurance Marketplaces, also known as “Insurance Exchanges,” which opened to the public on October 1, 2013. “Premium Assistance Tax Credits,” which are available from the Federal government to help subsidize the purchase of health insurance, are currently available only through the Insurance Exchanges. Additionally, cost-sharing subsidies are available to help qualified individuals pay additional costs of health care services, such as deductibles, coinsurance, and copayments. Individuals may also determine whether they are eligible for Medicaid and the Children’s Health Insurance Program (“CHIP”) through the Insurance Exchanges.

Individuals may also purchase Minimum Essential Health Insurance Coverage directly from an insurance carrier of their choice and avoid using the Insurance Exchanges; however, Premium Assistance Tax Credits are currently only available in connection with insurance purchased on the Insurance Exchanges. In this regard, the Insurance Exchanges, are expected to make available “billions of dollars of government subsidies starting next year to millions of low and moderate income Americans who don’t get health coverage at work” to assist them in purchasing insurance. N. Levey, *Obama Touts Savings From HealthCare Law*, Los Angeles Times, July 18, 2013. See <http://articles.latimes.com/2013/jul/18/news/la-pn-obama-savings-healthcare-law-20130718>

In this paper, I present the basic facts of the Individual Mandate, with commentary by Financial Advisor and Licensed Insurance Broker Russell Paskett, of Keystone Financial Strategies, and Theresa Niland, Senior Associate General Counsel and Privacy Officer for Blue Cross of Idaho.

## **B. Enrollment specifics**

Although the ACA deadline for obtaining coverage with a January 1, 2014, effective date was December 24, 2013, individuals may still sign up for insurance on the Insurance Exchange or directly from an Insurance Carrier until March 31, 2014. The open enrollment period officially ends upon this date.

Individuals who purchase insurance by February 15, 2014, will get a coverage start date of March 1, 2014. Those who purchase insurance by March 15, 2014, will have an April 1, 2014, coverage start date. Those who purchase health insurance from March 16, 2014, through March 31, 2014, will have a coverage start date of May 1, 2014.

On October 28, 2013, the Department of Health and Human Services (HHS) released guidance indicating that those who sign up for health insurance by March 31, 2014, will not be subject to a tax penalty.

See <http://www.webcrawler.com/search/web?q=October+28,+2013+HHS+open+enrollment+period>.

After March 31, 2014, individuals may not sign up for qualifying ACA health insurance, unless they experience a “qualifying event” that triggers a special enrollment date, such as a change in jobs, or loss of a job, a move to a new geographic area, marriage, or the adoption or birth of children. For a comprehensive list of qualifying events, contact a licensed insurance broker.

Those who fail to sign up for qualifying ACA health insurance, and do not have a qualifying event that triggers a special enrollment date will not be able to enroll in qualifying ACA health insurance until enrollment re-opens on November 15, 2014.

After March 31, 2014, individuals may be able to purchase short-term medical policies directly from an insurance carrier to provide them with health insurance until their qualifying ACA health insurance coverage starts in January, 2015. Such short-term health insurance policies do not qualify as ACA health insurance policies, however, and they do not cover pre-existing conditions.

## **C. Minimum essential health insurance coverage**

### **(1) What does minimum essential health insurance coverage include?**

Per the ACA, the term “Minimum Essential Health Insurance Coverage” includes all of the following:

- **Government sponsored health programs** — such as Medicare (including Medicare Advantage), Medicaid, Children’s Health Insurance Program (CHIP), medical coverage under chapter 55 of title 10, U.S.C., including coverage under the TRICARE program, coverage for members of the U.S. military, certain types of Veterans’ health care (including CHAMPVA and certain children of Vietnam and Korean Vets), RICARE, health care for Peace Corps volunteers, and DOD non-appropriated Fund Health Benefits. *Id.*, §1.5000A (f)(1)(A);
- **Eligible employer-sponsored plans** — such as group health plans (whether an insured or self-insured group health plan) or group health insurance coverage offered through the small or large group market within a state, governmental plans, church plans, and grandfathered plans. Coverage provided by an employer to a former employee, including coverage under COBRA and retiree health coverage, qualifies as coverage under an eligible employer-sponsored plan. *Id.*, §1.5000A (f)(1)(B) and §1.5000A (f)(2);
- **Plans in the individual (non-group) market, and plans offered by an Exchange.** *Id.*, §1.5000A (f)(1)(C)
- **Grandfathered group health plans**—(coverage in effect on March 23, 2010) *Id.*, §1.5000A (f)(1)(D) ;
- **Other coverage**—Such other health benefits coverage, such as a state health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary of the Treasury, recognizes for purposes of this subsection. *Id.*, §1.5000A (f)(1)(E).

The Department of Health and Human Services (“HHS”) has authority to designate additional types of coverage as Minimum Essential Health Insurance Coverage. In this regard, on June 26, 2013, HHS designated Refugee Medical Assistance supported by the Administration for Children and Families and Medicare Advantage plans as Minimum Essential Health Insurance Coverage. HHS also designated state high risk pools and self-funded health coverage offered to students by universities for plan or policy years that begin on or before December 31, 2014, as Minimum Essential Health Insurance Coverage. For plan or policy years that begin after December 31, 2014, sponsors of state high risk pools and individual self-funded student health plans may apply to HHS to be recognized as Minimum Essential Health Insurance Coverage through the process outlined in 45 C.F.R. Section 156.604.

See <http://www.gpo.gov/fdsys/pkg/FR-2013-02-01/html/2013-02139.htm>.

**(2) The ACA requires that certain benefit categories be included in minimum essential health insurance coverage**

The following ten benefit categories must be included in Minimum Essential Health insurance Coverage:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventative and wellness services (including chronic disease management, and all plans must include annual doctor visits and medical screenings like mammograms and colonoscopies) with no out of pocket costs to members); and
- Pediatric services (including oral and vision care).

Anyone who is under the age of 19 will be required to have dental insurance. If an Insurance Exchange offers stand-alone dental plans, the other health plans offered on the Insurance Exchange need not provide for the pediatric dental care otherwise required as an Essential Health Benefit.

**(3) Minimum essential health insurance coverage does not include coverage providing limited benefits**

Minimum Essential Health Insurance Coverage does not include coverage providing only limited benefits, such as coverage only for vision care or dental care, workers' compensation, disability, automobile liability insurance, coverage only for a specific disease or condition, or coverage for employer-provided on-site clinics.

#### **(4) COMMENTARY**

*By Russell Paskett, Keystone Financial Strategies  
and Theresa Niland, Blue Cross Of Idaho*

As we have heard in the news, millions of Americans on the individual insurance market received notices that their plans did not meet the ACA requirements of "Minimum Essential Health Insurance Coverage," and would be canceled.

No one in Idaho got such a notice, because Idaho took a different approach. In Idaho, the Insurance Department decided that no plans were to be cancelled, but plans that lacked the above-mentioned "Essential Health Benefits" would not be renewed in 2014, and people would be moved to ACA compliant plans when they renewed in 2014. Plans and carriers in Idaho took the next step of contacting individuals and informing them that their plan was not going to be renewed, and if they did not choose a plan to replace the plan that was not going to be renewed, they would be automatically moved to a plan that would be comparable to the one that they had, so that there would be no gap in coverage.

On Thursday November 14, 2013, the President indicated that he will allow insurance companies to continue offering existing individual plans even if they do not meet the standards set by the new health care law. Note, however, that certain provisions of the ACA had to be inserted into these plans. Unfortunately, some people who chose to keep these plans are actually paying more for less benefits than they would have been paying if they had shopped around on the Insurance Exchange to compare their existing plan with the other ACA compliant plans that were available.

Individuals would be well-advised to contact a licensed insurance broker to compare their existing non-conforming insurance plan with the other ACA conforming plans that are available, in order learn whether they may be better served with another conforming plan that may provide more benefits for the same or less money. Individuals can choose to end their non-conforming policies early, and enroll in an ACA conforming plan by March 31, 2014, which is the end of open enrollment.

Additionally, if persons with non-conforming plans that were terminated do not wish to pay the additional money that a qualified health plan may cost, they may go to the Insurance Exchange or directly to a carrier, and select a catastrophic plan that does conform with the ACA.

Individuals who do not purchase ACA qualifying health insurance coverage before March 31, 2014, and who do not purchase a short-term medical policy, and then experience a health problem, will not be covered, and will have to rely on their own resources to pay for the medical care they may need, or attempt to seek charity assistance, such as that which may be available through the Idaho Medical Indigency Act.

## **D. The Insurance Exchanges**

### **(1) Purpose**

The basic function of the insurance exchanges is to provide health insurance options for the uninsured or underinsured.

### **(2) Individuals and small businesses are entitled to use the Insurance Exchanges**

Per the ACA, individuals and small businesses with 100 or fewer employees are entitled to purchase qualified coverage on their state Insurance Exchanges from a choice of certified insurance plans that have been rated by the Insurance Exchange. The ACA does allow individual states to drop that figure down to 50 or fewer employees until 2016. That is what Idaho has done.

Small businesses seeking coverage for their employees can use the “Small Business Health Options Program” (“SHOP”) exchange. The SHOP exchange is designed to assist qualified small employers and their employees with the purchase of Qualified Health Plans offered in the small group market. Qualified small employers are able to select one or more of the Qualified Health Plans available in the SHOP to offer to their employees. They can also set the amount they will contribute to Qualified Health Plan premiums. (Note that small businesses seeking coverage on the SHOP exchange will not be eligible for any tax credits or any cost-sharing reductions at the employee level. These are only available to individuals purchasing insurance through the Individual Insurance Exchange.)

In 2017, states can decide whether to let large businesses use the Insurance Exchanges.

### **(3) Four different levels of coverage are available on the Insurance Exchanges**

The Insurance Exchanges offer four levels of insurance plans, all of which provide “Minimum Essential Health Insurance Coverage.” The ACA requires that the lowest “Bronze” level of coverage provide insurance benefits that are actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan.

According to the government’s web site, the term “actuarial value means: “The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy.”

The four levels of insurance coverage available on the Insurance Exchanges are as follows:

- a. Bronze level plan: Provides insurance benefits that are actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan.

- b. Silver level plan: Provides insurance benefits that are actuarially equivalent to 70% of the full actuarial value of the benefits provided under the plan.
- c. Gold level plan: Provides insurance benefits that are actuarially equivalent to 80% of the full actuarial value of the benefits provided under the plan.
- d. Platinum level plan: Provides insurance benefits that are actuarially equivalent to 90% of the full actuarial value of the benefits provided under the plan.

Catastrophic plans may also be offered on the Insurance Exchanges. These plans will have actuarial values that are less than those offered at the Bronze level of coverage. These plans are expected to have lower premiums, because they will offer less generous coverage, and higher cost-sharing. Such plans are only available to individuals who are under 30 years of age, and to individuals who are exempt from the Individual Mandate because they do not have access to affordable coverage, or because they have experienced a hardship. These plans include coverage for “Minimum Essential Health Insurance Coverage,” which will be defined below, as well as coverage for three primary care visits before the deductible is reached.

#### **(4) Tax credits and cost sharing subsidies**

Premium Assistance Tax Credits are available to help reduce the cost of insurance purchased through a Health Insurance Exchange. In order to be eligible for such a Premium Assistance Tax Credit:

- An “Applicable Taxpayer” must have a household income that is between 100% and 400% of the Federal Poverty Level for the taxpayer’s family size. (This figure is estimated to be \$31,545 to \$98,872 for a family of four in 2014).
- The taxpayer must not have “affordable” or “adequate” Minimum Essential Health Insurance Coverage available through his or her employer or the government. (An employer’s insurance plan does not provide affordable or adequate Minimum Essential Health Insurance Coverage if the required employee contribution exceeds 9.5% of the employee’s household income, or if the plan provides coverage for less than 60% of total allowable costs under the plan.)
- The taxpayer must be enrolled in qualified health insurance through the Insurance Exchange.
- Married taxpayers must file “Married Filing Jointly.”
- The taxpayer cannot be claimed by another taxpayer as a dependent.
- The taxpayer must be a “qualified individual,” which means that the taxpayer must be a U. S. Citizen or national, or an alien lawfully in the U. S., and the taxpayer must not be incarcerated.



Individuals may determine the amount of Premium Tax Credits to which they are entitled, by using the “Subsidy Calculator” provided on the Kaiser Family Foundation website. This tool, which can be found at [www.kff.org/interactive/su](http://www.kff.org/interactive/su), illustrates the health insurance premiums and subsidies available to people purchasing insurance on their own in the Insurance Exchanges created by the ACA. A licensed insurance broker can also help individuals make the necessary calculations. Individuals can also seek this assistance directly from the enrollment departments of insurance carriers providing this service.

Individuals wishing to avail themselves of any Premium Tax Credits to which they may be entitled can then go to an Insurance Exchange to enroll in an insurance plan of their choice. In this situation, individuals report their household income to the Insurance Exchange, and then enroll in one of the plans offered through the Insurance Exchange. The financial information provided to the Insurance Exchange is then used to calculate the individual’s required share of premiums for the health plan. (Note that in this situation, the taxpayer is providing an estimated household income for the coming year, since the credit is paid in advance of filing the tax return.) The required share of premiums is then subtracted from the premiums for the second lowest-cost Silver plan, adjusted for age, to determine the amount of Premium Assistance Tax credit.

The IRS will pay the Premium Tax Credit directly to the insurance company chosen by the taxpayer. The individual will then pay the amount that is above the Premium Assistance Tax Credit. Persons who fail to pay all or part of the remaining premium are given a mandatory three month grace period prior to being terminated from participation in the plan.

Additional cost-sharing subsidies are available to help qualified individuals pay additional costs of health care services, such as deductibles, coinsurance, and copayments.

Note that cost-sharing subsidies are only available on Silver plans, whereas Premium Assistance Tax Credits are available on any of the plans available on an Insurance Exchange.

**(5) Medicaid and CHIP eligibility is determined at the Insurance Exchanges**

As stated above, the Insurance Exchanges also determine whether an individual is eligible for Medicaid and the Children’s Health Insurance Program (“CHIP”).

**(6) The Insurance Exchanges will assist with penalty calculations and exemptions**

As noted above, Insurance Exchange websites will assist individuals in determining individual and employer penalty calculations.

The Insurance Exchanges will also provide certifications for certain penalty exemptions. As will be discussed fully below, the religious conscience exemption and most hardship exemptions are available only by applying for an exemption certificate from an Insurance Exchange. The exemptions available for members of Native American Indian tribes, members of health care sharing ministries, some hardship certifications, and individuals who are incarcerated are available either by applying for an exemption certificate at an Insurance Exchange, or by claiming the exemption as part of filing a Federal Income Tax return.

The Insurance Exchanges will transfer to the Treasury a list of individuals who are issued a certification of an exemption from a penalty.

**(7) Cost-sharing subsidies are available at the Insurance Exchanges**

As noted above, cost-sharing subsidies are available at the Insurance Exchanges, to help qualified individuals pay additional costs of healthcare services, such as deductibles, coinsurance, and copayments.

**(8) Individuals don't have to use the Insurance Exchanges for ACA qualifying insurance**

Individuals who (1) do not qualify for any Premium Assistance Tax Credits, or (2) do qualify for such credits, but do not find them to provide sufficient incentive to purchase insurance on an Insurance Exchange, may simply purchase health insurance directly from the health insurance carrier of their choice. The decision to forgo any Premium Tax Credits that an individual may have available to him or her and apply for health insurance directly from a health insurance carrier is entirely a personal decision that centers around the individual's desire to use or avoid using an Insurance Exchange.

A licensed insurance broker can help shepherd individuals through the decision as to whether it would be best for him or her to purchase insurance directly through a carrier or through an Insurance Exchange. There is never a change for the services of an insurance broker in this regard. His or her fee is paid directly by the insurance carrier selected by the individual. There is no discount for not using a broker.

**(9) An employer who fails to offer "affordable" health coverage, whose employee then receives tax credits via the Insurance Exchange may face tax penalties**

In addition to the Individual Mandate, the ACA also imposes an "Employer Mandate" or "Employer Responsibility Provisions" on employers with the equivalent of 50 or more full time employees to provide "Affordable" Minimum Essential Health Insurance Coverage that provides a "Minimum Value" of coverage to a certain percentage of their full time employees. *See* 26 U.S. Code §4980H; <http://www.law.cornell.edu/uscode/text/26/4980H>; *See also* <https://www.federalregister.gov/articles/2014/02/12/2014-03082/shared-responsibility-for-employers-regarding-health-coverage>. Those employers who are required to offer such coverage, but fail to do so, must make a "Shared Responsibility Payment." *Id.* According to the Treasury Department, the purpose of the Shared Responsibility Payment is "to help offset the costs to taxpayers of their employees getting tax credits through the Health Insurance Marketplace." *See* <http://www.treasury.gov/press-center/press-releases/Pages/jl2290.aspx>.

On February 10, 2014, the U.S. Department of the Treasury and the Internal Revenue Service issued final regulations implementing the Employer Responsibility Provisions under the ACA that take effect in 2015. *See* <http://www.treasury.gov/press-center/press-releases/Pages/jl2290.aspx>. As stated by the Treasury Department, these regulations "phase in the standards...." *Id.* "[C]ompanies with 50- 99 employees that do not yet

provide quality, affordable health insurance to their full-time workers will report on their workers and coverage in 2015, but have until 2016 before any employer responsibility payments will apply.” *Id.* Besides giving businesses with between 50 and 99 workers an additional year to comply, the Administration has changed the rules so that larger employers with 100 or more employees must offer Minimum Essential Health insurance Coverage to 70% of their full time workers—rather than 95%, as had previously been required—by 2015. *Id.* Such larger businesses will have to offer health insurance to 95% of their workers in 2016 and beyond. *Id.*

“Small businesses” with fewer than the equivalent of 50 employees are not required to provide coverage or fill out any forms in 2015, or in any year, under the ACA. <http://www.treasury.gov/press-center/press-releases/Pages/jl2290.aspx>. Employees of small businesses are, however, required to carry Minimum Essential Health Insurance Coverage, per the ACA Individual Mandate.

An employee who is not eligible for Medicaid or other programs may be eligible for Premium Assistance Tax Credits in connection with the purchase of health insurance on an Insurance Exchange if his or her income is below certain thresholds and the individual’s employer does not offer health coverage, or offers health coverage that is not affordable, or offers health coverage that is not adequate because it does not provide minimum value.

A plan fails to provide “minimum value” if the plan’s share of the total allowable costs of benefits provided under the plan is less than 60% of those costs. Stated differently, a plan is considered to provide adequate coverage, or minimum value, if the plan’s actuarial value (ie: the share of the total allowable costs that the plan is expected to cover) is at least 60%. If the coverage offered by an employer fails to provide minimum value, an employee may be eligible to receive a Premium Assistance Tax Credit from a state Insurance Exchange and to purchase coverage through the Exchange, potentially resulting in a tax penalty to his or her employer.

Health coverage is not “affordable,” if an employee’s share of employer-provided coverage would cost the employee more than 9.5% of that employee’s annual household income. “Household income” means the modified adjusted gross income of the employee and any members of the employee’s family (which would include any spouse and dependents) who are required to file a Federal Income Tax return. Such an employee may be eligible for Premium Assistance Tax Credits in connection with the purpose of health insurance on an Insurance Exchange.

If an employer offers multiple healthcare coverage options, the affordability test applies to the lowest-cost option available to the employee that also meets the “minimum value” requirement.

The IRS will send employers a §1411 Certificate informing them that an employee has received Premium Assistance Tax Credits in connection with the purchase of health insurance on an Insurance Exchange, and informing the employers of their potential liability for tax penalties in connection with the same. Employers will be provided with

an opportunity to respond before any liability is assessed or notice and demand for payment is made.

## (10) Commentary

*By Russell Paskett, Keystone Financial Strategies  
and Theresa Niland, Blue Cross Of Idaho*

As we have heard in the news, the ACA Insurance Exchanges were beset with technical problems, including hardware failures, glitches and website crashes. This made it very difficult for individuals to complete an entire insurance application, and enroll in an ACA qualified plan on the Insurance Exchange.

It bears repeating that one does not have to purchase ACA qualifying health insurance from an Insurance Exchange. One may choose to instead buy such insurance coverage directly from an insurance carrier.

If an individual is not sure whether he or she has finished the enrollment process on an Insurance Exchange, he or she can call the insurance company in question directly, and confirm enrollment and payment of the premium for the first month.

Note that if you have a health condition that has made it difficult or expensive for you to obtain health insurance in the past, you may now be able to purchase more affordable insurance coverage directly from an insurance carrier. However, if you obtain health insurance directly from a health insurance carrier, you will not be able to avail yourself of any Premium Assistance Tax Credits to which you may have otherwise have been entitled.

Employers with concerns as to whether their insurance plans comply with the ACA can check with their insurance brokers, and then double-check with their insurance carriers directly.

## E. Exemptions

Exemptions are available from the Individual Mandate requirement to purchase Minimum Essential Health Insurance Coverage, as well as from the Individual Mandate penalty. *See* 26 U.S.C. § 5000A; <http://www.gpo.gov/fdsys/pkg/USCODE-2011-title26/pdf/USCODE-2011-title26-subtitleD-chap48-sec5000A.pdf>; *See also* <http://www.gpo.gov/fdsys/pkg/FR-2013-08-30/pdf/2013-21157.pdf>

The exemptions from the Individual mandate requirement to purchase Minimum Essential Health Insurance Coverage include:

- (1) Religious conscience exemption—This exemption is available for members of religious sects that are recognized as conscientiously opposed to accepting any insurance benefits. (The Social Security Administration administers the process by which such sects are recognized. To qualify for this exemption, a state Insurance Exchange must issue a certificate certifying that you adhere to the established tenets or teachings of your sect. *Id.*, § 1.5000A (d)(2)(A).

- (2) Members of health care sharing ministries—This exemption is available for members of recognized §501 (c)(3) health care sharing ministries. These ministries share a common set of ethical or religious beliefs, and share medical expenses among themselves. *Id.*, §1.5000 A (d)(2)(B).
- (3) Individuals not lawfully present — This exemption is available for individuals who are neither U.S. citizens, U.S. nationals, nor aliens lawfully present in the U.S. *Id.*, §1.5000 A (d)(3).
- (4) Incarcerated individuals — This exemption is available for individuals who are in a jail, prison, or similar penal institution or correctional facility after the disposition of charges against them. *Id.*, §1.5000A (d)(4).

Exemptions are also available from the Individual Mandate penalty. They include:

- (1) Individuals who cannot afford coverage—This exemption is available for individuals who can't afford coverage because the minimum amount they must pay for the premiums is more than 8% of their household income. *Id.*, §1.5000 A (e)(1).

Note that when determining household income, a taxpayer's family includes all individuals for whom the taxpayer properly claims a personal exemption deduction. If self-pay only coverage is affordable to an employee, but family coverage is unaffordable, the employee is subject to the Individual Mandate penalty if he or she does not maintain Minimum Essential Health Insurance Coverage. However, any individual who is eligible for employer coverage due to his or her relationship with an employee (i.e. a spouse or child of an employee) is exempt from the penalty if that individual does not maintain Minimum Essential Health Insurance Coverage because family coverage is not affordable.

The question of “affordability” is based on any employer-sponsored coverage that might be available to the individual. Those without insurance coverage available through an employer must calculate the “affordability” of the coverage provided through the Insurance Exchange Bronze plan, minus any Premium Assistance Tax Credit available through the Exchange.

- (2) Taxpayers with household income below income tax filing threshold—This exemption is available for households that are not required to file tax returns, because the household income is below the minimum threshold for filing a tax return. (In 2013, the filing threshold was \$10,000 for a single person, or a married person filing separately, and \$20,000 for married persons filing jointly.) *Id.*, §5000A (e)(2).
- (3) Coverage gap of less than 3 months—This exemption is available to individuals who went without coverage for less than three consecutive months during the year. (Note that if the gap in coverage is for a continuous period that is less than three months, there is no penalty. If the continuous period is greater than three

months, the penalty applies to the entire period. If there are a multitude of gaps in coverage, the relief applies to the first gap in coverage only). *Id.*, §1.5000A (e)(4).

- (4) Hardships--This exemption is available for individuals for whom an Insurance Exchange has issued a certification that they have suffered a hardship that makes them unable to obtain coverage. *Id.*, §1.5000A (e)(5).
- (5) Members of Native American Tribes—This exemption is available for members who are on the roll of federally recognized Native American Indian tribes. *Id.*, §1.5000A (e)(3).
- (6) Individuals residing outside of the U.S.—This exemption is basically available to those who meet the rules to qualify for the foreign earned income exclusion. This means that in order to qualify for this exemption, an individual must be a bonafide resident of a foreign country, or live outside of the United States for 330 or more days out of a 365 day period. *Id.*, §1.5000A (f)(4).
- (7) Dependents—Dependent individuals are not subject to the penalty. Rather, the penalty is imposed on the taxpayer who claims the dependent on his or her income tax form. *Id.*, §1.5000A; *See also* <http://www.gpo.gov/fdsys/pkg/FR-2013-08-30/pdf/2013-21157.pdf>.

The religious conscience exemption and most hardship exemptions are available only by applying for an exemption certificate from an Insurance Exchange.

The exemptions for members of Native American Indian tribes, members of health care sharing ministries, some hardship certifications, and individuals who are incarcerated are available either by applying for an exemption certificate at an Insurance Exchange, or by claiming the exemption as part of filing a Federal Income Tax return.

The exemptions for unaffordable coverage, short coverage gaps, and residency can only be claimed as part of filing a Federal Income Tax return.

The exemption for those under the Federal Income Tax return filing threshold is available automatically. No special action is needed.

All of the exemptions are tested annually, except those available for members of recognized religious sects and members of Native American tribes.

#### **F. Annual penalty for failing to comply with the individual mandate**

The annual penalty for not having Minimum Essential Health Insurance Coverage will be the greater of a flat dollar amount per individual, or a percentage of the individual's taxable income. For any dependent under the age of 18, the penalty is half of the individual amount. The adult or married couple who can claim a child as a dependent for Federal Income Tax purposes is responsible for making the payment.

For 2014, the Individual Mandate penalty is \$95 per adult, and \$47.50 per child (with a maximum cap of \$285 per family, which is three times that amount), or 1.0% of the family's income, whichever is greater.

For 2015, the Individual Mandate penalty is \$325 per adult, and \$162.50 per child (with a maximum cap of \$975.00 per family, which is three times that amount), or 2.0% of the family's income, whichever is greater.

For 2016, the Individual Mandate penalty is \$695 per adult, and \$347.50 per child, (with a maximum cap of \$2,085.00 per family, which is three times that amount), or 2.5% of the family's income, whichever is greater.

After 2016, the penalty amounts are increased by a cost of living adjustment.

“Income” is defined as the total income in excess of the filing threshold for income taxes, which in 2013 was \$10,000 for an individual, and \$20,000 for a family.

The amount of any payment is pro-rated by the number of months in a given year that an individual is without coverage or an exemption.

As will be discussed below, there is no penalty for a single gap in coverage of less than three months in a year.

The penalty will be paid as a Federal Income Tax liability on Federal Income Tax returns, and is enforced by the Treasury.

The law prohibits the IRS from using liens or levies to collect any payment that may be owed related to the Individual Mandate, if an individual, his or her spouse, or a dependent included on his or her tax return does not have Minimum Essential Health Insurance Coverage. However, the IRS may offset any owed Shared Responsibility Payment against any tax refunds that may be due.

*Id.*, § 5000A (c); *see also* <http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision>.

Note for comparison purposes that per the Kaiser Family Foundation, “in 2012, employees paid \$95 on average towards the cost of individual coverage in an employer plan, and \$4,316 for a family of four.” Kaiser Family Foundation, “*The Requirement to Buy Coverage Under the Affordable Care Act*,” July 17, 2013, <http://kff.org/infographic/the-requirement-to-buy-coverage-under-the-affordable-care-act/>.