McGraw Wentworth

REFORM Update

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The Internal Revenue Service and the Department of Treasury recently released proposed regulations addressing the premium insurance tax credits created by health care reform. These regulations include important clarifications that will affect how employers evaluate the affordability measures required under health care reform. The government is actively seeking comments on these proposed regulations, which means some elements may be changed when the final regulations are later issued.

The regulations address two issues in depth:

- An employer's calculation of "affordable" coverage
- Eligibility for, and calculation of, premium credits in the public health exchange

In 2014, the market will change when the "play or pay" provisions become effective. If employers offer minimum essential coverage that is deemed affordable, then employees and any of their eligible dependents will not be qualified to purchase subsidized coverage in the Exchange. It is important for employers to understand the elements of these new regulations as they think about the implications of 2014 for their health plans.

Calculation of "Affordable" Coverage

In 2014, the public health exchange will offer a viable alternative to employer-sponsored health coverage. Employers must decide if they will continue to offer a group health plan, or instead pay the penalty for failing to offer coverage. This "play or pay" mandate applies to employers with 50 or more full-time employees. One of following two annual penalties may apply:

1. **The Mandate Penalty ($2,000) applies if an employer does not offer group health coverage.** The penalty is calculated on all full-time employees, less the first 30. At least one employee has to purchase subsidized coverage in the Exchange for this penalty to apply. However, for most employers, it is highly likely that at least one employee will do this.
2. **The Qualification Penalty ($3,000) applies if the employer fails to offer a qualifying plan to any employee. If any of those employees purchase subsidized coverage through the Exchange the penalty applies.** This penalty is assessed based on the number of employees that are not offered qualifying coverage and subsequently purchase subsidized coverage through the Exchange.

This latest guidance provides important clarifications on the type of employer coverage that would be considered "qualifying." The official guidance calls such a plan "minimum essential coverage." To be considered minimal essential coverage, two metrics must be met:

1. **Coverage must provide minimum value**. The statute delineates minimum value as at least a 60% benefit level. More guidance will be issued. Most employers offer a 60% benefit level or better. Based on McGraw Wentworth's 2011 Mid-Market Benefit Survey, the median PPO plan offers roughly a 75% benefit value.
2. **Coverage must be affordable**. The statute indicates that the employee contributions cannot exceed 9.5% of the employee's household income. The new regulations clarify that the required contribution for determining affordability is based on the contribution for "self-only" coverage. This is very important, as it makes the affordability test much easier for employers to pass. If the family contribution exceeds 9.5% of the household income, the plan can still be considered affordable. The plan is affordable if the contribution for single coverage is less than 9.5% of household income.

If these qualifications are met for all employees, then the employer will be assessed no penalties and none of the employees or dependents will be eligible for subsidized coverage.

More interesting details reviewed in these regulations, include:

- **The IRS will release future guidance about a new safe harbor for calculating employee affordability.** This was briefly addressed in the new guidance. It appears the IRS will create a safe harbor to allow employers to calculate the 9.5% contribution for single coverage against the employee's current W-2 earnings.

  Sometimes an employer will determine an employee passes the affordability test based upon W-2 earnings but the employee's income is actually less than the employer has recorded. In this case, the employee can purchase coverage through the Exchange and may qualify for a subsidy based on the household income measure. The employer will not be subject to the qualification penalty. This situation will apply only in limited circumstances, as it is rare that household income will be less than the income paid to an employee. An example would be an employee's spouse with a failing business that has a negative impact on household income.
- **If an employee chooses not to enroll in the employer's qualifying plan, the employee and any eligible dependents will not be qualified for subsidies in the Exchange.** The only exception to this is COBRA coverage. A qualified beneficiary must actually be enrolled in COBRA in order for it to be treated as minimum essential coverage.
- **An employee safe harbor was included.** If the Exchange determines that employer-sponsored coverage is unaffordable, the employee can secure subsidized coverage through the Exchange. Employer-sponsored coverage will be treated as unaffordable for the entire plan year. This applies even if the employer lowers contributions to the point where they would pass the affordability test for the individual.

  This safe harbor will be welcomed by employees. Once an individual declines coverage in an employer-sponsored health plan, the individual can wait until the next annual

enrollment period to return to the employer's plan. This allows employees to annually consider the possibility of Exchange coverage without any financial impact mid-year if the employer plan circumstances change.

However, an individual can still lose subsidy credits during the year for other reasons, such as a change in income. If an income increase would place the employee at more than 400% of the federal poverty limit (FPL), premium credits would be eliminated mid-year.

- **If an employee enrolls in the employer-sponsored health plan, he or she will be considered to have minimum essential coverage.** This applies even if the plan fails to pass the affordability or minimum value test.

Eligibility for, and Calculation of, Premium Credits in the Exchange

The regulations included a lengthy discussion about the premium credits available to eligible low- and moderate-income individuals. More details were provided on how the premium credit process will work when qualified individuals purchase subsidy-eligible coverage through the Exchange.

The Exchange will be responsible for making an advance determination of premium credit eligibility for individuals enrolling for coverage. Using information available at the time of enrollment, the Exchange determines:

1. Whether an individual meets the income and other requirements for advance premium credit payments
2. The amount of the advance premium credits

Advance premium credit payments will be paid monthly to the health insurance carrier in whose plan the individual enrolls.

To be eligible for premium credits, an individual must be an applicable taxpayer, defined as:

1. Having a household income between 100% and 400% of the FPL for the taxpayer's family size
2. Not claimed as a dependent of another taxpayer
3. If married, filing a joint return (limited exceptions apply)

The individual may also be an alien lawfully present in the United States whose household income is 100% or less of the FPL, and who is not eligible for Medicaid.

Any taxpayer that receives advance credit payments must file an income tax return on or before the 15th day of the fourth month following the close of the tax year (typically, April 15). There is a provision allowing the government to grant a reasonable extension to this time filing requirement.

A taxpayer's family consists of individuals for whom the taxpayer claims a personal exemption deduction under Section 151. The taxpayer can claim personal exemptions for him/herself, a spouse or anyone that meets the definition of a dependent under Section 152. Family size is equal to the number of individuals in the taxpayer's family.

Household income is defined under Internal Revenue Code Section 36(d)(2) as the modified adjusted gross income of all individuals included in the family size who are required to file an income tax return. Modified adjusted gross income means the adjusted gross income increased by amounts excluded from gross income under Section 911, which addresses income and benefits earned in foreign countries and tax-exempt interest that a taxpayer receives or accrues during the taxable year.

A taxpayer's annual premium assistance credit amount is the sum of all coverage months in the tax year for a taxpayer and his or her family. A coverage month is any month in the tax year in which a taxpayer or any family member is enrolled in an Exchange qualified plan and the premium is paid by the taxpayer or through an advanced credit payment. A coverage month for any individual does not include any month in which the individual is eligible for minimum essential coverage. This can include coverage through an employer or through a government-sponsored plan like Medicare, Medicaid, CHIP, Tricare or veterans' health care coverage.

The regulations deem that the Department of Health and Human Services and the Treasury Department may designate other health benefits as minimum essential coverage.

The actual dollar amount of the premium credits depends on a number of factors. Monthly health plan premium amounts are capped for the taxpayer based on his or her household size and the relationship of the household's income to the FPL. The premium amount is determined as a percentage of household income. For 2014, the premium cap is set at 2% of household income for up to 133% of the FPL, and increases from 3% to 9.5% for taxpayers with household incomes between 133% and 400% of the FPL.

The actual premium credits are determined based on the cost of the second-lowest cost Silver plan (70% value plan) in the Exchange. Most states will have their own Exchanges. The market will drive the premiums for the second-lowest cost Silver plan. The premium credit amount is the actual cost of the second-lowest cost Silver plan less the premium that must be paid by the taxpayer. Taxpayer amounts are as determined by household size and as a percent of household income. Once the actual amount of the premium credit is determined, the taxpayer can apply that credit to any plan he or she would like to purchase in the Exchange. The taxpayer must pay any additional premiums required for the plan selected. Although this sounds complicated, it is very likely that each state will develop technology to support the necessary calculations. Applicants will likely see their options and associated costs, less any premium credits for which they qualify.

At the end of the year, the taxpayer must reconcile the actual credit for the taxable year with the amount of advanced payments received. This will be done on the tax return. If the actual credits allowed exceed the amount of advanced credits received, then the taxpayer will receive the excess as a tax refund. But if the advanced credits received exceed the actual credits allowed, then the taxpayer owes the excess as additional tax liability. The regulations do place a limit on repayment amounts, ranging from $300 to $2,500 based on coverage level and income related to the FPL.

The Exchange will be responsible for determining when an individual will be eligible for premium credits. The Exchange may approve an individual's eligibility based upon projected household income. If the individual's actual household income is less than 133% of the FPL, then the individual would still be considered an applicable taxpayer. Even though, income at less than 133% of the FPL qualifies the individual for Medicaid. If the individual applies for Medicaid mid-year, he or she will be treated as eligible for minimum essential government coverage no sooner than the first day of the first calendar month after approval. At that point the individual would lose premium credits.

Medicaid is frequently provided with a retroactive effective date. Because the termination of Exchange coverage cannot be retroactive, termination will occur after the Medicaid coverage is approved. This requirement will ensure access to cost-effective government options for low-income workers.

More regulations discussing the details of tax reconciliations and the mechanics of premium credits are expected.

Concluding Thoughts

From an employer's standpoint, the clarification to the calculation of the affordability test should make it easier to pass. In addition, the coming IRS safe harbor will allow employers to use only the employee's income when determining affordability of the plan. This means employers will have much more control in determining the affordability measures.

In addition, employers should have a rudimentary understanding of the Exchanges and how premium credits will be determined and applied in 2014. Only small employers will be able to purchase coverage directly through Exchange. However, larger employers should understand the process, especially if it is likely that some employees will seek coverage through the Exchange.

The government has asked for stakeholder comments, and is likely to issue additional guidance that continues to clarify the 2014 "play or pay" requirements.