McGraw Wentworth
a Marsh & McLennan Agency LLC company

REFORM Update

Issue Eighty-Two February 2014

February 25, 2014

The Internal Revenue Service (IRS) recently proposed rules addressing Minimum Essential Coverage (MEC). An individual covered by MEC satisfies the individual mandate, which requires most Americans to secure qualified health coverage or to pay a tax penalty. The individual mandate is a key provision of the Affordable Care Act (ACA).

The proposed rules provide more detail related to the individual mandate:

- Determining affordability of employer-sponsored group health coverage in situations with health reimbursement accounts (HRAs) and wellness rewards
- Clarifying the status of stand-alone dental and vision plans
- Adopting the hardship exemptions for individuals who enroll in a Qualified Health Plan (QHP) through the Marketplace during the initial enrollment period
- Waiving the MEC requirements for specific government programs

Affordability of Employer-Sponsored Group Health Coverage

Most employers are aware of the affordability measure for group health coverage under the employer mandate. For coverage to be affordable, single coverage cannot cost more than 9.5 percent of the employee's earnings.

Taxpayers are exempt from the tax penalty if they cannot find affordable coverage. The measure of affordability for this exemption is that coverage cannot cost more than 8 percent of the taxpayer's household income in 2014. This measure of affordability applies to all plans available to the taxpayer. Affordability applies to both individual plans available through the Marketplace and employer-sponsored coverage.

The government has already issued guidance for employers on how to calculate affordability when HRAs or wellness rewards are offered. This guidance was discussed in our *Reform Update* at http://www.mcgrawwentworth.com/Reform_Update/2013/Reform_Update_66.pdf.

These proposed rules adopt the same parameters, but apply them in terms of the individual mandate. These situations are handled as follows:

- Employer contributions to an integrated HRA can be counted when determining affordability, as long as the HRA permits the payment of premiums with HRA funds. Current-year funding is the only funding that should be considered when determining affordability.

- Employer health plans often offer rewards when a participant meets certain requirements under a wellness plan. Any reward amounts tied to an incentive to reduce tobacco use should be included when determining affordability. This means non-smoker premium contributions would be used to determine if the plan is affordable to a taxpayer. Any other wellness rewards should not be considered when determining affordability. For example, if a reward was provided when an employee lost two percent of body weight, that reward would not be included when determining affordability.

The proposed rules also request comments on how to determine affordability when an employer offers a full "cafeteria" plan. In such plans, the employer offer funds to employees to purchase an array of benefits with pre-tax and post-tax dollars. Typically, employer-sponsored health plans are part of the menu of choices. However, there is no requirement that the funds be spent on the medical plan.

For individuals who are not eligible for employer-sponsored coverage, the required cost for coverage is determined by the plan options in the Marketplace and any premium credits for which the individual may be eligible. When determining affordability, the required contribution for health coverage is the annual premium for the ***applicable plan*** reduced by any premium tax credits permitted for the taxable year. The applicable plan for these purposes is the lowest-cost bronze plan available in the Marketplace to the taxpayer and any non-exempt family members. In addition, tobacco surcharges cannot be taken into account when determining affordability.

Status of Stand-Alone Dental and Vision Plans

The regulations have so far defined MEC as it relates to employer-sponsored health plans. MEC is an employer-sponsored health plan that does not consist solely of excepted benefits. These proposed regulations adopt the exclusion for excepted benefits but apply it in terms of the individual mandate. Coverage consisting solely of excepted benefits, such as stand-alone dental and vision plans, is not considered MEC. Many state Marketplaces offer stand-alone dental and vision plans as coverage options. If an individual purchases only excepted benefit coverage and **not** a comprehensive health program though the Marketplace, then the tax penalty may apply.

Hardship Exemptions for Individuals Who Enroll In A QHP During the Initial Enrollment Period

At the end of 2013, the government had to make a number of concessions following significant problems with the launch of the Marketplaces. It was noted that an individual could enroll during the Marketplace's initial enrollment period (ending on March 31, 2014) and still be subject to the tax penalty. Based on current rules, if an individual enrolls in a QHP as of March 31, 2014, the coverage effective date will be May 1, 2014. Because individuals were generally unable to enroll as of October 1, 2013, the government will exempt individuals from the penalty if they enroll in a QHP during the initial enrollment period.

The exemption applies only to individuals enrolling in a QHP through a state Marketplace during the initial enrollment period. This is referred to as a hardship exemption. Individuals may claim the exemption when filing their 2014 tax returns in 2015.

Waiving the MEC Requirements for Specific Government Programs

Previous guidance has specified a number of governmental programs that are considered MEC, including:

- Medicaid (comprehensive program)
- Medicare
- TRICARE
- Federal Employee Health Plan

Medicaid has certain limited benefit programs, such as family planning services, optional tuberculosis services, pregnancy-related services and coverage for emergency medical services. These limited benefit programs were excluded from the definition of MEC in previous regulations.

However, that list is not all-inclusive. Additional limited benefit programs are clarified as not MEC in this latest proposed guidance. These limited government benefit programs include:

- Medicaid coverage for the medically needy (i.e. individuals who **are not** eligible for Medicaid due to income, but because of significant medical expenses may spend down their income with incurred medical expenses in order to work toward Medicaid eligibility). States have the option to offer more limited benefits to the medically needy.
- Certain Medicaid demonstration projects for expansion populations.
- TRICARE coverage for individuals who access a facility of the uniformed services on a space-available basis.
- TRICARE coverage for certain individuals not on active duty who are entitled to care because of an injury, illness or disease incurred or aggravated in the line of duty. This is limited coverage related only to the treatment of the specific injury, illness or disease.

While these government programs do not meet MEC requirements, it is proposed that they be considered MEC for 2014 to spare their enrollees tax penalties. These enrollees were likely unaware that their plans did not meet MEC requirements at the time of enrollment. Consequently, they should not be liable for paying the individual mandate penalty in 2014.