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Final Rule on Individual Mandate Exemptions and Minimum Essential Coverage

Beginning in 2014, the Affordable Care Act (ACA) requires most individuals to obtain acceptable health insurance coverage for themselves and their family members or pay a penalty. This rule is often referred to as the "individual mandate." Individuals may be eligible for an exemption from the penalty in certain circumstances.

On Jan. 30, 2013, the Department of Health and Human Services (HHS) issued a proposed rule relating to the individual mandate. On June 26, 2013, HHS issued a **final rule** that finalizes the proposed standards. This final rule outlines exemptions from the individual mandate and establishes standards and procedures for Exchanges to determine eligibility for exemptions and designate coverage as constituting minimum essential coverage.

In conjunction with the final rule, HHS' Centers for Medicare & Medicaid Services issued additional guidance specifically on the hardship exemption.

THE INDIVIDUAL MANDATE

Under the individual mandate, a penalty will be assessed against an individual for any month during which he or she does not maintain "minimum essential coverage," beginning in 2014 (unless an exemption applies). A taxpayer is also liable for the penalty for any nonexempt individual whom the taxpayer may claim as a dependent.

Minimum essential coverage includes coverage under an eligible employer-sponsored plan. An eligible employer-sponsored plan is a group health plan (whether an insured group health plan or a self-insured group health plan) or group health insurance coverage offered by an employer to the employee that is:

A governmental plan;

Any other plan or coverage offered in a state's small or large group market (including a self-insured group health plan); or

A grandfathered health plan offered in a group market.

IRS Notice 2013-42 provides **transition relief** from the individual mandate penalty for certain months in 2014 for individuals who are eligible to enroll in eligible employer-sponsored health plans with plan years other than the calendar year (non-calendar year plans).

EXEMPTIONS FROM THE INDIVIDUAL MANDATE

The ACA provides the following nine categories of individuals who are **exempt from the penalty** for not maintaining minimum essential coverage:

Individuals who cannot afford coverage (those for whom a required contribution for coverage would cost more than 8 percent of their household income);

Taxpayers with income below the filing threshold;

Members of federally recognized Indian tribes;

Individuals who experience a hardship;

Individuals who experience a gap in coverage for less than a continuous three-month period (may only be used for one period without coverage per year);

Members of certain religious sects;

Members of a health care sharing ministry;

Incarcerated individuals; and

Individuals who are not citizens, nationals or lawfully present in the United States.

An individual who is eligible for an exemption for **any one day** of a month is treated as exempt for the entire month.

Exemption for Members of Federally Recognized Indian Tribes

For purposes of this exemption, the IRS defines what constitutes a federally recognized Indian tribe. Because this definition is very limited, the final rule creates a separate hardship exemption for Indians who do not meet the IRS' definition but are eligible for services through the Indian Health Service or through Indian health care providers.

Hardship Exemption

The hardship exemption is intended for individuals who have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan. Under the final rule, a hardship exemption is available for a month or months in which:

An applicant experienced financial or domestic circumstances, including an unexpected natural or human-caused event, that caused a significant, unexpected increase in essential expenses;

The expense of purchasing minimum essential coverage would have caused the applicant to experience serious deprivation of food, shelter, clothing or other necessities; or

The applicant has experienced other factors similar to those described above that prevented him or her from obtaining minimum essential coverage.

HHS has enumerated several situations that will always be treated as constituting a hardship for purposes of the hardship exemption, including:

Individuals who turn down coverage because the Exchange projects it will be unaffordable (even if their actual income for the year turns out to be higher so that they are not eligible for the affordability exemption);

Individuals who, in addition to one or more employed members of their families, have been determined eligible for affordable self-only employer-sponsored coverage, but for whom the aggregate cost of employer-sponsored coverage for all the employed members of the family is unaffordable;

Certain individuals who are not required to file an income tax return but who technically fall outside the statutory exemption for those with household income below the filing threshold;

Individuals who would be eligible for Medicaid under the expansion, but live in a state that chooses not to expand Medicaid eligibility (this exemption is available for households up to 138 percent of poverty, even though those over 100 percent of poverty may qualify for premium tax credits); and

Individuals who are Indians (as well as their spouses and descendants) who are eligible for services through an Indian health care provider.

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The final rule also provides that the hardship exemption will be available on a case-by-case basis for individuals who face other unexpected personal or financial circumstances that prevent them from obtaining coverage. CMS' additional guidance on the hardship exemption establishes criteria that federally facilitated Exchanges (FFEs) will use to determine eligibility for the hardship exemption. State-based Exchanges have the option of using these criteria.

Exemption for Religious Conscience Objectors

Applicants are eligible for the religious conscience exemption if they are members of, and subscribe to the tenets of, religious groups that object to having insurance coverage (including Medicare and Social Security) on religious grounds. Qualification for the religious conscience exception can be established by proof of Social Security and Medicare tax exemption or by attestation of membership in a group recognized by the Social Security Administration (SSA) as exempt.

Parents can apply for this exemption for their families as well as themselves. The proposed rule required children of families with an exemption certificate to apply on their own behalf at age 18. However, the final rule recognizes that most groups covered by this exemption (mainly Mennonite and Amish groups) recognize the age of adulthood as age 21. As a result, the final rule raises the age to reapply on one's own behalf to age 21. Once an eligible family member reaches age 21, the Exchange will send notice of his or her need to apply on his or her own behalf.

Claiming an Exemption

Four categories of exemptions will be available **exclusively through the tax filing process** – for individuals who are not lawfully present, individuals with household income below the filing threshold, individuals who cannot afford coverage and individuals who experience a short coverage gap. In addition, certain subcategories of the hardship exemption will be available exclusively through the tax filing process.

Three exemptions—those for members of a health care sharing ministry, individuals who are incarcerated and members of federally recognized Indian tribes—could be provided either through an Exchange or through the tax filing process.

The religious conscience exemption and most categories of the hardship exemption are available **exclusively through an Exchange**. Individuals must apply for these exemptions by filing an application with the Exchange. The final rule allows an individual to apply for multiple exemptions simultaneously. However, individuals will generally be required to submit a new application for exemptions each year. The Exchanges will not send applicants notice of their obligation to reapply.

Once an application is received, the Exchange will determine eligibility and will issue certificates of exemption for each eligible applicant. Exchanges will grant certificates of exemption regardless of whether the applicant seeks coverage through the Exchange or not.

Exemption certificates for membership in a health care sharing ministry and for incarceration can only be granted retrospectively, since the Exchange cannot know prospectively how long the applicant will remain incarcerated or with the sharing ministry. Certificates for the religious conscience exemption and for members of Indian tribes can be applied for prospectively and retrospectively and can last indefinitely, since qualification for these exemptions persists from year to year.

The Exchanges must report exemption certifications to the IRS. Individuals who have been denied an exemption will have the right to appeal. In addition, an applicant who is no longer qualified for an exemption but is otherwise eligible to enroll in a QHP will be eligible for a special enrollment period.

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MINIMUM ESSENTIAL COVERAGE

The ACA lists seven categories of coverage that qualify as minimum essential coverage. The final rule also designates other types of coverage, not specifically listed by the ACA, as minimum essential coverage:

> Self-funded student health coverage and state high-risk pools for plan or policy years that begin on or before Dec. 31, 2014. For plan or policy years that begin after Dec. 31, 2014, sponsors of self-funded student health plans and state high risk pools may apply to be recognized as minimum essential health coverage through a process outlined in the final rule;
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> Refugee Medical Assistance supported by the Administration for Children and Families;
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> Medicare Advantage plans; and
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> Any additional coverage that HHS designates or recognizes as minimum essential coverage.

Minimum essential coverage does not include certain specialized coverage, such as coverage only for vision care or dental care, workers' compensation or coverage only for a specific disease or condition.

Eligibility for Minimum Essential Coverage for Purposes of the Premium Tax Credit

In general, an individual is not eligible for a premium tax credit if he or she is eligible for other minimum essential coverage. On June 26, 2013, the IRS released Notice 2013-41, which provides guidance for when an individual is treated as eligible for certain types of minimum essential coverage where special circumstances exist.

> **CHIP Waiting Period** – An individual subject to a waiting period before he or she can enroll in CHIP is not treated as eligible for CHIP and therefore may receive a premium tax credit during that waiting period.
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> **Coverage Tied to a Certain Condition** – An individual eligible for either (1) Medicaid coverage as a result of disability or blindness or (2) Medicare coverage as a result of disability or illness is considered eligible for minimum essential coverage under Medicaid or Medicare only upon a favorable determination of eligibility by the responsible agency. As a result, an individual with a condition that may make him or her eligible for Medicaid or Medicare may still be eligible for a premium tax credit unless and until the individual is determined to be eligible for Medicaid or Medicare.
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> **Other Coverage, Including Coverage that may have a Substantial Premium** – Individuals are considered eligible for certain types of minimum essential coverage only if they are actually enrolled. These include:
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> - Medicare part A coverage requiring payment of premiums;
> - State high-risk pools;
> - Student health plans; and
> - Certain TRICARE programs, such as Young Adult and Reserve Select.

Source: U.S. Department of Health and Human Services