**PART I: GOALS and MAJOR COMPONENTS OF HEALTHCARE REFORM**

Overview

1. What is healthcare reform?

The term “healthcare reform” refers to the healthcare law passed in March 2010, known as the Affordable Care Act (“ACA”) or the Patient Protection and Affordable Care Act (PPACA),[[1]](#footnote-1) including regulations and other guidance implementing that law. The effective date of the law is March 23, 2010, although various provisions have their own effective dates from January 1, 2010, (the small business income tax credit) through 2018.

2. What terms and acronyms will be used repeatedly in this book?

The following are the most common terms and acronyms that will be used throughout this book.

* **Applicable Large Employer (ALE).** An employer with fifty or more full-time employees.
* **Code.** Internal Revenue Code, as amended. Also referred to as “IRC” or “Title 26”.
* **Employer Mandate.** A tax penalty on certain employers not offering a group health plan or offering one that does not meet specified requirements.
* **ERISA.** The Employee Retirement Income Security Act of 1974, as amended, which governs employer-sponsored, qualified retirement plans and welfare benefit plans, including group health plans.
* **Essential Health Benefits.** The benefits that must be offered in non-grandfathered plans sold in the small group market on or outside of an exchange beginning in 2015. Grandfathered plans, self-insured group health plans, and health insurance coverage offered in the large group market are not required to offer essential health benefits. *Minimum essential coverage* is a separate concept. It is the term used to describe the coverage required to fulfill the individual mandate and coverage that employers must offer to avoid the employer mandate tax.
* **Exchange, State Exchange,” or Health Insurance Exchange.** State or multi-state exchanges where health insurance options may be compared and purchased.
* **Grandfathered Health Plan.** A group health plan in existence on March 23, 2010, that meets specified requirements and is exempt from certain health reform requirements.
* **Group Health Plans.** Plans provided by employers or employee organizations (unions) providing comprehensive health benefits. The term does not include “excepted benefits” or retiree-only plans.
* **Healthcare Reform.** Health reform under the Patient Protection and Affordable Care Act of 2010.
* **Health FSA.** Flexible savings accounts (FSAs), often found in cafeteria plans (sometimes called “flex plans”), for health care, but not dependent care.
* **Health Reform.** The 2010 federal law known as the Affordable Care Act (ACA) or the Patient Protection and Affordable Care Act (PPACA), including regulations and other guidance implementing that law. Health reform amended the Code, ERISA, and the Public Health Service Act (PHSA).
* **HHS.** The U.S. Department of Health and Human Services.
* **HIPAA.** The Health Insurance Portability and Accountability Act of 1996.
* **Individual Mandate.** The tax penalty imposed on individuals (unless they are exempt) who do not have health coverage from an employer or individual health insurance.
* **MEC.** Minimum essential coverage.
* **MLR.** Medical Loss Ratio, a concept limiting how much insurers can pay for administrative expense for health insurance governed by health reform.
* **PHSA or PHS Act.** Public Health Service Act.
* **QHP**. A qualified health plan offered on a state health insurance exchange.
* **SBC.** A summary of benefits and coverage summarizing health plan or health insurance benefits that must meet specified requirements.

3. What does health reform do?

The 2010 law has and will materially change healthcare law in the United States. Healthcare reform included an array of new requirements for individuals, employers, health plans, and healthcare providers. The purpose of this law is to:[[2]](#footnote-2)

* make insurance companies more accountable
* lower healthcare costs
* guarantee more choice of providers and plans
* make health care more available (including but not limited to eliminating exclusions for pre-existing conditions as well as Medicare and Medicaid expansions)
* expand preventive services, and
* promote the use of health information technology through electronic medical records, and generally to enhance the quality, safety, and coordination of health care

4. Will healthcare reform work to reduce costs?

The healthcare reform law has a carrot and stick approach. One big carrot is the subsidies individuals can receive for purchasing insurance on an exchange if their income is less than 400 percent of federal poverty level. Two of the sticks are the employer mandate and the individual mandate penalties.

There are low participation rates in company-sponsored health insurance, even in many companies that offer health coverage and especially those with lower wage workers. One CEO has asked employees why they do not participate in the employer provided coverage.[[3]](#footnote-3) The answers he received are typical:

* Younger workers were unconcerned about illness or injury
* Others already had insurance through a spouse or parent
* A significant number said they declined coverage because they could get medical treatment "for free at the emergency room." This fact remains true in and after 2014 as the federal law known as EMTALA requires hospitals to provide emergency services, even to those who cannot pay.
* Among those who had signed up, many said it was because they were concerned about developing a medical condition and then being unable to get affordable coverage due to this preexisting condition. Significantly, in 2014, these people will be able to obtain health insurance on exchanges despite any preexisting conditions, which will further cause disincentive to enrollment in both employer and exchange offered health insurance.

This reality leads to the idea that healthcare reform may be proven to be more expensive and not work as hoped. The law’s success depends on young, healthy people who are lower risk signing up for health insurance to offset the costs of insuring individuals with preexisting conditions, many who in the past have been unable to purchase insurance and who are at higher risk for the need for expensive medical care. If predominantly high-risk individuals sign up on the state exchanges, that health insurance will be expensive. Nevertheless, people will still be able to get medical care at the emergency room. Further, the law in 2014 prohibits insurers from denying coverage because of preexisting conditions. Therefore, individuals have even less incentive to purchase health insurance as they will no longer have much incentive to get health insurance as a hedge against the possibility of developing a medical condition when they are presently healthy.

One of the law’s answers to these issues is the individual mandate penalty tax on uninsured individuals that goes into effect in 2014. The penalty in 2014 is $95 or 1 percent of household income, whichever is greater. It increases in 2016 to $695 or 2.5 percent of household income, whichever is greater. The individual mandate is not sufficient to change the behavior of many persons who are not otherwise inclined to buy health insurance. A person making $50,000 per year with no health coverage will be subject to an initial individual mandate penalty of $500 and a maximum penalty of $1,250 in 2016. The typical share of employee cost for company sponsored health coverage will often exceed this amount, often by a significant amount. Low paid employees who earn, for example, $11,500 per year would be subject to an initial penalty of $115 in 2014 and a maximum penalty of $695 in 2016. Such workers’ share of health insurance premiums, even if there is an exchange insurance subsidy, will again often be much more than any potential penalty.

5. What is the focus of this book?

This book will focus on the health reform requirements for employers and individuals. It does not discuss in any detail the rules that relate to healthcare providers, such as physicians, hospitals, or accountable care organizations, etc., except in their capacity as employers. For this book, health reform primarily relates to the requirements for major medical coverage offered by employers, both insured and self-insured, and purchased by individuals from insurance companies.

The book is written in several parts, and each part covers specific provisions of healthcare reform as it pertains to employers and individuals.

Many healthcare reform provisions (such as the individual and employer mandates, healthcare exchanges, and the ban on preexisting conditions) go into effect in 2014 or 2015. However, many of the group health plan and individual health insurance requirements for content, design, and administration are effective sooner, and many are now in effect. Part III of this book contains a timeline as to when the various requirements become effective. Part IV discusses financial and tax decisions that should be made by the end of 2012, although some can be made later as well.

6. What benefits are regulated by health reform?

The 2010 health reform law imposes many new requirements on individual health insurance policies and group health plans, both insured and self-insured. The new requirements on group health plans are in addition to those previously imposed by HIPAA in 1996.

A group health plan is defined as an insured or self-insured plan of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.[[4]](#footnote-4) The definition of a group health plan does not include any group health plan that has fewer than two participants who are current employees—one subset of which is retiree-only plans.[[5]](#footnote-5) While this is an important exclusion, there are a number of open issues regarding the scope of retiree-only plans. In addition, a group health plan does not include a plan offering “excepted benefits.”[[6]](#footnote-6)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposed several new requirements for group health coverage that are designed to provide protection to health plan participants. These protections include:

* limitations on exclusions from coverage based on pre-existing conditions
* the prohibition of discrimination on the basis of health status[[7]](#footnote-7)
* guaranteed renewability in multiemployer plans and certain employer welfare arrangements[[8]](#footnote-8)
* standards relating to benefits for mothers and newborns[[9]](#footnote-9)
* mental health benefits parity;[[10]](#footnote-10) and
* coverage of dependent students on medically necessary leaves of absence.[[11]](#footnote-11) [These requirements are located in HIPAA Chapter 100 of Subtitle K, Group Health Plan requirements.

For plan years beginning on or after May 21, 2009, Code section 9834 made it explicit that the tax imposed by Code section 4980D applies to any failure to satisfy the requirements of Code sections 9801 through 9812. The excise tax is $100 for each day in the noncompliance period with respect to each individual to whom such failure relates. Civil suits may be brought for violation of certain HIPAA requirements under ERISA section 701.[[12]](#footnote-12)

7. What health benefits are not affected by health reform?

Health reform does not change the rules for “excepted benefits” or retiree-only plans. These items will be discussed below, at Q 12 through Q 22.

8. Do the provisions of healthcare reform only apply to businesses and residents in the United States?

HHS Reverses Prior Position & Exempts Five U.S. Territories From Most Healthcare Insurance Reforms.

By letter dated July 16, 2014,[[13]](#footnote-13) HHS has reversed its position that healthcare reform required insurers in five US territories to comply with the law’s major market reforms, i.e., guaranteed coverage, mandated benefits, and limits on insurers’ profits. Healthcare reform does not require residents in Puerto Rico, the U.S. Virgin Islands, American Samoa, Guam and the Northern Mariana Islands to get coverage nor does it provide subsidies like those on the states’ exchanges to help lower income persons afford coverage. Now in 2014 HHS has determined, contrary to its prior position, that the definition of “state” in the Public Health Service Act, which is the law that imposes the insurance mandates, indicates that the ACA market rules don’t apply to the territories, HHS declared, reversing its prior position. The territories will be exempted from guaranteed coverage, community rating, single risk pools, rate review, the medical loss ratio, and essential health benefits. However, group health plans in the territories must still comply with other requirements, such as the prohibition on lifetime and annual limits (PHS Act section 2711), the prohibition on rescissions (PHS Act section 2712), coverage of preventive health services (PHS Act section 2713), and the internal and external appeals process (PHS Act section 2719).

9. Where are the provisions of the health reform law found?

PPACA, the health reform law, is contained in three places:

* the Internal Revenue Code,
* the Employee Retirement Income Security Act (ERISA), and
* the Public Health Service Act (PHS Act or PHSA).

For health reform, the IRS, Department of Labor (DOL), and Department of Health and Human Services (HHS) respectively administer the laws. Many of the regulations are co-authored by all three federal agencies. The states have the primary authority to enforce the PHSA provisions with respect to group and individual market health insurance issuers, and HHS will only step in to the extent HHS believes the state has failed to substantially enforce these provisions. HHS, IRS and DOL have already issued several PPACA regulations, some interim, and some final and more regulations are expected. In many cases, the law is vague, and regulations are needed to know what it means in practice.

10. How does healthcare reform provide for expanded coverage?

The law does this in several ways. Healthcare reform provides incentives for (1) individuals without health coverage to buy insurance and (2) employers to provide group health benefits. It also requires employer-provided group health plans and insurers to meet certain standards, with some exceptions for plans and coverage existing on March 23, 2010, referred to as “grandfathered health plans.” New rules contain requirements for health plans and health insurance, including coverage requirements and administration. Provisions exist, for example, for eliminating preexisting condition exclusions, limiting waiting periods, eliminating annual and lifetime limits, expanded adult child coverage, and claims appeals.

Expanded health coverage is encouraged with a carrot-and-stick approach. The carrots include mechanisms to expand coverage through state health insurance exchanges and tax subsidies for specified individuals and small employers. The sticks include a tax penalty for individuals, with several exceptions, who do not have health insurance (called the individual mandate), as well as penalties for certain employers with fifty or more full-time equivalent employees who provide:

1. no healthcare benefits or

2. coverage that does not meet several tests, including affordability, minimum essential health benefits, and a minimum employer contribution.

The penalties are known as the employer mandate.

11. Has healthcare reform been revised since it was enacted?

Yes. Part II of this book discusses the provisions that have already expired, been repealed, or will not be implemented. Part III provides a timeline of implementation dates, many of which have been revised since 2010.

Health Coverage Not Affected by Healthcare Reform: “Excepted Benefits” and Retiree-Only Plans

12. What benefits are not governed by PPACA, the 2010 health reform law?

The law does not apply to “excepted benefits” and retiree-only health plans.

13. What are the “excepted benefits” that are not covered by the health reform law?

The Internal Revenue Service, Department of Labor and Public Health Service Act regulations identically define excepted benefits.[[14]](#footnote-14)

Excepted benefits are:

(1) Accident, or disability income insurance, or any combination thereof; a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; or other similar insurance coverage, specified in regulations;[[15]](#footnote-15)

(2) Benefits not subject to requirements if offered separately and not part of a health plan:

* limited scope dental or vision benefits;
* long-term care, nursing home care, home healthcare, community-based care, or any combination thereof; and
* similar benefits specified in regulations;[[16]](#footnote-16)

(3) Benefits not subject to requirements if offered as independent, noncoordinated benefits. (Coverage only for a specified disease or illness; or hospital indemnity or other fixed indemnity insurance;[[17]](#footnote-17)

(4) Medicare supplemental health insurance (so-called “Medigap insurance”) offered by a separate policy.[[18]](#footnote-18)

PPACA inadvertently removed the exemption for retiree-only plans and “excepted benefits” from the PHS Act, but left those exemptions intact in the Internal Revenue Code and ERISA. The preamble to the interim final grandfathered plan regulations clarifies the issue by stating that the exemption for retiree-only plans and excepted benefit plans still applies for those plans subject to the Code and ERISA. Thus, with respect to retiree-only and excepted benefits, the regulators have decided that they will read the PHS Act as if an exemption for retiree-only and excepted benefit plans is still in effect, and they have encouraged state insurance regulators to do the same.

14. What are the retiree-only health plans that are not governed by PPACA?

A retiree-only plan that is exempt from PPACA's mandates for a particular plan year is defined as any group health plan (and group health insurance coverage offered in connection with a group health plan) with less than two participants who are current employees. Exempt retiree plans covering dependents need not follow the adult child to age twenty-six rule but they must follow any applicable state rule unless the plan is self-insured, in which case state insurance law does not apply.

15. Is the retiree-only exemption available for self-funded and insured plans?

Yes, the retiree-only exemption applies to both self-funded and insured plans. PPACA technically eliminates the exemption in the Public Health Services Act for “plans with less than two participants who are current employees” but preserves the exemption under the parallel provisions in ERISA and the Internal Revenue Code.

The PHSA is applicable to governmental plans and to issuers of insured plans. The preamble to the PPACA grandfathering Interim Final Regulation, however, confirms that the retiree-only plan exemption under ERISA and the Code has been preserved, and also provides that, even though the exemption was technically eliminated from the PHSA:[[19]](#footnote-19)

* HHS will not enforce the requirements of HIPAA or PPACA with regard to non-federal governmental retiree-only plans, and
* States are encouraged not to apply the provisions of PPACA to issuers of retiree-only plans (i.e., insured plans).

16. From which PPACA mandates are retiree-only plans exempt?

Retiree-only plans are exempt from the PPACA-mandated “insurance market reforms” listed below (referring to PPACA sections):

* Section 2711 - No lifetime or annual limits
* Section 2712 - Prohibition on rescission
* Section 2713 - Coverage of preventive health services
* Section 2714 - Extension of dependent coverage
* Section 2715 - Development and utilization of uniform explanation of coverage documents and standardized definitions
* Section 2715A - Provision of additional information
* Section 2716 - Prohibition on discrimination in favor of highly compensated individuals for insured plans
* Section 2717 - Ensuring the quality of care reporting
* Section 2718 - Medical loss ratio restrictions
* Section 2719 - Required appeals process
* Section 2719A - Patient protections (selecting providers and emergency room services)
* Section 2794 - Rate review
* Section 2704 - Prohibition of preexisting condition exclusions or other discrimination based on health status
* Section 2701 - Restrictions on what criteria can be used in rating and rate band limits
* Section 2702 - Guaranteed issue
* Section 2703 - Guaranteed renewability
* Section 2705 - Prohibiting discrimination against individual participants and beneficiaries based on health status
* Section 2706 - Non-discrimination towards healthcare providers
* Section 2707 - Cost-sharing requirements and essential benefit requirements
* Section 2708 - Prohibition on waiting periods of more than ninety days
* Section 2709 - Coverage for individuals participating in approved clinical trials

17. Does the 2018 “Cadillac Tax” apply to retiree-only health plans?

It is unclear to what extent other PPACA provisions apply to retiree-only plans. For example, the excise tax on high-cost employer-sponsored health coverage[[20]](#footnote-20) applies to “qualified retirees.” The Cadillac Tax is discussed in more detail in Part VIII of this book.

18. Who are current employees for purposes of the retiree-only exemption?

The HIPAA regulations do not provide any guidance defining who is a current employee for purposes of the retiree-only plan exemption. However, a retiree who is rehired as an employee (and receives either a Form W-2 or Form 1099 for the year) should be treated as a current (i.e., active) employee that counts against retiree-only plan status and should be covered under the ERISA plan maintained for purposes of current employees immediately upon rehire.

HHS issued an FAQ indicating that the retiree-only exemption may be available for plans that cover both retirees and persons on long-term disability. Until further guidance is issued, HHS will treat such plans as satisfying the retiree-only exemption. To the extent future guidance on this issue is more restrictive with respect to the availability of the retiree-only exemption; the guidance will be prospective, applying to plan years that begin sometime after its issuance.

19. What should plan sponsors do in order to demonstrate that they have established a retiree-only plan that satisfies the exemption?

For ERISA welfare plans, the plan sponsor should maintain a separate plan document and summary plan description (SPD) and file a separate Form 5500 (if it has more than 100 participants at the beginning of the plan year). Plan sponsors that do not currently maintain a separate retiree-only plan but intend to establish one on a prospective basis for the following plan year should also follow these steps.

For non-ERISA retiree-only plans (for example, government plans), the plan should be a separate document and cover fewer than two current employees, other than dependents, who are beneficiaries for this purpose. Because non-ERISA plans do not file a Form 5500 or maintain SPDs as required by ERISA, as part of the certification process some insurance companies will require formal documentation describing the plan’s eligibility rules.

20. What will happen if a plan sponsor does not amend its group health plan to carve out retirees into a separate retiree-only ERISA plan?

If a plan sponsor continues covering current employees and retirees under the same ERISA plan, the retiree-only plan exemption will most likely not be met. This means that PPACA's requirements will apply. Plans that are not exempt from PPACA still may be “grandfathered” if they were in effect on March 23, 2010, and meet the criteria in PPACA for grandfathered status. Grandfathered plans are subject to some but not all of the PPACA mandates.

21. Can a plan sponsor amend its plan to carve out retirees into a retiree-only plan and preserve the grandfather status of the plan for current (i.e., active) employees?

Yes. Regulators have informally confirmed that amending a plan to carve out retirees into a separate retiree-only plan will not impact the grandfathered status of the plan for current employees under the following conditions:

* No changes may be made to the benefits or cost sharing for current employees, and
* The new separate retiree-only plan must be created as the new plan in the sequence.

The grandfathered plan Interim Final Regulations contain complex anti-abuse rules for changes in plan eligibility, but these rules apply only when the individuals transferred into another plan are employees, not retirees.[[21]](#footnote-21)

**21.01. Is a retiree with an option to receive retiree health coverage from a former employer eligible to buy insurance on an exchange (marketplace) and receive, if qualified, a subsidy?**

Yes, if the retiree is not enrolled in the retiree coverage. If the retiree can opt out of the retiree coverage, the retiree may qualify for the credit, even if the retiree coverage is otherwise affordable and provides minimum value. Current employees don’t have that flexibility – if the offered coverage is affordable and provides minimum value they are precluded from the credit whether they take the employer coverage or not.

The rule for former employees depends on whether they are actually covered. Prop. Treas. Reg. 1.36B-2(c)(3)(iv) states: “A former employee who may enroll in continuation coverage required under Federal law or a State law that provides comparable continuation coverage, and an individual who may enroll in retiree coverage under an eligible employer-sponsored plan, are eligible for minimum essential coverage under this coverage only for months that the individual is enrolled in the coverage.”

22. How does the retiree-only exemption relate to the Retiree Drug Subsidy Program (RDS) and Early Retiree Reinsurance Program (ERRP)?

A plan may receive reimbursements under the ERRP or subsidies under the RDS regardless of whether it meets the retiree-only plan exemption for HIPAA (and PPACA) purposes.[[22]](#footnote-22)

Employer and Individual Mandates

See Part XI for a Complete Discussion of the Employer Mandate Provisions and Appendix B Copies of Several Mandatory Notices

23. What mandates were delayed by the IRS in July 2015?

IRS Notice 2013-45 provided a one-year delay to three requirements under the healthcare reform law:

* The annual obligation under section 6055 of the Internal Revenue Code (Code) for insurers, self-insuring employers and other parties that provide “minimum essential coverage” to provide certain information to the IRS.
* The annual obligation under Code section 6056 for applicable large employers to report to the IRS and to the employer’s full-time employees as to whether and what healthcare coverage is offered to such employees.
* The requirement under Code section 4980H for applicable large employers to offer healthcare coverage to full-time employees or pay penalties, commonly known as the “play-or-pay” penalties (POP).or employer mandate. A second delay for certain employers was later announced. In 2015, the ACA's employer shared responsibility provisions will generally apply to larger firms (applicable large employers or ALEs) with 100 or more full-time employees. Employers with 50-99 full-time employees will have to comply starting in 2016.

Under additional transition relief, an employer may determine its status as an ALE for 2015 by reference to a period of at least six consecutive calendar months, chosen by the employer, during the 2014 calendar year, rather than the entire 2014 calendar year. This period must begin no later than July 1, 2014, and end no earlier than 90 days before the first day of the plan year beginning on or after Jan. 1, 2015 (90 days being the maximum permissible administrative period).

To avoid a payment for failing to offer health coverage in 2015, ALEs will need to offer coverage to 70 percent of their full-time employees. (It is 95% in 2016 and thereafter.)Employers who are new ALEs (employers not in existence in 2014) will not be subject to penalties for January through March of their first year of applicability, as long as they offer employee coverage that provides minimum value on or before April 1.

Other aspects of PPACA that were scheduled to become effective in 2014 will go into effect in 2014.

23.01 What final regulations have been issued regarding employer information reporting for healthcare reform for employers subject to the employer mandate?

Sections 6055 and 6056 of the Internal Revenue Code (“Code”) prescribe reporting of healthcare coverage and are effective for 2015, with the first forms to be filed in 2016, an administratively delayed effective date.[[23]](#footnote-23) The employer mandate generally requires employers with 50 or more full-time employees (applicable large employers or “ALEs”) to offer coverage to their full-time employees that meets minimum value and affordability standards under the ACA or pay a penalty. Employers that have fewer than 50 full-time and full-time equivalent employees are exempt from the ACA employer shared responsibility provisions and therefore from the employer reporting requirements. The final March 2014 regulations on this reporting provide for a single, combined form for information reporting under both Code 6055[[24]](#footnote-24) and 6056[[25]](#footnote-25) as well as a simplified option for employer reporting of “qualified offers” of coverage to employees.

Employers subject to a delayed employer mandate, i.e., those with at least 50 full-time employees but fewer than 100 full-time employees (including full-time equivalent employees), in transitioning into compliance with section 4980H, the final regulations provide transition relief from section 4980H for 2015 (plus, in the case of any non-calendar plan year that begins in 2015, the portion of the 2015 plan year that falls in 2016).[[26]](#footnote-26)

Code 6055 describes reporting requirements to the IRS and individuals for self-insuring employers, insurers, government entities, and certain other providers of minimum essential coverage (“MEC”). Wellness programs that are an element of other minimum essential coverage (such as wellness programs offering reduced premiums or cost sharing under a group health plan) do not require separate § 6055 reporting. Code 6056 describes reporting requirements for applicable large employers to provide employees with information so that they can determine whether they can receive a premium tax credit if they purchase insurance from a health care exchange. section 6056 also requires such employers to report to the IRS information concerning health care coverage. Reporting under these new requirements will be similar to the reporting of W-2 information where individual statements are provided to each employee on form W-2 and the W-2s are accumulated and summarized on Form W-3. Employers who sponsor self-insured health care plans and who are therefore required to report under both sections 6055 and 6056 may file a combined report for the IRS and employees. Electronic reporting is required for employers who have more than 250 employees for whom individual reports are required. Large employers that self-insure (employers that pay their employees’ medical costs directly, instead of joining a traditional plan) will fill out both sections of the form. Large employers that do not self-insure will only fill out the top half of the form, for reporting under Code 6056.

The final regulations under Code 6055 require an employer to report information about the employer, the employees insured, and information on the minimum essential coverage provided, including employee and dependent social security numbers or a date of birth if the SSN is not available after reasonable efforts to obtain it. Code 6056 requires applicable large employers to report information about themselves, such as the number of full-time employees for each month during the calendar year, certify whether they offered coverage to their full-time employees, and provide certain information about the plan offered, including the monthly premium for the plan.

The regulations provide that a qualifying offer of coverage is “an offer of minimum value coverage that provides employee-only coverage at a cost to the employee of no more than about $1,100 (9.5 percent of the estimated federal poverty level in 2015) in 2015” combined with an offer of coverage to the employee’s family, which does not need to meet the cost threshold. An employer makes a qualifying offer if it offered the employee coverage that provides 60 percent minimum value at an employee cost for employee-only coverage of no more than 9.5 percent of the federal poverty line, and also offered minimum essential coverage to employees’ spouses and dependents. For employees receiving a qualified offer for all 12 months, employers will need to report only the names, addresses, and taxpayer identification numbers of such employees. For employees receiving a qualifying offer in fewer than 12 months in the year, employers will be able to report such employees for each of those months by simply entering a code.

Employers need not report their health plan waiting periods nor the employer’s share of costs paid under the health plan.

24. What else does Notice 2013-45 specify regarding information reporting??

The IRS encourages employers, insurers and other reporting entities to voluntarily comply with the proposed rules for information reporting for 2014, but no penalties for failure to comply with these reporting provisions now exist for 2014.

The Notice makes clear that the 2014 transition relief is limited solely to these three items and has no effect on the effective date or application of other provisions under the Act, many of which go into effect in 2014. For example, the transition relief has no effect on the provisions taking effect in 2014 as to premium tax credits for those purchasing subsidized health insurance on an exchange marketplace or the individual mandate requirements under Code section 5000A for individuals to maintain healthcare coverage for themselves or pay penalties.

25. What is the employer mandate that begins in 2015?

Health reform and its “employer mandate” do not require employers to provide health coverage for their employees. However, beginning in 2015, any applicable large employer (one with fifty or more full-time employees) can be liable for a substantial “assessable payment”[[27]](#footnote-27) if it “fails to offer its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan.”[[28]](#footnote-28) As discussed above, however, employers with at least 50 full-time employees but fewer than 100 full-time employees (including full-time equivalent employees), enjoy transition relief from section 4980H for 2015 (plus, in the case of any non-calendar plan year that begins in 2015, the portion of the 2015 plan year that falls in 2016).

There are two alternative penalties for the employer mandate. The annual amounts are $2,000 or $3,000, but the actual amount is calculated monthly. Both the $2,000 and $3,000 penalty amounts will be adjusted for inflation.[[29]](#footnote-29) Neither penalty is triggered unless an employee receives a tax credit for the purchase of health insurance on a state exchange.

Generally, if an employee is offered affordable minimum essential coverage (MEC) under an employer-sponsored plan, then the individual is ineligible for a premium tax credit and cost-sharing reductions for health insurance purchased through a state exchange. However, an employee may be offered minimum essential coverage by the employer that is either “unaffordable” or that consists of a plan under which the plan's share of the total allowed cost of benefits is less than 60 percent. In that situation, the employee is eligible for a premium tax credit and cost-sharing reductions if the employee declines to enroll in the coverage and purchases coverage through an exchange.

“Unaffordable” is defined by PPACA as coverage with a premium required to be paid by the employee that is more than 9.5 percent of the employee's household income (as defined for purposes of the premium tax credit[[30]](#footnote-30) for individuals, discussed in Question 29). This percentage of the employee's income is indexed to the per capita growth in premiums for the insured market as determined by the Secretary of Health and Human Services. The employee must seek an affordability waiver from the state exchange and provide information as to family income and the lowest cost employer option offered to the employee. The state exchange then provides the waiver to the employee. The employer penalty generally applies for employees receiving an affordability waiver.

For purposes of determining whether coverage is unaffordable, required salary reduction contributions are treated as payments required to be made by the employee. However, if an employee is reimbursed by the employer for any portion of the premium for health insurance coverage purchased through the exchange, including any reimbursement through salary reduction contributions under a cafeteria plan, the coverage is employer-provided and the employee is not eligible for premium tax credits or cost-sharing reductions. Thus, an individual is not permitted to purchase coverage through the exchange, apply for the premium tax credit, and pay for the individual's portion of the premium using salary reduction contributions under the cafeteria plan of the individual's employer.[[31]](#footnote-31)

26. How does the state insurance exchange obtain information on the affordability to an individual?

The Tax Code[[32]](#footnote-32) permits the disclosure of taxpayer return information to assist exchanges and state agencies, but not employers, in performing certain functions for which income verification is required. Under proposed regulations, the IRS would be permitted to disclose income and other specified information about an individual taxpayer to HHS for purposes of making eligibility determinations for advance payments of the premium tax credit or the cost-sharing reductions.[[33]](#footnote-33) HHS could then disclose the information to the Exchange or the state agency processing the individual’s application. As a condition for receiving return information, each receiving entity (i.e., HHS, the Exchanges, and state agencies as well as their respective contractors) is required to adhere to the privacy safeguards established under Code section 6103(p)(4).

27. How do the two employer mandate penalties work?

Employers can be penalized for not providing minimum essential coverage or for having an inadequate health plan.

***No Minimum Essential Coverage - $2000 Per Full Time Employee Less 30 Penalty.*** Employers with at least fifty full-time equivalent employees and with at least thirty-one full-time employees must offer minimum essential health coverage meeting specified requirements. If the employers offer no health plan, they must pay a $2,000 per full-time employee penalty if any of the full-time employees receive a federal premium subsidy through a health care exchange.

The calculation of “a large employer” includes part-time workers. However, the $2,000 per Full-Time Employee Less 30 Penalty is only calculated based on full-time workers therefore, not all large employers who have a full-time employee receiving a credit would actually pay a penalty. This could occur because the first thirty workers are not counted.

For example, an employer with 100 part-time workers (fifteen hours per week) and thirty full-time workers (thirty-plus hours per week) would be considered a large employer with eighty full-time equivalent workers. Even if one or more workers received a premium credit, the penalty would only be assessed against the number of full-time workers: (30-30) x $2,000 = 0. Thus, read literally, if only one employee purchases insurance on an exchange and receives a premium tax credit, the penalty applies to all full-time employees less thirty full-time employees times $2,000.

The IRS has indicated that “it is contemplated that the proposed regulations will make clear that an employer offering [minimum essential] coverage to all, or substantially all, of its full-time employees would not be subject to the 4980H(a) ‘all-full time employees minus 30’ assessable payment provisions.”[[34]](#footnote-34)

To avoid the $2,000 penalty, the employer must offer “minimum essential coverage” to its full-time employees and their dependents.[[35]](#footnote-35) Dependents can include not only children, but also parents, siblings, uncles, aunts, nieces, nephews, grandchildren, and various in-laws.[[36]](#footnote-36) Any person who has the same principal place of abode and is a member of the same household as the taxpayer is eligible to become a dependent.[[37]](#footnote-37)

The minimum essential coverage that an employer must offer in order to avoid the “all full-time employees minus 30” penalty calculation is defined in the statutory provisions imposing the individual mandate. It includes only:

* government-sponsored programs (such as Medicare, etc.)
* eligible employer-sponsored plans
* plans offered in the “individual market”
* grandfathered health plans, and
* other coverage that “the Secretary of Health and Human Services, in coordination with the Secretary [of the Treasury], recognizes” for purposes of this determination.[[38]](#footnote-38)

There are some fundamental unresolved issues with respect to this definition. First, an “eligible employer-sponsored plan” is defined as a “group health plan or group health insurance coverage” that is either a governmental plan or another “plan or coverage offered in the small or large group market within a State.”[[39]](#footnote-39) Even though the language of that definition specifically seems to contemplate a “group health plan,” as opposed to “group health insurance coverage,” there was a question as to whether a private self-insured plan would qualify as “any other plan or coverage offered in the small or large group market within a State.” However, the IRS has indicated that self-insured plans qualify.[[40]](#footnote-40)

Second, the grandfathered health plan exception may not be applicable because of the ease with which a plan can lose grandfathered status. The actions that can destroy grandfathered status include:

* the elimination of all or substantially all benefits to diagnose or treat a particular condition
* any increase in a percentage cost-sharing requirement
* a decrease in the employer contribution rate by more than 5 percent, and
* certain changes to annual limits on benefits[[41]](#footnote-41)

In addition, it seems that failure annually to give plan participants a notice that the plan is grandfathered causes a loss of grandfathered status.[[42]](#footnote-42)

Third, minimum essential coverage is treated as being provided only if “the plan’s share of the total allowed costs of benefits provided under the plan is at least 60 percent of such costs.”[[43]](#footnote-43) However, if the employee nevertheless participates in the plan, this rule does not apply.[[44]](#footnote-44) Determining whether this requirement is satisfied is easy only for fully insured plans with no deductibles, co-pays or coinsurance. When the employer pays 60 percent or more of the premium, such a plan would be treated as providing “minimum essential coverage.”

How deductibles, co-pays, and coinsurance should be handled is not clear. The plan’s 60 percent share is measured against “the total allowed costs of benefits provided under the plan.” To the extent that an employee pays deductibles, co-pays, and coinsurance, those benefits are not provided under the plan. If deductibles, co-pays, and coinsurance are to be counted, then, application of the 60 percent test is much more difficult.

***Inadequate Health Plan - $3000 Per Full-Time Employee Penalty***. A different penalty applies for employers of at least fifty full-time equivalent employees that offer minimum essential coverage that does not meet the federal requirements. Employers that offer health coverage will not meet the requirements if:

* at least one full-time employee obtains a premium credit in an exchange plan, and
* the plan does not provide:
* minimum essential benefits,
* the employee’s required contribution for self-only coverage exceeds 9.5 percent of the employee’s household income, or
* the employer pays for less than 60 percent of the benefits.

In 2015, the monthly penalty assessed to the employer for each full-time employee who receives a premium credit will be one-twelfth of $3,000 for any applicable month. However, the total penalty is limited to the total number of the firm’s full-time employees minus thirty, multiplied by one-twelfth of $2,000 for any applicable month. After 2015, the penalty amounts will be indexed by the premium adjustment percentage for the calendar year.

This penalty is imposed for any month in which “at least one full-time employee of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan through a state health insurance exchange for which a tax credit is allowed or paid.”[[45]](#footnote-45) As explained in Question 29, this individual tax credit is available to most low- and middle-income individuals that are not offered affordable, minimum essential coverage by their employers and are not covered by Medicaid.[[46]](#footnote-46)

28. Is the employer mandate excise tax deductible?

The employer mandate excise tax is not deductible. The IRS is establishing a vast information-gathering process through which it will calculate and assess the tax proactively without self-reporting by employers. To avoid the tax, proper health coverage must be offered to at least 95 percent of an employer’s employees. Independent contractors who should be treated as full-time employees under the common law standards must be taken into account in the 95 percent threshold test.

29. How is the 95 percent of the employer’s employees calculated?

The 95 percent (70% in 2015 for those ALEs subject to the employer mandate in 2015) threshold must be calculated monthly, because the excise tax is assessed monthly, at a rate of $166.67 ($2,000/12). Therefore, each month, an employer must identify its full-time employees based on weekly average hours of service during the month and determine whether they have been offered coverage for the month. For hourly employees, actual hours must be counted. For salaried employees, actual hours may be counted or hours-equivalency rules may be used to eliminate the administrative burden of counting actual hours.

To make the full-time employee determination more predictable, an employer can take advantage of rules that allow an employee’s status as a full-time employee in future periods to be based on hours of service in prior periods. While these rules are helpful, they, too, are complex and have exacting standards.

30. Does the employer have to offer coverage for all days of the month in order to avoid the penalty?

Yes. If an employer fails to offer coverage to a full-time employee for any day of the month, the employee is treated as not having been offered coverage for the entire month.

31. How are full-time and full-time-equivalent employees calculated?

A large employer potentially subject to the employer mandate penalty is an employer with more than fifty full-time-equivalent employees during the preceding calendar year. Additionally, an employer who is part of a group of employers treated as a single employer under Code sections 414 (b), (c), (m), or (o) (including employees of a controlled group of corporations, employees of partnerships, proprietorships, etc., which are under common control, and employees of an affiliated service group) is treated as a single employer.[[47]](#footnote-47) When a mandate penalty applies, it is to be paid ratably by members of the group.[[48]](#footnote-48) For employers not in existence throughout the preceding calendar year, the determination of large employer is based on the average number of employees a firm is reasonably expected to employ on business days in the current calendar year.[[49]](#footnote-49) Any reference to an employer includes a reference to any predecessor of that employer.[[50]](#footnote-50)

The statutes use the term “full-time employee” in the definition of large employer, but then expand on the definition to include both full- and part-time workers.[[51]](#footnote-51) Full-time employees are those working thirty or more hours per week.[[52]](#footnote-52) The number of full-time employees excludes any full-time seasonal employees[[53]](#footnote-53) who work for less than 120 days during the year.[[54]](#footnote-54) The hours worked by part-time employees (i.e., those working less than 30 hours per week) are included in the calculation of a large employer, on a monthly basis, by taking their total number of monthly hours worked divided by 120.[[55]](#footnote-55) In addition, an employer will not be considered a large employer if its number of full-time-equivalent employees exceeded 50 for 120 days or less or the employees in excess of 50 employed during the 120-day period were seasonal workers.[[56]](#footnote-56)

***Example***: A firm has 35 full-time employees who work 30 or more hours per week. In addition, the firm has 20 part-time employees who all work 24 hours per week (96 hours per month). These part-time employees’ hours would be treated as equivalent to 16 full-time employees, based on the following calculation:

20 employees x 96 hours = 1920

1920 / 120 = 16

32. Can you provide examples of the employer mandate tax penalties?

***Example A:*** The large employer does not offer coverage, but no full-time employees receive credits for exchange coverage. No penalty would be assessed.

***Example B:*** The large employer offers coverage and no full-time employees receive credits for exchange coverage. No penalty would be assessed.

***Example C:*** The large employer does not offer coverage, and one or more full-time employees receive credits for exchange coverage. The annual penalty calculation is the number of full-time employees minus 30, times $2,000. The penalty does not vary if only one employee or all fifty employees received the credit; the employer’s annual penalty in 2015 would be $40,000 calculated as follows:

50 - 30 = 20

20 x $2,000 = $40,000.

***Example D:*** The employer offers health plan coverage, but one or more full-time employees receive credits for exchange coverage. The number of full-time employees receiving the credit is used in the penalty calculation for an employer that offers coverage. The annual penalty is the *lesser of* the following:

* The number of full-time employees minus 30, multiplied by $2,000, or $40,000 for the employer with fifty full-time employees, as shown in Example C, or
* The number of full-time employees who receive credits for exchange coverage, multiplied by $3,000.

Thus, for an employer that hires only full-time employees, hiring that fiftieth employee could trigger a penalty of $40,000 if the employer does not offer health coverage to its employees. This will likely affect hiring for small employers close to the “applicable large employer” fifty full-time-equivalent employee limit.

Although the penalties are assessed on a monthly basis (with the dollar amounts above then divided by 12), this example uses annual amounts, assuming the number of affected employees is the same throughout the year.

***Example E:*** If the employer with fifty full-time employees had ten full-time employees who received premium credits, then the potential annual penalty on the employer for those individuals would be $30,000. Because this is less than the overall limitation for this employer of $40,000, the employer penalty in this example would be $30,000.

However, if the employer with fifty full-time employees had thirty full-time employees who received premium credits, then the potential annual penalty on the employer for those individuals would be $90,000. Because $90,000 exceeds this employer’s overall limitation of $40,000, the employer penalty in this example would be limited to $40,000.

33. What reporting is required by employers, other than the W-2 requirements?

Beginning in 2015[[57]](#footnote-57), large employers with fifty or more full-time-equivalent employees and “offering employers”[[58]](#footnote-58) will have certain reporting requirements with respect to their full-time employees.[[59]](#footnote-59) Employers will have to file a return including:

* The employer’s name, address, and employer identification number
* A certification as to whether the employer offers its full-time employees (and dependents) the opportunity to enroll in minimum essential overage under an eligible employer-sponsored plan
* The length of any waiting period
* The months that coverage was available
* Monthly premiums for the lowest-cost option
* The employer plan’s share of covered healthcare expenses
* The number of full-time employees; and
* The name, address, and tax identification number of each full-time employee

Additionally, an offering employer will have to provide information about the plan for which the employer pays the largest portion of the costs (and the amount for each enrollment category).

Insurers must also report certain information to the IRS[[60]](#footnote-60) as discussed subsequently in this book.

Additionally, the employer must also provide each full-time employee with a written statement showing contact information for the person preparing the required return, and the specific information included in the return, for that individual employee. An employer may enter into an agreement with a health insurance issuer to provide necessary returns and statements.

34. How do the information reporting requirements and the employer mandate penalties interact?

The information reporting required by Code sections 6055 and 6056 must occur for the IRS to enforce and administer the employer mandate requirements under Code section 4980H. Additionally, this information is needed by the employee and the IRS for the administration of the premium tax credit for the purchase of health insurance on an exchange. The employer mandate penalties are triggered if one or more of an applicable large employer’s full-time employees are entitled to premium tax credits for the purchase of insurance on a state exchange marketplace under Code section 36B and (1) the employer fails to offered 95 percent of full-time employees and their dependents the opportunity to enroll in minimum essential coverage or (2) the employer offers full-time employees and dependents the opportunity to enroll in minimum essential coverage but the coverage is not affordable or does not provide minimum value. The second penalty can never exceed the first penalty.

An employer typically will not know whether a full-time employee has received such a tax credit, and the employer will not have all the information needed to determine whether it owes an employer mandate penalty. Therefore, IRS Notice 2013-45 provides that applicable large employers do not have to calculate employer mandate penalties or file returns submitting payment for such penalties. Instead, the IRS, after receiving the information returns filed by applicable large employers under Code section 6056 and the information about employees claiming the premium tax credit for any given calendar year, will determine whether any of the employer’s full-time employees received the premium tax credit and, if so, whether any employer mandate penalty is due. The IRS will thus contact any applicable large employer if the employer owes a penalty, and the employer will have an opportunity to respond to the information provided by IRS before any penalty is assessed.

35. Can employees still receive premium tax credits in 2014?

Yes. IRS Notice 2013-45 states that the transition relief does not affect an individual’s eligibility for a premium tax credit if he or she purchases health insurance through one of the health insurance exchange marketplaces established under the Act. Participants in the exchanges will continue to qualify for premium tax credits if their household income is within the specified range and they are not eligible for other minimum essential coverage. Such other minimum essential coverage includes eligible employer-sponsored group health plans that are affordable and provide minimum value.

36. Does a state health insurance exchange notify the employer if an individual is determined to be eligible for the income tax credit?

HHS regulations require the Exchange to notify the employer and identify the employee when the Exchange determines an applicant is eligible to receive advance payments of the premium tax credit or cost-sharing reductions based in part on a finding that his or her employer does not provide minimum essential coverage, or provides coverage that is not affordable, or does not meet the minimum value standard.[[61]](#footnote-61) The notice includes the employee’s identity, that the employee has been determined eligible for advance payments of the premium tax credit, that the employer may be liable for a shared responsibility payment, and that there is an opportunity to appeal.[[62]](#footnote-62) The details such as the employee’s tax return information or the exact reason the employee is eligible for assistance are not included.[[63]](#footnote-63)

37. Under what circumstances may employers otherwise subject to the tax qualify for exemption?

Employers otherwise subject to the tax are exempt if (1) no full-time employee decides to purchase health insurance through a state or federal exchange or (2) no full-time employee’s household income is low enough to qualify for a premium tax credit or subsidy. Income below these levels below qualifies for the subsidy. The premium credits will be provided as advanceable, refundable federal tax credits ultimately calculated through individual tax returns (although the credit payments will go directly to insurers). The credits can only be obtained by qualifying individuals (among others, lawful state residents) who file tax returns and are not eligible for other acceptable minimum essential coverage, such as an employer plan (that is affordable [IRS and HHS will issue guidance and provide an on-line calculator for this] and pays for at least 60 percent of projected health costs), Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), coverage related to military service, a grandfathered plan. The federal poverty level that applies is that of the preceding year, i.e., for determining the federal poverty level (FPL). For 2014 subsidies, the 2013 FPL applies.

|  |  |
| --- | --- |
| **# of individuals** | **Household income[[64]](#footnote-64)(four times federal poverty level in 2013)** |
| 1 | $45,960 |
| 2 | $62,040 |
| 3 | $78,120 |
| 4 | $94,200 |
| 5 | $110,280 |
| 6 | $126,360 |
| 7 | $142,440 |
| 8 | $158,520 |

38. What effect will a state’s decision whether to expand Medicaid under the ACA have on the employer mandate penalty?

If a state elects to expand Medicaid under healthcare reform, a person earning less than 138 percent[[65]](#footnote-65) of the Federal Poverty Level or FPL ($15,857 for an individual in 2014) can qualify even if not a parent or not disabled. If a state does not elect the healthcare reform Medicaid expansion, additional penalty exposure is created for employees whose household income is between 100 percent and 138 percent of FPL because they could be eligible for exchange purchased health insurance premium subsidies.

39. How does an employer appeal the tax penalties?

Employers will have an appeals mechanism to contest a determination that it is liable for the new employer mandate penalties imposed under Code section 4980H because:

* The employee was not eligible for an individual tax credit due to the employee's household income or
* The employer had provided minimum essential coverage that was affordable.

As part of the appeals process, the employer will “have access to the data used to make the determination to the extent allowable by law,” but it is still subject to the nondisclosure provision.[[66]](#footnote-66) This appeals mechanism would be in addition to the employer’s appeals rights under the Internal Revenue Code.[[67]](#footnote-67)

This process raises several questions – with no clear answers – regarding the extent to which, if at all, an employer may contest an employee's income taxes. For instance, if an employee claims numerous dependents (which could significantly reduce household income) would an employer be able to investigate whether the employee provided more than 50 percent of the support for those claimed dependents? Could an employer seek to challenge above-the-line business deductions claimed by an employee?

40. What other issues must be considered by employers in planning for the employer mandate tax penalties?

Applicable large employers (those with 50 or more full time equivalent employees) that may be subject to an employer mandate penalty will need to consider taking action, if possible, (1) to avoid the employer mandate versus (2) minimizing its effect or (3) embracing it strategically. Certain industries and business sectors will be hit hard while others will gain relief. In addition, the competitive balance regarding costs will be impacted. For example, consider regional and national restaurants operating as one employer versus franchised operations where the small franchisees will not be subject to the employer mandate tax penalty. Issues to be considered include workforce size and composition.

* Workforce size determines whether the mandate applies and potential cost/penalty exposure.
* Workforce composition will trigger other issues, such as
* Part-Time vs. Full-Time Employees
* Independent Contractors and/or Leased Employees
* Lower-Income vs. Higher-Income
* Bargaining-Unit Employees

***Risk of Independent Contractor Reclassification*.** An employer may have one or more independent contractors that are reclassified as employees. As a result, that employer with fewer than fifty full-time employees could find itself with fifty or more after the reclassification. Additionally, such persons could trigger one of the employer mandate penalties if they receive a tax credit for purchasing health insurance on an exchange.

***Changing Status of Full-Time Employees.*** Employers with group health plans that consider converting full-time employees to part-time status or independent contractors, or terminating employees to avoid the employer mandate penalties, could face ERISA claims by these employees.

A group health plan is an employee welfare plan governed by ERISA. Under ERISA section 510, it is unlawful to hire, suspend, fine, discipline, expel, or discriminate against a participant or beneficiary for the purpose of interfering with the attainment of any right to which such a participant may become entitled under the plan or ERISA. A plaintiff in such a case typically has the burden of proving there was an adverse action against the participant or beneficiary for the purpose of interfering with the attainment of an ERISA benefit. However, employers should be cautious as to the reasons and documentation for any such employee changes.

***Employers Slightly Below 50 Full-Time Equivalent Employee Limit***. Thus, for an employer that hires only full-time employees, hiring that fiftieth employee could trigger a penalty of $40,000 if the employer does not offer health coverage to its employees. This will likely affect hiring for small employers close to the “applicable large employer” fifty full-time-equivalent employee limit.

40.01 Is there any employer relief for misclassified independent contractors in the final employer mandate regulations?

The final employer mandate (a/k/a/ shared responsibility or play or pay) regulations[[68]](#footnote-68) offer no relief for an applicable large employer’s failure to offer that coverage due to employee misclassification. Counting employees is important for determining whether an employer is an applicable large employer potentially subject to the Code § 4980H(a) or (b) employer mandate penalties, and if so, if an offer of health coverage has been made to enough employees to avoid the Code § 4980H(a) $2000 per employee per year penalty. The final regulations, like the proposed regulations, take the position that an “employee” is defined by reference to a common law standard, which means an employment relationship where the entity controls how and what the employee does in the scope of his or her provision of services to the employer. This definition excludes individuals who are correctly classified as independent contractors; as such, employers are not required to count independent contractors for purposes of determining whether the coverage mandate applies or which individuals must be offered coverage under the employer’s plans. The employee definition also excludes a leased employee (a technical term[[69]](#footnote-69)), a sole proprietor, a partner in a partnership, or a more than two-percent S corporation shareholder.

No relief is provided for reasonable but wrong decisions classifying employees as independent contractors. The final regulations preamble specifically provides that there is no “Section 530 Relief,” which allows employers to cut off liability for failing to withhold federal income tax, FICA and FUTA taxes due to worker misclassification if certain requirements are met.[[70]](#footnote-70) Thus, there is no avenue for the employer mandate penalty to ameliorate the impact of a misclassification error on compliance with the employer mandate provisions. Thus, employers should review their arrangements with independent contractors, consultants, and other non-employee workers to ensure that they have been properly classified.

To avoid penalties, applicable large employers are required to offer coverage to 95% (70  
% in 2015) their “common law” full-time employees. An individual is a common law employee of a company if the company has the right to “control and direct the individual who performs the work, not only as the result is to be accomplished by the work but also as the to the details and means by which that result is accomplished.” If paying with a Form 1099, the employer has cause to worry. If workers paid with a Form 1099 should actually be employees and are classified incorrectly as independent contracts, the employer could be on the hook for an offer of coverage.

When it comes to temporary staffer, an individual might be issued a W-2 by one company, but another company has the right to control and direct that individual as to what job needs to be done and how to do it. Here, the company has the right to control and direct that individual has the obligation to offer coverage, even though it might not be the employer for payroll purposes. There are rules that allow the client employer to take credit for an offer of coverage made by a staffing agency, but the arrangement between the client employer and the staffing agency must meet certain criteria.

41. What is the individual mandate that is effective in 2014?

The U.S. Supreme Court ruled that the individual mandate is constitutional.[[71]](#footnote-71) Beginning January 1, 2014, health reform requires most individuals to have some form of health coverage. If an applicable individual does not have minimum essential coverage, for that individual or his or her dependents who also meet the definition of applicable individual, a tax “penalty” will be imposed on the individual. [[72]](#footnote-72) The penalty is equal to the greater of:

(i) the “applicable dollar amount” for the individual and all such dependents (up to a maximum of three applicable dollar amounts), or

(ii) a specified percentage of the applicable individual’s household income.

The minimum penalty ranges from $95 in calendar year 2014 up to $695 in calendar year 2016, and is inflation-adjusted thereafter.[[73]](#footnote-73) Moreover, the applicable percentage of income increases from 1percent in calendar year 2014, to 2percent in calendar year 2015 and to 2.5percent for calendar year 2016 and thereafter.[[74]](#footnote-74) For low-income employees, the minimum penalty is small in comparison to the actual cost of coverage, thereby increasing the likelihood that an individual without minimum essential coverage will not purchase health insurance, although the tax credit subsidies will make the insurance less expensive.

In no event will the penalty be more than “the national average premium for qualified health plans which have a bronze level of coverage with coverage for the applicable family size involved, that are offered through exchanges.”[[75]](#footnote-75) Rev. Proc. 2014-46 sets forth the monthly national average premium for the bronze coverage for 2014. The monthly average premium for bronze level coverage for an individual is $204, i.e., $2,448 for twelve months. For a family of five or more members, it is $1020 per month or 5 times the individual coverage premium, $12,240 for twelve months.

41.01 Have there been clarifications issues as to when health insurance needs to be obtained to avoid penalty under the Affordable Care Act?

The White House has issued a statement clarifying when an applicable individual must obtain insurance on the Affordable Insurance Exchange Marketplace (Exchange) to avoid a penalty under the Affordable Care Act (ACA).

Code section 5000A requires most U.S. citizens and legal residents for tax years ending after December 31, 2013 to maintain minimum essential health insurance coverage or pay a penalty. “Health insurance coverage” includes government sponsored programs such as Medicare, Medicaid, The Children's Health Insurance Program; eligible employer-sponsored plans; plans in the individual market; certain grandfathered group health plans; and other coverage as recognized by the Department of Health and Human Services. This requirement is referred to as the “individual mandate,” and the penalty is often referred to as the “shared responsibility payment.” The individual mandate was highly controversial and challenged soon after the ACA was enacted. The mandate was upheld by the Supreme Court as a valid exercise of Congress's taxing power.

Applicable individuals have a choice of either maintaining minimum essential coverage for themselves and any nonexempt family members or including an additional payment with the Federal income tax return. The amount of the shared responsibility payment for any tax year is generally the sum of monthly penalty amounts for all months in the tax year in which any nonexempt individual for whom the taxpayer is liable under Code section 5000A(b) did not have minimum essential coverage, computed based on either a flat dollar amount or a percentage of the taxpayer's income over established thresholds. (Code section 5000A(c))

A number of situations can apply in which an individual is exempt from the penalty imposed by Code section 5000A(a), including “short coverage gaps,” i.e., when the individual isn't covered by minimum essential coverage for a continuous period (beginning no earlier than January 1, 2014) of less than three months. There has been confusion about the “short coverage gaps” provision as it applies to the operative dates for the individual mandate.

The individual mandate goes into effect on January 1, 2014. Open enrollment for coverage on the Exchange is from October 1, 2013 through March 31, 2014. A non-exempt individual will face a penalty if he doesn't have coverage for three consecutive post-2013 months (including January, February, and March of 2014). Under these rules, a person could purchase insurance on the Exchange within the open enrollment period, and if the policy doesn't go into effect until after March, still face a penalty for exceeding the exception for a short coverage gap. This would force many Americans to purchase insurance under the Exchange no later than February in many cases to avoid a penalty.

The Administration has now clarified the deadline, stating that individuals who sign up for insurance on the Exchange within the open enrollment period won't face a penalty. The Administration, as well as the Department of Health and Human Services (HHS), have emphasized that this “clarification” isn't a substantive modification and that the start date for benefits and overall deadline for enrolling remain unchanged. This clarification is viewed by many as welcome news as it effectively gives individuals more time than originally thought to obtain coverage and not face a penalty. On the other hand, a number of politicians are calling for even more change such as extending the open enrollment period or delaying the individual mandate penalty for a year.

See also Q 392.

42. Will the individual mandate work to induce individuals to purchase health insurance?

There are low participation rates in health insurance, even in many companies that offer health coverage. One CEO has asked employees why they do not participate in the employer provided coverage.[[76]](#footnote-76) The answers he received are typical:

* Younger workers were unconcerned about illness or injury.
* Others already had insurance through a spouse or parent.
* A significant number said they declined coverage because they could get medical treatment "for free at the emergency room." This fact remains true in and after 2014, as the federal law known as EMTALA requires hospitals to provide emergency services, even to those who cannot pay.
* Among those who had signed up, many said it was because they were concerned about developing a medical condition and then being unable to get affordable coverage due to this preexisting condition. Significantly, in 2014, these people will be able to obtain health insurance on exchanges despite any preexisting conditions, which will further disincentive to enrollment in both employer and exchange offered health insurance.

This reality may mean that healthcare reform may be more expensive and not work as hoped. The law’s success depends on young, healthy people who are lower risk signing up for health insurance to offset the costs of insuring individuals with preexisting conditions, many who in the past have been unable to purchase insurance, and who are at higher risk for the need for expensive medical care. If predominantly high-risk individuals sign up on the state exchanges, that health insurance will be expensive. Nevertheless, people will still be able to get medical care at the emergency room. Further, the law in 2014 prohibits insurers from denying coverage because of preexisting conditions. Therefore, individuals have even less incentive to purchase health insurance as they will no longer have much incentive to get health insurance as a hedge against the possibility of developing a medical condition when they are presently healthy.

One of the law’s answers to these issues is the individual mandate penalty tax on uninsured individuals that goes into effect in 2014. The penalty in 2014 is $95 or 1 percent of household income, whichever is greater. It increases in 2016 to $695 or 2.5 percent of household income, whichever is greater. The individual mandate is not sufficient to change the behavior of many persons who are not otherwise inclined to buy health insurance. A person making $50,000 per year with no health coverage will be subject to an initial individual mandate penalty of $500 and a maximum penalty of $1,250 in 2016. The typical share of employee cost for company sponsored health coverage will often exceed this amount, often by a significant amount. Low paid employees who earn, for example, $11,500 per year, would be subject to an initial penalty of $115 in 2014 and a maximum penalty of $695 in 2016. Such workers’ share of health insurance premiums will again often be more than any potential penalty.

Thus, the individual mandate will likely neither raise as much money as projected nor induce as many uninsured to purchase insurance as hoped. In addition, if more individuals move from employer to subsidized state exchange provided insurance than projected, this too will make healthcare reform much more expensive than projected.

Controlled Group and Affiliated Service Group Issues

43. Are there special issues for controlled groups and affiliated service groups?

If there is more than one such business involved, the thirty-employee base amount must be allocated among all such businesses “ratably” on the basis of the number of full-time employees in each business. However, there are still some unanswered questions, for example:

* What if one employer within a controlled group of corporations provides coverage for all of its employees? Will it be exempt from the penalties, even though another employer within the same controlled group is not?
* Will the exempt employer’s employees serve to increase the penalty on a related taxable employer?

***Example:*** A married couple owns two businesses: a financial planning business (with fourteen full-time (FT) employees and six part-time employees), plus a franchise (with eighteen FT employees and fifty part-time employees). The businesses are treated as a single employer because they are commonly owned (80 percent or more by same five or fewer people) by the husband and wife. Assuming the part-time employees each work an average of eighty hours per month, they collectively count as thirty-seven full-time-equivalent employees.

FTE status is calculated by taking the average number of hours worked per month times the number of part-time employees [those regularly scheduled to work less than 30 hours per week] divided by 120, rounded down to the whole number). Thus, the combined business will be subject to the employer mandate once it takes effect in 2015 (because 32 FT employees and 37 FTEs is a total of 69 FTEs).

First, if the businesses do not provide all of the full-time employees of both businesses with coverage that meets the new standards, the combined businesses will be subject to a $4,000 per year nondeductible excise tax. While the businesses are subject to the employer mandate, the penalty is calculated on the basis of full-time employees only (a total of thirty-two) and there is an exemption for the first thirty full-time employees.

32 – 30 = 2

2 x $2,000 = $4,000.

Second, even if the businesses do not provide affordable minimum essential coverage, the penalty will not exceed $4,000 per year even if one or more full-time employees:

* Opt out of the coverage,
* Purchase their own coverage on an exchange, and
* Qualify for taxpayer-subsidized coverage (because their family incomes fall below the applicable federal thresholds).

The overall penalty is limited to what it would be if the employers provided no coverage at all.

43.01 What are the types of Controlled Groups and how are they treated under the Employer Mandate?

Employees of companies within the same controlled group must be aggregated to determine whether the commonly owned companies are subject to the employer mandate. IRC § 4980H(c)(2)(C)(i) states that all persons treated as a single employer under Code subsections 414 (b), (c), (m), or (o) shall be treated as one employer. Thus, the employer controlled group definition is the same as for pension purposes, and the common ownership requirement is 80 percent.

**Three Types of Controlled Groups**

There are three types of controlled groups that are considered one employer for the purposes of the ACA employer mandate. The IRS defines, and provides example of, these three controlled groups in [IRS Code § 414 (b) and 414 (c)](http://www.irs.gov/pub/irs-tege/epchd704.pdf).

**1.** **Parent-Subsidy Group:** When one or more businesses are connected through stock ownership with a common parent corporation (such as a chain); and

* 80 percent of the stock of each corporation (except the common parent) is owned by one or more corporations in the group, and
* Parent Corporation must own 80 percent of at least one other corporation.

**2. Brother-Sister Group:** A group of two or more corporations, where five or fewer common owners own directly or indirectly a "controlling interest" of each group and have “effective control.”  A common owner must be an individual, a trust, or an estate.

* Controlling interest: Generally means 80 percent or more of the stock of each corporation (but only if such common owner own stock in each corporation); and
* Effective control: More than 50 percent of the stock of each corporation, but only to the extent such stock ownership is identical with respect to such corporation.
* Example: A Individuals A and B own 100 percent of corps X and Y as follows:

Identical

Individuals Corps Ownership

X Y

A 30% 70% 30%

B 70% 30% 30%

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total 100% 100% 60%

As A and B own all of the stock of both corporations, the 80-percent ownership of the vote or value, has been satisfied.

Reviewing the identical ownership in the two corporations, A's identical ownership in respect of X and Y is 30 percent, and likewise, B's identical ownership in the two corporations is 30 percent. For purposes of the test it is the combined identical ownership of the five or fewer shareholders that must exceed 50 percent. Since A and B together have identical ownership in X and Y of 60 percent that aspect of the test is satisfied. Accordingly, X and Y are members of a brother-sister controlled group.

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**3. Combined Group:**A group consisting of three or more organizations that are organized as follows:

* Each organization is a member of either a parent-subsidiary or brother-sister group, and
* At least one corporation is the common parent of a parent-subsidiary, and is also a member of a brother-sister group

44. Will applicable employers terminate their health plans so that employees must purchase health insurance on a state exchange because the penalties are much less than the costs of a group health plan?

Whether employers subject to the employer mandate will decide to cease offering health coverage in 2015 or thereafter and elect to pay the $2,000 “all-full time employees minus 30” penalty is likely to substantially affect the ultimate impact of health reform.[[77]](#footnote-77) An employer’s annual healthcare costs will be much greater than the penalty. Even though the penalty is nondeductible and amounts paid for employee healthcare coverage should continue to be deductible, some – and perhaps many – employers will consider ceasing to offer a group health plan in 2015 or thereafter, especially those with low-paid workforces whose employees will receive income tax subsidies for health insurance purchased on a state exchange. The tax credit discussed in Q 49 for low- and middle-income persons (with incomes below 400 percent of the federal poverty level) buying insurance through the exchanges will be substantial. Therefore, as described in more detail in Q 49 although health coverage is an important part of many employers’ benefit packages, discontinuing such coverage would allow some employers with lower wage employees, as well as the employees themselves, to both come out ahead economically. For example, the employer could terminates health coverage and pass some of the net savings (after taking the penalty into account) on to its employees in the form of additional cash compensation.

However, it could be more expensive for many employers to discontinue coverage and increase employee compensation up to the amount saved in health costs less the penalty paid. Depending on workforce demographics, offering coverage may save money.

**Exchanges and Individual Tax Subsidies Change Calculations**[[78]](#footnote-78)

Today about 163 million workers and their families receive health insurance coverage from their employers. Proponents of PPACA insisted that a key tenet was to build on this system of employer-sponsored coverage. Importantly President Obama himself repeatedly promised that individuals would get to keep their own health insurance if they liked it.

Roughly half of the $900 billion of spending in PPACA is devoted to subsidies for individuals who do not receive health insurance from their employers. These subsidies are remarkably generous, even for those with relatively high incomes. For example, in 2014:

* A family earning about $59,000 a year would receive a premium subsidy of about $7,200
* A family earning about $71,000 would receive a premium subsidy of about $5,200
* A family earning about $95,000 would receive a premium subsidy of almost $3,000

By 2018, subsidy amounts and the income levels to qualify for those subsidies would grow substantially:

* A family earning about $64,000 would receive a subsidy of m $10,000
* A family earning $77,000 would receive a subsidy of $7,800, and
* Families earning $102,000 would receive a subsidy of almost $5,000

An obvious question is how employers will react to the presence of an alternative – a subsidized source of insurance for their workers – that can be accessed if companies drop coverage for their employees. The most simple calculation focuses on the tradeoff between employer savings and the $2,000 penalty (per employee) imposed by the PPACA on employers whose employees move to an exchange for subsidized health insurance.

The following chart shows situations in which the purely economic decision of an employer would be to drop or keep its health plan. The answer frequently depends on the size of the federal tax credit subsidy. The first row of the table below shows a worker at 133 percent of the Federal Poverty Level (FPL) or $31,521 in 2014. This worker is expected to be in the 15 percent federal tax bracket, which means that $100 of wages (which yields $85) is needed to offset the loss of $85 dollars of untaxed employer-provided health insurance. Consider now a health insurance policy worth $15,921, of which the employer pays 75 percent of the cost. The employer’s contribution to health insurance of $11,941 is the equivalent of a wage increase of $14,048, ignoring any state income taxes.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Healthcare Reform and Employer-Sponsored Insurance in 2014  Employer Health Plan Cost of $11,941**[[79]](#footnote-79) | | | | | | | |
| **Percent of Federal Poverty Level** | **Income[[80]](#footnote-80)** | **Tax Bracket[[81]](#footnote-81)** | **Wage Equivalent[[82]](#footnote-82)** | **Federal Subsidy** | **Pay Raise[[83]](#footnote-83)** | **Employer Cash Flow[[84]](#footnote-84)** | **Decision[[85]](#footnote-85)** |
| 133% | $31,521 | 15% | $14,048 | $14,176 | -$128 | $9,941 | Drop |
| 150% | $35,550 | 15% | $14,048 | $13,385 | $663 | $9,941 | Drop |
| 200% | $47,400 | 25% | $15,921 | $10,985 | $4,936 | $9,941 | Drop |
| 250% | $59,250 | 25% | $15,921 | $7,530 | $8,391 | $9,941 | Drop |
| 300% | $71,100 | 25% | $15,921 | $5,187 | $10,734 | $9,941 | Keep |
| 400% | $94,800 | 28% | $16,585 | $2,935 | $13,650 | $9,941 | Keep |

The Congressional Budget Office (CBO) estimated that only nineteen million residents would receive subsidies, at a cost of about $450 billion over the first ten years. This analysis suggests that the number could easily triple (nineteen million plus an additional thirty-eight million in 2014). The gross price tag would be roughly $1.4 trillion, which would be partially offset by employer mandate tax penalties.[[86]](#footnote-86)

PEO (Staffing Industry) Compliance with Employer Mandate

45. Will the employee mandate and related penalties apply to professional employer organizations (PEO), also known as the staffing industry?

The healthcare reform employer mandate tax penalty (also called Play or Pay or Shared Responsibility) rules apply to “applicable large employers,” which include employers with fifty or more full-time and full-time equivalent employees. Many if not most Professional Employer Organizations (PEOs), also known as staffing firms and employee leasing companies, are applicable large employers.

There is no one right answer for how employers will comply with the employer mandate penalty. Some will continue to offer health insurance or not offer it if they do not now. Others may adopt a different program or cease to offer health coverage.

See Q 23 through Q 40 for information on the employer mandate and the employer mandate penalty. See also Part XI for a detailed discussion of the employer mandate penalties.

46. How does the nature of a PEO’s clients affect how the PEO may handle the employer mandate?

The complexity in complying with the employer mandate rules differs based on the nature of the recipient, i.e., the client of the PEO. Industries with large, stable workforces consisting mostly of full-time employees who are provided with major medical benefits will likely continue these benefits and will be able to comply with the employer mandate rules without significant difficulty. However, businesses that rely on variable hour, contingent, or low paid workers will face difficulties. Many PEOs, along with hospitality, retail, and restaurant businesses, are in this latter group and face significant issues in dealing with the employer mandate rules.

PEOs specializing in IT or professional employees routinely offer comprehensive health care coverage to employees placed on long assignments. PEO firms often provide several services and benefits, including permanent placement, temp-to-permanent, and payroll for the recipient employer in addition to the placement of temporary workers on short-term assignments to supplement a client company’s core workforce.

47. What specific issues will PEOs likely need to consider in regard to the employer mandate?

***Issues for PEOs from Employer Mandate***

Most PEOs employ internal staff who run the company and recruit the temporary employees and workers to perform temporary work for the PEO firms’ clients (recipients). The latter often consist of lower-wage employees, sometimes with high rates of turnover.

Temporary employees have, at least in the past, shown little interest in obtaining health insurance coverage. Thus, many PEO firms have not provided health benefits to those workers. They are more likely to have arrangements under which the internal employees are provided major medical benefits, and the temporary employees are offered no plan or perhaps a limited benefit plan. The employer mandate rules encourage broad-based offers of major medical health coverage to all full-time employees and dependents. Thus, many PEO firms that do not offer affordable minimum value coverage to at least 95 percent of their full-time employees will be subject to an annual nondeductible employer mandate penalty of $2,000 multiplied by the number of all full-time employees, including full-time temporary employees, less thirty.

Additionally, nondiscrimination rules, presently delayed, will apply to health insurance plans. Those rules are to be based on IRS regulations, not yet issued, modeled on the nondiscrimination rules that apply to self-insured plans. There are exclusions in the self-insured nondiscrimination rules that allow exclusion of high-turnover employers or part-time employees.

***Employer Mandate and PEO Employees Working for Recipient Employers***

For the employer mandate, employee status is determined under the common law standard. A worker is a common law employee if the employer has the right to control and direct the individual who performs the services, not only as to the result to be accomplished by the work but also as to the details and means by which that result is accomplished. It is not necessary that the employer actually direct or control the manner in which the services are performed; it is sufficient if the employer has the right to do so.

Historically, many temporary employees assigned by PEO firms to client firms have been treated as common law employees of the PEO firm. There is no reason to believe this will change, at least with respect to traditional temporary PEO services. PEO employees performing services for many clients, such as payroll services, likely will continue to be PEO employees unless the PEO leases back employees performing payroll solely for one recipient employer. However, where the PEO employee is assigned to one recipient employer, it is likely that the worker will be the common law employee of the recipient if the recipient determines the services to be performed and has a right to determine the details and means used by the employee to perform those services.

Additionally, the employer mandate proposed regulations preamble states that if the primary purpose of the PEO arrangement is to avoid the employer mandate provisions of the Act, the client may be the responsible employer.

***Obtaining Minimum Value Coverage to Satisfy Employer Mandate***

Healthcare reform’s insurance market reforms require that insurers guarantee the availability and renewability of health insurance products in the individual and group markets with no exclusions for preexisting health problems. Thus, PEO firms that want to offer coverage in 2015 and beyond should be able to obtain coverage that provides 60 percent of minimum value, the required minimum threshold for adequate coverage. Prior to 2014, health insurers have often required employers to meet minimum participation requirements to meet their underwriting requirements and avoid adverse selection. This practice will no longer be permitted in 2014 and thereafter. In the past, many health plans also imposed annual and lifetime payment limits to contain health care coverage costs. Beginning in 2014, this practice is no longer allowed. The Act also imposes maximum limits on out-of-pocket costs. Large PEO firms may also elect to self-insure their own health plan, administered by an insurance company or a third-party administrator.

The requirement of guaranteed availability means that carriers cannot apply traditional underwriting practices. This could result in adverse selection with greater numbers of people needing health care to elect it, which would increase the cost of health coverage. Final HHS regulations acknowledge that adverse selection may present a significant economic exposure to insurance companies. As a result HHS allows insurance companies to limit open enrollment periods in the individual and small group markets to once a year to reduce the risk that those needing health care would wait to purchase it when they needed the coverage.

However, HHS did not extend that provision to the large group market. Despite measures to limit adverse selection, insurance costs could still increase substantially due to these insurance reform rules, thereby making affordable, minimum value coverage impracticable for many PEOs. However, non-minimum value health plans may provide a solution, as discussed hereafter.

***PEOs and Other Employers May Offer Non-minimum Value Group Health Plans***

Penalties under the Code section 4980H(b) apply where an employer offers health coverage that is not affordable or does not provide minimum essential coverage. The term “minimum essential coverage” refers to the source and not the scope of the coverage. Medicare, Medicaid, and VA health benefits provide minimum essential coverage, as does coverage under an eligible employer-sponsored health plan. An “eligible employer-sponsored plan” means a “group health plan” that provides for medical care other than just a HIPAA excepted benefit (e.g., stand-alone vision and/or dental, fixed indemnity, and single disease plans).[[87]](#footnote-87)

Code section 5000A, the individual mandate, requires U.S. citizens and green card holders to maintain minimum essential coverage for themselves and any nonexempt family members or pay a penalty with their federal income tax return. Employer-sponsored minimum essential coverage need not provide for essential health benefits. Nevertheless, it avoids the employee mandate penalty if it is affordable, in which the cost does not exceed 8 percent of the individual’s household income for self-only Bronze coverage or individual and family Bronze coverage where the individual has nonexempt family members. Essential health benefits are ten types of health coverage[[88]](#footnote-88) that must be included in fully-insured products sold in the individual and small group markets as part of an “essential health benefits package.” These rules don’t apply, however, to large group and self-funded plans.

Minimum essential coverage need not offer minimum value, which requires that the coverage pay for sixty percent or more of expected health costs. As discussed, if an employer plan does not provide minimum value coverage, an employee may apply for subsidized coverage through a public exchange, which could trigger a $3,000 employer penalty per full-time employee per year. If an employer is not concerned with meeting the minimum value standard, it may sponsor a group plan that covers “medical care” and that complies with the Act’s insurance market reforms. Thus, a plan that covers only preventative care and clinical trials covers medical care and qualifies as an eligible employer-sponsored plan. Indeed, excepted benefits included dental or vision insurance offered under a separate policy, certificate, or contract of insurance, so theoretically it is possible that a self-insured vision plan could be minimum essential coverage.

Non-minimum value plans will generally be much less expensive and may not require underwriting. Such plans allow the employer to satisfy the coverage option and avoid the $2,000 per full-times employee less thirty no-coverage penalty. Admittedly, the employer can be liable for the 4980H(b) penalty. In many cases, however, the plan’s cost plus any penalty will be much lower than the cost of providing affordable coverage that provides minimum value.

Plans that fail to provide minimum value means that low-income employees in firms sponsoring such plans can still obtain subsidized coverage under a plan that provides an essential health benefits package from a public exchange, and the applicable large employer can be subject to the employer mandate penalties. Moreover, for low-income employees, the cost of subsidized coverage will in most cases be less than 9.5 percent of household income, which is what an “affordable” employer plan would cost. If the employee decides to forgo exchange coverage and buys the employer’s non-minimum value product, he or she will not be subject to the individual tax penalty for failing to have minimum essential coverage, and the employer will not be subject to the employer mandate for such employees.

Impact of Individual Mandate on Employer Decision Making

48. What is the expected impact of the individual mandate on employer decision making?

To the extent that the individual mandate achieves its purpose of inducing individuals to purchase health insurance coverage, it may have an impact on employer compensation practices. If employees believe that they must purchase health insurance, their favorable perception of the value of employer-provided coverage should increase. This could result in employers providing health insurance coverage in lieu of cash compensation, which has additional employment and income tax advantages for the employer and employee.

However, this would not be the case for employees subject to and paid at the lowest permissible minimum wage. For minimum wage employees, employers have an incentive to keep their hours below thirty per week as a result of the $2,000 employer mandate penalty. Thus, to the extent employees perceive health insurance coverage as being relatively more valuable, vis-à-vis cash compensation, employers should be relatively more likely to provide it.

***Example***: ABC Corp has 100 full-time employees earning an average of $50,000 per year. ABC Corp’s family coverage costs $15,000 per year, of which employees pay $3,000 per year. Most of ABC Corp’s employees enroll in family coverage. Mike Smith, a full-time employee has a spouse, Melinda, who also earns $50,000, and Mike has family coverage through ABC Corp’s plan.

Mike and Melinda do not qualify for a tax subsidy from the state exchange. If ABC Corp drops its plan altogether, Mike will be required to get coverage through the exchange or pay a penalty. Family coverage for a similar plan in the state exchange costs $15,000.

Mike would need a raise to pay for coverage through the exchange. Since it would be taxable (paid with extra taxable income), to “break even” he would need approximately $14,500 ($12,000 + tax of $1,500). ABC Corp would also have to pay payroll taxes of $1,109 on this amount. In addition, ABC Corp would have to pay the $2,000 penalty. While the coverage now costs ABC Corp $12,000, which is completely deductible, the increased compensation of $14,500, payroll taxes of $1,109, and nondeductible penalty total $17,609 – a net loss to the employer.

For employers that fail to meet the “minimum essential coverage” test, the penalty is based on an annualized amount of $2,000 per year times the number of full-time employees in excess of thirty.[[89]](#footnote-89) There are issues as to how the triggering language for this penalty – whether an employer fails to “offer to its full-time employees (and their dependents)” – will be interpreted. For example, does this penalty apply even to an employer who employs hundreds of full-time employees and provides most, but not all, of them with “minimum essential coverage?” If this is the rule, what happens if an employer does offer such coverage to all of its full-time employees, but incorrectly characterizes another full-time worker as an independent contractor and fails to provide that individual with such coverage? Could that employer potentially be subject to a $2,000 penalty with respect to all of its employees in excess of 30 as a consequence of that single failure to provide coverage?[[90]](#footnote-90)

The IRS has indicated that “it is contemplated that the proposed regulations will make clear that an employer offering [minimum essential] coverage to all, or substantially all, of its full-time employees would not be subject to the 4980H(a) ‘all-full time employees minus 30’ assessable payment provisions.”[[91]](#footnote-91)

Individual Health Insurance Premium Tax Credits

49. Who is entitled to a subsidy in the form of a tax credit for purchasing health insurance from a state exchange?

The premium tax credit (cost-sharing reduction) for individuals who purchase in insurance on a state exchange is what triggers both the $2,000 all-full time employees minus 30 and $3,000 per-employee penalties for violating the employer mandate, employee eligibility for either of these subsidies is likely to be a matter of significant concern for many employers. Both subsidies are available to lower and middle income taxpayers with “household incomes” up to 400% of the “poverty level.”[[92]](#footnote-92) The following chart reflects the federal poverty level (“FPL”) and multiples of income. The FPL that applies for determining premium credits and subsidies for a year is that in effect for the preceding calendar year, i.e., for 2014 the 2013 FPL applies.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **2013 Federal Poverty Level Percentage of Gross Yearly Income** | | | | | | | |
| **Family**  **Size** | **100%** | **133%** | **150%** | **200%** | **250%** | **300%** | **400%** |
| 1 | $11,490 | $15,282 | $17,235 | $22,980 | $28,725 | $34,470 | $45,960 |
| 2 | $15,510 | $20,628 | $23,265 | $31,020 | $38,775 | $46,530 | $62,040 |
| 3 | $19,530 | $25,975 | $29,295 | $39,060 | $48,825 | $58,590 | $78,120 |
| 4 | $23,550 | $31,322 | $35,325 | $47,100 | $58,875 | $70,650 | $94,200 |
| 5 | $27,570 | $36,668 | $41,355 | $55,140 | $68,925 | $82,710 | $110,280 |
| 6 | $31,590 | $42,015 | $47,385 | $63,180 | $78,975 | $94,770 | $126,360 |
| 7 | $35,610 | $47,361 | $53,415 | $71,220 | $89,025 | $106,830 | $142,440 |
| 8 | $39,630 | $52,708 | $59,445 | $79,260 | $99,075 | $118,890 | $158,520 |
| For each additional person, add | $4,020 | $5,347 | $6,030 | $8,040 | $9,907 | $12,060 | $16,080 |
| Source: The information is compiled from the 2013 HHS Poverty Guidelines, U.S. Dept. of Health and Human Services at http://aspe.hhs.gov/poverty/13poverty.cfm. | | | | | | | |

Under the current poverty-line income levels and the household income multiples thereof triggering eligibility for the premium tax credit and cost-sharing, a large part of the population will be eligible for these subsidies. [[93]](#footnote-93) As the chart above shows, an individual with annual income below $45,960 and a family of four with a household income of $94,200 would qualify for the tax credit based on 400 percent of the calendar year 2013 poverty-level numbers, which are adjusted each year for inflation. The median household income in the United States was $49,445 in 2010.[[94]](#footnote-94) Note that these 2013 numbers are for illustration purposes and the actual numbers will be based on the 2014 federal poverty level numbers.

The applicable poverty level for any given employee is dependent upon the number of dependents for which he or she is entitled to personal exemption deductions. Generally, employers typically do not have this information, even though they may be obligated to provide coverage for all such dependents.

A large number of Americans purchasing insurance on a state exchange will be eligible for the individual premium subsidies and cost-sharing reductions. The following chart shows the percent of household income that an individual is required to spend on his insurance premiums. The federal government will provide the rest of the health insurance premium cost with a tax subsidy.

|  |  |
| --- | --- |
| **Income Level\*** | **Premium/Percent of Income** |
| • 100-133% of FPL | 2% of income |
| • 133-150% of FPL | 3-4% of income |
| • 150-200% of FPL | 4-6.3% of income |
| • 200-250% of FPL | 6.3-8.05% of income |
| • 250-300% of FPL | 8.05-9.5% of income |
| • 300-400% of FPL | 9.5% of income |
| \*Note: In 2013, 100% of FPL for a family of 4 is $23,550; 400% is $94,200. The actual numbers that will apply will be based on the 2014 federal poverty level tables. | |

***Household Income Defined.*** Household income is defined as the modified adjusted gross income of the taxpayer and all other individuals for whom the taxpayer is allowed a dependency exemption.[[95]](#footnote-95) Moreover, proposed regulations would limit this to include only dependents who actually file their own income tax returns.[[96]](#footnote-96) Modified adjusted gross income is adjusted gross income increased by the foreign earned income exclusion, tax-exempt interest, and the tax-exempt portion of Social Security benefits.[[97]](#footnote-97)

Knowing employees' household income is important to an employer for several reasons. First, the employee will only be entitled to a premium tax credit or cost-sharing reduction if his or her household income is below 400 percent of the poverty level.[[98]](#footnote-98) The required contribution for the employer mandate affordability test is based on the cost of self-only coverage to the employee. Employer-sponsored coverage is affordable for an employee (and his or her dependents) if the cost of employer-sponsored self-only coverage is less than 9.5 percent of household income, even if the employee selects employer-sponsored family coverage at a cost greater than 9.5 percent of household income. [[99]](#footnote-99)

Second, even if an employer offers minimum essential coverage, an employee is eligible for the premium tax credit or cost-sharing reduction if that employee’s required contribution to obtain employer coverage exceeds 9.5 percent [[100]](#footnote-100) of “household income.”[[101]](#footnote-101) An employee who is offered such affordable minimum essential coverage by the employer cannot claim the premium tax credit or cost-sharing reduction, even though he or she would otherwise be eligible.[[102]](#footnote-102)

The determination of affordability is made at the time that the employee enrolls in the exchange, and the determination lasts the entire plan year.[[103]](#footnote-103) Thus, if the exchange initially determined that the employer-sponsored plan was not affordable, then it is treated as such, regardless of whether the employee's household income ultimately proves high enough to make it affordable in hindsight. On the other hand, the employer will not be responsible for the penalty if the exchange determines that the coverage is not affordable but in fact it is.

***W-2 Safe Harbor.*** The regulations will provide an affordability safe harbor for employers. An employer that meets certain requirements, including offering its full-time employees (and their dependents) the opportunity to enroll in eligible employer-sponsored coverage, will not be subject to an assessable payment under section 4980H(b) (the $3,000 “per-employee” penalty) with respect to an employee who receives a premium tax credit or cost-sharing reduction for a taxable year if the employee portion of the self-only premium for the employer’s lowest cost plan that provides minimum value does not in fact exceed 9.5 percent of the employee’s current wages from the employer, as shown in Box 1 of Form W-2.[[104]](#footnote-104)

For employers who are interested in providing coverage only to the extent necessary to avoid penalties, these household income and poverty level tests are problematic. It will be difficult, if not impossible, for an employer to reliably know what an employee’s household income is.[[105]](#footnote-105) Even if the employer pays an employee compensation in excess of 400 percent of the poverty level, it is still possible for the employee or his or her spouse to have a net loss from partnership, S corporation, or even sole proprietorship activities that will bring their joint household income down below that level.

Employees eligible for Medicaid are treated as being “eligible for minimum essential coverage other than eligibility for coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market),” and therefore not eligible for the premium tax credit or cost sharing reduction.[[106]](#footnote-106) Such eligibility is typically based, at least in part, on an individual’s income in relation to the poverty level or a related statistic.

Additionally, it could be difficult or impossible for an employer to procure such household income information for an employee and his or her dependents. The employee can refuse to provide it. Section 1411(f)(2)(B) of PPACA provides as follows:

Notwithstanding any provision of this title (or the amendments made by this title) or section 6103 of the Internal Revenue Code of 1986, an employer shall not be entitled to any taxpayer return information with respect to an employee for purposes of determining whether the employer is subject to the penalty under section 4980H of such Code with respect to the employee, except that –

(i) the employer may be notified as to the name of an employee and whether or not the employee’s income is above or below the threshold by which the affordability of an employer’s health insurance coverage is measured; and

(ii) this subparagraph shall not apply to an employee who provides a waiver (at such time and in such manner as the Secretary may prescribe) authorizing an employer to have access to the employee’s taxpayer return information.

There is a question as to whether this provision only restricts the federal government from disclosing this information, or whether it precludes an employer from asking the employee for such information. To avoid penalties, an employer potentially subject to the penalty may have to provide minimum essential coverage to each of its employees if it does not know whether their respective household incomes are or were above or below 400 percent of the poverty level (or low enough to trigger Medicaid). Under the above provision, the employer would only be entitled to know “whether or not the employee’s income is above or below the threshold by which the affordability of an employee’s health insurance coverage is measured.”[[107]](#footnote-107) Presumably, the employer would have to inform the Secretary of HHS of what the actual employee contribution was and then the Secretary would be able to tell the employer whether the employee is eligible for reduced cost-sharing or the premium tax credit (and the employer was therefore subject to the penalty). It could be too late for the employer to avoid substantial penalty(ies) for prior years.

The affordability tests are for employee-only coverage. It must cost no more than the household income or one of several safe harbors, such as the employee’s current Box 1, W-2 income: 9.5 percent of the employee’s rate of pay, or 9.5 percent of the FPL for a single person. The insurance offered in 2015 must be for employees and dependents (including children under 26 but not their spouses), but only the employee coverage needs to meet the affordability test. Uninsured spouses are eligible for exchange subsidies if they qualify, based on household income being under 400 percent of FPL and dependents (where employer dependent coverage is offered but not selected) may be eligible for coverage in a state sponsored plan.

**49.01. How is income determined for determining who is eligible for a subsidy for health insurance purchased on an exchange?**

The section 36B tax credits and subsidies for health insurance purchased on an exchange where the employer does not offer affordable minimum value coverage are based on household income under IRC

§36B(b)(3)(A) between 100 – 400 percent of federal poverty level (“FPL”), using the FPL for the preceding calendar year. Household income is defined as modified adjusted gross income. See Q 443 for discussion of “affordable value”.

Section 36B(d)(3) defines “modified adjusted gross income” as adjusted gross income increased by (1) any amount excluded from gross income under section 911, (2) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax, and (3) any social security benefits not included in gross income. IRC §36B(d)(2) defines household income as the sum of the (1) modified adjusted gross income of the taxpayer, (2) the aggregate modified adjusted gross incomes of all other individuals who determine the taxpayer’s family size, and (3) the portion of the taxpayer's social security not included in gross income.

Family size is determined under IRC §36B(d)(1) as the number of individuals for whom the taxpayer is allowed a dependent deduction under IRC §151.

Thus, an individual not eligible for Medicare or Medicaid would include in income taxable income from an employer: interest from tax exempt bonds, trust payments, untaxed social security payments, and taxable retirement plan and annuity payments, but not the value of gifts.

**49.02. What explanations has CMS issued regarding same-sex marriage recognition rules for exchange determinations of premium tax credits and for Medicaid and CHIP?**

CMS has issued guidance[[108]](#footnote-108) directing the Health Insurance Marketplaces (Exchanges) to follow IRS guidance in Rev. Rul. 2013-17 on recognition of same-sex marriages when determining eligibility for advance payment of premium tax credits and cost-sharing reductions for coverage purchased through the Exchange.

The definition of a “spouse” is important to determine eligibility for advance payments of the premium tax credit and cost-sharing reductions because a taxpayer’s spouse is included in determining family size, and household income must include both spouses’ incomes.

Additionally, married couples must file a joint tax return to qualify for premium tax credits. Rev. Rul. 2013-17 recognizes same-sex marriages for federal tax purposes so long as they are valid in the state or country of celebration, even if the married couple is domiciled in a state that does not recognize same-sex marriages. Applying this same standard to advance payments of premium tax credits and cost-sharing reductions, CMS requires Exchanges to evaluate marital status based on the law of the state or country where the marriage was entered into, even if the state of residence does not recognize same-sex marriages. Federally facilitated Exchanges are now prepared to recognize same-sex marriages for this purpose with respect to married couples who attest that they expect to file a joint tax return for the 2014 tax year.

State-based Exchanges are given time to adjust their systems to reflect this guidance but must implement interim workarounds where reasonably practicable. Exchanges in states that do not recognize same-sex marriages cannot simply apply their own states’ marriage laws. They must consider whether same-sex couples were lawfully married in a different state or country. On the other hand, other “marriage equivalent” relationships (e.g., registered domestic partnerships, civil unions) are not recognized as “marriage” for purposes of premium tax credit eligibility.

In separate, contemporaneous guidance,[[109]](#footnote-109) CMS explains eligibility for Medicaid and the Children’s Health Insurance Program (CHIP), which are joint federal-state, needs-based programs. For income-based eligibility determinations under these programs, CMS will permit states to apply their own choice-of-law rules in deciding whether a couple is lawfully married. The guidance acknowledges the discrepancy between the marriage recognition rules for premium tax credits and those for Medicaid and CHIP, and notes a potential benefit eligibility gap where premium tax credit eligibility is based on recognition of a same-sex marriage and Medicaid/CHIP eligibility is not.

CMS is considering this issue and will consult further with states. For other eligibility determinations, CMS indicates that financial eligibility is based on methodologies applied by the Social Security Administration, which is still developing its same sex marriage recognition policy.

**50. Can the federal government subsidize health insurance premiums for people in thirty-six states that use an exchange run by the federal government rather than the state?**

Two United States Circuit Courts have issued conflicting rulings on whether the federal government can subsidize health insurance premiums for people in thirty-six states that use an insurance exchange run by the federal government. Due to this split in the Circuits and the importance of the issue, it seems very likely that the U.S. Supreme Court will rule on this issue, likely in its next term that begins in October, 2014. However, that could be mooted if the entire DC panel issues a contrary decision, and the administration plans to ask for a decision by a full panel of the DC Circuit, an *en banc* review, which triggers an automatic stay of the effect of this decision.However, the issue is pending in other federal circuits as well.

The Fourth Circuit in *King v. Burwell*, No. 14-1158 (4th Cir. July 22, 2014) unanimously upheld the subsidies, saying that the regulations issued by the IRS saying that the eligible (by income below set thresholds) residents of all states are eligible for the subsidies was “a permissible exercise of the agency’s discretion.” The DC Circuit ruled 2-1 in *Halbig v. Burwell*, No. 14-5018 (D.C. Cir. July 22, 2014), that the federal government could not subsidize insurance for people in states whose exchanges were established by HHS and vacated the IRS regulations under IRC § 36B. The IRS interpreted section 36B broadly to authorize the subsidy also for insurance purchased on one of the thirty-six exchanges established by the federal government.[[110]](#footnote-110) For some of those exchanges, the states in question assisted the federal government in creating the exchange for that state. Initially, fourteen states and the District of Columbia established their own exchanges.

The key language in dispute is the provision that the tax subsidies are available to eligible taxpayers “enrolled in through an Exchange established by the State. “[[111]](#footnote-111) In essence, those who argue that all exchanges qualify argue that all exchanges are state exchanges, including those states where the exchange was established for that state by HHS or by HHS in cooperation with that state and that the purpose of the law would be frustrated if those only in state created state exchanges would qualify for the tax subsidies. Those arguing that the tax subsidies should only be given to lower income taxpayers in states in which the state itself established the exchange point to the literal language of the law, arguing that its purpose was to encourage states to create their own exchanges so that their residents could enjoy the tax subsidies.

The ultimate outcome of this issue is extremely important, as more than half of those purchasing health insurance on an exchange receive a subsidy. No doubt, many if most of those would not purchase the insurance without the subsidy, frustrating on of healthcare reform’s purposes to expand health insurance coverage.

HISTORICAL BACKGROUND

A group of small business owners (and individuals) in six states filed a lawsuit on May 2, 2013, against the federal government over an IRS regulation making available the Exchange-provided tax credits and subsidies to all Exchanges, including those state exchanges run by HHS. The plaintiffs claimed that the law would force the plaintiffs to pay exorbitant fines, cut back employees’ hours, or severely burden their businesses due to the employer mandate penalty on employers with fifty or more full-time and full-time equivalent employees.

Plaintiffs stated that employers would, but for their employees’ eligibility for subsidies, be exempt from the potential employer mandate tax penalty. Plaintiffs also alleged that individuals would, but for their eligibility for federal subsidies, be exempt from the Act’s individual mandate penalty under an exemption applicable to low- or moderate-income individuals for whom insurance is “unaffordable.” For these people, the Subsidy Expansion Rule, by making insurance less “unaffordable,” subjects them to the individual mandate’s requirement to purchase costly, comprehensive health insurance that they otherwise would forgo.

The Code § 36B credit is designed to make health insurance purchased on a state Exchange (marketplace) affordable for taxpayers whose income is less than 400 percent of the federal poverty level and who do not have affordable, minimum value health insurance from their employer. Healthcare reform requires each state to establish a health insurance Exchange by January 1, 2014. If a state decides not to do so, HHS has established an Exchange. Most state Exchanges are run by HHS. The Exchange makes subsidy payments on the individual's behalf to the health plan, based on information available at the time of enrollment, then that person’s income tax return for the year reconciles the actual credit that he is due with the amount of the subsidy payments that were made.[[112]](#footnote-112)

In describing the premium assistance amount, Code § 36B(b)(2)(A)[[113]](#footnote-113) refers to “the monthly premiums for...qualified health plans offered in the individual market...which were enrolled in through an Exchange established by the State ” (emphasis added). However, the regulations under Code § 36B provide that the premium tax credit is not limited to state-created Exchanges, but also includes federally facilitated Exchanges.[[114]](#footnote-114) The plaintiffs in *Halbig v. Sebelius* contend that the Code § 36B regulations contradict the express text of the law that provides for tax credits and subsidies for state-established Exchanges.

The U.S. District Court for the District of Columbus in the case of *Halbig v. Sebelius* (D.C.D.C. January 15, 2014) had ruled in favor of the federal government in a lawsuit contending that the IRS did not have the authority under healthcare reform to write rules that provide tax credits provided by Code §36B to individuals purchasing health insurance on the thirty-four state health insurance exchanges (a/k/a marketplaces) set up and run in whole or part by the federal government.

The IRS issued a final regulation in May 2012 implementing the premium tax credit provision of the Affordable Care Act, in which it interpreted the ACA as authorizing the agency to grant tax credits to individuals who purchase insurance on either a state-run health insurance exchange or a federally run exchange. An eligible taxpayer receives a tax credit if he or she, or a member of his or her family, “[i]s enrolled in one or more qualified health plans through an Exchange.” [[115]](#footnote-115) The law defines “Exchange” as follows:

Exchange means a governmental agency or non-profit entity that meets the applicable standards of this part and makes [Qualified Health Plans] available to qualified individuals and/or qualified employers. Unless otherwise identified, this term includes an Exchange serving the individual market for qualified individuals and a [Small Business Health Options Program] serving the small group market for qualified employers, ***regardless of whether the Exchange is established and operated by a State (including a regional Exchange or subsidiary Exchange) or by HHS***.[[116]](#footnote-116)

The plaintiffs, who included the conservative Competitive Enterprise Institute, contended that the IRS’s interpretation was contrary to the statute, which, they asserted, authorizes tax credits only for individuals who purchase insurance on state-run exchanges, but not on federal exchanges. The plaintiffs in the case claimed that the rule promulgated by the IRS exceeded the agency’s statutory authority and was arbitrary, capricious, and contrary to law, in violation of the Administrative Procedure Act.

The court ruled that the statute, the statutory structure, and the statutory purpose make clear that Congress intended to make premium tax credits available on both state-run and federally-facilitated exchanges. The court stated that the scant legislative history that exists supports this conclusion.

See Q 49 and Q 51.

51. Who are qualified individuals for purposes of the final regulation for the Code section 36B credit?

T.D. 9611, 01/30/2013, Reg. §1.36B explains the Code section 36B health insurance premium tax credit enacted by healthcare reform. The regulation applies to tax years ending after December 31, 2013, and provides guidance to individuals related to employees who may enroll in eligible employer-sponsored coverage and who wish to enroll in qualified health plans through Affordable Insurance Exchanges and claim the premium tax credit. The regulations extend these tax credits and subsidies to the purchase of health insurance on state created exchanges and federal exchanges created in states without exchanges of their own.

52. What is the purpose of the Code section 36B credit regulation?

The Code section 36B credit is designed to make health insurance affordable to individuals with modest incomes (i.e., between 100 percent and 400 percent of the federal poverty level, or FPL) who are not eligible for other qualifying coverage, such as Medicare, or “affordable” employer-sponsored health insurance plans. Eligibility for other coverage is determined on a month-by-month basis. The credit applies beginning in 2014.

Code section 5000A(e) provides an employer-sponsored plan is not affordable if the employee's required contribution for single (self-only) coverage exceeds 9.5 percent of household income for the tax year. The percentage may be adjusted after 2014. The employee’s cost for self-only coverage is used even if the employee has family coverage, which is more expensive. For an individual other than an employee who is eligible to enroll in the plan because of a relationship the individual bears to the employee, affordability is also measured by the employee’s cost of self-only coverage.

Thus, the statutory language specifies that for both employees and others (such as spouses or dependents) who are eligible to enroll in employer-sponsored coverage because of their relationship to an employee (related individuals), the coverage is unaffordable only if the required contribution for “self-only” coverage exceeds 9.5 percent of household income.

In May of 2012, final Code section 36B regulations were issued. However, Reg. §1.36B-2(c)(3)(v)(A)(2) reserved the question of determining affordability of employer-sponsored coverage for related individuals. Consistent with these statutory provisions, the proposed regulation would provide that an employer-sponsored plan also is affordable for a related individual if the employee's required contribution for self-only coverage under the plan does not exceed 9.5 percent of the applicable taxpayer's household income for the tax year, even if the taxpayer’s required contribution for the family coverage exceeds 9.5 percent of household income for the year.

52.01 How did the October 2013 “No Subsidies without Verification Act change the rules for verification of individuals financial information on the healthcare exchanges (marketplaces)?

Healthcare reform provides premium tax credits to make health insurance affordable to individuals with modest incomes between 100 percent and 400 percent of the federal poverty level. These credits are available to those who are not eligible for other qualifying coverage, such as Medicare, or “affordable” employer-sponsored health insurance plans that provide “minimum value.” They are refundable tax credits, applicable for tax years ending after December 31, 2013, available to individuals who purchase coverage through “Affordable Insurance Exchanges,” also known as Marketplaces.[[117]](#footnote-117)

In July 2013, the federal Department of Health and Human Services (HHS) issued a final rule for the exchange's income verification process, which the *Washington Post* reported would "significantly scale back" the law's verification requirement for those receiving federally subsidized coverage.[[118]](#footnote-118) Note however, that the Exchange subsidies are not paid to individuals but, rather, to insurers.

These July 2013 regulations[[119]](#footnote-119), which were delayed for one year from 2014 until 2015, include two reporting requirements for certain large employers and health insurance coverage providers. Under the final July 2013 HHS regulation, applicants' income is to be verified against their IRS and Social Security records. When that cannot be achieved, income will be checked against employer records submitted to Equifax. If the IRS, the Social Security Administration, and Equifax cannot provide data to substantiate the income information a consumer has supplied, the consumer will have to provide an explanation or additional documentation of income.[[120]](#footnote-120)

The July 2013 regulation also allows state exchanges to check a statistically valid sample of applicants in cases where an applicant claims income more than 10 percent below what IRS and Social Security records show and there is no Equifax data.

In the summer of 2013, shortly after announcing the one-year delay of the ACA’s employer mandate and its associated reporting requirements, the Administration delayed a requirement that state-run Marketplaces verify an ACA subsidy applicant’s claim that he does not receive employer health insurance. The Administration also relaxed the verification requirements with respect to individuals who reported a significant decrease in income.

H.R. 2775, the 2014 Continuing Appropriations Act containing the bill entitled the No Subsidies without Verification Act, passed in October 2013. In addition to continuing U.S. appropriations, it requires that HHS ensure that the Exchanges verify that individuals applying for coverage in the Marketplace and seeking premium tax credits and cost-sharing reductions are, in fact, eligible for these subsidies. The HHS Secretary must submit a report to Congress by January 1, 2014, detailing the verification procedures, and the Inspector General for HHS must submit a report to Congress by July 1, 2014, on the procedures' effectiveness.

Section 1001 of the Act requires HHS on the exchanges it runs to: (1) ensure that American Health Benefit Exchanges (healthcare reform’s health care exchanges, also called marketplaces) verify that individuals applying for premium tax credits and reductions in cost-sharing for the purchase of qualified health benefit plans are eligible for such credits and cost sharing reductions consistent with healthcare reform’s requirements and (2) prior to making such credits and reductions available in January 2014, certify to Congress that the Exchanges have a program to verify such eligibility.

The language of H.R. 2775 is unclear regarding the meaning of the term “program.” That term might be construed to go beyond regulations and guidance to encompass operational competence, such as software and enrollment procedures that have been proven to work. Determining whether or not those systems work, however, may not be possible until there is some experience or data that can be used to evaluate the systems.[[121]](#footnote-121)

53. How can a qualified individual receive a Code section 36B credit?

The eligible individual purchases affordable coverage through “Affordable Insurance Exchanges” that will make qualified health insurance plans available to individuals as well as small businesses.

The Exchange makes subsidy payments to the qualified health plan on behalf of the individual. The subsidy payments take the form of an advance credit payment (“monthly premium assistance amount”) under Code section 36B. Using information available at the time of enrollment, the Exchange determines (1) whether the individual meets the income and other requirements for advance credit payments, and (2) the amount of the advance payments. Advance payments are made monthly to the issuer of the qualified health plan in which the individual enrolls. The monthly premium assistance amount is the lesser of the premium for the qualified health plan in which a taxpayer or family member enrolls, or the excess of the premium for the benchmark plan (the second-lowest “silver plan”) over the applicable percentage of the taxpayer's household income. The applicable percentage of the premium assistance increases as the percentage of the FPL for the taxpayer's family size increases.

The eligible individual reconciles the actual credit for the tax year computed on the taxpayer's tax return for the prior year with the amount of advance payments paid on the taxpayer’s behalf. If a taxpayer's credit amount exceeds the amount of advance payments paid on the taxpayer’s behalf for the tax year, the taxpayer may receive the excess as an income tax refund. If advance payments made on the taxpayer's behalf exceed the taxpayer’s credit amount, the taxpayer owes the excess as an additional income tax liability. However, Code section 36B(f)(2)(B) caps the additional tax liability for taxpayers with household income under 400 percent of the FPL. The repayment limitation amounts range from $600 to $2,500 (one half that amount for single taxpayers) depending on FPL, and will be adjusted to reflect changes in the cost of living beginning in 2015.

For tax years beginning before January 1, 2015, an eligible employer-sponsored plan is affordable for related individuals if the portion of the annual premium the employee must pay (the employee’s required contribution percentage) for self-only coverage does not exceed 9.5 percent of the taxpayer's household income.[[122]](#footnote-122)

54. How does the Code section 36B credit work for related individuals?

**The final regulation** provides guidance to individuals related to employees who may enroll in eligible employer-sponsored coverage and who wish to enroll in qualified health plans through Affordable Insurance Exchanges and claim the premium tax credit.

***Example:*** H is married to W and Employer X's plan requires H to contribute $5,300 for coverage for H and W for 2014, which reflects 11.3 percent of H's household income. However, the contribution attributable to self-only coverage of $3,450 does not exceed 9.5 percent of household income as required by Reg. §1.36B-2(c)(3)(v)(A)(2). Therefore, X's plan is affordable for both H and W. Reg. §1.36B-2(c)(3)(v)(D), Example 2.

By contrast, Code section 5000A, which establishes the shared responsibility payment applicable to individuals (the individual mandate) for failure to maintain minimum essential coverage addresses affordability for employees in Code section 5000A(e)(1)(B) and for related individuals in Code section 5000A(e)(1)(H). The proposed regulations under Code section 5000A provide that, for purposes of applying the affordability exemption from the shared responsibility payment in the case of related individuals, the required contribution is based on the premium the employee would pay for employer-sponsored family coverage.[[123]](#footnote-123)

55. How can employers use the Code section 36B in its health-insurance planning?

If an employer limits every employee’s premium for self-only coverage at 9.45 percent of pay, it will never pay the $3,000 employer mandate penalty for failure to provide affordable coverage. It is perfectly legal to set lower premium for lower-paid employees. An employer can set the employee’s premium for family coverage as high as it wishes.

56. May an employer establish an employee contribution schedule and allow employees to be eligible for reduced contributions if they provide evidence that their required contributions would otherwise be in excess of the affordability limits?

An employee’s information for as many as three taxable years could be relevant in making all of these various determinations. First, eligibility for the premium tax credit is dependent upon an employee’s household income for the current taxable year.[[124]](#footnote-124) Second, the determination as to whether an employee is eligible for reduced cost-sharing is apparently going to be based on the employee’s income for the preceding taxable year.[[125]](#footnote-125) Third, any advance payment of the credit or cost-reduction, which can also trigger an employer penalty, must be made “on the basis of the individual’s household income for the most recent taxable year for which the Secretary of HHS, after consultation with the Secretary of the Treasury, determines information is available,” which could easily be the employee’s second preceding taxable year.[[126]](#footnote-126)

57. Can applicable large employers with 50 or more full-time equivalent employees avoid the employer mandate penalty by offering an actuarially equivalent contribution to an HSA or FSA so that employees can buy health care coverage on the exchange or in the private non-group market?

To avoid the employer penalties, coverage must be minimum essential coverage. Health savings accounts (HSAs) are not minimum essential coverage because they are not group health plans under ERISA.[[127]](#footnote-127) For health flexible spending accounts (FSAs), the answer is not clear but likely no. It is possible that FSAs could be minimum essential coverage if they are the only coverage offered by the employer and the employer contribution is greater than two times the employee contribution, or $500 over the employee contribution.

Additional guidance is needed to clarify if such FSAs are minimum essential coverage. If so, then perhaps an FSA contribution could avoid the employer mandate penalty. However, FSAs cannot be used to pay premiums for other coverage (other than COBRA coverage, if the plan allows). Accordingly, this rule would need to be changed in order for individuals to use FSA money to purchase exchange coverage. The way employee contributions are used to purchase insurance in a cafeteria plan is through premium conversion so that the employee election is specifically and solely for employer sponsored health insurance.

58. What is minimum essential coverage?

The individual mandate requires individuals to be responsible for ensuring that they, and any of their dependents, are covered under minimum essential coverage. Minimum essential coverage includes:

* Government sponsored programs including: Medicare, Medicaid, Children’s Health Insurance Program coverage (CHIP), TRICARE, coverage through Veterans Affairs, and Health Care for Peace Corps volunteers
* Employer-sponsored plans including governmental plans, grandfathered plans, and other plans offered in the small or large group market
* Individual market plans, including grandfathered plans; and
* Other coverage designated as minimum essential coverage by HHS and/or the Dept. of the Treasury.[[128]](#footnote-128) There is more detail on this in the following section.

59. What individuals are not subject to the individual mandate?

Beginning January 1, 2014, all U.S. residents are required to maintain minimum essential coverage unless the individual falls into one of the following exceptions:

* individuals with a religious conscience exemption (applies only to certain faiths)
* incarcerated individuals
* undocumented aliens
* individuals who cannot afford coverage (i.e. required contribution exceeds 8 percent of household income)
* individuals with a coverage gap of less than three months
* individuals in a hardship situation (as defined by HHS)
* individuals with income below the tax filing threshold; and
* members of Indian tribes[[129]](#footnote-129)

60. Could you provide more detail on persons who are not subject to the individual mandate because they are not “applicable individuals”?

***Applicable Individual.*** The individual mandate tax penalty applies only to applicable individuals, and the definition of that term excludes designated categories of individuals. These excluded categories include members of certain religious faiths already exempt from self-employment tax, members of healthcare-sharing ministries which, among other things, share medical expenses among members and have been in continuous existence since December 31, 1999, illegal aliens, and incarcerated individuals after they have been convicted.[[130]](#footnote-130)

There are also exemptions for members of Indian tribes, short-term coverage gaps of one or two months, hardships (as determined by the Secretary of HHS) and persons residing outside of the United States or within U.S. possessions.[[131]](#footnote-131) There are no corresponding exceptions for employers under the employer mandate. Thus, it appears that both the “all full-time employees minus 30” and per-employee penalties under the employer mandate would take such employees into account.[[132]](#footnote-132)

***Affordability.*** Another major exemption is the one for applicable individuals whose “required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual’s household income for the taxable year.”[[133]](#footnote-133) For this exemption, the required contribution for an individual eligible to participate in an employer-sponsored plan is equal to “the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage.”[[134]](#footnote-134) For individuals whose sole option is to purchase insurance through an exchange, the required contribution is equal to the annual premium for the lowest cost bronze plan available in the individual market through the exchange in the state in the rating area in which the individual resides reduced by the amount of the credit allowable under Section 36B for the taxable year (determined as if the individual was covered by a qualified plan offered through the exchange for the entire taxable year).[[135]](#footnote-135) The tax code provision does not define required contribution for other types of plans. For example, the Medicare Part A premium should be the required contribution for individuals over sixty-five who are not eligible to participate in employer-sponsored plans.

While an individual’s current “required contribution” is “determined on an annual basis,” the 8 percent affordability amount is determined “on the basis of the individual’s household income for the most recent taxable year for which the Secretary of Health and Human Services, after consultation with the Secretary of the Treasury, determines information is available.”[[136]](#footnote-136) Thus, the household income for affordability is likely to be determined on the basis of the income tax return filed for the preceding, and possibly the second preceding, taxable year of the applicable individual. Finally, the 8 percent affordability factor is to be adjusted to reflect “the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.”[[137]](#footnote-137)

***Income Below Filing Threshold*.** Taxpayers whose household income for a taxable year is less than the gross income necessary to trigger an income tax return filing requirement[[138]](#footnote-138) are not applicable individuals and are not subject to the employee mandate. These gross income levels are unlikely to exempt many applicable individuals who are not already exempt under the 8 percent affordability exemption discussed above. However, many such individuals are also likely to be eligible for Medicaid and thus exempt from the penalty as long as they apply to procure such coverage.

***Dependents.*** The individual mandate Code provisions’ use of the dependency deduction for triggering and calculating the penalty creates conflicting planning considerations for individuals who may be subject to the penalty. Claiming someone as a dependent is favorable under the Code. For example, in addition to the dependency exemption itself and possible qualification for head-of-household tax rates,[[139]](#footnote-139) there is the benefit of having a higher applicable poverty-level threshold for purposes of the premium tax credit discussed above. On the other hand, the $95/$325/$695 (inflation adjusted) 2014/2015/2016 minimum penalty is increased with each additional dependent, although at a rate of only one-half of the applicable dollar amount for children under the age of 18.[[140]](#footnote-140) Thus, a parent getting divorced may be less willing to be allocated the dependency deduction for children of the marriage if it means being obligated to procure health coverage for such children.[[141]](#footnote-141) Parents will be less inclined to provide over one-half of the individual’s support for the calendar year (the requirement to be a dependent) if it means that the taxpayer will end up owing a penalty for failure to procure health coverage for such individual.[[142]](#footnote-142)

It seems that the household income of a young child with no income would be zero, and therefore such a child would not trigger additional penalty obligations for his or her parents under the individual mandate provisions as a result of the affordability and filing threshold exemptions.

***Spouses***. The individual mandate creates issues for certain spouses. Both spouses are jointly liable for whatever penalty is due on a joint return.[[143]](#footnote-143) However, the individual mandate only requires that an applicable individual ensure that minimum essential coverage is procured both for the individual and any dependent of the individual who is an applicable individual. [[144]](#footnote-144) Additionally, the definition of “family-size” for determining household income is “the number of individuals for whom the taxpayer is allowed a deduction under section 151.”[[145]](#footnote-145) Neither spouse is a dependent of the other. Rather, they are each entitled to the deduction on a joint return.[[146]](#footnote-146) There is a provision that entitles a taxpayer to take an additional exemption for his or her spouse when the spouse has no gross income and is not a dependent of another taxpayer. However, this provision only applies when a joint return is *not* filed.[[147]](#footnote-147)

As for dependents, there is an issue of how the penalty is calculated for a non-earning spouse. Such spouse should be entitled to an exemption based on the 8 percent affordability test or the low-income filing threshold test. Both are based on household income, but, again, that in turn is defined by reference to the modified adjusted gross income of the taxpayer and all other “individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions).”[[148]](#footnote-148) Thus, it seems that the income of the earning spouse and dependent should not be included in a non-earning spouse’s household income. Therefore, a non-earning spouse might not be taken into account in calculating the penalty for the earning spouse because the Code provides that “[n]o penalty shall be imposed . . . with respect to” exempted individuals. Although there is no penalty with respect to a non-earning spouse, that spouse is still jointly and severally liable for the individual mandate penalty with respect to his or her spouse and the dependents of his or her spouse. The non-earning spouse could refuse to sign a joint return. However, in addition to the tax bracket, deduction, and other ramifications of that decision, the earning spouse would also then not be eligible for the premium tax credit.[[149]](#footnote-149)

60.01 What policies are available for those with cancelled health insurance policies?

The Obama administration announced December 19, 2013 that individuals whose insurance plans have been canceled will be eligible for “hardship exemptions” from the individual mandate requirement to have coverage in 2014 or pay a penalty. HHS Secretary Kathleen Sebelius outlined the policy in a letter[[150]](#footnote-150) to Sen. Mark Warner and five other senators who had raised concerns about the issue. “I agree with you that these consumers should qualify for this temporary hardship exemption, and I can assure that the exemption will be available to them,” Sebelius said. However, she made it clear that the exemption is limited to persons who have difficulty purchasing exchange coverage.

Sebelius also announced that individuals with canceled policies will be allowed to purchase catastrophic coverage. Previously, only individuals under the age of 30 could avoid incurring a financial penalty after March 31, 2014 by purchasing such plans. However, there are no federal subsidies available for those buying catastrophic coverage.

Thus, the application of the hardship exemption to consumers whose plans were canceled does not appear to be a change in policy. The form[[151]](#footnote-151) for the application for a waiver from the individual mandate already includes such a category: “You received a notice saying that your current health insurance plan is being canceled, and you consider the other plans available unaffordable.”

Thus, the announcement by the administration is largely symbolic and a political response to the criticism that healthcare reform is causing people to lose the policies and physicians they liked and wanted to keep, as they were told generically that they could keep.

In fact, some argue that the hardship definition is so broad that it undermines the individual mandate.

See also Q 59 and Q 60.

61. How is the individual mandate tax penalty enforced?

The law limits the IRS ability to collect this tax penalty from individuals. Although the individual mandate tax penalty is supposed to be assessed and collected in the same manner as other penalties assessable under the Code, there can be no criminal prosecution or penalty for failure to pay the penalty,[[152]](#footnote-152) though presumably civil penalties could be applicable. Moreover, the Service “shall not . . . file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the [Individual Mandate] penalty . . . or levy on any such property with respect to such failure.”[[153]](#footnote-153)

Thus, the IRS's collection tools are limited, although it could send a notice of demand and/or offset refunds as to the applicable individual who fails to pay the assessed penalty.

Health Plan and Insurance Changes: Coverage Mandates

62. What are the ten essential health benefits (EHBs) required by the 2010 federal health reform? How do state health insurance mandates relate to them?

The 2010 Patient Protection and Affordable Care Act[[154]](#footnote-154) requires the Secretary of HHS to define the EHBs through regulation. It also requires that at least some items and services within specific categories of benefits be included in the definition. The term “essential health benefits” means the benefits that non-grandfathered plans sold in the small group market on or outside of a state exchange must have, beginning in 2014. Grandfathered plans, self-insured group health plans, and health insurance coverage offered in the large group market are not required to offer essential health benefits. Minimum essential coverage is a separate concept and the phrase used to describe the coverage required to fulfill the individual and employer mandates.

The ten EHB categories are:

* Ambulatory patient services
* Emergency services
* Hospitalization
* Maternity and newborn care
* Mental health and substance use disorder services, including behavioral health treatment[[155]](#footnote-155)
* Prescription drugs
* Rehabilitative and habilitative services and devices
* Laboratory services
* Preventive and wellness services and chronic disease management; and
* Pediatric services, including oral and vision care

The scope of essential health benefits is intended to equal the scope of benefits provided under a “typical employer plan” and establish an appropriate balance among the ten benefit categories.[[156]](#footnote-156) Each state’s essential health benefits are based on that state’s base-benchmark plan.[[157]](#footnote-157) After the application of any adjustments, the plan is known as the “EHB-benchmark plan.”[[158]](#footnote-158) The EHB-benchmark plan contains the scope of services and limits offered by a typical employer plan in that state. This EHB benchmark plan process applies for at least the 2014 and 2015 benefit years.[[159]](#footnote-159)

HHS is required to take into account:

* The need for balance between the ten federal EHB categories
* The needs of diverse segments of the population; and
* The need to not discriminate against individuals because of age, disability, or expected length of life

|  |  |  |
| --- | --- | --- |
| **EHB Requirements by Market Segment**[[160]](#footnote-160) | | |
| **Market Segment** | **Subject to EHB Requirement** | **Not Subject to EHB Requirement** |
| **Large Group**  **Market** | Effective 2017, states may allow large group purchasing through the exchange, which would subject large group plans and policies to EHB requirements[[161]](#footnote-161) | **Outside the Exchange:**  • State regulated plans and policies |
| **Small Group**  **Market** | **Outside the Exchange:**  • State regulated plans and policies  **Inside the Exchange:**  • QHPs and CO‑OP plans[[162]](#footnote-162)  • Multistate Plans offered by the federal  Office of Personnel Management (OPM)[[163]](#footnote-163) | **Outside the Exchange:**  • Grandfathered plans  • Grandfathered policies |
| **Individual**  **Market** | **Outside the Exchange:**  • State regulated plans and policies  **Inside the Exchange:**  • State regulated QHPs, including:  - Catastrophic plans[[164]](#footnote-164)  - CO-OP plans[[165]](#footnote-165)  - Interstate healthcare choice compacts  • Multistate Plans, offered by the federal  Office of Personnel Management (OPM) | **Outside the Exchange:**  • Grandfathered plans  • Grandfathered policies |

62.01 Do the new FAQs relax the fixed indemnity standards and allow per-service payments as excepted benefits if the insured has other minimal essential coverage?

The Labor Department, Department of Health and Human Services, and the Treasury Department on January 9, 2014 issued FAQ Part XVIII[[166]](#footnote-166) regarding implementation of the market reform provisions of the ACA. FAQs are so-called subregulatory guidance intended to provide quick guidance in response to issues affecting group health plans. FAQ Part XVIII includes new relaxed rules for fixed indemnity plans that meet certain requirements. A fixed indemnity plan generally pays a fixed dollar amount upon the occurrence of a covered illness or injury, rather than an amount based on expenses actually incurred by the individual. For example, it might pay $100 upon admission to a hospital for particular treatments. These fixed indemnity plans can be designed to fit within the category of "excepted benefits" that are exempt from healthcare reform.

In an earlier FAQ, FAQ Part XI, the Departments had indicated that a fixed indemnity plan could not pay on a "per-service basis," even if it was a fixed amount. Instead, it would have to pay benefits on a "per-period basis." For example, if an individual was injured, the preferred way to pay the benefit was to pay a certain amount per day regardless of the services provided as opposed to reimbursing different amounts for different services. By contrast, a plan that covers doctors' visits at $50 per visit, surgical procedures at $75 per procedure, or prescription drugs at $15 per prescription would not be considered to be a fixed indemnity plan under FAQ Part XI (and would not be an excepted benefit) because the payments would be provided on a per-service basis.

In FAQ Part XVIII, which can be relied upon now, the Departments have changed position and will be writing regulations that permit a fixed indemnity plan to reimburse on a per-service basis and still be considered excepted benefits if the plan[[167]](#footnote-167):

* Is sold only to individuals who have other health coverage that is minimum essential coverage
* Does not coordinate between the provision of benefits and an exclusion of benefits under any other health coverage
* Pays benefits in a fixed dollar amount regardless of the amount of expenses incurred and without regard to the amount of benefits provided with respect to an event or service under any other health coverage; and
* Includes a prominently displayed notice informing policyholders that the coverage does not meet the definition of minimum essential coverage and will not satisfy the individual mandate

63. How will the essential health benefits mandate be implemented?

Federal health reform requires coverage of essential health benefits (EHBs) for most major medical health plans and policies sold in the individual and small group markets, both inside and outside the state’s health insurance exchange. Broadly, inside the state’s health insurance exchange, qualified health plans (QHPs) will be subject to state and federal mandates. See Q 76. Self-insured group health plans, health insurance offered in the large group market (generally companies with more than 100 employees), and grandfathered health plans are not required to cover essential health benefits or provide minimum essential coverage. Additionally, outside of a state’s health insurance exchange, non-grandfathered plans and policies in the individual and small group markets will be required to cover essential health benefits. Effective in 2017, states may allow large group purchasing through the exchange, which would subject large group plans and policies to the EHB requirements.[[168]](#footnote-168)

Federal health reform requires that certain items and services within ten specific categories of benefits must be included in the essential health benefits, which must be defined by HHS through regulation. [[169]](#footnote-169) The law distinguishes between a plan’s covered services and the plan’s cost-sharing features, such as deductibles, copayments, and coinsurance. The cost-sharing features will determine the level of actuarial value of the plan, expressed as a “metal level” as specified in the statute:

* Bronze at 60 percent of actuarial value
* Silver at 70 percent of actuarial value
* Gold at 80 percent of actuarial value, and
* Platinum at 90 of percent actuarial value

In December 2011, HHS released initial guidance on essential health benefits. HHS’s approach to defining the essential health benefits allows states to select a benchmark plan from four options that reflect the scope of services offered by a “typical employer plan.”[[170]](#footnote-170) The general categories to be considered in defining a typical employer plan (which is undefined by the statute or regulations) include large employer, small employer, and government health plans.

HHS states that the following four benchmark plan types for 2014 and 2015 best reflect the statutory standards for EHB in the Affordable Care Act: [[171]](#footnote-171)

A state may select its base-benchmark plan from four types of health plans:

* one of the three largest by enrollment small group plans in the state
* one of the three largest by enrollment state employee health plans
* one of the three largest by enrollment federal employee health plan options; or
* the largest by enrollment insured commercial HMO operating in the state[[172]](#footnote-172)

A plan’s enrollment is determined from that of the first quarter two years prior to the coverage year.[[173]](#footnote-173) If a state fails to select, the benchmark plan will be the largest plan by enrollment in the largest product in the state’s small group market.[[174]](#footnote-174)

64. What is required to become a state selected EHB-benchmark plan?

In order to become a state selected EHB-benchmark plan, a base-benchmark plan must include coverage of the ten categories listed previously.[[175]](#footnote-175) A state’s benchmark selection in 2012 is applicable for the 2014 and 2015 benefit years, and be based on plan benefits offered by the selected benchmark at the time of selection, including any applicable state-required benefits enacted prior to December 21, 2011.[[176]](#footnote-176)

The state’s EHB-benchmark plan standard covers the benefits, limits on coverage (including limits on the amount, duration, and scope of covered benefits), and prescription drug benefits.[[177]](#footnote-177) Mental health and substance use disorder services must be provided in a manner that complies with the parity standards under the Mental Health Parity and Addiction Equity Act of 2008.[[178]](#footnote-178) Insurers may substitute benefits, or sets of benefits, that are actuarially equivalent to the benefits in the state’s EHB benchmark plan within each of the ten categories[[179]](#footnote-179) but not between different benefit categories.[[180]](#footnote-180) Additionally, benefit substitution cannot occur for prescription drug benefits.[[181]](#footnote-181) For prescription drug benefits, a plan must cover at least the *greater of* one drug in every category or class; or the same number of drugs in each category and class as the EHB-benchmark plan.[[182]](#footnote-182) Thus, if the EHB benchmark plan’s drug list offers more than one drug in a category or class, then plans covering essential health benefits must offer at least the number of drugs in the EHB-benchmark plan for that class.

The benefits and services included in the benchmark plan option selected by the state would be considered the essential health benefits. State benefit mandates that fall within the benchmark plan selected by the state would be included in the defined essential health benefits for 2014. A requirement in the law that states must defray the costs of state benefit mandates that fall outside the essential health benefits would be waived. However, for any mandates that fall outside the selected benchmark plan, the state would be required to cover the cost of those mandates.

Whether the coverage for an existing state benefit mandate will be included in the essential health benefits will depend on the benchmark plan the state selects. State laws regarding required coverage of benefits vary widely in number, scope, and topic, so that generalizing about mandates and their impact on typical employer plans is difficult. All states have adopted at least one health insurance mandate, and there are more than 1,600 specific service and provider coverage requirements across the fifty states and the District of Columbia.[[183]](#footnote-183) Each of the benchmark plan options will include a differing set of state benefit mandates. For example, one of the four benchmark plan options, the Federal Employee Health Benefits Plan, will not include any state benefit mandates as these plans are not subject to state benefit mandates. However, if the state selects the small-group insurance product benchmark plan option, some subset of state benefit mandates would be included in the benchmark plan that would define the essential health benefits. Given the potential for additional marginal costs to the state of benefit mandates above the essential health benefits, there seems to be an incentive for states to select a benchmark plan that includes state benefit mandates.

Because of the complexity of identifying the differing benchmark plan options – and thus identifying the possible essential health benefits for a state – it remains to be seen which state benefit mandates would be included for each of the benchmark options. Under HHS’s regulatory approach for defining essential health benefits, until a state selects a benchmark plan, which state benefit mandates, if any, will be included in the essential health benefits for 2014 is unknown, as is the potential cost to the state of benefit mandates outside the essential health benefits.

65. What new requirements are there for grandfathered health plans?

Grandfathered health plans are those continuously in existence since March 23, 2010, and with no prohibited changes subsequently described in this book. Grandfathered health plans are subject to certain health reform requirements, as follows:

* Prohibition of annual and lifetime benefit limits (except that provisions annual limit prohibitions not applicable for individual health insurance coverage but not group coverage).[[184]](#footnote-184)
* No rescission except for fraud or intentional misrepresentation.[[185]](#footnote-185)
* For plan years beginning before January 1, 2014, children who are not eligible for employer-sponsored coverage must be covered up to age twenty-six on an employee’s family policy.[[186]](#footnote-186)
* Preexisting condition exclusions for covered individuals younger than age nineteen are prohibited.[[187]](#footnote-187)
* Preexisting condition exclusions prohibited for all persons in 2014.[[188]](#footnote-188)
* Plans may not require a waiting period of more than ninety days.[[189]](#footnote-189)
* Plans must provide a Summary of Benefits and Coverage (SBC).[[190]](#footnote-190)
* Medical Loss Ratio provisions.[[191]](#footnote-191)

66. What new requirements are there for new and non-grandfathered health plans?

New and non-grandfathered plans are subject to the requirements for grandfathered plans (described in Q 65) plus the following requirements:

* The plan must guarantee that coverage is renewable regardless of health status, utilization of health services, or any other related factor. Coverage can only be cancelled under specific, enumerated circumstances.[[192]](#footnote-192)
* The plan may not require cost-sharing for preventive services, immunizations, and screenings.[[193]](#footnote-193)
* Discrimination based on salary is prohibited (the effective date has been postponed until regulations are issued).[[194]](#footnote-194)
* Children must be covered up to age twenty-six on a family policy, regardless of whether they are eligible for coverage with their employer.[[195]](#footnote-195)
* The plan must provide internal appeal and external review processes to ensure independent review.[[196]](#footnote-196)
* Emergency services must be available at the in-network cost-sharing level with no prior authorization.[[197]](#footnote-197)
* Parents must be allowed to select a pediatrician as a primary care physician for children and women must be allowed to select an OB-GYN as their primary care physician.[[198]](#footnote-198)
* Health insurance issuers may not charge discriminatory premium rates. The rate may vary only by whether such plan or coverage covers an individual or family, the rating area, the actuarial value of the plan, the age of the plan participant, and tobacco use.[[199]](#footnote-199)
* Health insurance companies in the small group and individual markets (and large group markets to the extent of purchasing insurance through state exchanges) must include coverage that incorporates defined essential benefits, provides a specified actuarial value, and requires all group health plans to comply with limitations on allowable cost sharing.[[200]](#footnote-200)
* Health insurance issuers are prohibited from dropping coverage because an individual (who requires treatment for cancer or another life-threatening condition) chooses to participate in a clinical trial. Issuers also may not deny coverage for routine care that they would otherwise provide because an individual is enrolled in a clinical trial.[[201]](#footnote-201)
* HIPAA nondiscrimination requirements are continued and no discrimination due to health status is permitted for wellness programs and individual insurance.[[202]](#footnote-202)
* Group health plans and health insurance issuers offering group or individual health insurance coverage must disclose certain enrollee information, such as claims payment policies and practices and enrollee rights, to the federal government and the state insurance commissioner. Such plans and issuers also must provide information to enrollees on the amount of cost-sharing for a specific item or service.[[203]](#footnote-203)
* Health insurance issuers must report information on initiatives and programs that improve health outcomes. A wellness program may not require the disclosure or collection of any information relating to the presence or storage of a lawfully possessed firearm or ammunition in the residence or the lawful use, possession, or storage of a firearm or ammunition by an individual.[[204]](#footnote-204)

**66.01 Cancelled policies not compliant with healthcare reform – administration about-face allows continuation of non-compliant policies**

A part of the basis of the federal healthcare reform was that when individuals are required to have health insurance (or pay a penalty), the insurance must be worth buying, meaning

1. important benefits must be covered, and
2. older and unhealthier people should not be charged amounts dramatically larger than young, healthy individuals.

On November 14, 2013,[1](#_bookmark0) HHS announced a one-year retreat and now allows policies that do not comply with certain healthcare reform requirements to continue to be sold if the insurance companies wish to do so and if the state insurance regulators allow them to do so. The Obama administration has announced through this HHS letter that it will allow insurance companies to renew individual and small group market policies that do not meet health law standards through the end of 2013 and 2014 for policy years starting between January 1 and October 1 if that coverage was in effect for the insured or small group on October 1, 2013. Such policies may be renewed for one policy year beginning between January 1, 2014, through October 1, 2014, if insurers decide to do so and if the state insurance regulators permit.

As discussed at the end of this item, there is also legislation pending that would change the law in different ways than announced by HHS. The new administration policy seems designed, at least in part, to deflect blame for the current cancellations to insurers (those electing not to continue the old policies or which cannot do so due to the short time available) and to reduce the likelihood that Democrats would vote for one of these pending legislative proposals discussed later in this post. This is another example of the administration changing the law administratively (like the delay in the employer mandate) without a legislative change to the law or its effective dates. No mention has been made yet about the individual mandate and whether it is suspended for those buying these policies that otherwise would have been cancelled.

This HHS action was in response to the complaints that millions of individuals have received notices that the insurance they had in 2013 would be cancelled, thus meaning that those people would not be able to keep their insurance, even if they liked it. Under this HHS change, a person with a policy that ends in June 2014 would have the option to renew that same plan for one more year, but only if their insurance company decides to continue the policy and the state allows it to be sold.

Experts have indicated that many policies that have been or will be cancelled will not be profitable after the implementation of healthcare reform, meaning that many insurers may not continue to offer noncompliant policies to those who had them on October 1, 2013. This abrupt change of administration policy may be aimed at causing those unhappy with the policy cancellations to be upset with insurers who choose not to continue the cancelled policies rather than Congress and the administration. Had the website HealthCare.gov been working properly, many people getting cancellations could see if they could get a better deal in an exchange (better coverage, lower cost due to subsidies, or both).

1 See HHS, CMS, Center for Consumer Information & Insurance Oversight (CCIIO) letter from CCIIO Director Gary Cohen to state insurance commissioners at [http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF.](http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF) Footnote 2 of this letter indicates that the IRS and Department of Labor concur with this program

Insurers who use this new option must notify policyholders

1. of the various health law benefits missing from the plan[2](#_bookmark1) and
2. about the other options they would have on the health law's state exchanges (marketplaces), including the possibility of financial assistance, and outside the exchanges that comply with healthcare reform requirements.

Such notices must be sent as soon as possible to those who have received cancellation notices or when a cancellation notice would have otherwise in the future been sent. The administration’s change will only allow people who are already signed up for these pre-Obamacare plans to keep buying them.

State insurance regulators must react to this new federal policy, and initially the state of Washington and Washington, D.C., announced[3](#_bookmark2) that it would not allow the noncompliant policies to be sold by insurers. Additionally, insurance companies who decide to continue existing and otherwise noncompliant policies must, before January 1, 2014

1. reprogram their computer systems for cancelled policies, rates, and eligibility,
2. send notices to the policyholders who have received cancellation notices via U.S. Mail describing the differences are between specific policies and Obamacare compliant plans,
3. ask the person for his decision, and
4. enter those decisions into their systems without creating mistakes regarding billing, claim payment, and provider (hospital and physician) panel lists.

Additionally, if insurers want rate changes to these otherwise discontinued policies, that will prove difficult to run through the state insurance department and have a result in place by January 1, 2014.

Anyone remaining in one of these pre-Obamacare plans will be in a separate risk pool, meaning that their premiums are set based on those in their group. Everyone who buys an Obamacare-compliant plan will be in a different risk pool. If many insurers continue these pre-Obamacare plans, many if not most persons who have them may be willing to have their lesser benefit packages. These individuals would tend to be healthier, which would drive up premiums sold on the state exchanges.

**Pending Legislation**. Under one proposal pending in Congress, anyone who is accepted by an insurer (meaning that pre-existing conditions could be considered by the insurer) could enroll in one of these pre- Obamacare plans, whether or not they are covered by one now. The passage of this Republican legislation in the Senate would seem unlikely. Different proposed legislation would *require* insurers to continue

2 These could include any or all of the following requirements contained in the following sections of the Public Health Service Act, as amended by healthcare reform: 2701 (relating to fair health insurance premiums); 2702 (relating to guaranteed availability of coverage); 2703 (relating to guaranteed renewability of coverage); 2704 (relating to the prohibition of pre-existing condition exclusions or other discrimination based on health status), with respect to adults, except with respect to group coverage; 2705 (relating to the prohibition of discrimination against individual participants and beneficiaries based on health status), except with respect to group coverage; 2706 (relating to non-discrimination in health care); 2707 (relating to comprehensive health insurance coverage); and 2709 (relating to coverage for individuals participating in approved clinical trials).

3 “Insurers Caught off Guard by Policy Reversal,” Wall Street Journal, p.1 A-1 (November 15, 2013) and online as “Health Insurers Express Worries Over Obama Shift on Policy Cancellations” at

[http://online.wsj.com/news/articles/SB10001424052702303289904579198053626111152?mod=ITP\_pageone\_0.](http://online.wsj.com/news/articles/SB10001424052702303289904579198053626111152?mod=ITP_pageone_0)

offering the plans they intended to cancel. One version is for an indefinite extension of those policies and another is for two years. There is a good argument that both of these proposals are unconstitutional because they require insurers to sell certain products.

State Health Insurance Exchanges[[205]](#footnote-205)

67. What are the state health insurance exchanges?

The law refers to state health insurance exchanges, a major component of the federal health reform, as "American Health Benefit Exchanges."[[206]](#footnote-206) The rules for the state exchanges or marketplaces are discussed in detail in Part X of this book. In theory, insurance companies will compete for business on a transparent, level playing field, which should reduce costs and give individuals and small businesses the purchasing power enjoyed by big businesses. However, health reform does many things to increase costs by covering those who are now uninsurable and by increasing mandated benefits. Many predict these factors will far outweigh any efficiencies created by the exchanges and that health insurance prices will increase. If exchanges succeed, they will create the first viable alternative to the group markets for the younger than age sixty-five population.

Beginning in 2014:

* Each state is required to create an exchange (a governmental agency or nonprofit organization, established by the state[[207]](#footnote-207)) to facilitate the sale of qualified health plans (QHPs), including federally administered multistate plans and nonprofit cooperative plans.[[208]](#footnote-208) The law requires HHS to create an exchange in states that do not set up their own exchanges. However, the health reform law does not provide the federal government with adequate funding to set up or operate federal health insurance exchanges.
* States can create either one exchange to serve both small group and individual markets[[209]](#footnote-209) or separate exchanges for these pools.
* One goal is to facilitate a comparison of available health insurance options by purchasers.
* Standards for qualified coverage must include:
* Mandated essential coverage
* Cost-sharing requirements (deductibles, copayments, and coinsurance)
  + Out-of-pocket limitations
  + Minimum actuarial value of 60 percent, which means that the policy, on average, pays 60 percent of the costs for essential health benefits and the insured pays the remaining 40 percent. [The coverage levels are Bronze (60 percent), Silver (70 percent), Gold (80 percent), and Platinum (90 percent).]
* Catastrophic coverage for purchasers aged thirty and younger in the individual market.
* States must also create Small Business Health Option Programs, or “SHOP Exchanges,”[[210]](#footnote-210) for small employers to purchase coverage. See Q 77. The states can expand the programs to include large employers beginning in 2017.

States can offer employers certain options:

* Employers can choose any QHP offered in the SHOP in any tier;
* Employers can select specific tiers from which an employee may choose a QHP;
* Employers can select specific QHPs from different tiers of coverage from which an employee may choose a QHP; or
* Employers can select a single QHP to offer employees.

68. How do employers use exchanges?

There is rolling enrollment for employers, but, upon enrollment, the employer is locked into the plan for one-year periods. The plan premiums are also locked in for the same amount of time. Once the employer enrolls in a state exchange:

* The employer must offer Exchange coverage to all employees.
* The Exchange must provide an aggregate bill to the employer for all employees.
* Employers must notify the Exchange about any employee change of status, for example, adding dependents or terminating employment.
* Employers with multiple worksites can offer access to a single Exchange or to state Exchanges where employees are located.

69. Are there any issues with state exchanges?

There are several issues that may affect a state’s exchange. For example, states do not have full authority over their own exchanges. HHS has final approval authority for each exchange.

Another issue is the interaction with cafeteria plans regulated by Code section 125. Coverage offered through an exchange is not a permitted benefit under Code section 125 and cannot be offered under a cafeteria plan[[211]](#footnote-211) unless the employer offers its employees the opportunity to enroll through an exchange in a group market.[[212]](#footnote-212)

Although the law does not provide the federal government with adequate funding to set up or operate federal health insurance exchanges, exchange costs must be funded by HHS until January 1, 2015. Thereafter, all exchanges must be self-funded.

70. How do individuals apply for health insurance from an Exchange?

HHS has posted a package of draft applications[[213]](#footnote-213) that will be used by individuals seeking to enroll in health insurance coverage through an Exchange, via an online application, for 2014. Exchanges are to begin taking applications for coverage when open enrollment begins on October 1, 2013. The applications will collect information to determine whether the applicant (1) is eligible to purchase a qualified health plan through an Exchange and (2) qualifies for any affordability programs, such as advance payment of premium tax credits, cost-sharing reductions, or Medicaid.

One basic application is eight pages, and a second is twenty-one pages. Appendix A, which lists all possible questions an individual may be asked, is sixty pages long. Items will be displayed on the online application depending on applicants’ household and income situations, so applicants will not be required to complete the entire list of items if they apply online. The information that is available from other federal sources, such as taxable income from the prior year from the IRS, are automatically shown on the on-line application. The completed application can be printed out for the applicant’s records. The completed form will list the programs for which the individual qualifies, including advance application of the premium tax credit, which can also be applied for online. Additionally, a person can apply for Exchange provided health insurance using a paper form, over the phone, and in person. There is a video[[214]](#footnote-214) walking through the application process for a single person and another for a family of three.

71. What is a loophole in the law as to exchange purchased insurance and its impact on insureds and providers?

Doctors and hospitals who contract with insurers selling policies on state health insurance exchanges in 2014 and thereafter may find themselves liable for treatment costs due to the healthcare reform law. Under the ACA,[[215]](#footnote-215) families who obtain subsidized health plan coverage through an exchange and who fail pay their premiums have a three-month grace period for premium payment[[216]](#footnote-216) before the policy is cancelled.[[217]](#footnote-217)

However, insurers are responsible only for paying claims during the first month of this three-month grace period. During months two and three, families are asked to pay their hospital and doctor's bills or their insurance premium if they seek health care services. However, if they do not pay either bill, providers will not be paid for the cost of the treatment. Such families would face a tax penalty for the advance payment of the premium tax credit paid on their behalf when the initial coverage was purchased, but they would not receive a fine, a premium rate increase, or a repayment order. They could also purchase another subsidized exchange policy the next year.

The three-month grace period was meant to ensure continuity of care for low-income families who might be between jobs and cannot afford to pay their premiums for a few weeks. However, it is not the provider’s job to manage this risk.

Health plans are supposed to give providers fifteen days’ notice of the termination of payment by the policy, in which case providers might be unable to avoid treating exchange patients. However, contracts by providers with large health insurers often include an "all-products" clause, which requires that doctors treat any patients covered under the health plan. Additionally, doctors have legal and ethical obligations not to abandon their patients during course of treatment. A round of chemotherapy can cost tens of thousands of dollars or more.

In a notice published in the Federal Register,[[218]](#footnote-218) HHS acknowledged that nonpayment of premiums for subsidized exchange policies would "increase uncertainty for providers and increase the burden of uncompensated care." HHS officials said that the agency will "monitor this issue moving forward and will continue to work on the development of policies to prevent misuse of the grace period."

Here is how this three-month grace period works per examples in the regulations:

***Example 1:*** Individual misses $50 payment that is due February 28 for March coverage and misses $50 payment that is due March 31st for April coverage. Individual Pays $150 on April 30 for March, April, and May coverage.

* Issuer adjudicates claims for March
* Coverage continues for April and May (2nd and 3rd months of the grace period), but:

1) Providers are notified of the potential for a denied claim.

2) Issuer pends claims for services performed in April and May until individual pays outstanding premiums.

3) Individual has paid full premium for March, April, and May and is eligible for premium tax credit for March, April, and May.

***Example 2:*** Same facts as Example #1 except that the individual does not pay enrollee's share of premium for March, April, or May.

* Coverage terminated retroactively to March 31
* Issuer can deny claims for services rendered during April and May. Provider could then seek payment directly from the individual for any services provided during that time.
* Individual may have additional tax liability attributable to the $450 for the advance payment of the premium tax credit paid on his or her behalf for March's coverage. The exact amount of additional tax liability would be determined in accordance with the rules for tax credit reconciliation under section 36B of the Code.

72. Were there any operating state exchanges prior to 2014?

Massachusetts and Utah have operating exchanges, but neither one has produced lower costs. Massachusetts has some of highest insurance rates in the United States,[[219]](#footnote-219) and Utah’s exchange rates are higher than purchasing outside the exchange.[[220]](#footnote-220)

One study, conducted for the Ohio Department of Insurance,[[221]](#footnote-221) has predicted that the likely cost increases for health insurance in Ohio will be a total of 55 percent to 85 percent for several reasons, including:

* The law's requirements for commercial, employer-sponsored, small group, and individual health insurance markets, both inside and outside the exchanges, including guaranteed issue of insurance coverage regardless of preexisting medical conditions or health status,
* Adjusted community rating with premium rate variations only for benefit plan design, geographic location, age rating (limited to ratio of 3:1), family status, and tobacco usage (limited to ratio of 1.5:1),
* Premium rate consistency inside and outside the exchanges, and
* Requirements for essential health benefits.

In addition, the study noted that:

* Although the percentage of Ohio residents with coverage could rise by about 7.9 percent, the price of individual health insurance coverage might rise by about 55 percent to 85 percent, excluding the impact of medical inflation, Milliman predicts. These increases will be 8 percent to 12 percent higher than adjusted small group rates. This is primarily driven by the estimated health status of the new individual health insurance market and the expansion of covered benefits.
* The small group market (from 2 to 100 individuals) is expected to see increases of 5 percent to 15 percent.
* Due to community ratings, some groups could see an increase of 150 percent while others could receive a decrease of up to 38 percent.
* Employers with age fifty-five and older dominant demographics are likely to see the decreases.
* The highest rate increases are expected in companies with two to nine employees.
* Large groups are expected to see an increase of 0 percent to 5 percent.
* None of these increases take into account the increase in medical inflation, which for 2012 is estimated to be 7 percent to 8 percent.
* One important factor for cost increases in group plans is the pass-through fees resulting from increased taxes on insurance companies and medical manufacturers.

73. What are the functions of the state health insurance exchanges?

The exchange functions and responsibilities[[222]](#footnote-222) include the following:

* Certification, recertification, and decertification of health insurance options as qualified,
* Operation of a toll-free hotline,
* Maintenance of a website for providing information on plans to current and prospective enrollees,
* Assignment of a price and quality rating to plans,
* Presentation of plan benefit options in a standardized format,
* Provision of information on Medicaid and CHIP eligibility and determination of eligibility for individuals in these programs, as well as eligibility for the refundable income tax credit,[[223]](#footnote-223)
* Provision of an electronic calculator to determine the actual cost of coverage, taking into account eligibility for premium tax credits and cost sharing reductions,
* Certification of individuals exempt from the individual responsibility requirement,
* Provision of information on certain individuals and to employers, and
* Establishment of a “navigator” program that provides grants to entities assisting consumers.

74. What are the areas over which HHS has responsibility for the state health insurance exchanges?

HHS is responsible for regulatory standards in five areas that insurers must meet in order to be certified as qualified health plans (QHPs) by an exchange:

* marketing,
* network adequacy,
* accreditation for performance measures,
* quality improvement and reporting, and
* uniform enrollment procedures.[[224]](#footnote-224)

75. What are the primary federal requirements for state exchanges?

Only lawful U.S. residents may obtain coverage in an exchange.[[225]](#footnote-225) Exchanges must comply with federal regulatory standards in the following areas:

* Information on the availability of in-network and out-of-network providers, including provider directories and availability of essential community providers;
* Consideration of plan patterns and practices with respect to past premium increases and a submission of the plan justifications for current premium increases;
* Public disclosure of specific plan data, including claims-handling policies, financial disclosures, enrollment and disenrollment data, claims denials, rating practices, cost sharing for out-of-network coverage, and other information identified by HHS;
* Timely information for consumers requesting their amount of cost sharing for specific services from specified providers;
* Establishment of "navigators" to assist consumers in selecting their health insurance;[[226]](#footnote-226)
* Information for participants in group health plans;
* Information on plan quality-improvement activities;
* Presentation of enrollee satisfaction-survey results; and
* Publication of data on the Exchange’s administrative costs.[[227]](#footnote-227)

Additionally, exchanges must meet detailed requirements for call centers and an Internet web site.[[228]](#footnote-228)

76. What is a Qualified Health Plan (QHP)?

A qualified health plan (QHP) is health insurance certified by a state Exchange that offers “essential health benefits.”[[229]](#footnote-229) A QHP must be offered by an insurer that:

(1) Is licensed and in good standing to offer health insurance coverage in each state in which it offers health coverage;

(2) Agrees to offer at least one QHP in the silver level and at least one QHP in the gold level in each Exchange;

(3) Agrees to charge the same premium rate for each QHP, whether offered through an Exchange or offered directly from the insurer or through an agent; and

(4) Complies with regulations to be issued by HHS and any requirements established by an applicable Exchange.[[230]](#footnote-230)

However, a QHP may vary premiums by rating area.[[231]](#footnote-231)

For QHP purposes, the term health plan includes “health insurance coverage” and a “group health plan.”[[232]](#footnote-232) Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurer.[[233]](#footnote-233)

A “group health plan” is an ERISA welfare benefit plan that provides medical care.[[234]](#footnote-234) Health plans must be subject to state regulation; therefore, the term “health plan” does not include a group health plan or multiple employer welfare arrangement (MEWA) not subject to state insurance regulation under ERISA section 514. Thus, self-insured group health plans cannot qualify as QHPs.[[235]](#footnote-235)

Health insurance plans must:

* Meet certain marketing requirements;
* Ensure a sufficient provider choice and include, where available, providers that serve low-income and medically underserved individuals;
* Be accredited (see Q 23) for clinical quality, patient experience, consumer access, and quality assurances, and implement a quality improvement strategy;
* Use a uniform enrollment form and a standard format for presenting plan options; and
* Provide information on quality standards used to measure plan performance.[[236]](#footnote-236)

The U.S. Office of Personnel Management (OPM) must enter into contracts with health insurers to offer at least two multistate QHPs through each Exchange in each state.[[237]](#footnote-237)

77. How are state health insurance exchanges regulated?

The Patient Protection and Affordable Care Act includes two federal requirements for state health insurance exchanges:[[238]](#footnote-238)

* Minimum functions that Exchanges must perform directly or by contract, and
* Oversight responsibilities Exchanges must exercise in certifying and monitoring the performance of Health Plans.[[239]](#footnote-239)

Plans participating in the exchanges also must comply with state insurance laws and federal requirements in the Public Health Service Act.

The final regulations set “standards for establishing exchanges, setting up a Small Business Health Options Program (SHOP), performing the basic functions of an exchange, certifying health plans for participation in the exchange,” and establishing “a streamlined, web-based system for consumers to apply for and enroll in qualified health plans and insurance affordability programs.” HHS has also issued questions and answers on federally facilitated Exchanges, including for instance, how the Exchanges will interact with state departments of insurance.[[240]](#footnote-240)

State exchanges are to be operational in 2014. A change in the final rule gives more flexibility to states that are not able to show "complete readiness" to operate an exchange on January 1, 2013. HHS may conditionally approve a state-based exchange upon demonstration that it is likely to be fully operationally ready by October 1, 2013. Applications of a state's Exchange Blueprint must be submitted thirty 30 business days before January 1, 2013, or by November 16, 2012.

Individuals and small businesses will be able to purchase private health insurance via these exchanges. Starting in 2014, exchanges are intended to:

* Facilitate the comparison by individuals and small businesses of health plans,
* Provide answers to questions,
* Determine eligibility for tax credits for private insurance or health programs like the Children's Health Insurance Program (CHIP), and
* Allow enrollment by individuals and small employers in a Qualified Health Plan (QHP).

78. How should states set up health insurance exchanges?

The U.S. Department of Health and Human Services (HHS) issued final regulations[[241]](#footnote-241) that provide a framework to assist states in building health insurance exchanges, state-based competitive marketplaces authorized by the 2010 federal health care reform law.[[242]](#footnote-242) These rules set minimum standards for exchanges and give states some flexibility to design the exchanges to fit their insurance markets, subject to HHS approval. The regulations propose rules and guidance on how to structure the exchanges in two areas:

* Setting standards for establishing exchanges, setting up a Small Business Health Options Program (SHOP) , performing the basic functions of an exchange, and certifying health plans for participation in an exchange; and
* Ensuring premium stability for the exchanges, especially in the first three years.

According to HHS, forty-eight states and the District of Columbia have been awarded grants to help plan and operate exchanges.[[243]](#footnote-243) By mid-June 2013, seventeen states and the District of Columbia were pursuing state-based exchanges, six were pursuing state partnership exchanges, and twenty-eight declined to establish a state-based exchange and will default to a federally facility exchange. All of the twenty-four states working toward state-based or state partnership exchanges have been conditionally approved by HHS.[[244]](#footnote-244)

The rules allow states to decide:

* Whether their exchanges should be local, regional, or operated by a nonprofit organization,
* How to select plans to participate, and
* Whether to collaborate with HHS for the work.

However, HHS must approve each exchange and the criteria for its insurance policies.

In 2014, exchanges will initially be available only to individuals and small employers, but states may expand them in 2017 to be available to large employers as well.

Using the standards and processes in the regulations to approve exchanges, HHS must determine by January 1, 2013, whether an exchange will be operational by 2014, which means it must begin open enrollment on October 1, 2013. In states that do not obtain this HHS approval (or decide not to establish an Exchange), a federally facilitated exchange would be implemented for 2014.

***Initial Open Enrollment.*** The initial open-enrollment period is proposed to extend from October 1, 2013, through March 31 2014.[[245]](#footnote-245) Only those enrolling in a qualified health plan (QHP) on or before December 22, 2013, would be ensured coverage effective January 1, 2014. Special enrollment periods are also provided in the regulations.[[246]](#footnote-246) The annual enrollment period for 2015 and subsequent years will begin on October 15 and end after December 7.[[247]](#footnote-247)

***Eligibility and Consumer Assistance.*** Exchanges would make eligibility determinations and provide consumer assistance tools, including a toll-free call center, a website with comparative information about available qualified health plans (QHPs), and a “navigator” program that facilitates enrollment and provides other information and services. Navigators cannot be insurers but can be agents or brokers. They cannot receive direct or indirect compensation from an insurer for enrolling eligible individuals, employers, or employees in a QHP.

Each exchange must provide the following:

* A toll-free call center to address the needs of those seeking assistance;
* An Internet website providing a variety of features, including comparative information on available QHPs, certain financial information, and information about the Navigator and call center;
* An Exchange calculator to facilitate comparisons of QHPs that takes into consideration the premium tax credit and any cost-sharing reductions;
* A consumer-assistance function, including the Navigator program discussed below; and
* Outreach and education activities.[[248]](#footnote-248)

***Small Business Health Options Program (SHOP).*** Each state will establish insurance options for qualifying small businesses through a SHOP, and participation by small employers will be voluntary. SHOP is intended to give small employers the same purchasing power that large employers have and to allow them to offer employees a choice of plans for a single monthly payment. For 2014 through 2016, only employers with fewer than 100 employees or fewer than fifty employees (states have the option of choosing either) will be granted access to the SHOP exchange. As discussed in Q 23, certain small employers will be eligible to receive a small business tax credit for up to 50 percent of the contributions they make toward employees’ premiums for two consecutive years if certain tax rules are met. See Q 79 for additional information on SHOPs.

***QHP Certification.*** Exchanges must establish procedures, which must be approved by HHS, for certification, recertification, and decertification of qualified health plans (QHPs). The regulations do not require exchanges to accept all eligible QHPs, although that is allowed. Alternatively, exchanges could limit QHP participation to those plans that meet the state’s selection criteria. The regulations include minimum standards for QHPs and QHP issuers. States may impose additional requirements, if approved by HHS.

An Exchange is required to allow the insurer of a plan that provides certain limited-scope dental benefits to offer the plan through the Exchange (either separately or in conjunction with a QHP) if the plan provides pediatric dental benefits.[[249]](#footnote-249)

***Reinsurance, 3-Year Risk Corridor Program, and Risk Adjustment.*** The HHS regulations outline standards for various programs required by healthcare reform that are intended, beginning in 2014, to mitigate the impact of adverse selection and stabilize premiums in the individual and small group markets. Standards are established for the transitional reinsurance program, which is a required state-based program that reduces uncertainty for insurers during the first three years the exchange is in operation by making payments for high-cost cases. A temporary risk corridor program from 2014 through 2016 will protect against uncertainty in setting rates within the exchanges by limiting the extent of insurer losses and gains.

The proposed regulations also include standards for a risk adjustment program, which is an optional program that a state may establish inside or outside of an exchange, after 2014. The program is intended to provide stability in the individual and small group markets by transferring funds from insurers of lower-risk enrollees to insurers of higher-risk enrollees.

78.01 What issues have been raised regarding the Healthcare Reform Navigator security and privacy concerns?

Healthcare reform requires HHS to establish the Navigator Program, which is designed to certify individuals as navigators to assist with enrollment in the exchanges (marketplaces) for health insurance. Numerous concerns have been raised about the security of Americans’ personal information given to the navigators. Republicans on the House Oversight Committee issued a report that navigators are not required adequately to secure individuals’ health information, Social Security numbers, yearly income and other tax information.[[250]](#footnote-250) The concern about the lack of security protection for personal health and financial information given to navigators is widespread. In August 2013, thirteen state attorneys general sent a letter to Health and Human Services Secretary Kathleen Sebelius saying that the personal information of those who sign up for insurance under the federal healthcare reform will not be properly protected.[[251]](#footnote-251)

Rep. Lynn Jenkins (R-KS) wrote to HHS Secretary Sebelius about these concerns on November 19, 2013.[[252]](#footnote-252) Jenkins reported on February 24, 2014 that Secretary Sebelius’ response confirms that government “failed to set up basic safeguards to the Navigators Program.”[[253]](#footnote-253) Rep. Jenkins states that while HHS says it is working on it, HHS has no rules to prevent felons from accessing confidential information because navigators are not required to submit to criminal background checks. An official with the Department of Health and Human Services told FactCheck.org in an email that there is “no statutory requirement for Navigators to complete background checks, although some organizations already conduct background checks and some states have laws that require it of Navigators.”[[254]](#footnote-254) States that have laws that require navigators to undergo criminal background checks include Arkansas, Florida, Georgia, Indiana and Ohio.

Rep. Jenkins also reports that Secretary Sebelius wrote her that no navigators will be fired for ethical lapses, and no formal ethical training will take place. If a navigator has acted in an unethical manner, Jenkins says that Sebelius states that the offending navigator will be put on probation.[[255]](#footnote-255)

79. What is the status of federal SHOP exchanges in 2014 for small employers?

Each state Exchange is required to create a Small Business Health Options Program (SHOP).[[256]](#footnote-256) HHS has also provided for a federally facilitated SHOP (FF-SHOP) in states that do not establish a state-based Exchange.[[257]](#footnote-257) Participation in a SHOP is strictly voluntary for small employers.

Beginning in 2014, however, purchasing employer-provided health coverage for employees through a SHOP is the only way for qualified employers to obtain a small business health care tax credit.[[258]](#footnote-258) Both state operated SHOPs and federally facilitated SHOPs (FFSHOPs) are to allow employees to have a choice among all QHPs at the metal level chosen by the employer (bronze, silver, gold, or platinum). However, SHOP regulations delay the effective date for this “employee-choice” model for FFSHOPS until 2015, so that, for plan years beginning before January 1, 2015, FFSHOPS will only offer one option and state-operated SHOPs may choose but are not be required to offer an employee choice option.[[259]](#footnote-259)

This will allow employers who prefer to offer employees a single Qualified Health Plan (QHP) to participate in an FFSHOP and retain potential eligibility for the small business tax credit, which, beginning in 2014, is only available through a SHOP Exchange.

For SHOP eligibility, a “small employer” is an employer that employed an average of at least one but not more than 100 employees on business days during the preceding calendar year and that employs at least one employee on the first day of the plan year.[[260]](#footnote-260) A qualified employee is an individual employed by a qualified employer who has been offered health insurance coverage by such qualified employer through the SHOP.[[261]](#footnote-261)

For counting employees to determine whether an employer is a small employer that is SHOP eligible, the regulations use the Code section 4980H(c)(2) employer mandate counting method, which counts not only full-time employees, i.e., those averaging 30 hours of service per week, but also part-time employees as full-time equivalents under Code section 4980H(c)(4)). However, a transitional rule allows state-operated SHOPS to rely on state counting methods, which in some states may not include part-time employees, for determining group size and status as a full-time employee until 2016.[[262]](#footnote-262) A qualified employer participating in a SHOP must provide information to its employees about the methods for selecting and enrolling in a QHP through the SHOP.[[263]](#footnote-263) This requirement is in addition to the Notice of Exchange.

79.01 What is the status of federal SHOP online enrollment for small employers?

The Small Business Health Options Program (SHOP) marketplace is part of the state health insurance exchanges and makes it possible for small businesses (fifty or fewer full-time-equivalent employees) to provide qualified health plans to their employees. HHS said in the fall of 2013 that it would delay SHOP online enrollment in federally run state exchanges from October 1, 2013, until sometime in November 2013.[[264]](#footnote-264) Then on November 27, 2013, HHS announced another delay, a one-year delay in SHOP online enrollment for federally run exchanges until November 2014.[[265]](#footnote-265)

For 2013 enrollment for 2014 coverage, small businesses in the thirty-six states with federally run exchanges must use an insurance agent, broker, or contract directly with an insurer for SHOP policies. For assistance, employers can call the SHOP Small Employer Call Center at 1-800-706-7893 between the hours of 9 a.m. – 7 p.m. Eastern Time or they can visit Localhelp.HealthCare.gov. CMS also announced that beginning in December 2013, while employers will not be able to enroll online for SHOP policies in the federally run state exchanges, they may enter the ages of employees on HealthCare.gov and see premium amounts for employees.[[266]](#footnote-266)

Fourteen states and Washington, D.C., are running their own exchanges, have online SHOP enrollment now for 2014 health coverage, and are allowing employees to choose from a variety of plans. For the federally run exchanges, employers, not employees, will select the coverage for employees in 2014.

Small businesses had until December 23, 2013, instead of December 15 to sign their employees up for SHOP coverage effective January 1, 2014.[[267]](#footnote-267) Employers can buy coverage on the SHOP marketplace at any time during the year, with no open enrollment deadline. Qualifying small businesses with less than twenty-five employees and average wages under $50,000 can qualify for tax credits of up to 50 percent of the insurance cost if they pay at least half the premiums for their employees for a SHOP exchange policy. HHS also announced on November 27, 2013, that small businesses no longer have to apply to be certified for the tax credits before enrolling. HHS will allow businesses to file the application for tax credit approval any time before the business files its taxes.

79.03 Rules for small business health insurance tax credit change in 2014

For tax years 2010 through 2013, eligible small employers have been entitled to a 35 percent tax credit for health insurance premiums they pay for employees. Tax-exempt entities have been eligible for a 25 percent credit.

Employers with ten or fewer full-time equivalent employees (FTEs) and average annual wages of $25,000 or less are eligible for the maximum tax credit. There is a phase-out of the credit for employers that have eleven through twenty-four FTEs or average annual wages from $25,001 to $49,999.99. Employees who are owners and family members do not count for the number of employees or the average compensation. To qualify for the credit, an employer must pay at least 50 percent of the premium for qualifying employee only (not spouses’ or dependents’) health insurance.

Employers claim the credit using IRS Form 8941. Taxable employers claim the credit on their federal tax return and can apply the credit to both regular and alternative minimum tax. Tax-exempt employers claim the credit by filing Form 990-T, and can receive a refundable credit up to the amount of the employer’s payroll taxes.

2014 Changes. In 2014, employers will only be eligible for the credit if they purchase health insurance through the new Small Business Health Options Program (SHOP). The SHOP is one component of the state based health insurance exchanges, also known as marketplaces. In addition:

* The maximum credit increases to 50 percent (35 percent for tax-exempt organizations).
* The $50,000 and $25,000 average annual dollar amounts will be indexed for inflation.
* The credit is based on the lesser of the employer’s actual premium payments or the average premiums in the small group market in its employees’ rating area.
* The credit is only available for two consecutive tax years after 2013, but it can be carried back or carried forward.

79.04 Small business insurance exchange revisions – SHOP enrollment periods & 2015 insurance choice exception

Regulations proposed in March 2014 make the following changes in the operation of the

Small Business Health Options Program (SHOP) program.

SHOP Enrollment Period. The annual open enrollment periods for qualified employers and qualified employees in all SHOPs, both state based or federally facilitated, are the same as the open enrollment in the corresponding individual marketplace exchanges.[[268]](#footnote-268)

SHOP Insurance Choices and 2015 Exception. For plan years beginning on and after January 1, 2015, all SHOPs must make available to qualified employers the option of selecting an actuarial value level of coverage (bronze, silver, gold and platinum[[269]](#footnote-269)) and making all qualified health plans at that level available to qualified employees (‘‘employee choice’’).[[270]](#footnote-270) However, HHS and state insurance commissioners are concerned that, in some circumstances, implementing employee choice in 2015 might significantly disrupt some small group markets and negatively affect the ability of small business employees to access coverage. The concern is that employee choice might lead to sicker people enrolling in disproportionate numbers in certain plans, which could have the effect of discouraging issuers from participating in the SHOP or causing adverse selection that cannot be fully addressed by the single risk pool provisions of the statute or the premium stabilization programs. Thus, there is a one year transition under which a SHOP would be permitted to not implement employee choice in 2015 under specific circumstances: (1) If employee choice would result in significant adverse selection in the State’s small group market that could not be fully remediated by the single risk pool or premium stabilization programs; or (2) if there is an insufficient number of issuers offering qualified health plans or qualified stand-alone dental plans to allow for meaningful plan choice among qualified health plans or qualified stand-alone dental plans for all actuarial value levels in the State’s SHOP. During this first year, a state regulatory agency, such as the state department of insurance, could submit a recommendation to the state SHOP[[271]](#footnote-271) or HHS in the case of an FF-SHOP.

80. What is the Employer Exchange Notice requirement?

The 2010 health reform law amends the Fair Labor Standards Act (FLSA)[[272]](#footnote-272) to require that employers provide all new hires and current employees with a written notice (Employer Exchange Notice) about the exchange and some of the consequences if an employee decides to purchase a qualified health plan through the exchange in lieu of employer-sponsored coverage.[[273]](#footnote-273) Regulations implementing the Employer Exchange Notice requirement will be issued and enforced by the Department of Labor.[[274]](#footnote-274)

The Employer Exchange Notice requirement is effective on March 1, 2013. Employees hired on or after the effective date must be provided with the notice when they are hired. All employees already employed on the effective date must be provided with the notice no later than the effective date (i.e., no later than March 1, 2013).[[275]](#footnote-275)

The Employer Exchange Notice rule applies to employers that are subject to the FLSA. The FLSA’s minimum wage and maximum hour provisions apply to entities that are engaged in interstate commerce and have a gross annual volume of sales that is not less than $500,000 (enterprises engaged in commerce or in the production of goods for commerce).[[276]](#footnote-276) However, the Employer Exchange Notice requirement does not have the same limitation. As a result, it seemingly applies to “any person acting directly or indirectly in the interest of an employer in relation to an employee.”[[277]](#footnote-277)

The Employer Exchange Notice must include the following information:[[278]](#footnote-278)

* Employees must be informed of the existence of an Exchange, given a description of the services provided by the Exchange, and told how to contact the Exchange to request assistance.
* Employees must be informed that they may be eligible for a premium tax credit (under Code section 36B) or a cost-sharing reduction (under PPACA section 1402) through the Exchange if the employer’s plan share of the total cost of benefits under the plan is less than 60 percent.
* Employees must be informed that:
* If they purchase a qualified health plan through the Exchange, they may lose any employer contribution toward the cost of employer-provided coverage; and
* All or a portion of the employer’s contributions to employer-provided coverage may be excludable for federal income tax purposes.

81. What is the role of health insurance brokers or agents in the state health insurance exchanges?

The final regulation contains welcome news for agents and brokers of health insurance.[[279]](#footnote-279) HHS, in the final regulation, permits states to allow an agent or broker to enroll individuals, employers or employees in qualified health plans (QHPs), in a manner that constitutes “enrollment through the exchange,” on their own Web site. It is up to each state to determine whether its exchange can list approved insurance agents and brokers.[[280]](#footnote-280) [However, navigators need not be agents or brokers.[[281]](#footnote-281)] An individual can be enrolled in a QHP through an exchange with the assistance of an agent or broker only if the agent or broker ensures that the individual receives an eligibility determination through the state’s Exchange Web site.[[282]](#footnote-282)

If the consumer would be eligible for a refundable federal income tax credit (See Q 49) for a QHP purchased on the exchange’s Web site, the consumer may access the tax credit for purchases through the broker or agent’s private Web portal.

The regulation sets out a series of requirements brokers or agents must meet in order for their clients to be able to access the tax credits for purchases through their Web sites. For consumers to do this, brokers and agents must be registered with the Exchange. This means that the state (or the federal government in the case of a federally facilitated exchange (FFE)), controls whether their exchange remains the exclusive market for the tax credit or whether brokers and agents can assist eligible individuals and families in obtaining the subsidies.

Additionally, all QHPs must be available for purchase through the Web site, and the agents and brokers assisting the customer must be trained on all QHP options. Thus, a single-carrier exchange will not meet the qualifications for a purchaser to access the tax credit. The private websites must present all QHPs and all QHP data in a manner that meets HHS standards and must not use financial incentives, such as rebates or free prizes, to lure customers to one QHP instead of another. Consumers may withdraw from this process at any time and use the exchange website. Any private web portal must be compliant with exchange privacy and security standards. Of course, state laws related to the qualifications and conduct of agents and brokers continue to apply.

Interestingly, the private web portals, unlike the state or federally facilitated exchanges, do not have restrictions on selling products other than QHPs. Thus, brokers and agents can use their existing web portals to sell other products as well as QHPs, as long as the requirements noted previously in this section are met.

Thus, if permitted to use an agent or broker, consumers never have to go to the state exchange website to buy a product and access the refundable tax credit. All of the information transfers between the private broker site, the exchange, and the insurance carriers can be invisible to the consumer.

This aspect of the final regulation indicates that HHS believes that private distribution of exchange health insurance will help to stimulate the use of exchanges. For agents, brokers, and private exchanges, the shift presents a new opportunity to access the exchange population. For consumers, it is likely that more will look into whether or not they qualify for a tax credit while shopping for insurance, which could increase QHP sales.

Employer Funds for Insurance Purchased on State Exchange and ERISA

82. Are individual health or other policies purchased in whole or part with employer funds an ERISA plan and subject to COBRA?

This will be an important issue if employers provide funds for employees to purchase policies at a state health insurance exchange beginning in 2014. While the policies purchased by individual employees are not necessarily ERISA plans, a program where the employer systematically pays all or a portion of the premium may become an ERISA plan. Consider whether an HRA or cafeteria plan funded at least in part by the employer that allows reimbursement for individual health insurance purchased by employees creates an ERISA plan for the policies themselves. Clearly, there is a plan as to the HRA or cafeteria plan.

As discussed in this section, there are several court decisions finding that where an employer pays for or contributes to an individual policy for one or more employees, there is an ERISA plan. There are also cases to the contrary. The employer's payment of all or part of the premiums on behalf of the employee is an important factor when courts determine whether an individual policy is part of an ERISA welfare plan.

83. How does ERISA define a group health plan? How does the IRS define a group plan?

ERISA defines a group health plan as one “established or maintained by an employer” (rather than “of, or contributed to by, an employer”).[[283]](#footnote-283) Seemingly, while the HRA or 125 plan with employer funding is an ERISA plan, the individual policies purchased by employees with no employer involvement in their selection may mean that the policies themselves are not part of an ERISA plan. See *Waks v. Empire Blue Cross/Blue Shield*, 263 F3d 872 (9th Cir. 2001) where the issue arose as to whether an individual policy arising out of a conversion from a group health plan is covered by ERISA preemption. There, the Ninth Circuit ruled no, that the conversion policy was not an ERISA plan, and stated:

We conclude that claims arising under a converted individual policy are not "related to" an ERISA plan for purposes of ERISA preemption. This conclusion is consistent not only with the words but also the purposes of the statute. A converted policy is created when an ERISA plan participant leaves the plan and obtains a new, separate, individual policy based on conversion rights contained in the ERISA plan. The contract under the converted policy is directly between the insurer and insured. It is independent of the ERISA plan and does not place any burdens on the plan administrator or the plan. There are also no relevant administrative actions by the employer.

Arguably, the same analysis applies and the fact that the employer funds are in an ERISA plan does not mean that the policies purchased with those funds by employees without any employer involvement in the purchase are part of an ERISA plan. However, the conclusion is not clear. Additionally, *Brooks v. Blue Cross & Blue Shield of Florida,* 116 F.3d 1364 (11th Cir. 1997) held that individual health insurance policies purchased through payroll deduction do not constitute a group health plan for purposes of the Medicare Secondary Payor rule, despite the fact that Medicare regulations include an “employee-pay-all plan.” See Q 172 for additional information on ERISA and the ACA requirements.

Group Health Plan – Internal Revenue Code Definitions

Code § 5000(b)(1) (Tax on nonconforming health plans) – “The term “group health plan” means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.” Employer does not include a federal or any other government entity. Under *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), a plan requires a commitment to systematically pay benefits, including ongoing administrative responsibilities to determine eligibility and calculate benefits. It would be an unusual situation where an arrangement providing health benefits to employees will not qualify as a plan, fund, or program.

The regulations at Reg. §1.5000A-1(d)(7) state that group health plan has the same meaning as in section 2791(a)(1) of the Public Health Service Act, 42 U.S.C. 300gg-91(a)(1). Reg. § 54.9831-1(a)(1) provides special rules for group health plans and defines group health plan as “a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.”

Code §§ 4980D (Tax For Failure to Meet PHSA Mandates), 4980B(g)(2) (Tax for COBRA failures), and 9832(a)(definitions) all cross reference the Code § 5000(b)(1) definition.

84. What is the DOL safe harbor on ERISA plan status?

DOL regulations establish a safe harbor that provides no ERISA plan exists where several conditions are met: (1) the employer does not contribute any funds; (2) employee participation is voluntary; (3) the employer does not endorse the arrangement (interpreted from employee’s point of view, not that of insurance company); (4) the employer does nothing more than allow uninsured to publicize the arrangement to employees and to collect premiums through payroll deductions; and (5) the employer receives no consideration beyond reasonable compensation for administrative services.[[284]](#footnote-284) In addition, ERISA does not apply to government and church plans.[[285]](#footnote-285)

85. What is the three-part test to determine whether an ERISA plan exists?

Determining whether an ERISA plan exists involves a three-part test, which was established in *Thompson v. American Home Assurance Co.*, 95 F.3d 429, 434-35 (6th Cir. 1996). This case provides for a detailed analysis of whether a plan is an ERISA plan. The existence of an ERISA plan is a question of fact, to be answered in light of all the surrounding circumstances and facts from the point of view of a reasonable person.[[286]](#footnote-286)

First, the court must apply the so-called "safe harbor" regulations established by the Department of Labor to determine whether the program was exempt from ERISA.[[287]](#footnote-287) See Q 84.

Second, the court must look to see if there was a "plan" by inquiring whether "from the surrounding circumstances a reasonable person [could] ascertain the intended benefits, the class of beneficiaries, the source of financing, and procedures for receiving benefits."[[288]](#footnote-288) Finally, the court must ask whether the employer "established or maintained" the plan with the intent of providing benefits to its employees.[[289]](#footnote-289)

Some courts collapse the first and third prongs of this analysis by interpreting the Department of Labor regulations as the indicia for determining whether a plan is established and maintained by the employer.[[290]](#footnote-290) However, those courts agree that even if a plan is not within the safe harbor, there must be an additional finding that the employer intended to establish or maintain a plan in order to find that an ERISA plan exists.

A policy will be exempted under ERISA only if all the "safe harbor" criteria of 29 CFR 2510.3-1(j) are satisfied.[[291]](#footnote-291)

Often, the third part of the test, whether the employer "endorsed the policy," is argued by insurers to establish ERISA preemption. In *Thompson*, the Sixth Circuit adopted the test set out previously by the First Circuit in *Johnson v. Watts Regulator Co.[[292]](#footnote-292)* In *Johnson*, the First Circuit clarified the standards that govern a finding of endorsement, including its belief that "endorsement of a program requires more than merely recommending it."[[293]](#footnote-293) According to the *Johnson* court, “[a]s long as the employer merely advises employees of the availability of group insurance, accepts payroll deductions, passes them on to the insurer, and performs other ministerial tasks that assist the insurer in publicizing the program, it will not be deemed to have endorsed the program under 29 CFR 2510.3-1(j) It is only when an employer purposes to do more, and takes substantial steps in that direction, that it offends the ideal of employer neutrality and brings ERISA into the picture.”[[294]](#footnote-294) The First Circuit further found that, while the *Hansen* court had relied on the employer's intent in determining endorsement, the proper focus was on whether employees could reasonably conclude that the employer had endorsed the policy based on their observation of the employer's activities in connection with the plan.[[295]](#footnote-295)

The Sixth Circuit ruled that the First Circuit's approach in *Johnson* was consistent with Congress' intent in enacting ERISA. According to the Department of Labor, "employer neutrality is the key to the rationale for not treating such a program as an employee benefit plan".[[296]](#footnote-296) As Johnson noted, therefore, where the employer "offends the ideal of employer neutrality" because of its level of involvement, ERISA is properly invoked.[[297]](#footnote-297) "Where, however, the employer separates itself from the program, making it reasonably clear that the program is a third party's offering, not subject to the employer's control, then the safe harbor may be accessible."[[298]](#footnote-298)

Thus, the Sixth Circuit explained that the key element whether an employer endorsed a plan, is whether the employer acted neutrally. A finding of endorsement is appropriate if, upon examining all the relevant circumstances, there is some factual showing on the record of substantial employer involvement in the creation or administration of the plan.[[299]](#footnote-299) For example, where the employer plays an active role in either determining which employees will be eligible for coverage or in negotiating the terms of the policy or the benefits provided thereunder, the extent of employer involvement is inconsistent with "employer neutrality" and a finding of endorsement may be appropriate.[[300]](#footnote-300) Similarly, where the employer is named as the plan administrator, a finding of endorsement may be appropriate.[[301]](#footnote-301)

The test of whether the employer "endorsed" the plan is not measured from the point of view of the insurance company, but from the point of view of the employee viewing the conduct of the employer.[[302]](#footnote-302) In *Thompson,* the Court found that the employer did not endorse the plan. While the insurance policy here included an introductory letter encouraging employees to obtain accident insurance, that letter was not printed on Burns' letterhead, nor did it refer to the accident insurance policy as Burns' plan. Further, while Burns' name was featured on the cover of the policy description, this fact may be as consistent with identification as endorsement, depending on what the evidence on remand shows concerning the circumstances of its placement. The policy documentation nowhere mentions that the policy is subject to ERISA, nor does it set out a description of an employee's rights under ERISA. It is unclear from the record whether Burns acts as an administrator, nor is it clear whether Burns participated in either devising the terms of the policy or in processing claims, although the record does indicate that Thompson submitted her claim directly to American Home. The court finds that such evidence presents a material question of fact as to whether Burns endorsed the policy under the DOL regulation.[[303]](#footnote-303) ("The question of endorsement vel non is a mixed question of fact and law. In some cases, the evidence will point unerringly in one direction so that a rational fact finder can reach but one conclusion. In those cases, endorsement is a question of law In other cases, the legal significance of the facts is less certain, and the outcome will depend on inferences that the fact finder chooses to draw In those cases, endorsement becomes a question of fact. This case is of the latter type.").[[304]](#footnote-304)

In remanding the claim, the Sixth Circuit gave specific instructions as to what factors a trial court should consider:

The district court's further consideration of this issue, whether in the context of a renewed summary judgment motion based on a more complete factual record or at trial, should take into account, but is not limited to, Burns's role in administering benefits under the plan, whether the policy language itself contemplates the application of ERISA, and Burns's role in determining eligibility and coverage. The crucial question is whether Burns was substantially involved in the creation and administration of the plan to such an extent that employees could reasonably conclude that Burns had endorsed the plan. Further, if the district court determines that the policy is not excluded from ERISA coverage under the safe harbor regulations, the court on remand must also determine that a "plan" exists under the standards set forth in *Int'l Resources, Inc.[[305]](#footnote-305)* Furthermore, the district court must conclude that Burns "established or maintained" the plan with an intent to provide benefits to its employees.[[306]](#footnote-306) ("In addition to some meaningful degree of participation by the employer in the creation or administration of the plan, the statute requires that the employer have had a purpose to provide health insurance, accident insurance or other specified types of benefits to its employees.[[307]](#footnote-307) Thus, the evidence must show that the employer had an intent to provide its employees with a welfare benefit program through the purchase and maintenance of [the] group insurance policy.") Only upon completing a three-step factual inquiry can a district court ascertain that an ERISA plan exists, thus requiring the application of the federal common law of ERISA to the underlying insurance claim.[[308]](#footnote-308)

86. What other factors have been used to determine whether a plan does fall under ERISA?

ERISA applies if the employer intends to establish or maintain a plan to provide benefits as part of the employment relationship, regardless of whether the employer intended the plan to be governed by ERISA.[[309]](#footnote-309) However, as noted in the following, if there is a plan document and it says it is governed by ERISA, that is a factor counting toward ERISA plan status in some court decisions.

In determining whether an ERISA “plan, fund or program” exists when individual policies are purchased, courts must "determine whether from the surrounding circumstances a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits." *Donovan v. Dillingham*,[[310]](#footnote-310) is the seminal case followed in all circuits and holds that the purchase of a group policy or multiple individual policies covering a class of employees was substantial evidence that a plan, fund, or program had been established under ERISA if a reasonable person could ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits.

The courts have gone both ways on the issue of whether individual policies can constitute an ERISA plan.

87. Which courts have ruled that plans are not employee welfare benefits plans under ERISA despite employee contributions to them?

In *McCall v. Focus Worldwide Television Network Inc.,* 2009 WL 1046791 (E.D. La. 2009) the court ruled that an employer’s employment contract agreement to pay premiums for an employee’s life insurance policy of $10,000 per year “funded in her name and on her behalf” was not an employee welfare benefit plan under ERISA. In *New Eng. Mut. Life Ins. Co., Inc. v. Baig,[[311]](#footnote-311)* the court stated that no ERISA plan had been established from an employer’s reimbursement of premiums paid directly by an employee. The policy was not initially established by a contractual arrangement between Cardiology Associates and New England Mutual, and Baig made the initial purchase and paid the premiums directly.

88. What are examples of cases with rulings that plans with employer financial involvement do fall under ERISA?

In *O’Leary v. Provident Life and Accident Ins. Co.[[312]](#footnote-312)* the court reasoned that an ERISA plan existed where an employer agreed to provide disability insurance to one employee, when the employee applied for the individual policy and the employer paid the premiums. *O’Leary* noted that, while an ERISA plan can be established through the purchase of insurance, the purchase of insurance does not mean that an ERISA plan always exists. *O’Leary* stated that to prove an ERISA plan, the employer must have paid the premiums and intended to provide benefits on a regular and long-term basis.

Another example is *Pierson v. Cont'l Cas. Co*.[[313]](#footnote-313) In this case, an ERISA plan existed where the employee was insured under two individual income protection policies issued by CNA that were individual policies not issued pursuant to a master policy and the employee paid 100 percent of the premiums for the policy. In *Peterson v. American Life & Health Ins. Co*.,[[314]](#footnote-314) the court held that an individual insurance policy was part of an ERISA plan where the employer “not only paid its partners' and employees' insurance premiums but also played an active role in the administration of the coverage, including choosing the insurance, adding and deleting employees and partners from various policies, contacting insurance companies for employees and partners, and distributing information relevant to the coverage.

Other examples are:

*Heidelberg v. National Foundation Life Ins. Co.*,[[315]](#footnote-315)in which the court held that the employer’s purchase of two individual health insurance policies constituted an ERISA plan where there was evidence of employer intent to provide health insurance coverage for its white-collar employees and there was testimony that, had it been economically feasible, the employer would have purchased a group policy rather than two individual policies).

*Burrill v. Leco Corp*.,[[316]](#footnote-316) a case in which the court ruled that several individual insurance policies purchased by the employer constituted a group health plan for COBRA purposes where such plans were “an integral part of a broader scheme to provide health coverage to LECO employees.

*Strange v. Plaza Excavating, Inc*.,[[317]](#footnote-317) where individual health policies were provided to provide benefits on a regular and long term basis and COBRA applied.

*Madonia v. Blue Cross & Blue Shield*,[[318]](#footnote-318) which involved an individual health insurance policy of sole shareholder who is thus not an “’employee” but nevertheless was part of an ERISA plan. The court reasoned that payment of premiums on behalf of employees is substantial evidence that a plan, fund, or program was established.

***Other Examples***

When the employer selects the insurance and pays the premiums, an ERISA plan almost universally is found. This is shown in *Fugarino v. Hartford Life and Acc. Ins. Co.*[[319]](#footnote-319) and *Randol v. Mid-West Nat. Life Ins. Co. of Tennessee*.[[320]](#footnote-320)

The court ruled in *Heral v. Unum Life Ins. Co. of Am*.[[321]](#footnote-321) that individual disability policies purchased by the employer for two or more employees was an ERISA plan, but a separate policy that the employer purchased for an owner from another insurer was not a plan. That program did not cover at least one employee.

In *Burrill v. Leco Corp*.[[322]](#footnote-322) the court held that a short-term individual health insurance policy purchased by the employer for employees before they became eligible for the employer’s group health plan is an ERISA employee welfare benefit plan.

The court, in *Nicholas v. Standard Ins. Co.*,[[323]](#footnote-323) ruled that ERISA applied where the insurance agent who sold the policy testified that he helped procure employee benefits for the employer, the employer was named as the plan administrator, and the documents specifically referred to ERISA.

The court, in *Libbey-Owens Ford v. Blue Cross & Blue Shield*,[[324]](#footnote-324) reasoned that an employer may establish an ERISA plan very easily, through the mere purchase of a group health insurance policy – even though it does not retain control, administrative power, or responsibility for benefits. Likewise, in *Int'l Resources v. New York Life Ins. Co*.,[[325]](#footnote-325) the court held that, where the employer obtained insurance coverage for employees and paid the premiums, an ERISA plan was established.

The 2012 U.S. Supreme Court Decision on Health Reform

89. What is the impact of the 2012 U.S. Supreme Court decision on the constitutionality of the health reform law?

The U.S. Supreme Court in *NFIB v. Sebelius* (June 28, 2012)[[326]](#footnote-326) upheld the health reform law (PPACA), except for the federal government’s power to terminate existing federal Medicaid funds for states not agreeing to participate in the law’s Medicaid expansion that begins in 2014. Several decisions were five to four, with different combinations of justices for different issues. Chief Justice Roberts proved to be the critical swing vote.

The threshold issue was whether the Supreme Court could rule on the constitutionality of the individual mandate, which is effective in 2014, before any taxpayer is required to pay the tax. Beginning in 2014, individuals who fail to have minimum essential coverage will be subject to a penalty,[[327]](#footnote-327) which is known as the individual mandate. The Anti-Injunction Act applies to suits “for the purpose of restraining the assessment or collection of any tax.”[[328]](#footnote-328) Under the Anti-Injunction Act, a court cannot rule on the validity of a tax until it has been assessed by the IRS on a taxpayer. The Supreme Court, by a vote of nine justices to none, stated that its decision on the validity of the individual mandate was not precluded by the Anti-Injunction Act, because the law calls the mandate a penalty, not a tax.

The Court ruled, in a five to four decision, that the individual mandate is not authorized by the Constitution’s Commerce Clause or the Necessary and Proper Clause, but it is valid because the federal taxing power allows it. For purposes of determining its constitutionality, the Court ruled that the individual mandate is a tax on individuals (despite being a penalty for purposes of the Anti-Injunction Act):

Our precedent demonstrates that Congress had the power to impose the exaction in section 5000A under the taxing power, and that section 5000A need not be read to do more than impose a tax. This is sufficient to sustain it.

The only effect of not complying with the mandate is that one must pay the tax.

Why did the Supreme Court rule that the individual mandate penalty is really a tax for this purpose? There were four reasons:

* A person who is subject to the “tax” has not violated the law.
* The “tax” is low enough so that a person can make a “reasonable financial decision” to pay the tax instead of doing whatever is being taxed. The tax is not at a “prohibitory” level.
* The “tax” is collected by the Internal Revenue Service in the same manner as other taxes.
* The individual mandate has no intent requirement. Intent (“scienter”) is required for crimes or other unlawful acts.

The third issue before the Court of whether the entire law is invalid if the individual mandate is invalid became moot when the individual mandate was upheld.

Finally, while the law’s Medicaid expansion was ruled constitutional by a seven to two vote, seven justices agreed that the law's sanction[[329]](#footnote-329) for not participating in the Medicaid expansion is unconstitutional. The Court held that it is unconstitutional for the federal government to withhold existing Medicaid funds for noncompliance with the Medicaid expansion provisions.[[330]](#footnote-330)

90. Under the health reform law, in 2014 individuals are eligible for Medicaid if their income is less than 133 percent of the federal poverty level. What are the implications of the Supreme Court’s decision?

***Medicaid Expansion not Fully Implemented.*** Some, perhaps many, states may decide not to participate in the Medicaid expansion due to political opposition to the federal health reform law or because the new federal funds are 10 percent less than the extra costs to the state (which will be the case in 2020 and thereafter). In that situation, the burden for the care of those persons who would have been covered by Medicaid will be shifted from federal and state governments to free care provided by hospitals and physicians, as is now the case.

***Health Reform May Still Be in Jeopardy.*** It is possible that health reform could be undone if the Republicans win the House, Senate, and presidency in November 2012. If President Obama is re-elected, any repeal legislation would require a two-thirds majority vote in the House and in the Senate to override the expected presidential veto. If there is a Republican sweep of the House, Senate, and presidency, bear in mind that the Senate traditionally requires sixty votes to avoid a filibuster by the other side.

Even if health reform is implemented, it may perform poorly and be more expensive than predicted, leading to calls for change. The mandate system was the second choice of many Democrats. It was an alternative to a “public option.” The idea for a public option to be added to existing options could be adopted. If passed, the public option could force private insurance to be priced out of business, perhaps then leading to a federal government single-payor plan.

Health Reform's Medicaid Expansion

91. What is the Medicaid expansion in the 2010 health reform law?

Medicaid provides healthcare and long-term care services for lower-income individuals. It is administered by the states and jointly funded by state and federal governments. The current Medicaid program offers federal funding to states to pay for healthcare for pregnant women, children, needy families, the blind, the elderly, and the disabled.[[331]](#footnote-331) Many states now cover adults with children but only if their income is considerably lower than 133 percent of the federal poverty level (FPL) and they meet certain asset tests. Most states do not cover childless adults at all.

Beginning in 2014, health reform would make everyone whose income is at or below 133 percent of the federal poverty level (FPL eligible for Medicaid.[[332]](#footnote-332) If all states participated, this would add about fifteen million individuals to the Medicaid program in 2014 and nearly twenty-six million by 2020.[[333]](#footnote-333) For the first three years of the expansion (2014 through 2016), the federal government will pay the entire extra cost of a state participating in the expansion.

If some (perhaps many) states do not accept this Medicaid expansion due to political opposition to the federal health reform law or because the new federal funds for the expansion will be 10 percent less than the extra cost to the state in 2020 and thereafter, the Supreme Court decision, by making participation in the Medicaid expansion optional for each state, will remove part of the law's safety net for people in states who decide not to participate in Medicaid expansion. However, many individuals, as they do now, likely will be able to get free care from hospitals and physicians.

Other reasons that a state may not, at least initially, participate in the Medicaid expansion include:

* Operational challenges that could affect their ability to meet Medicaid expansion and system development deadlines, such as time-consuming state procurement processes;
* The need to modify existing systems or develop new systems;
* Coordination of multiple programs and systems, and
* Resource limitations.

State eligibility determination systems must interface with a Federal Data Services Hub—an electronic service states will use to verify certain information with other federal agencies, such as an applicant’s citizenship, immigration status, and income data.[[334]](#footnote-334)

Despite the initial funding of the extra benefits at the rate of 100 percent by the federal government, participating states' costs could be increased by three aspects of Medicaid expansion:

* The administration for managing Medicaid enrollment,
* The acquisition or modification of information technology systems to support Medicaid (although federal assistance is available), and
* Enrolling previously eligible but not enrolled individuals in Medicaid.

Another complicating factor for those in states not participating in the expansion is that most individuals with incomes less than 100 percent of the federal poverty level will not eligible in 2014 for income tax subsidies to purchase insurance at the state insurance exchanges.[[335]](#footnote-335) These individuals still may end up without affordable access to insurance.

For states participating in the Medicaid expansion, states with low coverage levels and high uninsured rates will see the largest increases in coverage and federal funding. Higher levels of coverage will allow states to reduce the payments they make to support uncompensated care costs.[[336]](#footnote-336)

The state exchanges will determine eligibility for Medicaid. HHS regulations implement rules on Medicaid and Children’s Health Insurance Program (CHIP) eligibility, enrollment simplification, and coordination by the state exchange.[[337]](#footnote-337)

92. Can a state later change its 2014 decision as to whether to participate in the Medicaid expansion?

There is no clear answer to this question in the law.

The GAO has stated that in "the Supreme Court’s June 28, 2012, decision that states can make their own decisions about whether to expand Medicaid, HHS reiterated that:

(1) There is no deadline for a state to decide to undertake the expansion;

(2) A state can receive an enhanced administrative federal match for information technology costs, even if it has not yet decided whether to expand Medicaid, as long as it is modernizing its eligibility systems; and

(3) A state will not have to pay back the extra funding if it ultimately decides not to expand Medicaid."[[338]](#footnote-338)

1. . See H.R. 3590, the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (PPACA), signed on March 23, 2010; and H.R. 4872, the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (HCERA), signed on March 30, 2010. [↑](#footnote-ref-1)
2. . See <http://xnet.kp.org/reform/guiding_principles.htm>; John K. Iglehart, “Implementing Health Care Reform — An Interview with HHS Secretary Kathleen Sebelius” 364 N Engl. J. Med. pp. 297-99 (Jan. 27, 2011). [↑](#footnote-ref-2)
3. . CEO's-Eye View of ObamaCare, Wall Street Journal p. A-17 (July 22, 2013), available at http://online.wsj.com/article/SB10001424127887323309404578613653344566068.html?mod=hp\_opinion. [↑](#footnote-ref-3)
4. . IRC Secs. 9832(a) and 5000(b)(1). [↑](#footnote-ref-4)
5. . ERISA section 701(a); IRC section 9801(a). [↑](#footnote-ref-5)
6. . See Preamble to Grandfathered Health Plan Regulations, 75 Fed. Reg. 34537, 34539 (June 17, 2010) (confirming that the exceptions in the IRC and ERISA still exist, and announcing an HHS nonenforcement policy with respect to the PHSA provisions). [↑](#footnote-ref-6)
7. . ERISA section 702 and IRC section 9802. [↑](#footnote-ref-7)
8. . ERISA section 703; IRC section 9803(a). [↑](#footnote-ref-8)
9. . ERISA section 711 and IRC section 9811. [↑](#footnote-ref-9)
10. . ERISA section 712 and IRC section 9812. [↑](#footnote-ref-10)
11. . ERISA section 714 and IRC section 9813. [↑](#footnote-ref-11)
12. . ERISA section 502. Group health plans of governmental employers and churches that are exempt from ERISA by virtue of ERISA section 4(b) are not subject to ERISA section 701. Instead, plans of nonconforming, nonfederal governmental employers and church plans generally are subject to the parallel provisions under the PHSA. [↑](#footnote-ref-12)
13. See letter from HHS to US territory insurance commissioners at <http://www.cms.gov/CCIIO/Resources/Letters/Downloads/letter-to-Ilagan.pdf>. [↑](#footnote-ref-13)
14. . Treas. Reg. 26 CFR §54.9831–1(c), Labor Reg. 29 CFR §2590.732(c), PHSA Reg. 45 CFR §146.145(c). [↑](#footnote-ref-14)
15. . IRC section 9832(c)(1). [↑](#footnote-ref-15)
16. . IRC section 9832(c)(2). [↑](#footnote-ref-16)
17. . IRC section 9832(c)(3). [↑](#footnote-ref-17)
18. . IRC section 9832(c)(4). [↑](#footnote-ref-18)
19. . 75 Fed. Reg. 34538, 34540. [↑](#footnote-ref-19)
20. . PPACA §9001; new IRC section 4980I. [↑](#footnote-ref-20)
21. . 45 CFR §147.140(b)(2)(ii). [↑](#footnote-ref-21)
22. . See HHS questions and answers at <http://www.errp.gov/faq_eligible.shtml>. [↑](#footnote-ref-22)
23. IRS Notice 2013-45 delayed that law’s 2014 effective date until 2015. [↑](#footnote-ref-23)
24. Treas. Reg. § 1.6055-1 and 1.6055-2. [↑](#footnote-ref-24)
25. Treas. Reg. § 301.6056-1 and -2. [↑](#footnote-ref-25)
26. See section XV.D.6 of the preamble to the final regulations under section 4980H for a description of eligibility conditions for transition relief. [↑](#footnote-ref-26)
27. . In contrast, the amount that individuals are required to pay for failure to comply with the Individual Mandate is called a “penalty.” [↑](#footnote-ref-27)
28. . IRC section 4980H(a)(1), (2). [↑](#footnote-ref-28)
29. . IRC section 4980H(c)(5). [↑](#footnote-ref-29)
30. . IRC section 36B, as discussed in more detail hereafter. [↑](#footnote-ref-30)
31. . Joint Comm. Staff, Tech Explanation of the Revenue Provisions of the Reconciliation Act of 2010, as amended, in combination with the Patient Protection and Affordable Care Act (JCX-18-10), 3/21/2010, p.37. [↑](#footnote-ref-31)
32. . IRC section 6103(l)(21). [↑](#footnote-ref-32)
33. . 77 Fed. Reg. 25378 (Apr. 30, 2012). [↑](#footnote-ref-33)
34. . IRS Notice 2011-36. [↑](#footnote-ref-34)
35. . IRC section 4980H(a)(1), (b)(1)(A); IRC section 5000A(b)(3)(A). Several comments submitted in response to Notice 2011-36 argue that employers should not be obligated to provide coverage to dependents of full-time employees. These comments contend that employers should not be mandated to provide family or other types of coverage beyond self-only coverage and that such dependents will often either have minimum essential coverage available elsewhere or will not be required to carry minimum essential coverage under the exceptions contained in Code section 5000A . *See, e.g.,* Business Round Table Comments on IRS Notice 2011-36 (submitted June 17, 2011); Society for Human Resource Management Comments on IRS Notice 2011-36 (submitted June 17, 2011); American Benefits Council Comments on IRS Notice 2011-36 (submitted June 15, 2011). [↑](#footnote-ref-35)
36. . IRC Secs. 152(d)(2)(A)-(C), (E)–(G). [↑](#footnote-ref-36)
37. . IRC section 152(d)(2). [↑](#footnote-ref-37)
38. . IRC section 5000A(f)(1). [↑](#footnote-ref-38)
39. . IRC section 5000A(f)(2). [↑](#footnote-ref-39)
40. . *See* IRC§5000A(f)(5); 42 U.S.C. §18024(a)(1) (PPACA §1304(a)(1)) (defining “group market” as “the health insurancemarket under which individuals obtain healthinsurancecoverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by an employer” (emphasis added)). However, the preamble to the proposed regulations under Code section 36B, states that regulations under Code section 5000A will "provide that an employer-sponsored plan will not fail to be minimum essential coverage solely because it is a plan to reimburse employees for medical care for which reimbursement is not provided under a policy of accident and health insurance (a self-insured plan).” [↑](#footnote-ref-40)
41. . Treas. Reg. §54.9815-1251T(g)(1)(i), (ii), (v). When the interim final regulations were first issued, an employer’s entrance into a new policy, certificate or contract of insurance after March 23, 2010 (*e.g.*, because the previous policy, certificate or contract was not being renewed), would trigger loss of grandfathered status. Treas. Reg. §54.9815-1251T(a)(1)(ii). However, this was subsequently changed in Treasury Decision 9506. This decision amended the interim final regulations to allow employers to change insurance providers, so long as the new policy, certificate or contract did not otherwise make changes triggering loss of grandfathered status under the regulations. It should be noted that this amendment does not apply retroactively; therefore, plans undergoing carrier changes prior to November 17, 2010 still lost grandfathered status (subject to a special exception for collectively bargained plans). T.D. 9506 (amending Treas. Reg. §54.9815-1251T(a)(1)). [↑](#footnote-ref-41)
42. . This issue is discussed in more detail later in this book. [↑](#footnote-ref-42)
43. . IRC section 36B(c)(2)(C)(ii). This special rule does not apply if the employee, or dependent, does in fact procure coverage under the eligible employer-sponsored plan or grandfathered health plan. IRC section 36B(c)(2)(C)(iii). [↑](#footnote-ref-43)
44. . IRC section 36B(c)(2)(C)(iii). [↑](#footnote-ref-44)
45. . IRC section 4980H(a)(2). [↑](#footnote-ref-45)
46. . IRC section 36B(c)(1), (2)(C); 42 USC §18071(b) (PPACA §1402( b)). [↑](#footnote-ref-46)
47. . IRC section 4980H(c)(2)(C)(i). [↑](#footnote-ref-47)
48. . IRC section 4980H(c)(2)(D)(ii). [↑](#footnote-ref-48)
49. . IRC section 4980H(c)(2)(C)(ii). [↑](#footnote-ref-49)
50. . IRC section 4980H(c)(2)(C)(iii). [↑](#footnote-ref-50)
51. . IRC section 4980H(c)(2). [↑](#footnote-ref-51)
52. . IRC section 4980H(c)(4). [↑](#footnote-ref-52)
53. . The term ‘‘seasonal worker’’ means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by section 500.20(s)(1) of title 29, Code of Federal Regulations and retail workers employed exclusively during holiday seasons. IRC section 4980H(c)(2)(B)(ii). [↑](#footnote-ref-53)
54. . IRC section 4980H(c)(2)(B). [↑](#footnote-ref-54)
55. . IRC section 4980H(c)(2)(E). [↑](#footnote-ref-55)
56. . IRC section 4980H(c)(2)(B). [↑](#footnote-ref-56)
57. IRS Notice 2013-45 [↑](#footnote-ref-57)
58. . An offering employer is one that offers minimum essential coverage through an employer plan and pays for some of the costs. Reporting requirements apply to these employers, regardless of size, only if the required contribution for self-only coverage by any employee exceeds 8 percent of wages. This is required because individuals whose household income exceeds 8 percent of wages are exempt from the individual mandate and may be eligible for free-choice vouchers. However, an employer would only have knowledge of the individual’s wages, not his or her household income. Because this reporting requirement is linked to wages (and not household income), it is a first step in determining whether an individual is exempt from the individual mandate. [↑](#footnote-ref-58)
59. . PPACA §1502. [↑](#footnote-ref-59)
60. . PPACA §1501, 1502, and 10106 adding IRC Secs. 5000A and 6055. [↑](#footnote-ref-60)
61. . 45 CFR §155.310(h). [↑](#footnote-ref-61)
62. . 45 CFR §155.310(h). [↑](#footnote-ref-62)
63. . PPACA; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18310, 18357 (Mar. 27, 2012). [↑](#footnote-ref-63)
64. . This is Modified Adjusted Gross Income for federal purposes. These threshold amounts apply to the 48 contiguous states and the District of Columbia. The amounts are 25 percent higher for Alaska and 15 percent higher for Hawaii. They are adjusted annually to reflect changes in the cost of living. [↑](#footnote-ref-64)
65. . In fact, eligibility is not 133 percent but is 138 percent of FPL because §1004(e) of P.L. 111-152 requires income equivalent to 5 percent FPL to be disregarded. [↑](#footnote-ref-65)
66. . 42 USC §18081(f)(2) (PPACA §1411(f)(2)). [↑](#footnote-ref-66)
67. . *Id.* [↑](#footnote-ref-67)
68. IRC § 4980H; Reg. § 54.4980H-1 et seq. [↑](#footnote-ref-68)
69. IRC § 414(n). Note however if a worker is in fact the common law employee of the recipient employer, the worker is not a leased employee. [↑](#footnote-ref-69)
70. “In response to the limitation on the relief under section 530, commenters requested that the Treasury Department and the IRS formulate a similar provision in these final regulations applicable to potential liabilities under section 4980H. The Treasury Department and the IRS are concerned that the relief requested would serve to increase the potential for worker misclassification by significantly increasing the benefit of having an employee treated as an independent contractor. Accordingly, the final regulations do not adopt this suggestion.” See Explanation and Summary of Comments, Final Regulations, XII (Worker Classification and section 4980H) at <https://www.federalregister.gov/articles/2014/02/12/2014-03082/shared-responsibility-for-employers-regarding-health-coverage#h-17>. [↑](#footnote-ref-70)
71. . *NFIB v. Sebelius* (June 28, 2012). [↑](#footnote-ref-71)
72. . IRC section 5000A(f). [↑](#footnote-ref-72)
73. . IRC Secs. 5000A(c)(3)(A), (B), (D). [↑](#footnote-ref-73)
74. . IRC section 5000A(c)(2)(B). The net effect of these percentage increases for taxpayers who do not procure minimum essential coverage and whose income is sufficient to be above the minimum penalty is an increase in their marginal tax rate by 1 percent in calendar year 2014 rising to a 2.5 percent marginal tax rate increase for subsequent years. [↑](#footnote-ref-74)
75. . IRC Secs. 5000A(b)(1), (c)(1), (2). Use of the national average for bronze coverage means that calculation might not bear much relationship to the actual cost of coverage available in a specific location. However, the premium amounts likely will not be lower than the penalty. [↑](#footnote-ref-75)
76. . A CEO's-Eye View of ObamaCare, Wall Street Journal p. A-17 (July 22, 2013), available at: http://online.wsj.com/article/SB10001424127887323309404578613653344566068.html?mod=hp\_opinion. [↑](#footnote-ref-76)
77. . One study concludes that 30 percent of employers will definitely or probably stop offering traditional employer-sponsored coverage after 2014; the study found that the percentage increases to 50 percent among employers with a high awareness of the healthcare bills’ contents. *See* Shubham Singhal *et al.*, *How US Health Care Reform Will Affect Employee Benefits*, McKinsey Quarterly 2 (June 2011). [↑](#footnote-ref-77)
78. . See Douglas Holtz-Eakin, President & Cameron Smith, Labor Markets and Health Care Reform: New Results (May 2010), at http://americanactionforum.org/files/LaborMktsHCRAAF5-27-10.pdf. [↑](#footnote-ref-78)
79. . Id. Health plan costs $14,048 and employer pays 75 percent. [↑](#footnote-ref-79)
80. . Income calculated based on 2009 FPL for a family of four of $22,050 (HHS), indexed to CPI projections (CBO). [↑](#footnote-ref-80)
81. . 2010 tax brackets, indexed to CPI projections (CBO). [↑](#footnote-ref-81)
82. . Wage equivalent value of employer health plan; CBO estimate of Silver Plan in 2016, indexed to 2014 ($11,941),and divided by Tax Rate). [↑](#footnote-ref-82)
83. . Wage equivalent minus subsidies. [↑](#footnote-ref-83)
84. . Value of insurance plan minus $2,000 penalty. [↑](#footnote-ref-84)
85. . Employer decision to keep or drop health plan; drop if pay raise greater than free cash flow. [↑](#footnote-ref-85)
86. . See Douglas Holtz-Eakin, President & Cameron Smith, Labor Markets and Health Care Reform: New Results (May 2010), at http://americanactionforum.org/files/LaborMktsHCRAAF5-27-10.pdf. [↑](#footnote-ref-86)
87. . Medical care is amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body; it includes amounts paid for transportation primarily for and essential to such care, as well as amounts paid for insurance covering such care. [↑](#footnote-ref-87)
88. . Essential health benefits are ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. [↑](#footnote-ref-88)
89. . IRC section 4980H(c)(2)(D). [↑](#footnote-ref-89)
90. . *See* Technical Explanation, at 39-40 [↑](#footnote-ref-90)
91. . IRS Notice 2011-36. [↑](#footnote-ref-91)
92. . 42 USC §18071(b) (PPACA §1402(b)); IRC Secs. 36B(b)(2)(B)(ii), (3)(A). [↑](#footnote-ref-92)
93. . There is a single uniform poverty line for the 48 contiguous states and the District of Columbia, and separate ones for Alaska and Hawaii, respectively. The Secretary of HHS is to conduct a study to determine the feasibility and implications of adjusting the poverty line for different geographic locations. PPACA §1416, as added by PPACA §10105. [↑](#footnote-ref-93)
94. . DeNavas-Walt, Carmen *et al.*, Income, Poverty & Health Insurance Coverage in the United States: 2010, U.S. Census Bureau , (Sept. 2011), http://www.census.gov/prod/2011 pubs/p60-239.pdf. This is the last year for which such statistics are currently available. [↑](#footnote-ref-94)
95. . IRC Secs. 36B(d)(1), (2)(A). [↑](#footnote-ref-95)
96. . Prop. Treas. Reg. §1.36B-1(e). [↑](#footnote-ref-96)
97. . IRC section 36B(d)(2)(B) (as amended by the Three Percent Withholding Repeal and Job Creation Act, Pub. L. No. 112-56, §401). This is in contrast to the definition of “modified adjusted gross income” for purposes of the new Medicare tax on “net investment income”, which does not adjust for tax-exempt interest. [↑](#footnote-ref-97)
98. . IRC section 36B(c)(1)(A); 42 USC §18071(b) (PPACA §1402(b)). [↑](#footnote-ref-98)
99. . See Prop. Treas. Reg. §1.36B-2(c)(3)(v)(A)(*l*) and preamble thereto. [↑](#footnote-ref-99)
100. . This 9.5 percent cap may be adjusted for the excess of premium growth inflation over income growth and/or the consumer price index. *See* IRC section 36B(c)(2)(C)(iv), (b)(3)(A)(ii). [↑](#footnote-ref-100)
101. . IRC section 36B(c)(2)(C); 42 USC §18071(f)(2) (PPACA §1402(f)(2)). [↑](#footnote-ref-101)
102. . IRC section 36B(c)(2)(C). [↑](#footnote-ref-102)
103. . Prop. Treas. Reg. §1.36B-2(c)(3)(v). [↑](#footnote-ref-103)
104. . See IRS Notice 2011-73, which states that it believes this would be a “workable and predictable method” based on information that “employers know.” The Notice states that employers may be able to use the safe harbor prospectively to structure its plan and operations to set the employee contribution at a level so that the employee contribution for each employee would not exceed 9.5 percent of that employee's W-2 wages for the upcoming year. [↑](#footnote-ref-104)
105. . The safe harbor noted above based on an employee's actual W-2 wages from the employer would apply only for purposes of the affordability test. [↑](#footnote-ref-105)
106. . IRC Secs. 36B(c)(2)(B)(i); 5000A(f)(1)(A)(ii); Prop. Treas. Reg. §1.36B-2(c)(2). [↑](#footnote-ref-106)
107. . 42 USC §18081(f)(2)(B) (PPACA §1411(f)(2)(B)). Presumably, this language is intended to allow the employer to find out whether its required employee contribution is above or below the 9.5 percent household income affordability threshold for the employee in question, although the language is not clear. [↑](#footnote-ref-107)
108. See [http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/marketplace-guidance-on-irs2013- 17.pdf](http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/marketplace-guidance-on-irs2013-%2017.pdf). [↑](#footnote-ref-108)
109. See <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SHO-13-006.pdf>. [↑](#footnote-ref-109)
110. Treas. Reg.. § 1.36B-2(a)(1). [↑](#footnote-ref-110)
111. IRC § 36B(2)(A). [↑](#footnote-ref-111)
112. Code § 36B(b). [↑](#footnote-ref-112)
113. Enacted by PPACA §1311. [↑](#footnote-ref-113)
114. Treas. Reg. § 1.36B-1(k). [↑](#footnote-ref-114)
115. Treas. Reg. §1.36B-2(a)(1). [↑](#footnote-ref-115)
116. 45 C.F.R. §155.20. Treas. Reg. §1.36B-1(k) provides that the term Exchange “has the same meaning as in 45

     C.F.R. §155.20.” [↑](#footnote-ref-116)
117. IRC § 36B. [↑](#footnote-ref-117)
118. PPACA § 1411 establishes requirements whether someone meets the income and coverage qualifications for such premium tax credits and cost-sharing subsidies for those whose incomes are below 400 percent of federal poverty level. [↑](#footnote-ref-118)
119. 79 Fed. Reg. No. 135 at p. 42160 et seq., Medicaid and Children’s Health Insurance Programs (CHIPs): Essential Health Benefits (EHBs) in Alternative Benefit Plans, Eligibility Notices, Fair Hearings and Appeals Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment <http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf>. [↑](#footnote-ref-119)
120. 45 CFR §155.315. [↑](#footnote-ref-120)
121. See Congressional Budget Cost Estimate for H.R. 2775 (Sept. 10, 2013), online at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/hr2775.pdf>. [↑](#footnote-ref-121)
122. . Reg. §1.36B-2(c)(3)(v)(A)(2). [↑](#footnote-ref-122)
123. . See T.D. 9611, 01/30/2013. [↑](#footnote-ref-123)
124. . IRC section 36B(b)(2)(B)(ii). [↑](#footnote-ref-124)
125. . 42 USC §18071(f)(3); 18082(b)(1)(B) (PPACA §§1402(f)(3); 1412(b)(1)(B)). [↑](#footnote-ref-125)
126. . IRC section 4980H(c)(3)(C); 42 USC §18082(b)(1)(B) (PPACA §1412(b)(1)(B)). [↑](#footnote-ref-126)
127. . DOL FAB 2004-1. [↑](#footnote-ref-127)
128. . PPACA §1501, adding IRC section 5000A(f). [↑](#footnote-ref-128)
129. . PPACA §1501 and 10106 adding IRC section 5000A(d) and (e). [↑](#footnote-ref-129)
130. . IRC section 5000A(d)(2), (3), (4). [↑](#footnote-ref-130)
131. . IRC section 5000A(e)(3), (4), (5), (f)(4). [↑](#footnote-ref-131)
132. . *See generally* IRC section 4980H(c). [↑](#footnote-ref-132)
133. . IRC section 5000A(e)(1)(A). It is not clear why the affordability test for employers is 9.5 percent whereas this individual “affordability test” is 8 percent. [↑](#footnote-ref-133)
134. . IRC section 5000A(e)(1)(B)(i). This affordability test based on the premium for self-only coverage will be integrated into the penalty calculation under which an individual may also be responsible for providing coverage for a spouse and/or dependents. *See* Preamble to Proposed Regulations for Code section 36B. [↑](#footnote-ref-134)
135. . IRC section 5000A(e)(1)(B)(ii). [↑](#footnote-ref-135)
136. . IRC section 5000A(e)(1)(A); 42 USC §18082(b)(1)(B) (PPACA §1412(b)(1)(B)). [↑](#footnote-ref-136)
137. . IRC section 5000A(e)(1)(D). [↑](#footnote-ref-137)
138. . IRC section 5000A(e)(2). [↑](#footnote-ref-138)
139. . IRC section 2(b)(1)(A)(i) (being entitled to the dependency exemption for a child is a precondition to qualifying for head of household status). [↑](#footnote-ref-139)
140. . IRC section 5000A(c)(3)(C). [↑](#footnote-ref-140)
141. . *See* IRC section 152(e). [↑](#footnote-ref-141)
142. . *See* IRC section 152(b)(1)(C). [↑](#footnote-ref-142)
143. . IRC section 5000A(b)(3)(B). [↑](#footnote-ref-143)
144. . IRC section 5000A(a). [↑](#footnote-ref-144)
145. . IRC section 5000A(c)(4)(A). [↑](#footnote-ref-145)
146. . *See* IRC section 151, 152. [↑](#footnote-ref-146)
147. . *See* IRC section 151(b). [↑](#footnote-ref-147)
148. . IRC section 5000A(e)(1), (2), (c)(4)(b), (a). [↑](#footnote-ref-148)
149. . IRC section 36B(c)(1)(C). [↑](#footnote-ref-149)
150. At <http://www.scribd.com/doc/192619675/Sec-Sebelius-Response-to-Senator-Warner?wpisrc=nl_wonk>. [↑](#footnote-ref-150)
151. At <http://marketplace.cms.gov/getofficialresources/publications-and-articles/hardship-exemption.pdf>. [↑](#footnote-ref-151)
152. . IRC section 5000A(g)(2)(A). This leaves open the question of whether or not there could be a criminal penalty, for example under section 7203 of the Code, with respect to the failure “to make a return, keep any records or supply any information” as required by the Code for purposes of calculating and imposing the penalty. [↑](#footnote-ref-152)
153. . IRC section 5000A(g)(2)(B). [↑](#footnote-ref-153)
154. . PPACA §1302(b). [↑](#footnote-ref-154)
155. . In general, the plans and products studied cover inpatient and outpatient mental health and substance use disorder services; however, coverage in the small group market often has limits. ASPE Research Brief, “Actuarial Value and Employer Sponsored Insurance,” November 2011. Available at: <http://aspe.hhs.gov/health/reports/2011/AV-ESI/rb.pdf>. [↑](#footnote-ref-155)
156. . PPACA §1302(b). [↑](#footnote-ref-156)
157. . 45 CFR §156.100. [↑](#footnote-ref-157)
158. . 45 CFR §156.20. [↑](#footnote-ref-158)
159. . PPACA; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; 45 Parts 147, 155, and 156, 78 Fed. Reg. 12841 (Feb. 25, 2013). [↑](#footnote-ref-159)
160. . There are other sources of health insurance, including self-insured plans, the Veterans Administration, and Medicare, that are not addressed in this table. These coverages are not subject to the EHB coverage requirements. [↑](#footnote-ref-160)
161. . PPACA §1312(f)(2)(B). [↑](#footnote-ref-161)
162. . PPACA §1322 provides for nonprofit, member-run health insurance issuers offering qualified health plans (QHPs) in the individual and small group markets [↑](#footnote-ref-162)
163. . PPACA §1334 directs OPM to offer at least two multistate qualified health plans in each state exchange. [↑](#footnote-ref-163)
164. . PPACA §1302(e). [↑](#footnote-ref-164)
165. . PPACA §1322 provides for nonprofit, member-run health insurance issuers offering qualified health plans in the individual and small group markets. [↑](#footnote-ref-165)
166. FAQs about Affordable Care Act Implementation (Part XVIII) at <http://www.dol.gov/ebsa/faqs/faq-aca18.html>. [↑](#footnote-ref-166)
167. Q&A 11, FAQs about Affordable Care Act Implementation (Part XVIII). [↑](#footnote-ref-167)
168. . PPACA §1312(f)(2)(B). [↑](#footnote-ref-168)
169. . PPACA §1302(b). [↑](#footnote-ref-169)
170. . CCIIO, Essential Health Benefits Bulletin (December 16, 2011). Available at <http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf>. [↑](#footnote-ref-170)
171. . CCIIO, Essential Health Benefits Bulletin (December 16, 2011). Available at cciio.cms.gov/resources/files/Files2/.../essential\_health\_benefits\_bulletin.pdf. [↑](#footnote-ref-171)
172. . 45 CFR §156.100(a). [↑](#footnote-ref-172)
173. . PPACA; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; 45 Parts 147, 155, and 156, 78 Fed. Reg. 12841 (Feb. 25, 2013). [↑](#footnote-ref-173)
174. . 45 CFR §156.100(c). [↑](#footnote-ref-174)
175. . 45 CFR §156.100(a); PPACA; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; 45 Parts 147, 155, and 156, 78 Fed. Reg. 12841 (Feb. 25, 2013). [↑](#footnote-ref-175)
176. . PPACA; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; 45 Parts 147, 155, and 156, 78 Fed. Reg. 12841 (Feb. 25, 2013). [↑](#footnote-ref-176)
177. . 45 CFR §156.115(a)(1). [↑](#footnote-ref-177)
178. . 45 CFR §156.115(a)(2). [↑](#footnote-ref-178)
179. . 45 CFR §156.115(b)(1)(i). [↑](#footnote-ref-179)
180. . 45 CFR §156.115(b)(1)(ii). [↑](#footnote-ref-180)
181. . 45 CFR §156.115(b)(1)(iii). [↑](#footnote-ref-181)
182. . 45 CFR §156.120(a)(1). [↑](#footnote-ref-182)
183. . California Health Benefits Review Program, Interaction between California State Benefit Mandates and the Affordable Care Act’s “Essential Health Benefits” (March 2012). [↑](#footnote-ref-183)
184. . PHSA §2711. [↑](#footnote-ref-184)
185. . PHSA §2703. [↑](#footnote-ref-185)
186. . PHSA §2714. [↑](#footnote-ref-186)
187. . PHSA §2704. [↑](#footnote-ref-187)
188. . PHSA §2704. [↑](#footnote-ref-188)
189. . PHSA §2708. [↑](#footnote-ref-189)
190. . PHSA §2709. [↑](#footnote-ref-190)
191. . PHSA §2718. [↑](#footnote-ref-191)
192. . PHSA §2703. [↑](#footnote-ref-192)
193. . PHSA §2713. [↑](#footnote-ref-193)
194. . See IRC section 9815, incorporating by reference Public Health Service Act §2716, which in turn incorporates by reference the principles of IRC section 105(h). [↑](#footnote-ref-194)
195. . PHSA §2714. [↑](#footnote-ref-195)
196. . PHSA §2719. [↑](#footnote-ref-196)
197. . PHSA §2719A. [↑](#footnote-ref-197)
198. . PHSA §2719A. [↑](#footnote-ref-198)
199. . PHSA §2701. [↑](#footnote-ref-199)
200. . PHSA §2707. [↑](#footnote-ref-200)
201. . PHSA §2709. [↑](#footnote-ref-201)
202. . PHSA §2705. [↑](#footnote-ref-202)
203. . PHSA §2715A. [↑](#footnote-ref-203)
204. . PHSA §2717. [↑](#footnote-ref-204)
205. . For more detailed information see Part X of this publication, which discusses state health insurance exchanges (marketplaces) in detail. [↑](#footnote-ref-205)
206. . PPACA §1311(b). [↑](#footnote-ref-206)
207. . PPACA §1311(d)(1). [↑](#footnote-ref-207)
208. . PPACA §1311(f). [↑](#footnote-ref-208)
209. . PPACA §1311(b)(1)(C). [↑](#footnote-ref-209)
210. . PPACA §1311(b)(1)(B). [↑](#footnote-ref-210)
211. . PPACA §1515(a); IRC 125(f)(3)(A). [↑](#footnote-ref-211)
212. . PPACA §1515(a); IRC 125(f)(3)(B). [↑](#footnote-ref-212)
213. . See http://cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10440.html. [↑](#footnote-ref-213)
214. . See http://www.youtube.com/cmshhsgov. [↑](#footnote-ref-214)
215. . PPACA §1412(c)(2)(B)(iv)(II). [↑](#footnote-ref-215)
216. . 45 CFR §§155.430(b)(2)(ii)(A) and (B) and 156.270(d). [↑](#footnote-ref-216)
217. . 76 Fed. Reg. 41866; 45 CFR §§155.430 & 156.270 available at https://www.federalregister.gov/articles/2012/03/27/2012-6125/patient-protection-and-affordable-care-act-establishment-of-exchanges-and-qualified-health-plans#h-165. [↑](#footnote-ref-217)
218. . Id. [↑](#footnote-ref-218)
219. . Additionally, Massachusetts spent more than $29.4 million in 2009 on the Commonwealth Connector, not including the high administrative costs. "State Insurance Exchanges: The Case Against Implementation." The Heartland Institute at http://heartland.org/policy-documents/state-insurance-exchanges-caseagainst-Implementation. [↑](#footnote-ref-219)
220. . Lessons From Utah Health Insurance Exchange," Low Cost Health Insurance, at [www.californiahealthplans.com/blog/2010/10/lessons-from-the-utah-health-insuance-exchange](http://www.californiahealthplans.com/blog/2010/10/lessons-from-the-utah-health-insuance-exchange). [↑](#footnote-ref-220)
221. . Milliman Study for Ohio Department of Insurance (August 31, 2011). [↑](#footnote-ref-221)
222. . PPACA §1311(d)(4)(A)-(K). [↑](#footnote-ref-222)
223. . 45 CFR §155.300. [↑](#footnote-ref-223)
224. . PPACA §1311(c). [↑](#footnote-ref-224)
225. . PPACA §1312(f). [↑](#footnote-ref-225)
226. . 45 CFR §155.210. [↑](#footnote-ref-226)
227. . PPACA §1311. [↑](#footnote-ref-227)
228. . 45 CFR §155.205. [↑](#footnote-ref-228)
229. . PPACA §1301(a). [↑](#footnote-ref-229)
230. . PPACA §1301(a)(1). [↑](#footnote-ref-230)
231. . PPACA §1301(a)(4). [↑](#footnote-ref-231)
232. . PPACA §1301(b)(1(A)). [↑](#footnote-ref-232)
233. . PPACA §1301(b)(2); PHSA §2791(b)(1). [↑](#footnote-ref-233)
234. . PPACA §1301(b)(3); PHSA §2791(a)(1). [↑](#footnote-ref-234)
235. . PPACA §1301(b)(1)(B). [↑](#footnote-ref-235)
236. . PPACA §1311(c). [↑](#footnote-ref-236)
237. . PPACA §1334(a). [↑](#footnote-ref-237)
238. . PPACA §1311. [↑](#footnote-ref-238)
239. . PPACA §1301. [↑](#footnote-ref-239)
240. . See State Exchange Implementation Questions and Answers (November 29, 2011), at http://cciio.cms.gov/resources/files/Files2/11282011/exchange\_q\_and\_a.pdf.pdf (as visited June 11, 2012). [↑](#footnote-ref-240)
241. . Federal Register Volume 77, Number 59 (March 27, 2012), 45 CFR Parts 155 and 157 (March 27, 2012) (superseding two sets of proposed regulations, namely, Establishment of Exchanges and Qualified Health Plans, 45 CFR Parts 155 and 156, 76 Fed. Reg. 41866 (July 15, 2011); PPACA; Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment, 45 CFR Part 153, 76 Fed. Reg. 41930 (July 15, 2011)). [↑](#footnote-ref-241)
242. . Federal Register Volume 77, Number 59 (March 27, 2012), 45 CFR Parts 155 and 157 (March 27, 2012). [↑](#footnote-ref-242)
243. . <http://www.hhs.gov/ociio/regulations/guidance_to_states_on_exchanges.html>. Kansas governor Sam Brownback returned the state’s $30 million grant as did Alaska. [↑](#footnote-ref-243)
244. . www.cbpp.org. Center on Budget and Policy Priorities, Status of State Health Insurance Exchange Implementation. [↑](#footnote-ref-244)
245. . 45 CFR §155.410(b. [↑](#footnote-ref-245)
246. . PPACA §1311(c)(6) (2010). Special enrollment periods include those specified in Code section 9801, other special enrollments under circumstances similar to such periods under part D of title XVIII of the Social Security Act, and special monthly enrollment periods for Indians pursuant to section 4 of the Indian Health Care Improvement Act). [↑](#footnote-ref-246)
247. . 45 CFR §155.410(e). [↑](#footnote-ref-247)
248. . 45 CFR §155.205. [↑](#footnote-ref-248)
249. . PPACA §1311(d)(2) (2010). The limited-scope dental benefits must meet the requirements of IRC section 9832(c)(2)(A). The pediatric dental benefits must meet the requirements of PPACA §1302(b)(1)(J). [↑](#footnote-ref-249)
250. See “GOP Rips Obamacare 'Navigators'” at <http://thehill.com/blogs/healthwatch/health-reform-implementation/193201-obamacare-navigators-put-consumers-info-at#ixzz2uG9ZxFdn>. Their report is at <http://oversight.house.gov/wp-content/uploads/2013/09/Republican-Staff-Report-on-Navigators.pdf>. [↑](#footnote-ref-250)
251. See “Texas AG ‘Deeply Concerned’ Over ACA Navigators Access To Personal Information at <http://medcitynews.com/2013/08/texas-ag-deeply-concerned-over-aca-navigators-access-to-personal-information/#ixzz2uGDHmUSb>. [↑](#footnote-ref-251)
252. Jenkins’ letter is at <http://lynnjenkins.house.gov/uploads/Letter%20to%20Secretary%20Sebelius%20about%20Navigator%20Program2.pdf>. [↑](#footnote-ref-252)
253. See Rep. Jenkins weekly update at <http://lynnjenkins.house.gov/congresswoman-jenkins-weekly-updates/rep-lynn-jenkins-weekly-update-around-the-district-holding-admin-accountable-irs-targeting-hhs-security-concerns-stimulus-anniversary/> [↑](#footnote-ref-253)
254. See <http://www.factcheck.org/2013/10/gop-attack-on-health-care-navigators>. [↑](#footnote-ref-254)
255. See Rep. Jenkins weekly update at <http://lynnjenkins.house.gov/congresswoman-jenkins-weekly-updates/rep-lynn-jenkins-weekly-update-around-the-district-holding-admin-accountable-irs-targeting-hhs-security-concerns-stimulus-anniversary/> [↑](#footnote-ref-255)
256. . PPACA §1311(b)(1)(B). [↑](#footnote-ref-256)
257. . General Guidance on Federally-facilitated Exchanges (May 16, 2012); Fact Sheet: Affordable Insurance Exchanges (May 16, 2012) at http://cciio.cms.gov/resources/files/FFE\_Guidance\_FINAL\_VERSION\_051612.pdf. [↑](#footnote-ref-257)
258. . 45 CFR §§155.705(b)(2) and (3). [↑](#footnote-ref-258)
259. . Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program, 45 CFR Parts 155 and 156, 78 Fed. Reg. 15553 (Mar. 11, 2013). [↑](#footnote-ref-259)
260. . PPACA §§1304(b), 1312(f); HHS Reg. §155.20. [↑](#footnote-ref-260)
261. . 45 CFR §155.20. [↑](#footnote-ref-261)
262. . 45 CFR §155.20. [↑](#footnote-ref-262)
263. . 45 CFR §157.205(c). [↑](#footnote-ref-263)
264. See “Launching the Small Business Health Option Program Marketplace” at <http://www.hhs.gov/news/press/2013pres/09/20130926b.html>. [↑](#footnote-ref-264)
265. See “FAQs on NEW Enrollment Process for the Federally Facilitated SHOP Marketplace” at <http://marketplace.cms.gov/getofficialresources/publications-and-articles/faqs-on-shop-enrollment.pdf>. [↑](#footnote-ref-265)
266. See “FAQs on NEW Enrollment Process for the Federally Facilitated SHOP Marketplace” at <http://marketplace.cms.gov/getofficialresources/publications-and-articles/faqs-on-shop-enrollment.pdf>. [↑](#footnote-ref-266)
267. See “What key dates do I need to know?” at <https://www.healthcare.gov/what-key-dates-do-i-need-to-know/#part=3>. [↑](#footnote-ref-267)
268. 45 CFR § 155.725(c) and (e) (March 21, 2014). [↑](#footnote-ref-268)
269. PPACA § 1302(d)(1). [↑](#footnote-ref-269)
270. 45 CFR § 155.705(b)(2) and (3) (March 21, 2014). [↑](#footnote-ref-270)
271. 45 CFR § 155.705(b)(2) and (3) (March 21, 2014). [↑](#footnote-ref-271)
272. . 29 U.S.C. §201 et seq. [↑](#footnote-ref-272)
273. . FLSA §18B. [↑](#footnote-ref-273)
274. . DOL delegated responsibility for regulations under FLSA §18B, to its Employee Benefits Security Administration (EBSA). See FAQs About the Affordable Care Act Implementation Part V, Q/A-2, at <http://www.dol.gov/ebsa/faqs/faq-aca5.html>. [↑](#footnote-ref-274)
275. . FLSA §18B. [↑](#footnote-ref-275)
276. . 29 U.S.C. §§206 and 207. [↑](#footnote-ref-276)
277. . 29 U.S.C. §203(d). [↑](#footnote-ref-277)
278. . FLSA §18B. [↑](#footnote-ref-278)
279. . 45 CFR §155.220(a)(3). [↑](#footnote-ref-279)
280. . 45 CFR §155.205(b)(3). [↑](#footnote-ref-280)
281. . 45 CFR §155.210(c)(2). [↑](#footnote-ref-281)
282. . 45 CFR §155.220(c)(1). [↑](#footnote-ref-282)
283. . 29 U.S.C. §1002(1). [↑](#footnote-ref-283)
284. . 29 C.F.R. §2510.3-1(j). See *New England Mut. Life Ins. Co. v. Baig,* 166 F.3d 1 (1st Cir. 1999); *O’Brien v. Mutual of Omaha Ins. Co*., 99 F.Supp. 2d 744 (E.D. La. 1999). [↑](#footnote-ref-284)
285. . See ERISA §§4(b)(1), (3) and (32) and 4(b)(2) and 3(33), respectively. [↑](#footnote-ref-285)
286. . See *Credit Managers Ass'n of So. Calif. v. Kennesaw Life and Acc. Ins. Co.,* 809 F.2d 617, 625 (9th Cir.1987), citing *Donovan v. Dillingham*, 688 F.2d 1367, 1373 (11th Cir.1982) ( en banc ). Accord *Gahn v. Allstate Life Ins. Co.*, 926 F.2d 1449, 1451 (5th Cir.1991); *Wickman v. Northwestern Nat'l Ins. Co.*, 908 F.2d 1077, 1082 (1st Cir.), *cert. denied*, 498 U.S. 1013 (1990). [↑](#footnote-ref-286)
287. . *Fugarino v. Hartford Life and Accident Ins. Co.*, 969 F.2d 178, 183 (6th Cir. 1992) (abrogated on other grounds in *Yates v. Hendon*, 541 U.S. 1 (2004)). [↑](#footnote-ref-287)
288. . *Int'l Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294, 297 (6th Cir.1991) (citing *Donovan*, 688 F.2d at 1373), *cert. denied*, 504 U.S. 973 (1992). [↑](#footnote-ref-288)
289. . See *McDonald v. Provident Indem. Life Ins. Co.*, 60 F.3d 234, 236 (5th Cir.1995), *cert. denied*, 516 U.S. 1174 (1996); *Hansen v. Continental Ins. Co.*, 940 F.2d 971, 977 (5th Cir.1991). [↑](#footnote-ref-289)
290. . See, e.g., *Gahn*, 926 F.2d at 1451. [↑](#footnote-ref-290)
291. . *Fugarino*, 969 F.2d at 184, citing *Hansen*, 940 F.2d at 977. Accord *Grimo*, 34 F.3d at 150; *Gahn*, 926 F.2d at 1451; *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489, 492 (9th Cir.1988) (per curiam), *cert. denied*, 492 U.S. 906 (1989). [↑](#footnote-ref-291)
292. . 63 F.3d 1129 (1st Cir.1995). [↑](#footnote-ref-292)
293. . 63 F.3d at 1136. [↑](#footnote-ref-293)
294. . *Id.* at 1133. [↑](#footnote-ref-294)
295. . 63 F.3d at 1134 and 1137 n. 6. [↑](#footnote-ref-295)
296. . 40 Fed. Reg. 34,526 (1975). [↑](#footnote-ref-296)
297. . 63 F.3d at 1133. [↑](#footnote-ref-297)
298. . *Id.* at 1137. [↑](#footnote-ref-298)
299. . See *Hansen*, 940 F.2d at 977 (requiring "some meaningful degree of participation by the employer in the creation or administration of the plan"). [↑](#footnote-ref-299)
300. . See, e.g., *Custer v. Pan American Life Ins. Co.*, 12 F.3d 410, 417 (4th Cir.1993) (considering, inter alia, employer's role in negotiating terms and benefits of the policy in determining whether a plan should fall out of the safe harbor); *Wickman*, 908 F.2d at 1083 (considering, inter alia, employer's role in devising eligibility requirements when determining the applicability of the safe harbor regulations). [↑](#footnote-ref-300)
301. . See, e.g., *Kanne*, 867 F.2d at 493; *Shiffler v. Equitable Life Assur. Soc. of U.S.*, 838 F.2d 78, 82 n. 4 (3d Cir.1988) (both considering, inter alia, the employer's role in administering the plan when determining whether to allow the policy to come under the safe harbor provision of the DOL regulation). [↑](#footnote-ref-301)
302. . *Johnson*, 63 F.3d at 1134 & 1137 n. 6; *Thompson*, 95 F.3d at 436-7. [↑](#footnote-ref-302)
303. . See *Johnson*, 63 F.3d at 1135 n. 3. [↑](#footnote-ref-303)
304. . See 95 F.3d at 437. [↑](#footnote-ref-304)
305. . 950 F.2d at 297 (a "plan" exists if "from the surrounding circumstances a reasonable person [could] ascertain the intended benefits, the class of beneficiaries, the source of financing, and procedures for receiving benefits"). See also *Dist. of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 131 n. 2 (1992); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 12, (1987); *Belanger v. Wyman-Gordon Co.*, 71 F.3d 451, 454 (1st Cir.1995) (all defining "plan"). [↑](#footnote-ref-305)
306. . See *McDonald*, 60 F.3d at 236; Hansen, 940 F.2d at 977. [↑](#footnote-ref-306)
307. . 29 U.S.C. 1002(1). [↑](#footnote-ref-307)
308. . 95 F.3d at 437-8. [↑](#footnote-ref-308)
309. . *Anderson v. Unum Provident Corporation*, 369 F.3d 1257, 1262 (11th Cir. 2004). [↑](#footnote-ref-309)
310. . 688 F.2d 1367 (11th Cir. 1982). [↑](#footnote-ref-310)
311. . 166 F.3d 1 (1st Cir. 1999). [↑](#footnote-ref-311)
312. . 456 F. Supp. 2d 285 (D. Mass. 2006). [↑](#footnote-ref-312)
313. . 2000 U.S. Dist. LEXIS 21380, 4-5 (C.D. Cal. Nov. 22, 2000). [↑](#footnote-ref-313)
314. . 48 F.3d 404 (9th Cir. 1995). [↑](#footnote-ref-314)
315. . 2000 WL 1693635 (E.D. La. 2000). [↑](#footnote-ref-315)
316. . 1998 WL 34078144 (W.D. Mich. 1998). [↑](#footnote-ref-316)
317. . 2001 WL 114407 (N.D. Ill. 2001). [↑](#footnote-ref-317)
318. . 11 F.3d 444(4th Cir. 1993). [↑](#footnote-ref-318)
319. . 969 F.2d 178, 183 (6th Cir. 1992) (abrogated on other grounds in *Yates v. Hendon*, 541 U.S. 1 (2004)). [↑](#footnote-ref-319)
320. . 987 F.2d 1547, 1551-2 (11th Cir. 1993). [↑](#footnote-ref-320)
321. . 2008 U.S. Dist. LEXIS 94418, 6-8 (E.D. Ark. Nov. 18, 2008). [↑](#footnote-ref-321)
322. . 1998 U.S. Dist. LEXIS 8178 (W.D. Mich. May 11, 1998). [↑](#footnote-ref-322)
323. . 48 Fed.Appx. 557, 564 (6th Cir., 2002). [↑](#footnote-ref-323)
324. . 982 F.2d 1031, 1034 (6th Cir. 1993). [↑](#footnote-ref-324)
325. . 950 F.2d 294, 297-98 (6th Cir. 1991), cert. denied, 504 U.S. 973, 119 L. Ed. 2d 565, 112 S. Ct. 2941 (1992). [↑](#footnote-ref-325)
326. . *National Federation of Independent Business v. Sebelius*, 567 U.S. \_\_\_, 132 S. Ct. 2566, 183 L. Ed. 2d 450, 2012 U.S. LEXIS 4876, 2012 WL 2427810, 80 U.S.L.W. 4579; 2012-2 U.S. Tax Cas. (CCH) P50,423; 109 A.F.T.R.2d (RIA) 2563; 53 Employee Benefits Cas. (BNA) 1513. [↑](#footnote-ref-326)
327. . IRC section 5000A. [↑](#footnote-ref-327)
328. . IRC section 7421(a). [↑](#footnote-ref-328)
329. . 42 USC §1396c. [↑](#footnote-ref-329)
330. . Chief Justice Roberts’ opinion, joined by Justices Breyer and Kagan, contains the narrowest rationale and is controlling. [When Congress threatens to terminate other grants as a means of pressuring the States to accept a Spending Clause program, the legislation runs counter to this Nation’s system of federalism.] Justice Ginsburg, joined by Justice Sotomayor, upheld the expansion on a broader ground. [Construing the Commerce Clause to permit Congress to regulate individuals precisely because they are doing nothing would open a new and potentially vast domain to congressional authority.] [↑](#footnote-ref-330)
331. . 42 U. S. C. §1396d(a). [↑](#footnote-ref-331)
332. . PPACA §2001(a)(1). [↑](#footnote-ref-332)
333. . Office of the Actuary, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services: 2011 Actuarial Report on the Financial Outlook for Medicaid (Mar. 16, 2012). [↑](#footnote-ref-333)
334. . GAO letter to Sen. Charles Grassley (Aug. 1, 2012) at http://gao.gov/assets/600/593210.pdf. [↑](#footnote-ref-334)
335. . IRC section 36B(c)(1)(A). [↑](#footnote-ref-335)
336. . Kaiser, Medicaid and the Uninsured, at http://www.kff.org/healthreform/upload/medicaid-coverage-and-spending-in-health-reform-national-and-state-by-state-results-for-adults-at-or-below-133-fpl.pdf. [↑](#footnote-ref-336)
337. . Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 Fed. Reg. 17144 (Mar. 23, 2012). [↑](#footnote-ref-337)
338. . GAO letter to Sen. Charles Grassley (Aug. 1, 2012) at http://gao.gov/assets/600/593210.pdf. [↑](#footnote-ref-338)