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Health Reform

How Does the Individual Mandate Work?

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Beginning January 1, 2014, taxpayers (with certain limited exemptions) will be assessed a tax for any months during which they or their dependents lack minimum essential coverage. An individual has three choices: (1) qualify for an exemption, (2) get minimum essential coverage (with or without government assistance if under the Exchange), or (3) pay the individual mandate.

Minimum Essential Coverage and the Exchange

Minimum essential coverage includes most major medical coverage such as all of the following:

- Employer-provided medical coverage;
- Medicare Part A, Medicaid, the CHIP program, and TRICARE; and
- A qualified health plan through the individual market under an Exchange ("QHP").

Minimum essential coverage does not include things like workers' compensation, dental or vision benefits.

An Exchange, also know as the Marketplace, is basically an online marketplace for health insurance in each state. Policies offered in the Exchange will be provided by the major insurance carriers in the United States. The coverage options are:

- Bronze: pays 60% of covered benefits (least expensive);
- Silver: pays 70% of covered benefits;
- Gold: pays 80% of covered benefits; and
- Platinum: pays 90% of covered benefits (most expensive).

The Tax

All individuals (with limited exceptions) are subject to the tax. The following individuals are not subject to the tax:

- Individuals who are not lawfully present in the United States;
- Individuals whose household income does not exceed the threshold for filing a federal income tax return; and
- Individuals who cannot afford coverage – defined as individuals for whom a required contribution for coverage would cost more than 8% of their household income.

The taxpayer pays the tax on his or her behalf, as well as on the behalf of his or her tax dependents. The tax is paid in connection with the taxpayer's Form 1040 filing. Married individuals who file a joint return for a taxable year are jointly liable for any tax. For each taxable year, the tax is:

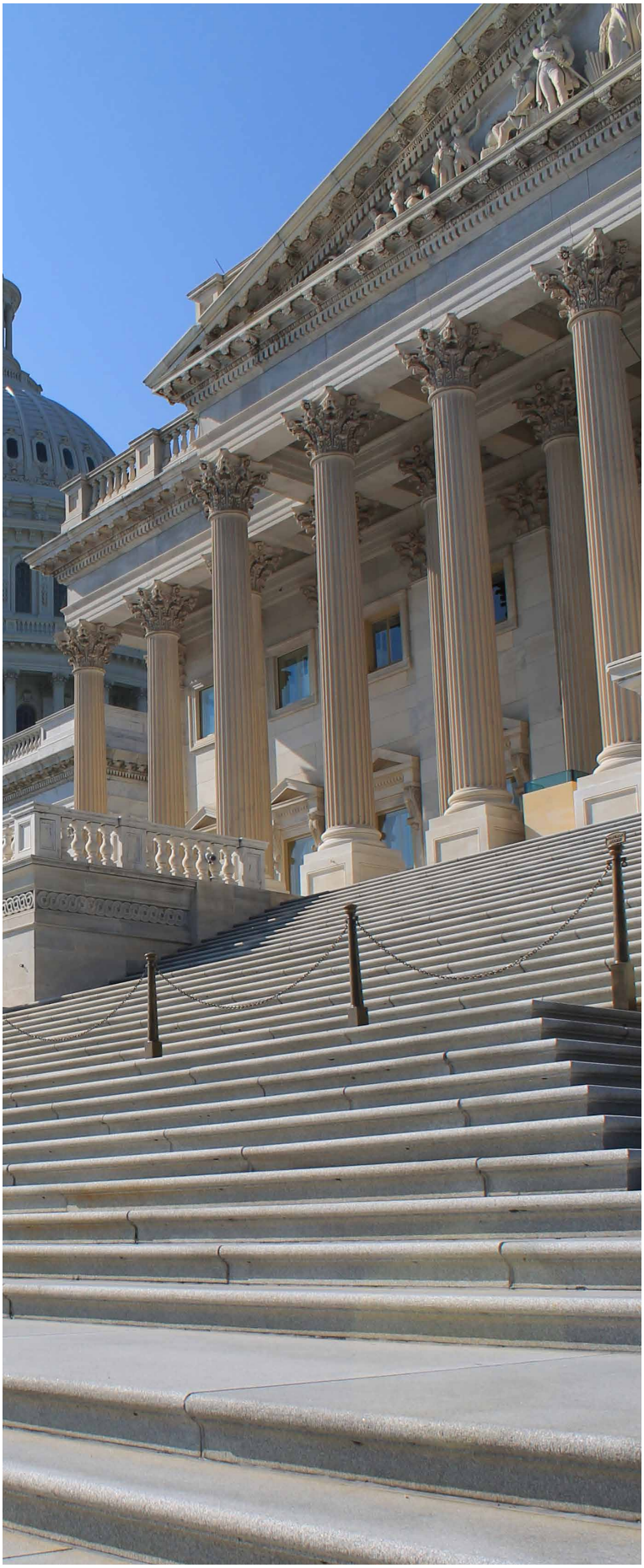
- For 2014: the greater of $95 per household member* (up to $285 per family) and 1% of household income;
- For 2015: the greater of $325 per household member* (up to $975 per family) and 2% of household income;
- For 2016: the greater of $695 per household member* (up to $2,085 per family) and 2.5% of household income.

** For children under the age of 18, use half of the applicable dollar amount.*

The tax is capped at the sum of the monthly national average bronze plan premiums for the family and is assessed monthly based on the annual amounts above.

Government Assistance

Effective January 1, 2014, certain individuals may receive government assistance to purchase a QHP. There are two forms of government assistance: a premium tax credit and a cost sharing subsidy. A premium tax credit is a refundable government subsidy for some of the premium paid toward a QHP. A cost sharing subsidy is a government subsidy for some of the cost-sharing (e.g., deductibles, coinsurance and copayments) toward a QHP.



Premium Tax Credits

To receive a premium tax credit, an individual must:

- have household income between 100% and 400% of the Federal Poverty Level;
- be enrolled in a QHP;
- be legally present in the United States and not incarcerated;
- not be eligible for other qualifying coverage, such as Medicare, Medicaid, or affordable employer-sponsored coverage of a minimum value; and
- not be enrolled in an employer-sponsored plan, even if the plan does not meet the affordability and minimum value conditions.

It is important to note that individuals and their families are not eligible for government assistance when the employer offers affordable employee-only coverage of a minimum value.

The amount of the premium tax credit is dependent on income. For a calculator, visit: http://healthreform.kff.org/SubsidyCalculator.aspx. For the fact sheet, visit: http://www.treasury.gov/press-center/Documents/36BFactSheet.PDF.

Individuals receiving premium tax credits will get an average of over $5,000 per year.

Can family members qualify for the premium tax credit when only the employee is eligible for affordable, minimum value coverage? An employer plan is affordable for family members if the cost of self-only coverage does not exceed 9.5% of the employee's household income. In other words, for purposes of determining whether family members are eligible for premium tax credits, the cost of family coverage is not taken into account – all that matters is whether the cost of self-only coverage is affordable to the employee. For example, if Jack is married to Jill and Jack's employer's plan requires Jack to contribute $5,300 for Jill's coverage for 2014 (11.3% of their household income), because Jack's required contribution for self-only coverage ($3,450) does not exceed 9.5% of household income, Jack's employer's plan is affordable for Jack and Jill.

In contrast to the affordability test for purposes of eligibility for premium tax credits, affordability for purposes of an exemption from the individual shared responsibility penalty does look at the cost of family coverage. Therefore, it is possible that an employee's family members may not qualify for premium tax credits (since the cost of self-only is deemed to be affordable for the whole family), but they may nevertheless avoid the individual shared responsibility penalty if the lowest-cost family coverage is not affordable to them; the individual mandate does not apply to individuals who cannot afford coverage – defined as individuals for whom a required contribution for coverage would cost more than 8% of their household income.

Cost-Sharing Reductions

To receive a cost-sharing reduction an individual must:

- be eligible for the premium tax credit;
- have household income between 100% and 250% of the Federal Poverty Level; and
- be enrolled in a silver level of coverage in a QHP.

The term "cost-sharing" includes deductibles, coinsurance, copayments, or similar charges, and any other expenditure required of an insured individual with respect to essential health benefits covered under the plan. Such term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

The amount is expected to range from 33% to 90%, depending on the income level of the individual.