Health Insurance Mandate for Individuals

Tab 1 Topics

Overview

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (P.L. 111-148), signed March 23, 2010, as amended by the Health Care and Education Reconciliation Act, signed March 31, 2010, is collectively referred to as the Affordable Care Act (ACA).

Individual mandate. Under the ACA, taxpayers were subject to a shared responsibility penalty beginning in 2014 for any months during which they didn't have minimum essential coverage (MEC) or qualify for an exemption. The Tax Cuts and Jobs Act reduced the individual shared responsibility penalty to zero, effectively eliminating the individual mandate, for months beginning on or after January 1, 2019. The individual mandate under IRC Sec. 5000A is still in effect; however, because the penalty for violations is zero, the IRS is not enforcing the mandate for years after 2018.

Note: In response to the reduction of the penalty to zero, the individual mandate was challenged as unconstitutional because it no longer triggers a tax. In December 2019, the Fifth Circuit affirmed the decision of the trial court in finding that the individual mandate is unconstitutional (*Texas v. U.S.*). The Supreme Court has added the case to its docket for the term beginning in October 2020. A decision is not expected until 2021. Until the case is decided by the Supreme Court, all provisions of the ACA remain in effect.

State Individual Health Coverage Mandates

Although the federal penalty for not having individual health insurance coverage has been reduced to zero for months beginning after 2018, several states have imposed an individual health care coverage mandate. When this *Handbook* was published, California, Massachusetts, New Jersey, Rhode Island, Vermont, and Washington, D.C. had mandates in place that require individuals to have certain health insurance coverage. As additional states are currently considering legislation to implement their own state health care mandate, this will be an important area to monitor.

An overview of the state mandates currently in place follows:

- *California*. Effective January 1, 2020. Residents and their dependents must have MEC, qualify for an exemption, or pay a penalty equal to the greater of 2.5% of gross income above filing threshold requirements, or $695 per adult and $347.50 per child, up to $2,085 per family. Employers that have any employees in California must comply with reporting requirements for that employee. IRS Forms 1094/1095 are used for state reporting. See Tab 8 for guidance on completing Forms 1094 and 1095.
- *Massachusetts.* Effective July 1, 2007. Residents over age 18 who are deemed able to afford health insurance must have minimum creditable coverage (MCC), which is a higher level of coverage than the MEC standard, or pay a penalty. For 2020 coverage, the penalty ranges from $22 per month to $135 per month depending on income, age, and family size. Employers are required to report annually. Employees with private insurance receive a Form MA 1099-HC with information used to report their coverage.
- *New Jersey.* Effective January 1, 2019. Residents and all family members must have MEC, qualify for an exemption, or pay a penalty equal to 2.5% of household income above the filing threshold or $695 per adult, up to $2,085 per family. Employers are required to report annually using IRS Forms 1094/1095. See Tab 8 for guidance on completing Forms 1094 and 1095.
- *Rhode Island.* Effective January 1, 2020. Residents and their dependents must have MEC, qualify for an exemption, or pay a penalty equal to the greater of 2.5% of household income, or $695 per adult and $347.50 per child, up to $2,085 per family. Information on employer reporting was not yet available.
- *Vermont.* Effective January 1, 2020. Vermont had not released any details on the reporting requirements or established 2020 penalty amounts when this *Handbook* was published.
- *Washington, D.C.* Effective January 1, 2019. Residents and their dependents must have MEC, qualify for an exemption, or pay a penalty equal to the greater of 2.5% of family income above the federal tax filing threshold, or $695 per taxpayer. Employers are required to report annually, within 30 days after the IRS filing deadline. Forms 1094/1095 are used for state reporting. See Tab 8 for guidance on completing Forms 1094 and 1095.

Qualifying for a General Hardship Exemption

An individual who, for any month, is determined to have suffered a hardship in obtaining MEC under a QHP is an exempt individual for that month [IRC Sec. 5000A(e)(5); Reg. 1.5000A-3(h)(1)]. Individuals who obtain a hardship exemption from a state marketplace are eligible to purchase catastrophic coverage through the marketplace even if they do not otherwise qualify for catastrophic coverage. The application to apply for a hardship exemption is available at **www.healthcare.gov**.

A hardship exemption may apply for a specific month, a period of months, or an entire calendar year. Additionally, it can apply for periods that are in more than one calendar year (for example, from July–June). The hardship exemption usually applies for at least the month before, a month or months during which, and the month after, an individual cannot obtain coverage under a QHP due to any of the following reasons [HHS Reg. 45 CFR 155.605(d)(1)]:

1) The individual experiences financial or domestic circumstances, including an unexpected natural or human-caused event, such that he has a significant, unexpected increase in essential expenses.
2) The expense of purchasing a QHP would cause serious deprivation of food, shelter, clothing, or other necessities.
3) The individual has experienced other circumstances similar to items 1 or 2 that prevent him from obtaining coverage under a QHP.

Generally, an individual experiencing any of the following circumstances for one or more months can qualify for a hardship exemption:

- Being homeless.

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- Being evicted or facing eviction or foreclosure.
- Receiving a shut-off notice from a utility company.
- Experiencing domestic violence.
- Experiencing the death of a close family member.
- Experiencing a fire, flood, or other natural or human-caused disaster that results in substantial damage to the individual's property.
- Filing for bankruptcy.
- Having medical expenses that could not be paid.
- Experiencing unexpected increases in essential expenses due to caring for an ill, disabled, or aging family member.
- Claiming a child as a tax dependent when that child has been denied coverage in Medicaid or CHIP, and another person is required by court order to provide medical support to the child.
- Having no (or inadequate) coverage while awaiting an appeals decision from the marketplace.
- Having been determined ineligible for Medicaid in a state that didn't expand Medicaid coverage.
- Living in a county in which no QHP is offered.
- Living in a county in which only one issuer offers coverage.
- Living in a county in which all affordable plans offered provide coverage of abortion and such coverage is contrary to the individual's beliefs.
- Experiencing personal circumstances that create a hardship, such as when no affordable plans provide access to needed specialty care.
- Experiencing a hardship not listed that prevented the individual from getting health insurance.

What Is Minimum Essential Coverage?

The concept of minimum essential coverage (MEC) was essential to administering the individual mandate. However, the concept is also used for purposes of determining eligibility for the premium tax credit (see Tab 3) and determining if employer-sponsored coverage meets certain requirements to avoid an employer shared responsibility penalty (see Tab 5).

MEC is health insurance coverage under [IRC Sec. 5000A(f); Reg. 1.5000A-2(a); HHS Reg. 42 CFR 156.600]:

1) A government-sponsored program,
2) An eligible employer-sponsored plan,
3) A plan in the individual market,
4) A grandfathered health plan, or
5) Other health benefits coverage specified by HHS.

MEC does not include coverage under plans that offer only excepted benefits or other limited-scope benefits offered under a separate policy [Reg. 1.5000A-2(g)]. See *Coverage That Does Not Qualify as MEC* on Page 1-3.

See the *Minimum Essential Coverage (MEC) Chart* on Page 1-4 for a list of coverage that is considered MEC.

Government-Sponsored Programs

Government-sponsored programs include the following [Reg. 1.5000A-2(b)]:

- The Medicare program under part A of Title XVIII of the Social Security Act.
- The Medicaid program under Title XIX of the Social Security Act. Limited Medicaid coverage or optional coverage (for example, tuberculosis-related services) is generally not included.
- The Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. CHIP "buy-in" coverage offered to individuals or families with income exceeding the eligibility level with little or no government subsidy for the premiums is MEC if the benefits provided are at least identical to the benefits provided under a state's regular CHIP coverage.
- Medical coverage under Chapter 55 of Title 10, U.S.C., including coverage under the TRICARE program.
- The medical benefits package authorized for eligible veterans under 38 U.S.C. 1710 and 38 U.S.C. 1705.
- The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) authorized under 38 U.S.C. 1781.
- The comprehensive health care program authorized under 38 U.S.C. 1803 and 38 U.S.C. 1821 for certain children of Vietnam veterans and veterans of covered service in Korea who are suffering from spina bifida.
- A health plan under Section 2504(e) of Title 22, U.S.C. for Peace Corps volunteers.

Eligible Employer-Sponsored Plan

In general, an *eligible employer-sponsored plan* means a group health plan or group health insurance coverage offered by an employer to the employee that is [IRC Sec. 5000A(f)(2); Reg. 1.5000A-2(c)(1)]:

- A governmental employer plan offered by a state, local government, or federal employer.
- Any plan or coverage offered in the small or large group market within a state.
- A grandfathered health plan (that is, a group health plan that was in existence on March 23, 2010) offered in a group market. See *Grandfathered Health Plan* on Page 1-3.
- A self-insured group health plan (offered in the large or small group market in a state), offered by, or on behalf of, an employer to the employee.
- COBRA or retiree coverage.
- Coverage under an expatriate health plan for employees and their family members.
- The Nonappropriated Fund Health Benefits Program of the Department of Defense.

Plan in the Individual Market

A *plan in the individual market* means health insurance coverage offered to individuals not in connection with a group health plan, including a qualified health plan (QHP) offered through the state insurance marketplace [Reg. 1.5000A-2(d)]. However, coverage under a short-term, limited duration individual policy is not MEC.

Qualified Health Plan (QHP). A *QHP* is a health plan that (1) meets certain criteria of the marketplace through which it is offered, (2) provides an essential health benefits package, and (3) is offered by a health insurance issuer that is licensed and in good standing [Reg. 1-5000A-1(d)(14).]

Health insurance coverage. The term *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 (1) hospital or medical service policy or certificate, (2) hospital or medical service plan contract, or (3) health maintenance organization contract offered by a health insurance issuer.

Medical care. *Medical care* means amounts paid for [IRC Sec. 213(d)(1)]:

1) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

2) Amounts paid for transportation primarily for and essential to medical care as described in item 1 above; and

3) Amounts paid for insurance covering both items 1 and 2 above.

Health insurance issuer. A *health insurance issuer* is an insurance company, insurance service, or insurance organization that is licensed to engage in the business of insurance in a state and is subject to state law that regulates insurance.

Essential benefits package. An *essential health benefits package* (1) provides for essential health benefits, (2) limits cost-sharing for such coverage, and (3) provides either a Bronze (actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan), Silver (70%), Gold (80%), or Platinum (90%) level of coverage.

Essential health benefits. Neither the ACA nor HHS regulations define essential health benefits. Instead, they are presented as coverage in the following 10 broad categories:

- 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;
- Preventative and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Grandfathered Health Plan

A *grandfathered health plan* is any health plan or health insurance coverage that was in existence on March 23, 2010 (with at least one individual enrolled in coverage on that date), that has continuously provided coverage to any individual since that date and has not done anything that would cause it to lose its grandfathered status.

With respect to a group health plan or health insurance coverage that an individual was enrolled in on March 23, 2010, and that is renewed after that date, family members of the individual are permitted to enroll in the plan or coverage, if enrollment was permitted under the terms of the plan in effect as of March 23, 2010.

A group health plan that provided coverage on March 23, 2010, may provide for the enrollment of new employees (and their families) in the plan. See Tab 9 for additional information on grandfathered health plans.

Other Health Benefits Coverage

MEC includes any plan or arrangement recognized by the HHS as MEC. HHS has determined that the following qualify as MEC (HHS Reg. 45 CFR 156.602):

- Foreign coverage that qualifies as expatriate coverage for individuals working in the U.S., or has been recognized as MEC by HHS.
- Refugee medical assistance supported by the Administration for Children and Families, a federally-funded program that provides up to eight months of coverage to certain noncitizens who are considered refugees under the Immigration and Naturalization Act.
- Medicare advantage plans under Part C of Title XVIII of the Social Security Act, that provides Medicare Parts A and B benefits through a private insurer.
- AmeriCorps coverage offered to AmeriCorps volunteers, which is the domestic counterpart to the Peace Corps.

HHS has authority to recognize other coverage as MEC (HHS Reg. 45 CFR 156.604). A list of other coverage that has been recognized as MEC is available at **www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/minimum-essential-coverage.html**.

Coverage That Does Not Qualify as MEC

MEC does not include coverage under plans that offer only excepted benefits. Such plans include the following [Reg. 1.5000A-2(g)].

- Coverage only for accident or disability income insurance, or any combination thereof.
- Coverage issued as 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.
- Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.
- Limited scope dental or vision benefits that are offered separately, and certain health FSAs.
- Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.
- Coverage only for a specified disease or illness.
- Hospital indemnity or other fixed indemnity insurance.
- Supplemental excepted benefits such as Medicare supplemental health insurance (that is, Medigap or MedSupp insurance), TRICARE supplemental policies and similar supplemental insurance provided to coverage under a group health plan.
- Limited wraparound coverage (additional coverage an employer may offer to employees that wraps around or supplements their primary coverage) [Reg. 54.9831-1(c)(3)].
- Travel insurance.

Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs). Employers that are not applicable large employers (ALEs) as defined in IRC Sec. 4980H(c)(2) and do not offer a group health plan to any of their employees can provide QSEHRAs to their employees. Under these arrangements, the employer can reimburse an employee for medical expenses, including premiums paid for an individual insurance policy. A QSEHRA is not a group health plan and, therefore, does not qualify as MEC [IRC Sec. 9831(d)]. See Tab 9 for a discussion on QSEHRAs.

Limited-benefit government-sponsored programs. Certain limited-benefit government-sponsored programs are not considered MEC. Coverage in the following government programs are generally not considered MEC:

- Medicaid optional family planning services.
- Medicaid optional tuberculosis-related services.
- Medicaid coverage of pregnancy-related services (unless specifically recognized by HHS).
- Medicaid coverage limited to emergency medical conditions.
- Social Security Act Section 1115(a) demonstration project coverage (unless specifically recognized by HHS).
- Medicaid coverage for the medically needy (for example, spend-down Medicaid or share-of-cost Medicaid) (unless specifically recognized by HHS).
- TRICARE coverage that is solely limited to space available in a facility of the uniformed services for individuals excluded from regular TRICARE coverage.
- TRICARE coverage for an injury, illness, or disease incurred or aggravated in the line of duty for individuals who are not on active duty.

Minimum Essential Coverage (MEC) Chart

Coverage Type	Qualifies As MEC	Doesn't Qualify As MEC
Employer-sponsored coverage: • Group health insurance coverage for employees under— – A governmental plan, such as the Federal Employees Health Benefit program; – A plan or coverage offered in the small or large group market within a state or – A grandfathered health plan offered in a group market. • A self-insured group health plan for employees. • COBRA coverage. • Retiree coverage. • Coverage under an expatriate health plan for employees. • **Department of Defense Nonappropriated Fund Health Benefits Program.**	✓	
Individual health coverage: • Health insurance purchased directly from an insurance company. • Health insurance purchases through the Health Insurance Marketplace. • Health insurance provided through a student health plan. • Catastrophic plans. • Coverage under an expatriate health plan for nonemployees, such as students and missionaries.	✓	
Coverage under government-sponsored programs: • Medicare Part A coverage. • Medicare Advantage plans. • Most Medicaid coverage. • Children's Health Insurance Program (CHIP) coverage. • Most types of TRICARE coverage. • Comprehensive health care programs offered by the Department of Veterans Affairs. • Health coverage provided to Peace Corps volunteers. • Refugee Medical Assistance. • Coverage through a Basic Health Program (BHP) standard health plan.	✓	
Other coverage: • Certain foreign coverage. • Certain coverage for business owners. • Coverage recognized by HHS as MEC (plans recognized as MEC are listed at **www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/minimum-essential-coverage.html**, then click on the *Approved Plans* link).	✓	
Certain coverage that may provide limited benefits: • Coverage consisting solely of excepted benefits, such as: – Standalone dental and vision insurance, – Accident or disability income insurance or – Workers' compensation insurance. • Medicaid providing only family planning services.[1] • Medicaid providing only tuberculosis-related services.[1] • Medicaid providing only coverage limited to treatment of emergency medical conditions.[1] • Pregnancy-related Medicaid coverage.[1] • Medicaid coverage for the medically needy.[1] • Section 1115 Medicaid demonstration projects.[1] • Space available TRICARE coverage provided under chapter 55 of title 10 of the United States Code for individuals who are not eligible for TRICARE coverage for health services from private sector providers.[1] • Line-of-duty TRICARE coverage provided under chapter 55 of title 10 of the United States Code.[1] • AmeriCorps coverage for those serving in programs receiving AmeriCorps State and National grants. • AfterCorps coverage purchased by returning members of the PeaceCorps.		✓

[1] Medicaid programs that provide limited benefits generally don't qualify as MEC.

— End of Tab 1 —