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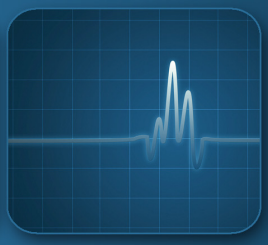
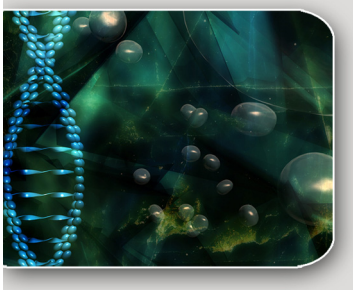



HEALTH CARE LAW IN THE NEWS

March 2013



Proposed and Final Rules Released Regarding the ACA's Individual Mandate

Beginning in 2014, the Affordable Care Act's (ACA) individual mandate requires most individuals to have "minimum essential coverage" or pay a "shared responsibility payment." In upholding the individual mandate last summer, the United States Supreme Court held that the individual mandate is not a legal command to buy insurance but rather a tax. Given this, if uninsured individuals do not obtain coverage they will be forced to pay a shared responsibility payment to the IRS at the end of the tax year.

On January 30, 2013, the U.S. Department of Health and Human Services (HHS) and the Internal Revenue Service (IRS) collectively released two proposed rules and a final rule regarding the individual mandate. In addition to providing guidance on minimum essential coverage, the regulations explain the mandate's shared responsibility provision and lay out the eligibility rules for receiving an exemption as well as the process by which individuals can receive certificates of exemption. Both agencies' proposed regulations include rules that will ease implementation and help ensure that the payment applies only to the limited group of taxpayers who choose to spend a substantial period of time without coverage despite having access to affordable health care.

According to the Congressional Budget Office (CBO) less than two percent of Americans will owe a shared responsibility payment.

Minimum Essential Coverage

The ACA defines minimum essential coverage as: coverage under a specified government sponsored program; coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan; or other health benefits coverage that the Secretaries of HHS and the Department of Treasury recognize.

HHS Proposed Rule

Under the proposed rule, certain types of coverage are automatically designated as minimum essential coverage. These coverage types include:

- Self-funded student health insurance plans;
- Foreign health coverage;
- Refugee medical assistance supported by the Administration for Children and Families;
- Medicare Advantage Plans; and,
- AmeriCorps coverage.

Additionally, HHS proposed that state high-risk pools also be deemed minimum essential coverage but reserved the right to assess and re-evaluate this decision. HHS is currently seeking comments on whether state high-risk pools should automatically be designated as minimum essential coverage or whether they should be required to follow the processes outlined in other sections of the proposed rule to be recognized as meeting the necessary requirements.

Shared Responsibility Payments and Exemptions

The ACA specifies the categories of individuals who are eligible to receive exemptions from the shared responsibility payment under section 5000A of the Internal Revenue Code (hereinafter the "Code") and directs the new health insurance marketplaces, called Affordable Insurance Exchanges (Exchanges), to issue certifications of exemption to eligible individuals.

- Individuals who are exempt from the shared responsibility payment include:
- Individuals whose religious beliefs conflict with acceptance of the benefits of private or public insurance;
- Taxpayers with income below the threshold for filing tax returns;
- Members of Indian tribes;
- Individuals who experience coverage gaps of less than three consecutive months;
- Members of a health care sharing ministry; and,
- Individuals who do not have an affordable health insurance coverage option available.

Individuals that do not fall within exempted categories have a choice: maintain minimum essential coverage for themselves and any nonexempt family members or include an additional payment with their federal income tax return.

Additionally, certain employers may be subject to a shared responsibility payment under the ACA. If the employer has at least one full-time employee who receives a premium tax credit or cost-sharing reductions under the health plan in which he or she is enrolled through the state insurance exchange, the payment assessed depends on whether or not the employer offers health coverage. If the employer does not offer coverage, and at least one full-time employee receives a premium tax credit or cost-sharing reductions, the employer must pay $2,000 for each full-time employee, not counting the first 30 employees. If the employer does offer coverage, and at least one full-time employee receives a premium tax credit or cost-sharing reductions, the employer will be required to pay the lesser of $3,000 for each employee who receives assistance or $2,000 per full-time employee (not counting the first 30 employees). In this case, the coverage offered to an employee and his or her dependents must meet the criterion of having a minimum essential value and not be considered either "inadequate" or "unaffordable." Coverage is considered "inadequate" if it covers less than 60% of the total allowed costs of benefits. Coverage is "unaffordable" if it exceeds 9.5% of the employee's household income. The IRS Final Rule provides additional explanation of "unaffordable."

HHS Proposed Rule

To supplement the ACA's procedures for determining an individual's eligibility for exemptions from shared responsibility payments, the HHS proposed rule sets forth standards and processes by which an Exchange will make eligibility determinations and grant exemptions. The intent of the rule is to implement the relevant provisions while continuing to afford states substantial discretion in the design and operation of an Exchange, with greater standardizations provided where directed by statute or where there are compelling practical, efficiency, or consumer protection reasons.

IRS Proposed Rule

The IRS Proposed Rule addresses the obligation of each taxpayer for a shared responsibility payment for himself and any dependents who, for a calendar month, do not have minimal essential coverage and are not exempt from this payment obligation. Under the proposed rule, an individual has minimal essential coverage for a calendar month if the individual has such for one day of the month. Moreover, the rule clarifies that a taxpayer is liable for shared responsibility payments of any individuals for which the taxpayer can receive a personal exemption deduction, regardless of whether the taxpayer actually claims the individual as a dependent. Lastly, the rule further explains the exemptions of the payment obligation as set forth in the ACA.

IRS Final Rule

In May 2012 the IRS released final regulations regarding eligibility for the health insurance premium tax credit available to certain low-income individuals who purchase a qualified health plan from an Exchange. The January 30, 2013 IRS Final Rule supplements these regulations, providing guidance on when an employer-sponsored plan is considered "affordable" for an individual related to the employee, for purposes of

eligibility for a premium tax credit. Under the ACA, employees may be eligible for a premium tax credit to purchase health insurance through the future health insurance exchanges if, among other reasons, the employer plan is deemed to not be affordable. The IRS Rule finalizes that a plan is affordable if the portion of the annual premium the employee must pay for self-only coverage does not exceed 9.5% of the employee's household income, for taxable years beginning before January 1, 2015. For related individuals, the required contribution is based on the premium the employee would pay for employer-sponsored family coverage. These final regulations apply to taxable years ending after December 31, 2013.

Essential Health Benefits

Under the ACA, non-grandfathered health plans in the individual and small market, Medicaid benchmark and benchmark-equivalent plans, and Basic Health Programs, must cover ten categories of essential health benefits (EHBs) beginning January 1, 2014. The ACA seeks to ensure that the scope of EHB is the same as that of benefits provided by a typical employer plan. In general, EHBs must be covered by individual and small market plans both inside and outside of an Exchange. EHBs, however, are different from the minimum essential coverage required to circumvent shared responsibility payments—insurance coverage need not include essential benefits to be minimum essential coverage. In addition to offering EHBs, non-grandfathered plans must meet specific actuarial values (AVs), ranging from 60% for a bronze plan, 70% for a sliver plan, 80% for a gold plan, and 90% for a platinum plan (referred to as "metal levels").

HHS Final Rule

The Final Rule defines EHB based on a state-specific benchmark plan, whereby the state selects such a plan from several options and all plans required to offer EHBs must offer benefits substantially similar to those offered by the benchmark plan. The Rule reiterates that States will still maintain their role in defining the scope of insurance benefits and can do so through choosing a benchmark plan that reflects the States' benefit priorities. Should the selected benchmark plan not contain all ten categories of EHBs, the Rule provides for the State of HHS to supplement the plan by utilizing another available base-benchmark plan's category.

Additionally, HHS is now providing an AV Calculator, whereby issuers can determine health plan AVs based on a standard population. The Rule finalized that a plan can meet a particular AV level if it does so within two percentage points of the standard. Further, the Rule sets forth an accreditation timeline for issuers offering coverage in a non-state operated marketplace.

The Individual Mandate's Impact on Health Care Providers

Importantly for health care providers, and despite the CBO's predictions that only two percent of Americans will owe a shared responsibility payment, the individual mandate does not address how hospitals will obtain full payment for services provided to certain categories of individuals based on their insurance status. At least three of these categories are as follows:

- Individuals who qualify for health insurance coverage but who have elected to pay the penalty in lieu of obtaining coverage;

- Individuals who are exempt from being penalized for not having health insurance and who are also not covered by either private insurance or a government program (e.g. those under religious exemption, undocumented immigrants, family income below a certain threshold, among others); and,

- Individuals who have insurance plans which cover a minimal amount of the patient's actual health care costs (e.g. "bronze" level plans, as described in the ACA).

Further affecting a hospital's ability to obtain full payment for services, certain states have chosen to expand their Medicaid programs, as originally required by the ACA. While fewer patients in these states will remain uninsured, more patients' health care reimbursement to providers in these states could be at Medicaid rates.

Thus, although it is too early to know the full extent, some of the previously existing challenges of providing care for uninsured and underinsured patients will continue for providers. With implementation not starting until 2014 however, providers have some time to assess how the new individual mandate regulations will affect revenue and begin to take steps to address and minimize the impact of the individual mandate in advance of its full implementation. One step that providers may be able to take in the near term would be to begin to examine their existing charity care or bad debt policies in light of these new regulations.

Moving Forward

HHS are IRS are currently seeking comments on these proposals. Comments on the Treasury Department (IRS) proposed regulations are due by May 2, 2013, and a public hearing will be held on May 29, 2013. Comments on the HHS proposed regulations are due by March 18, 2013.

- To read the HHS proposed rule, visit here.
- To read the IRS proposed rule, visit here.
- To read the IRS final rule, visit here.

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