SUTHERLAND

LEGAL ALERT

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Guidance on Purchasing Health Coverage in an Insurance Exchange

On August 17, 2011, the Departments of Health and Human Services (HHS) and Treasury, respectively, issued guidance on (1) the ability of individuals and small employers to purchase health coverage in an insurance exchange, and (2) the premium tax credits for individuals who buy that coverage and whose income is between 100% and 400% of the federal poverty level (FPL). Though neither set of rules has a direct impact on large employers, the rules have some implications for large employers under the so-called "employer shared responsibility" requirements. In addition, the preamble to the proposed Treasury regulations includes several statements regarding rules that are expected to be included in forthcoming guidance on the employer shared responsibility and other related rules.

Background

Section 1501 of the Patient Protection and Affordable Care Act (PPACA) amended the Internal Revenue Code (Code) to add section 5000A implementing the individual mandate effective for taxable years after 2013. The individual mandate requires individual taxpayers to obtain health coverage that provides minimum essential coverage for themselves and their dependents or pay a penalty.

Under section 1301, et seq. of PPACA, states must establish insurance exchanges by 2014. The exchanges are to offer qualified health plans to be issued by insurance carriers and that cover essential health benefits in 10 categories with specified limits on cost-sharing for covered individuals. The plans are to pay, an average, of at least 60% of the cost of covered services for bronze plans, 70% for silver plans, 80% for gold plans and 90% for platinum plans.

Code section 36B, which was added by section 1401 of PPACA, provides for a premium tax credit to help individuals buy coverage in an exchange if they meet certain income and other requirements. The exchanges are to determine individuals' eligibility for the premium tax credits, and the tax credits generally are to be advanced by Treasury to the insurers who provide coverage to these individuals. The Treasury regulations proposed to implement these tax credits effective for taxable years after 2013 are discussed below.

Section 1402 of PPACA provides for certain reductions in cost-sharing for individuals whose income is between 100% and 400% of the FPL and who buy silver coverage through an exchange.

The shared responsibility provisions of Code section 4980H, which was added by section 1513 of PPACA, apply to large employers, i.e., generally, employers that employ an average of at least 50 full time employees. Code section 4980H specifies that large employers that do not offer minimum essential health coverage to employees generally must pay a tax of up to $2,000 per full time employee if any employee enrolls in an exchange plan and the exchange certifies the employee is eligible for the premium tax credit or reduced cost-sharing under section 1402 of PPACA. This section of the Code also provides that any large employer that offers health coverage that is unaffordable or does not provide minimum value must pay a tax of up to $3,000 per full time employee who elects coverage through an exchange and qualifies for a premium tax credit or reduced cost-sharing.

Guidance Issued to Date on Exchange

HHS and Treasury have been issuing guidance related to the exchange in stages, including:

- A request for comments on August 3, 2010;
- Initial guidance to states on November 18, 2010;
- A proposed regulation on the application, review and reporting processes for waivers for state innovation on March 14, 2011;
- Two sets of proposed regulations that set forth requirements for states that elect to establish exchanges, outline minimum requirements for participating issuers, outline standards for employees that elect to participate in the Small Business Health Options Program (SHOP), and describe health insurance premium stabilization policies in PPACA on July 15, 2011; and
- Three sets of proposed regulations on the premium tax credits (summarized below); the process of determining eligibility for enrollment in an exchange plan (also summarized below); and coverage under Medicaid, the Children's Health Insurance Program (CHIP) and state health coverage programs.

Premium Tax Credits

The proposed Treasury regulations establish rules regarding the individuals eligible for a premium tax credit, the amount of the credit and the requirements for individuals who receive a credit to reconcile on their tax returns the credits received and the credits to which they are ultimately entitled. The regulations also require exchanges to report to covered individuals information on credits received on their behalf so that they will be able to complete the reconciliation on their tax returns.

General Rule. The general rule is that individuals can obtain a premium tax credit if they (1) buy coverage in an exchange, (2) have household income between 100% and 400% of the FPL for the family's size, (3) are not eligible for minimum essential coverage under another plan, other than in the individual insurance market, (4) may not be claimed as a dependent of another taxpayer, and (5) if married, file a joint tax return. In addition, the individuals must be lawfully present in the U.S., which all citizens are, and not be in jail. The tax credit is generally not available to individuals whose household income is less than 100% of the FPL since those individuals are generally eligible for Medicaid.

Eligibility for Employer Plan. Individuals are treated as eligible for an employer-sponsored group health plan providing minimum essential coverage only if (1) that coverage is both affordable and has at least a minimum value, or (2) the individual enrolls in the employer plan. The coverage is considered affordable only if the employee contribution for self-only coverage under the plan would be no more than 9.5% of the individual's household income, as further defined in the proposed rule. The rules clarify that this affordability test is always based on the employee premium for self-only coverage for employees and related individuals the employees are eligible to cover; the employee cost for family coverage is not used. A plan has a minimum value under these rules only if it covers 60% of the costs of medical care. An individual who becomes eligible for an employer plan that is determined by an exchange to be affordable and to have a minimum value but who chooses not to enroll in that plan during an applicable open enrollment or special enrollment period will generally be treated as eligible for that coverage (and, thus, not eligible for the premium tax credit) for the balance of the plan year. In contrast, an individual who becomes eligible for COBRA or other continuation coverage is treated as eligible for that coverage only if he or she chooses to enroll in it.

Exceptions. The proposed regulations include several exceptions to the general rules that are favorable to individuals seeking to benefit from the premium tax credit who might not qualify for a credit if the rules were strictly applied. Specifically:

- If an exchange determines an employer plan is not affordable to an individual but his or her income changes so that the plan ultimately is affordable, the plan is treated as not being affordable for the year based on the exchange's initial determination.
- If an exchange determines an individual will meet the income rules but the individual's income ultimately is less than 100% of the FPL and the individual has gotten a premium tax credit, the individual is treated as eligible for the months for which the tax credit was provided.
- Because aliens are not eligible for Medicaid even if they are lawfully present in the U.S., a special rule provides that an alien who is lawfully present in the U.S. and whose income is less than 100% of the FPL is treated as eligible for the premium tax credit.
- Under the general rule, an individual's eligibility for minimum essential coverage is determined on the first day of the first full month of coverage. However, a special rule provides that an individual who becomes entitled to retroactive coverage (e.g., for Medicaid) is treated as eligible for that coverage only after approval so as not to cut off his or her eligibility for the premium tax credit retroactively.

Amount of Credit. The premium tax credit for an eligible individual and his or her family is determined on a monthly basis and is equal to the lesser of (1) the actual premium paid for coverage in the exchange, or (2) an adjusted premium for the second lowest cost silver plan available to the individual and his or her family minus a percentage of his or her income, which represents the individual's required contribution for coverage. This percentage of income or required contribution is determined under a table in the proposed regulations that applies on a sliding scale based on the individual's income as a percentage of the FPL; i.e., for an individual whose income is 133% of the FPL, the required contribution is 2% of income.

Points of Interest for Large Employers. As noted above, though these rules have no direct impact on large employers, there are some significant implications of the rules for employers, and the preamble to the proposed regulations also indicates positions Treasury intends to take on related rules in forthcoming guidance.

- As described above, affordability of an employer plan for an employee and any related individual is tested on the basis of the employee contribution for self-only coverage, even if the contribution for family coverage exceeds the affordability threshold of 9.5% of income. This rule makes it less likely a plan will be considered unaffordable, which would subject the employer to the $3,000 shared responsibility tax.
- Though this affordability test for the premium tax credit is based on the cost of self-only coverage, the preamble says future regulations are expected to apply the similar affordability test for the individual mandate under Code section 5000A to an employee's family members based on the employee's required contributions for family coverage under the employer plan.
- According to the preamble, the employer shared responsibility rules to be addressed in future regulations are expected to include a safe harbor under which employers can determine affordability of employee contributions under their plans based on employees' W-2 wages, rather than on their household income, on which eligibility for the premium tax credit is based. This alleviates employers' concerns as to how they would obtain information on employees' household incomes. The preamble also says IRS and Treasury intend to request comments on this safe harbor.

- The preamble also says that regulations defining minimum essential coverage are expected to provide that an employer plan will not fail to be considered minimum essential coverage solely because it is self insured.
- Regulations defining essential health benefits under section 1302 of PPACA are expected to be proposed later this year. The preamble indicates the regulations:
  - are not expected to require either employer plans or health insurance in the large group market to provide each of the essential health benefits or even benefits in each of the 10 identified categories; and
  - will seek to foster the preservation of the current system under which health coverage is primarily provided by employer plans without allowing the employer responsibility standards under PPACA to be avoided.

  On a related note, the preamble says the agencies writing the regulations are considering whether employers need transition relief regarding the minimum value requirement.

Comments on the proposed regulations are due by October 31, 2011. Once they are final, the rules will be effective on January 1, 2014, the effective date for the exchanges.

Eligibility for Participation in Exchanges

The HHS proposed regulations address eligibility for participation in and subsidies under the exchanges, and standards for small employer participation in SHOP. SHOP provides access to exchange-based health plans to employers with up to 100 employees. The proposed rule states that future HHS guidance will address additional exchange-related issues, including exemptions from the individual mandate, benefits design standards for plans offered through the exchange (including the definition of essential health benefits), and quality standards for exchanges and issuers.

The proposed rules provide that, upon an individual's application to an exchange for coverage, the exchange will use a single, streamlined system to determine the individual's eligibility for (1) participation in the exchange, (2) any premium tax credit and discount programs, and (3) any state Medicaid or CHIP programs. The exchange will also take responsibility for enrolling the individual in the program(s) for which he or she is determined to be eligible. In conjunction with these rules, HHS has also proposed simplified eligibility rules for Medicaid and CHIP that align the new Medicaid eligibility process with eligibility rules for premium tax credits and cost-sharing reductions under the exchange based on an individual's modified adjusted gross income.

The exchange eligibility rules also set residency standards for participation in an exchange program in an individual's "service area." Under the proposed rule, individuals will be eligible to participate in the exchange that covers the service area where they reside, intend to reside, or where the primary taxpayer resides (in the case of a spouse or a dependent). The proposed rules also outline the procedure for the acceptance of applications by the exchange, standards for making eligibility determinations and notifying individuals, and the process for providing advance payments of premium tax credits to eligible exchange participants. Under the regulations, the exchange will be responsible for notifying individuals of their eligibility status, and, in addition, will notify state Medicaid or CHIP programs regarding eligibility and enrollment in those programs. If an individual is determined to be eligible to receive premium tax credits or cost-sharing reductions because his or her employer's coverage is not affordable or does not have minimum value (as determined under section 1513 of PPACA), the exchange will notify the employer. The preamble to the HHS regulations indicates that future guidance will include additional information on the content of this notice. Presumably that guidance will clarify how a determination of affordability of employer coverage by an exchange based on an individual's household income is to be coordinated with

an employer's determination based on the employee's W-2 wages. The proposed rules also provide for processes that will require exchanges to provide annual verification of information needed to determine eligibility for premium tax credits and cost-sharing reductions (i.e., citizenship status, income, eligibility for employer coverage, etc.), and standards for sharing and coordinating this information with state Medicaid, CHIP and Pre-Existing Conditions Insurance Programs.

Finally, the regulations also propose standards for small employer participation in SHOP, including a provision that will allow employers that initially qualify for the program to continue to participate if the number of employees surpasses the 100-employee limit, provided the employer continues to meet other SHOP eligibility criteria. In addition, the proposed regulations include rules on certain notice and reporting requirements applicable to SHOP employers.

Comments on the proposed rules are due by October 31, 2011. Once finalized, the rules will be effective on January 1, 2014, the effective date for the exchanges.

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If you have any questions about this Legal Alert, please feel free to contact any of the attorneys listed below or the Sutherland attorney with whom you regularly work.

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