HealthReformGPS
NAVIGATING IMPLEMENTATION
A project of the George Washington University's Hirsh Health Law and Policy Program and the Robert Wood Johnson Foundation

Update on Eligibility for Exemptions from the Personal Responsibility Tax Penalty and Designating Certain Health Benefits Coverage as Minimum Essential Coverage

By Sara Rosenbaum

Introduction

On July 1, 2013, HHS issued final implementing regulations[1] that specify which individuals may be eligible for exemptions from the Shared Responsibility penalty payment, a special tax established under the Affordable Care Act (ACA) that applies to non-exempt individuals who have access to affordable insurance but fail to purchase it.[2] The final rule also explains the role of Exchanges in granting "certificates of exemption" from the penalty payments, and identifies the range of health benefits that the government will consider as satisfying the Act's "minimum essential coverage" rule. The final rule shows some, but not a lot, of changes from its original proposed form.[3]

This update summarizes the highlights of the final rule.

Background

Under the ACA, nearly all Americans are required to maintain minimum essential coverage if it is affordable, and are subject to a tax penalty if they fail to do so. A very small number of people are entirely exempt from this obligation, as discussed below. Everyone else is subject to the coverage requirement and must either demonstrate that they have minimum essential coverage or pay a tax penalty. Non-exempt individuals may, however, qualify for an exemption from the penalty payment itself if they fit one of the categories recognized under the law.[4]

The ACA also specifies a role for Exchanges in implementing the tax penalty provisions. Under the Act, Exchanges are responsible for determining eligibility for and issuing certificates of exemption,[5] although the responsibility for making determinations regarding certain exemptions is reserved exclusively to the IRS, as part of individual tax filings. The HHS Secretary, in coordination with the Secretary of the Treasury, is responsible for designing the regulations that will in turn govern the provision of tax credits and cost-sharing reduction assistance, as well as the granting of exemptions.[6] Proposed Treasury Department regulations[7] have not yet been issued in final form.

The Final HHS Rule

The final regulation specifies as follows:

Exchange functions in the individual market: granting exemptions

The final rule[8] set forth the definitions that Exchanges must use in making their determinations of whether individuals are exempt from shared responsibility payments. (Exchanges have the option of contracting with an HHS service to carry out exemption determinations.[9])

The final rule clarifies that for purposes of information that is based on attestations, electronic data will be considered reasonably compatible if the "difference or discrepancy does not impact the eligibility of the applicant for the exemption or exemptions for which he or she applied.[10]

The final rule further provides that the exemptions are to be issued on a month-specific basis, meaning that the Exchange must decide which months during the tax year are covered by the exemption.[11] Exemptions are good only for the calendar year in which they are sought, meaning they must be renewed.

In the case of exemptions based on religious conscience (which exempt individuals totally from the obligation itself, not just the penalty), the exemption can last until an individual's 21st birthday or until the individual reports that he or she no longer meets the requirement applicable to the religious exemption under §1402(g) of the Internal Revenue Code.[12] The final rule also specifies exemptions from the minimum essential coverage obligation to members of Indian tribes, months of incarceration (other than incarceration pending disposition), and individuals covered through Health Care Sharing Ministries as defined under the Code.[13] In the case of Indian tribes, the exemption must be granted on a continuing monthly basis until the individual reports that he or she is no longer a member of the tribe.[14]

Exchanges must grant hardship exemptions to applicants under certain circumstances. These exemptions must begin the month before the application (i.e., be retrospective) and must last for the month or months during which the hardship happens, and must continue through the month after the hardship ends.[15]

The final rule lists certain general hardship categories that would qualify a non-exempt person from having to pay the tax penalty:[16]

- "financial or domestic circumstances, including an unexpected natural or human-caused event, such that he or she had a significant, unexpected increase in essential expenses that prevented him or her from obtaining coverage under a qualified health plan"

- "the expense of purchasing a qualified health plan would have caused him or her to experience serious deprivation of food, shelter, clothing, or other necessities"

- the applicant "experienced other circumstances that prevented him or her from obtaining coverage under a qualified health plan"

The rule also identifies certain other exemptions from having to pay the penalty:

- months during which the applicant experiences a lack of affordable coverage from an employer. An exemption claimed on this basis is based on an offer of minimum essential coverage from an employer (i.e., one that meets the 60% actuarial value threshold required under the Act). The applicant will be exempt for any months during which either the applicant or the applicant's family member is unable to afford coverage. This determination requires an annual income projection using household income.
    - In cases in which the exemption is sought for members of a family, the rule requires that Exchanges project income against the lowest cost family coverage plan available from the employer.
    - In the case of applicants who smoke, the affordability test would use the cost of the employer plan assuming that the smoker cannot satisfy any tobacco-related wellness incentives the plan might use.

- Similarly, in determining affordability, the final rule provides that other employer wellness incentives are treated as "not earned" for purposes of measuring their affordability against the applicant's projected household income. In other words, the final rule uses the highest price of the plan to determine affordability.

- Individuals with incomes below the federal tax filing threshold. This exemption can be claimed for a calendar year.

- Individuals ineligible for Medicaid based on a state's decision not to expand. This exemption would be for a calendar year if the individual has applied for Medicaid and has been found ineligible based on the state's refusal to expand its program.

- Individuals who have affordable self-only coverage under their employer-sponsored plans, if their other employed family members also are determined eligible for coverage under *their* employer's plan but if the total cost of paying the premiums for all working members of the household with access to coverage exceeds 8% of family income.

- Individuals during any month in which they are eligible for services from an Indian Health Service provider, and who are not already exempt as Indians.

Exemption eligibility determination process

The final rule sets forth the following process for determining eligibility for exemptions:[17]

- The rule requires Exchanges to use the HHS application unless they elect to use an alternative application approved by HHS.

- If an exemption applicant has first sought QHP coverage and insurance affordability program assistance and then seeks an exemption, the final rule requires the Exchanges to use the same information unless additional information is needed. The rule bars repeat requests for documentation and verification.

- The rule requires Exchanges to accept an exemption application and must provide an application tool. The rule also places limits on the collection of Social Security numbers to those that would be necessary to determine the exemption.

- The rule requires application determinations "promptly and without undue delay, using the time frame between the application date and the date of notification of the determination as the period in question for promptness determinations.

- The rule places a 3-year look-back window to the date of the hardship month or months on when applicants can file for exemptions.

- The rule also sets forth verification procedures to be used in the exemption application process.[18] The process covers verifications needed to secure a religious exemption, membership in a health care sharing ministry, an incarceration exemption, Indian tribal exemption[19], and hardship exemptions.

- The exchange must accept an "application filer's attestation for an applicant regarding eligibility for minimum essential coverage other than through an eligible employer-sponsored plan."

- Where information cannot be verified, including situations in which electronic data are needed, the final rule specifies a 90-day process that Exchanges must use to try to get alternative data sources, and provides that if Exchanges are unable to verify based on the data they have, a determination must be made based on the best available evidence.[20] The rule also provides for case-by-case "special circumstances," under which Exchanges can verify based on attestations alone when "documentation does not exist or is not reasonably available and for whom the Exchange is otherwise unable to resolve the inconsistency."

- The final rule also provides that HHS will approve Exchange Blueprints that modify information collection procedures, "provided that HHS finds that such modification would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delays," and ensure that privacy and confidentiality requirements are satisfied.[21] The final rule bars Exchanges from collecting "beyond the minimum necessary to support the eligibility process for exemptions."[22]

Exemption redeterminations

The final rule also provides a process for re-determining exemptions during the calendar year and requires Exchanges to maintain a process by which exemption recipients can report changes that would affect the exemption within 30 days of the change.[23]

Appeals

The final rule specifies that exemption determinations must include a notice of the right to appeal under appeals procedures set forth in 45 C.F.R. §155.610 and §155.625.

What constitutes minimum essential coverage?

The final rule also identifies "other coverage" that qualifies as minimum essential coverage for purposes of meeting the individual responsibility requirements of the ACA: self-funded student health plans (but only for the 2014 plan year; in later years plans must apply under the "other coverage" catch-all discussed below);[24] refugee medical assistance programs; Medicare Advantage plans; state high risk pool coverage. The final rule rejects automatic recognition of AmeriCorps plans as other coverage, instead requiring the plans to submit requests to be designated under the "other coverage" catch-all.[25]

The final rule specifies a catch-all "other coverage" standard that allows other coverage that meets the following criteria:[26]

- The plan must meet "substantially all" ACA requirements related to coverage in the non-grandfathered individual insurance market.

- The sponsor of the "other coverage" must provide information to HHS related to its identity, basic information about the plan, the name, title, address, and phone number of the individual authorized to make the representation, information about enrollees, eligibility criteria, cost-sharing requirements including deductible and cost-sharing rules, and a certification of compliance with the ACA's coverage rules in the individual non-grandfathered market.

- The rule also provides that CMS will provide a list of all types of coverage that have been recognized as meeting the minimum essential coverage standard as well as notifying the public of the revocation of any such coverage. The rule also specifies that plans qualifying as other coverage must comply with the information reporting requirements applicable to all plans under §6055 of the Internal Revenue Code, as provided for by the ACA.

- The final rule rejects a commenter suggestion that specific timeframes for data submission be established by regulation but notes that such timelines may be added "while developing this administrative process" for submission of other coverage information.

Treasury Guidance

In addition to the final HHS rule, the Treasury Department issued Notices 2013-41 and 2013-42.

- 2013-41 provides additional clarification regarding when individuals are entitled to minimum essential coverage under government-sponsored health programs and therefore not entitled to premium tax credits and cost-sharing assistance. The guidance also provides greater detail on when self-funded student health plans and state high risk pools qualify as minimum essential coverage.
    - Individuals locked out of Medicaid or CHIP for a period of time (known as the lock-out period) for failure to pay applicable premiums will be treated as eligible to enroll in government insurance and therefore will be denied premium tax credits.

    - By contrast, individuals denied CHIP enrollment because they are in a waiting period will be eligible to claim premium tax credits, similar to the rule that applies to people who are in waiting periods for employer-sponsored coverage.[27]

    - Individuals awaiting a disability determination will be eligible for premium tax credits during the period when disability is being determined, up until the time of a favorable determination.

    - Individuals whose minimum essential coverage is based on Medicare Part A, state high risk pools, student health plans, and TRICARE programs will be considered eligible for such coverage only when they are enrolled.

- Notice 2013-42 provides transitional relief from the shared responsibility payment for certain individuals whose employer plan years are not tied to the calendar year but instead to an alternative time period (e.g., August 1 2013-July 31 2014). Such individuals who elect not to enroll in their employer plans would not be required to make a penalty payment for the January 1-July 31 period of time in 2014, when their next enrollment opportunity comes up.

Issues

Process for reporting interim information during an exemption period. Individuals who receive exemptions are required to report changes during the exemption period that might affect their exemption. The exact reporting process is not spelled out in the final rule. How the FFE and state-based Exchanges design their exemption reporting systems will be an important issue to watch, as well as the notice given to individuals who receive exemptions regarding the obligation to report changes.

The monthly exemption time period. As with premium subsidies, most penalty exemptions are determined on a monthly basis. Through income projection processes, it is likely that exemptions tied to financial hardship and other financially based exemptions will be granted for periods spanning multiple months. But how the process of reporting monthly changes in income that could affect the exemption will work, remains to be seen. Because of high levels of income fluctuation, especially in the case of lower income wage earners, the group whose exemptions are tied to affordability may be expected to fluctuate considerably.

Designation of "other coverage". The final rule, like the proposed rule, empowers the Secretary to designate "other coverage" that qualifies as minimum essential coverage, using a process (not yet spelled out) that looks at a variety of factors including the scope and quality of the coverage in relation to the Act's requirements for non-grandfathered individual plans. At the same time, the standard set in the rule allows for designation of plans that are "substantially" equivalent to what the individual would receive through a QHP sold in the individual market. How will "substantially" be determined? Using an actuarial test? The final rule does not suggest that the sponsor will have to submit documentation showing actuarial equivalency. This remains an open question.

Hardship exemptions for people locked out of CHIP or Medicaid for failure to pay premiums. The final rule will result in the denial of premium credits to individuals who have been locked out of Medicaid or CHIP for failure to pay premiums. Presumably many of these individuals will have incomes below the federal income tax filing threshold and will qualify for exemptions from the penalty, but this, of course, leaves these people uninsured. It will be extremely important to track over time the group of individuals who receive exemptions because they are low income but who require the exemptions because they could not afford the premiums.

Eligibility tied to enrollment in governmental programs. Note that in the case of certain government insurance, individuals will not be considered eligible for minimum essential coverage unless they are actually enrolled (Medicare Part A, TRICARE). This is not the case for individuals eligible for CHIP or Medicaid. If these individuals appear eligible for CHIP or Medicaid, they will be either enrolled in those programs or assessed and referred to the state CHIP or Medicaid agencies. While their final eligibility

determinations are pending (in states that have elected to limit the Exchange to screen and assess only), these individuals will not be able to obtain premium tax credits.

---

[1] 78 Fed. Reg. 39494.
[2] ACA §1501, codified at §5000A of the Internal Revenue Code.
[3] 78 Fed. Reg. 7348, Feb 1, 2013.
[4] ACA §1501, IRC §5000A(e).
[5] ACA §1311(d).
[6] ACA §1411.
[7] 78 Fed. Reg. 7314, Feb. 13, 2013.
[8] 45 C.F.R. §155.600 et seq.
[9] 45 C.F.R. §155.625.
[10] 45 C.F.R. §155.600(c).
[11] 45 C.F.R. §155.605.
[12] IRC §1402(g)(1) provides a narrow exemption for individuals for people whose religious beliefs bar them from participation in any public or private insurance program.
[13] 45 C.F.R. §155.605.
[14] 45 C.F.R. §155.605.(f)(2).
[15] 45 C.F.R. §155.605(g).
[16] *Id*.
[17] 45 C.F.R. §155.610.
[18] 45 C.F.R. §155.615.
[19] The Preamble of the final rule, p. 39510 notes that the FFE will initially rely on paper documentation regarding tribal status.
[20] 45 C.F.R. §155.615(g).
[21] 45 C.F.R. §155.615(h).
[22] 45 C.F.R. §155.615(j).
[23] 45 C.F.R. §155.620.
[24] This is a change from the proposed rule.
[25] This is a change from the proposed rule.
[26] 45 C.F.R. §155.604.
[27] Note that while the ACA limits waiting periods, it does not bar them entirely. The ACA allows up to a 90-day waiting period. PHSA §2708, added by PPACA §1201. See 78 Fed. Reg. 17313 (March 21, 2013).