5-30-2014

Some Basics on the Individual Mandate, Subsidies, and Medicaid Expansion

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As of January 1, 2014, the Patient Protection and Affordable Care Act (PPACA) requires most U.S. citizens and lawful residents to either have "minimum essential coverage" or to pay a federal tax. This provision is known as the "Individual Mandate". The PPACA also requires each state to have a "Health Insurance Marketplace" (formerly called an Exchange) where individuals and small employers can purchase health insurance policies. People who have health coverage through employment or through a government program (such as Medicare, Medicaid or others) are not required to buy insurance in a Marketplace. This article explains the Individual Mandate, Subsidies, and the Medicaid Expansion provisions of the PPACA.

The Individual Mandate

Q1. Is everyone required to have health coverage or pay a tax?

No, there are specified exemptions and exceptions. Most U.S. citizens and lawful residents are required to have health coverage, but the following individuals are exempt from the requirement:

- Individuals who are incarcerated
- Individuals with a "religious-conscience exemption" (applies only to certain faiths)
- Individuals who are not lawfully present in the U.S. (undocumented)

Additionally, the tax will not be imposed on the following categories of individuals even though they are otherwise subject to the mandate to have health coverage:

- Individuals who cannot afford coverage because the premium for the lowest cost bronze policy is more than 8% of household income
- Individuals with income below the federal income tax filing threshold (for 2013 this is $9,500 for singles filers under age 65 and $19,000 for couples under age 65)
- Members of federally recognized American Indian tribes
- Individuals who were uninsured for short coverage gaps of less than three months
- Individuals who have received a "hardship" waiver from the Secretary
- Individuals who are residing outside of the United States or are bona fide residents of any possession of the United States.

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Q2. How much is the tax on individuals who do not have insurance or government health benefits?

The tax is the greater of the following amounts:

- 2014: $95 per person per year, or 1% of household income (MAGI*)
- 2015: $325 per person per year, or 2% of household income (MAGI*)
- 2016: $695 per person per year, or 2.5% of household income (MAGI*)

* MAGI is Modified Adjusted Gross Income. It is calculated by adding back certain items to your Adjusted Gross Income (e.g., IRA contributions that were deducted). Adjusted Gross Income (AGI) can be found on line 38 of Form 1040; line 22 of Form 1040A; or line 36 of your 1040NR (see IRS Publication 590, page 17, for a worksheet to calculate MAGI from AGI).

The above amounts are subject to several limitations:

- The "household income" tax amount cannot exceed the national average for a bronze level plan
- For children under age 18, the tax amount is half the specified amount
- For a family, the maximum "fixed dollar" tax amount cannot exceed the tax on three adults (e.g., for 2016, the maximum tax on a family with no health coverage is $2095, which is 3 x $695)

Subsidies in the Individual Exchange

Q3. What are the requirements to qualify for a subsidy?

The first requirement is that the subsidies only apply to qualified individuals who purchase health insurance in the individual Marketplace. They do not apply to insurance purchased outside the individual Marketplace, such as in the SHOP Marketplace, in private marketplaces, or from employer-provided or Union plans.

Second, the subsidies are only available to "qualified individuals" – defined as U.S. citizens or lawful residents with household income equal to 100%-400% of the FPL, who are not eligible for government health benefits (such as Medicare, Medicaid, SCHIP, Tri-Care or others) and not eligible for "affordable" employer-provided coverage that provides at least "minimum value" (defined as 60% actuarial value, as noted previously). See below for a matrix of FPLs dollar amounts by household size. Also note that in states that have expanded Medicaid eligibility to 138% of FPL, individuals with household income up to 138% of FPL will not be eligible for a subsidy.

It is worth reiterating that individuals who have affordable employer-based coverage available are not eligible for subsidies if they decline the employer coverage. They can purchase coverage in the Marketplace, but they will not be eligible for a subsidy. The "affordability" test is: the employee cost for self-only coverage cannot be more than 9.5% of household income.

Based only on household size and income, the following individuals will be eligible for subsidies in 2014 (this is based on household incomes of 138%-400% of the FPL, as detailed in the matrix below):

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- Individuals with an annual household income of $15,856 - $45,960
- Couples with an annual household income of $21,404 - $62,040
- Family of four with an annual household income of $32,499 - $94,200

Q4. How much are the subsidies for purchasing health insurance in the individual Marketplace?

There are two different types of subsidies: 1) Advanced Premium Tax Credits (APTC), and 2) Cost-sharing Reductions. The amounts of each will vary for different individuals or families depending on their household income level (as a percentage of the Federal Poverty Level, or FPL). See below for a matrix of FPLs.

1) Advanced Premium Tax Credit (APTC): The advance premium tax credit helps individuals and families afford the premium for health insurance. The federal government pays a specified amount each month directly to the health insurer in whose policy the individual and/or family members have enrolled. Enrollees do not have to pay the full premium and then request reimbursement from the government when they file a tax return after the end of the year. The premium assistance amount is applied when the individual or family first enrolls, and each month they pay only the net premium amount (i.e., the total premium minus the federal subsidy).

The premium tax credit amount is calculated using a formula that is based on:

- The premium for the second-lowest cost silver plan (for a particular individual based on geographic area, age and family tier), and
- The individual's household income above the tax filing threshold amount.

Specifically, the formula provides that the premium tax credit amount will be:

- The premium for the second-lowest cost silver plan (for a particular individual based on geographic area, age and family tier), minus
- The individual's *expected contribution,* which is the following percentage of household income above the tax filing threshold:
    - 2% if household income is less than 133% of the FPL
    - 3-4% if household income is 133-150% of the FPL
    - 4-6.3% if household income is 150-200% of the FPL
    - 6.3-8.05% if household income is 200-250% of the FPL
    - 8.05-9.5% if household income is 250-300% of the FPL
    - 9.5% if household income is 300-400% of the FPL

See below for a table showing 2013 FPLs (dollar amounts) for different size households.

The second lowest-cost silver option is called the "benchmark" plan. If a family or individual chooses a plan that is less expensive than the benchmark plan, the net cost will be less, but no one will be eligible for a refund by choosing a lower-cost plan.

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2) Cost-sharing Reductions: "Cost-sharing" is the amount an enrolled individual pays for deductibles, co-pays, coinsurance and other out-of-pocket costs for in-network services. It does not include amounts paid for premiums, out-of-network services, or non-covered expenses. Cost-sharing reductions are available only to individuals with household incomes up to 250% of the FPL who buy the silver level plan. The lower the income level, the higher the cost-sharing reduction. Cost-Sharing reduction amounts can be significant for lower income households. Two examples, from "Covered California's 2014 Sliding Scale Plans – Single Person":

- If the regular primary care office visit co-pay is $45, individuals with household incomes of 200% and 150% of the FPL would pay only $20 and $4, respectively.
- If the regular out-of-pocket maximum for an individual is $6,350, individuals with household income of 100-250% of the FPL would pay only $2,250.

These cost-sharing reductions might increase the actuarial value of an individual's health insurance policy, in some cases increasing a silver level plan to a gold plan.

The following matrix shows the dollar amounts of the FPLs for various household sizes. (This matrix applies in the 48 contiguous states. Separate tables apply for Alaska and Hawaii. These tables are at http://aspe.hhs.gov/poverty/13poverty.cfm (*accessed August 19, 2013*).

2013 Federal Poverty Level, by Family Size							
Family Size	**100% FPL**	**138% FPL**	**150% FPL**	**250% FPL**	**300% FPL**	**350% FPL**	**400% FPL**
1	$11,490	$15,856	$17,235	$28,725	$34,470	$40,215	$45,960
2	$15,510	$21,404	$23,265	$38,775	$46,530	$54,285	$62,040
3	$19,530	$26,951	$29,295	$48,825	$58,590	$68,355	$78,120
4	$23,550	$32,499	$35,325	$58,875	$70,650	$82,425	$94,200
5	$27,570	$38,047	$41,355	$68,925	$82,710	$96,495	$110,280
6	$31,590	$43,594	$47,385	$78,975	$94,770	$110,565	$126,360
7	$35,610	$49,142	$53,415	$89,025	$106,830	$124,635	$142,440
8	$39,630	$54,689	$59,445	$99,075	$118,890	$138,705	$158,520

Medicaid Expansion and Subsidies

Q5. What is the "Medicaid expansion" issue and how does it affect eligibility for subsidies?

Starting January 1, 2014, Health Care Reform offers states financial incentives to expand Medicaid eligibility to all state residents with household incomes up to 133% of the FPL. (There is a 5% cushion, so this upper limit actually will be 138% of the FPL in states that implement the Medicaid expansion.) States may opt out of the Medicaid expansion. In states that do not implement Medicaid expansion,, Medicaid is only available to specified categories of poor individuals, such as the elderly, blind, disabled, and families with dependent children. The expansion will make Medicaid available to low-income adults who do not have dependent

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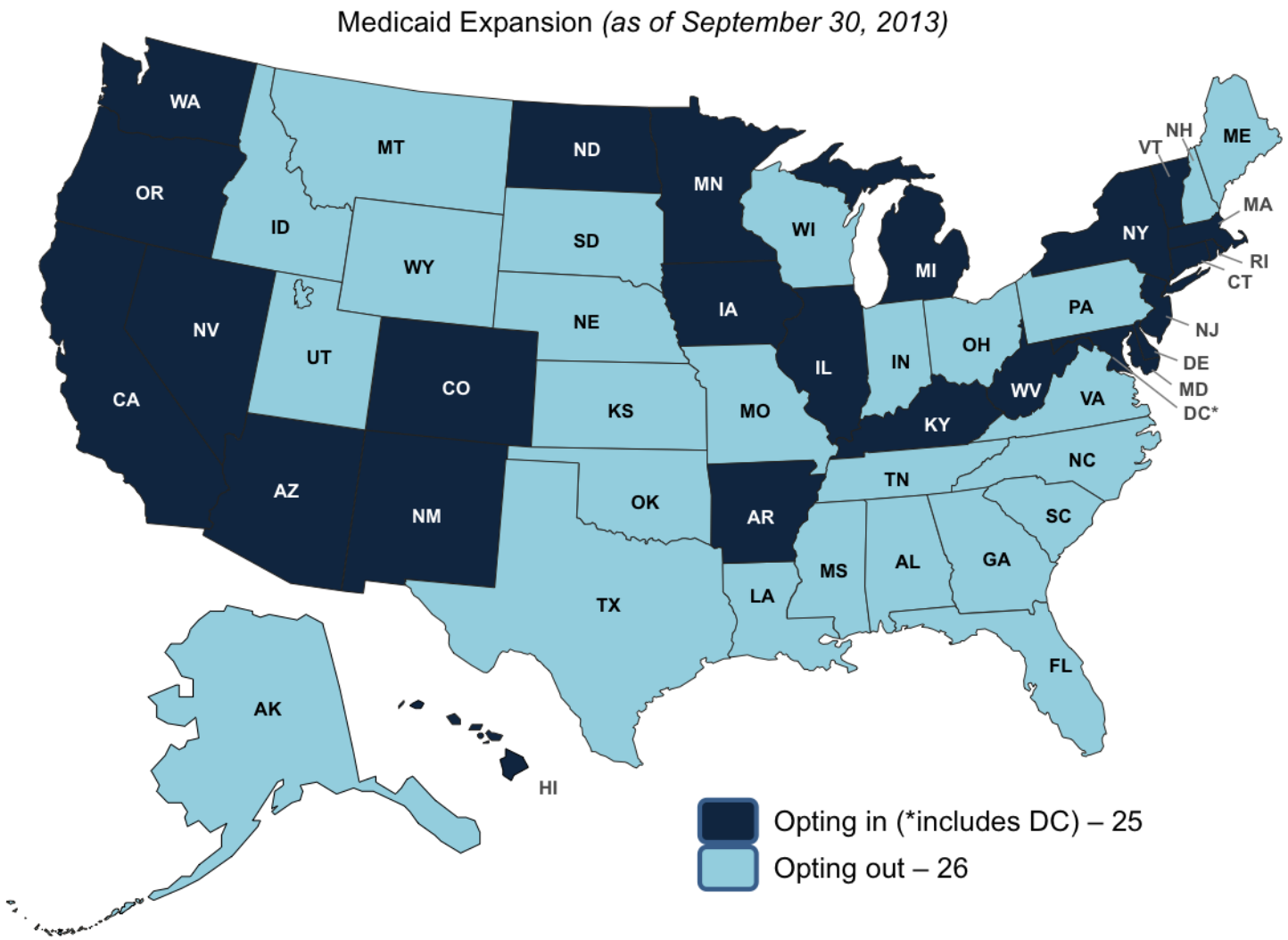
children. Individuals who qualify for Medicaid will not be eligible for a premium tax credit (because they will not have to *buy* insurance in the Marketplace). This affects employers because the "pay-or-play" penalty only applies if a full-time employee qualifies for subsidies, i.e. the premium tax credit or the cost-sharing reductions, to purchase insurance in a Marketplace. Thus, if an individual is covered under Medicaid the employer cannot incur a penalty under PPACA.

If a state does *not* implement the Medicaid expansion it is *more* likely employers in that state will incur penalties, because individuals with household incomes of 100%-400% of the FPL might qualify to receive a premium tax credit. In states that *do* implement the Medicaid expansion, however, only individuals with household incomes of 133% (or 138%)-400% of the FPL can qualify for the tax credit. As of September 2013, 26 states have opted not to implement the Medicaid expansion because it would be too costly, and 24 states plus the District of Columbia have implemented the Medicaid expansion. There is not a deadline by which states must declare their decision, so it remains to be seen which states ultimately will implement the expansion in 2014. As of September 2013, the state Medicaid expansion decisions are as follows:



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