Individual Mandate and Related Information Requirements under ACA

Annie L. Mach
Analyst in Health Care Financing

Manon Scales
Research Associate

Janemarie Mulvey
Specialist in Health Care Financing

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Summary

This report describes the ACA individual mandate. Beginning in 2014, ACA requires individuals to maintain health insurance coverage, with some exceptions. Most individuals will be required to maintain minimum essential coverage, which includes eligible employer-sponsored coverage, individual coverage, grandfathered health plans, and federal programs such as Medicare and Medicaid, among others. Certain individuals will be exempt from the individual mandate. For example, individuals with qualifying religious exemptions and those whose household income is less than the filing threshold for federal income taxes will not be subject to the penalty. Those who do not maintain minimum essential coverage and are not exempt from the mandate will be required to pay a penalty for noncompliance.

ACA also includes several reporting requirements designed, in part, to assist individuals in providing evidence of having met the mandate, as well as other related information about their health insurance. These requirements are also described in this report.

On July 11, 2013, H.R. 2668, the Fairness for American Families Act, was referred to the House Committee on Ways and Means. H.R. 2668 effectively delays implementation of the individual mandate penalty until 2015.

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This report describes the individual mandate under Section 1501 and Section 10106 of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).[1] The report also discusses the ACA reporting requirements designed, in part, to assist individuals in providing evidence of having met the mandate, as well as other related information about their health insurance.

Individual Mandate

Beginning in 2014, ACA, through amendments to the Internal Revenue Code (IRC), includes a mandate for most individuals to have health insurance or potentially pay a penalty for noncompliance.[2] Individuals will be required to maintain minimum essential coverage for themselves and their dependents. Some individuals will be exempt from the mandate and the penalty, while others may receive financial assistance to help them pay for the cost of health insurance coverage and the costs associated with using health care services.

Minimum Essential Coverage

Minimum essential coverage is defined in statute and in regulations as:

- coverage under a government-sponsored plan, including
    - Medicare part A,
    - Medicare Advantage plans,
    - Medicaid,
    - the State Children's Health Insurance Program (CHIP),
    - TRICARE and the TRICARE for Life program,[3]
    - the Department of Veterans Affairs (VA) health care program,[4]
    - the Peace Corps program;
- employer-sponsored plans, with respect to any employee, including
    - coverage offered by an employer which is a government plan,

[1] On June 28, 2012, the United States Supreme Court issued its decision in *National Federation of Independent Business v. Sebelius*, finding that the individual mandate in Section 5000A of the Internal Revenue Code (as added by §1501 of the Patient Protection and Affordable Care Act [ACA]), is a constitutional exercise of Congress's authority to levy taxes. However, the Court held that it was not a valid exercise of Congress's power under the Commerce Clause or the Necessary and Proper Clause.

[2] Section 1501(b) as amended by Section 10106 (b) of P.L. 111-148 and by Section 1002 of P.L. 111-152 adds Chapter 49, Maintenance of Essential Coverage, to Subtitle D of the Internal Revenue Code of 1986.

[3] TRICARE was added in P.L. 111-159.

[4] P.L. 111-173 amended ACA to clarify that coverage for certain VA health care programs would be determined by the Secretary of Veterans Affairs, in coordination with the Secretary of HHS and the Secretary of the Treasury. For more information on VA health care under ACA, see CRS Report R41198, *TRICARE and VA Health Care: Impact of the Patient Protection and Affordable Care Act (ACA)*, by Sidath Viranga Panangala and Don J. Jansen.

    - any other plan or coverage offered in the small or large group market within a state, and any plan established by an Indian tribal government;
- plans in the individual market;
- grandfathered health plans;[5]
- self-funded student health plans;[6]
- Refugee Medical Assistance supported by the Administration for Children and Families;
- state health benefits risk pool;[7] and
- any other coverage the HHS Secretary recognizes as meeting the requirements outlined in 45 CFR §156.604.

Minimum essential coverage does not include health insurance coverage consisting of excepted benefits, such as dental-only coverage.

Penalty

With some exceptions, individuals will be required to maintain minimum essential coverage for themselves and their dependents. Those who do not meet the mandate may be required to pay a penalty for each month of noncompliance. The penalty will be calculated as the *greater* of either:

1. a percentage of the "applicable income," defined as the amount by which an individual's household income exceeds the applicable filing threshold for the applicable tax year. The filing threshold comprises the personal exemption amount (doubled for those married filing jointly) plus the standard deduction amount,[8]
    - the percentage will be 1.0% in 2014, 2.0% in 2015, and 2.5% thereafter, or
2. a flat dollar amount assessed on each taxpayer and any dependents (e.g., family)
    - the annual flat dollar amount phased in—$95 in 2014, $325 in 2015, and $695 in 2016 and beyond (adjusted for inflation),[9] assessed for each taxpayer and any dependents;

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[5] Grandfathered plans are defined as those individual and group plans that an individual or family was enrolled in on the date of enactment (March 23, 2010). A plan that provides group coverage on the date of enactment may provide for the enrolling of new employees (and their families) in such plan. For additional information about grandfathered plans, see CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez.

[6] Self-insured coverage offered to students by institutions of higher education is designated as minimum essential coverage for plan or policy years beginning on or before December 31, 2014. For coverage beginning after that date, sponsors of self-insured student coverage may have to apply to HHS under the process described in 45 CFR §156.604 to be recognized as minimum essential coverage (78 *Federal Register* 39494, July 1, 2013).

[7] These programs are different from the temporary high risk health insurance pool program created under ACA (§1101), which ends on January 1, 2014.

[8] For 2010, the standard deduction was $5,700 and the personal exemption was $3,650, so that generally, the filing thresholds for individuals under age 65 were $9,350 for a single filing status and $18,700 for a married couple filing jointly.

[9] The inflation adjustment will be based on the cost-of-living adjustment (CPI-U), for the calendar year, with any (continued...)

- the amount is reduced by one-half for dependents under the age of 18;
- the total family penalty is capped at 300% of the annual flat dollar amount.

However, the penalty for noncompliance cannot exceed the national average premium for bronze-level-qualified health plans offered through exchanges (for the relevant family size).

Any penalty that taxpayers are required to pay for themselves or their dependents must be included in their return for the taxable year. Those individuals who file joint returns are jointly liable for the penalty. (See the **Appendix** for examples of individual mandate penalties.)

Exemptions

Certain individuals (and their dependents) may be exempt from the penalty. These individuals include those whose household income is less than the filing threshold for federal income taxes for the applicable tax year (filing threshold exemption), as well as those whose required contribution for self-only coverage[10] for a calendar year exceeds 8% of household income (affordability exemption).[11] After 2014, this percentage will be adjusted to reflect the excess rate of premium growth above the rate of income growth for the period. According to proposed regulations, these exemptions may be claimed on an individual's federal income tax return for the taxable year that includes the months for which the exemption is sought.[12]

Certain categories of individuals will be exempt from the individual mandate, including those with qualifying religious exemptions,[13] those in a health care sharing ministry,[14] individuals not

(...continued)

increase that is not a multiple of $50 rounded to the next lowest multiple of $50.

[10] Required contribution is defined as (1) in the case of an individual eligible to purchase minimum essential coverage through an employer (other than through the exchange), the portion of the annual premium that is paid by the individual for self-only coverage, or (2) for individuals not included above, the annual premium for the lowest cost bronze plan available in the individual market through the exchange in the state in which the individual resides, reduced by the amount of the premium credit for the taxable year.

[11] Household income is defined as the modified adjusted gross income (MAGI) of the taxpayer, plus the aggregate MAGI of all other individuals for whom the taxpayer is allowed a deduction for personal exemptions for the taxable year. Modified adjusted gross income is defined as adjusted gross income increased by foreign earned income (section 911 of the IRC) and any amount of tax-exempt interest received or accrued by the taxpayer during the taxable year.

[12] 78 *Federal Register* 7314, February 1, 2013.

[13] In order to qualify for the religious exemption, an individual must be a member of a recognized religious sect or division (as described in 1402(g)(1) of the Internal Revenue Code of 1986) by reason of which he or she is conscientiously opposed to acceptance of the benefits of any private or public insurance that makes payments in the event of death, disability, old-age, or retirement or makes payments toward the cost of, or provides services for, medical care (including the benefits of any insurance system established by the Social Security Act, such as Social Security benefits and Medicare). Such sect or division must have been in existence at all times since December 31, 1950. There is no list of specific religious groups that qualify for the exemption. For more information, see CRS Report RL34708, *Religious Exemptions for Mandatory Health Care Programs: A Legal Analysis*, by Cynthia Brougher.

[14] A health sharing ministry is defined as an organization described in Section 501(c) of the IRC (including corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, or testing for public safety) and is exempt from taxation under section 501(a). Members of the ministry share a common set of ethical or religious beliefs and share medical expenses, and retain membership even after they develop a medical condition. The health sharing ministry must have been in existence (and sharing medical expenses) at all time since December 31, 1999, and must conduct an annual audit by an independent certified public accountant, available to the public upon request.

lawfully present in the United States, and incarcerated individuals.[15] No penalty will be imposed on those without coverage for less than three months[16] or members of Indian tribes.[17]

Additionally, any individual whom the Secretary of HHS determines to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan will be exempt.[18] Qualifying individuals who would otherwise be subject to the mandate, but who are residing outside of the United States, as well as bona fide residents of any possession of the United States will be considered to have minimum essential coverage and therefore not be subject to the penalty.

Claiming an Exemption

Individuals claiming the short coverage gap, unlawfully present, filing threshold, or affordability exemptions may only do so on their federal income tax return.[19] In order to claim a religious exemption and some types of hardship exemptions,[20] an individual must obtain an exemption certification issued by the health insurance exchange serving the area in which the individual resides. All other exemptions may be certified by an exchange *or* may be claimed on the filer's federal income tax return.[21] Regulations provide that most exemptions be applicable retrospectively (with an exception for a specific hardship definition) and be recertified annually; only the religious and Indian tribe exemptions are eligible for prospective or retrospective applicability and continuous certification.[22] **Table 1** outlines the basic features of the nine exemption categories.

Table 1. Individual Mandate Exemptions under ACA

Exemption	Eligibility Certification	Applicability	Recertification
Religious conscience	Exchange only	Prospective or retrospective	Continuous[a]
Hardship	Exchange or tax filing	Retrospective[b]	Annual
Health care sharing ministry membership	Exchange or tax filing	Retrospective	Annual

[15] Does not include those who are pending the disposition of charges.

[16] This exemption only applies to the first short coverage gap in a calendar year.

[17] The term "Indian tribe" means any Indian tribe, band, nation, pueblo, or other organized group or community, including any Alaska Native village, or regional or village corporation, as defined in, or established pursuant to, the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), that is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

[18] Detailed definitions of hardship exemptions can be found in 45 CFR §155.605(g) and in guidance published by HHS, "Guidance on Hardship Exemption Criteria and Special Enrollment Periods."

[19] 78 *Federal Register* 7314, February 1, 2013.

[20] Several different types of hardship exemptions are described in regulations (78 Federal Register 39494, July 1, 2013); two of the types will be provided exclusively through the tax filing process, not through exchanges.

[21] According to regulations (78 Federal Register 39494, July 1, 2013), exchanges may only certify exemptions for applications made within the calendar year for which the exemption is being sought. Individuals seeking to claim exemptions after December 31[st] of the relevant year must do so on their federal tax return.

[22] See HHS final rule, available at http://www.ofr.gov/OFRUpload/OFRData/2013-15530_PI.pdf.

Exemption	Eligibility Certification	Applicability	Recertification
Indian tribe membership	Exchange or tax filing	Prospective or retrospective	Continuous
Incarceration	Exchange or tax filing	Retrospective	Annual
Affordability	Tax filing only	Retrospective	Annual
Unlawful resident	Tax filing only	Retrospective	Annual
Coverage gap	Tax filing only	Retrospective	Annual
Filing threshold	Tax filing only	Retrospective	Annual

Source: 45 CFR Parts 155 and 156 and 26 CFR Part 1.

a. Reapplication for the exemption is required when an individual reaches age 21. See 78 *Federal Register* 39494, July 1, 2013.

b. One type of hardship exemption is available prospectively; it is available to individuals for whom qualifying coverage is unaffordable based on *projected* income.

Failure to Pay Penalty

Taxpayers who are required to pay a penalty but fail to do so will receive a notice from Internal Revenue Service (IRS) stating that they owe the penalty. If they still do not pay the penalty, the IRS can attempt to collect the funds by reducing the amount of their tax refund in the future. However, individuals who fail to pay the penalty will not be subject to any criminal prosecution or penalty for such failure. The Secretary of Treasury cannot file notice of lien or file a levy on any property for a taxpayer who does not pay the penalty.

Potential Financial Assistance

While ACA requires most individuals to maintain minimum essential coverage, it provides financial assistance to some individuals to help them meet the requirement. Under the ACA Medicaid expansion, some states will be expanding their Medicaid programs beginning in 2014, or sooner at each state's option, to include all nonelderly, non-pregnant individuals with income below 133% of the federal poverty level (FPL), which is expected to significantly increase Medicaid enrollment.[23] Beginning in 2014, some individuals who do not qualify for Medicaid coverage, but who meet other ACA requirements, will be provided with subsidies to help pay for the premiums and cost-sharing requirements of health plans offered through an exchange.[24]

[23] Originally, the assumption was that all states would implement the ACA Medicaid expansion in 2014 as required in statute because implementing the ACA Medicaid expansion was required in order for states to receive *any* federal Medicaid funding. However, on June 28, 2012, the United States Supreme Court issued its decision in *National Federation of Independent Business v. Sebelius*, finding that the federal government cannot terminate the federal Medicaid funding states are receiving for their current Medicaid program if a state refuses to implement the ACA Medicaid expansion. This decision effectively made the ACA Medicaid expansion optional for states.

[24] For more information on premium credits and cost-sharing subsidies see, CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Thomas Gabe.

Health Insurance Information Provided to Individuals

ACA requires that information be provided to the IRS and to individuals, in part to ensure that they have both knowledge and proof of meeting the individual mandate. For example, individuals will receive written notice from anyone who provides them with minimum essential coverage. In addition, workers will receive information through their employer about the exchange, any health insurance that an employer may provide, and the value of their health insurance. These information and reporting requirements are described below.

Information on Minimum Essential Coverage

Every person (including employers, insurers, and government programs) that provides minimum essential coverage to any individual must provide a return[25] to the IRS (as described below).[26] That person must also provide this information to each primary insured person along with contact information.

The return must include

- the name, address, and tax identification number of the primary insured and others covered under the policy;
- the period for which each individual was provided with coverage;
- whether or not the coverage is a qualified health plan offered through an exchange and, if so, the amount of any advance payment of any cost-sharing reduction or any premium tax credit;
- for coverage provided through the group plan of an employer, the portion of the premium, if any, paid by the employer; and
- other information required by the Secretary of the Treasury.

Reporting entities were required to begin submitting returns in 2014; however, on July 9, 2013, the Department of Treasury published a notice that delays this reporting requirement until 2015.[27] The notice encourages reporting entities to voluntarily comply with the provision in 2014.

Health Insurance Information Provided by Employers to All Employees

The Secretary will issue regulations requiring employers to provide current and new employees written notice of (1) the existence of an exchange, including services and contact information; (2) eligibility information for premium credits and cost-sharing subsidies, if the employers' plan's

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[25] Section 1502 of P.L. 111-148, which creates Section 6055 of the Internal Revenue Code of 1986.

[26] See IRS Notice 2012-32.

[27] See IRS Notice 2013-45.

share of total allowed cost of benefits provided is less than 60%; and (3) notice that the employee may lose any employer contribution if the employee purchases a plan through the exchange.[28]

This requirement was intended to take effect not later than March 1, 2013, but in January 2013 the Department of Labor issued guidance stating that the effective date will be delayed for a number of reasons.[29] The guidance indicates that the Department of Labor expects the notices will be distributed in late summer or fall of 2013, to coordinate with the open enrollment period of the exchanges.

Information Provided on an Employee's W-2

Starting in tax-year 2011, the ACA required employers to report the value of the health insurance coverage they provide employees on each employee's annual Form W-2.[30] However, to provide employers the time they need to make changes to their payroll systems or procedures, the IRS deferred the reporting requirement until January 2013 for large employers (those with more than 250 W-2 form employees), making the reporting optional in 2011 and 2012.[31] IRS Notice 2012-9 provided further relief for smaller employers filing fewer than 250 W-2 forms by making the reporting requirement optional for them until further guidance is issued.

The W-2 will indicate the total dollar value of health insurance coverage sponsored by the employer, that is, it will show contributions made by both the employer and the employee. The value is determined using the same methodology used to calculate COBRA premiums.[32] However, if the plan provides for the same COBRA continuation coverage premium for both the individual and the family, the plan would be required to separate individual and family premiums for reporting purposes. This provision does not change the tax treatment of an employer's contribution toward workers' premiums; it continues to be available on a pre-tax basis.

Although this information must be included on the W-2, it is not counted as taxable income. It is included for informational purposes only. The amount will not include any amounts contributed to an Archer Medical Savings Account (MSA) or Health Savings Account (HSA), as these amounts are already required to be listed on the W-2. In addition, the reported amount will not include any salary-reduction contributions to a flexible spending arrangement (FSA) made through cafeteria plans.

Information Provided by Certain Employers to Full-Time Workers

Large employers (defined as those with more than 50 full-time equivalent employees) must provide a return to the IRS (as described below).[33] The employer must also provide its full-time

[28] Section 1512 of P.L. 111-148, which amends the Fair Labor Standards Act of 1938.

[29] See Department of Labor Technical Release No. 2013-02.

[30] Section 9002 of P.L. 111-148.

[31] See IRS Notice 2012-9 and 2011-28, which includes information on how to report, what coverage to include, and how to determine the cost of the coverage.

[32] Under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA; P.L. 99-272), certain employers who offer health insurance must continue coverage for their employees under certain circumstances. For more information, see CRS Report R40142, *Health Insurance Continuation Coverage Under COBRA*, by Janet Kinzer.

[33] Section 1514 of P.L. 111-148, which creates Section 6056 of the Internal Revenue Code of 1986.

employees the specific information included in the return for that individual, along with contact information.[34]

As prescribed by the Secretary of Treasury, the return must include

- the name, date, and employer identification number of the employer;
- a certification as to whether the employer offers its full-time employees (and dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan;
- the length of any waiting period, months coverage was available, and monthly premiums for the lowest cost option;
- the employer's share of total allowed cost of benefits (i.e., the percentage of covered benefits paid for by the plan);
- the number of full-time employees, and the name, address, and tax identification number of each full-time employee; and
- additionally, an offering employer must provide information about the plan for which the employer pays the largest portion of the costs (and the amount for each enrollment category).

The Secretary of the Treasury will work to coordinate this requirement with other similar requirements, and an employer may enter into an agreement with a health insurance issuer to provide necessary returns and statements.

In July 2013, the Department of Treasury issued a notice delaying the effective date of this reporting requirement until 2015.[35] Employers will receive "transition relief" from this requirement in 2014.

[34] See IRS Notice 2012-33.

[35] See IRS Notice 2013-45.

Appendix. Illustrative Examples of Individual Mandate Penalties

Examples

The following examples illustrate the penalty for a single individual and for a family. Certain assumptions, described below, are necessary that may somewhat under- or over-estimate the penalty amounts. Therefore these examples are best used to show the relative scope of the penalties and the relationship between the various components of the formulas for calculating the penalty. To summarize the penalty (as described above) for those individuals whose household income (i.e., modified adjusted gross income, MAGI) is above the filing threshold amount for federal income tax, the penalty is the greater of a flat dollar amount or a percentage of applicable income (income above the filing threshold).

Penalty for an Individual

Figure A-1 and **Figure A-2** show the amount of the annual penalty for a *single* individual who does not maintain minimum essential coverage and is not exempt from the mandate. Penalty amounts are shown for 2014, 2015, and 2016. These two figures are identical, except the second shows higher income levels, where the maximum penalty is reached. After 2016, the only difference compared to 2016 is that the flat dollar amount is adjusted for inflation. As shown in the figures, those individuals below the filing threshold for federal income tax will not pay a penalty.[36] As an individual's household income begins to exceed the filing threshold, the flat dollar amount penalty will apply. As household income continues to increase, eventually the penalty based on applicable income will be a greater amount than the flat dollar amount. As shown in **Figure A-1**:

- In 2014, those with income above the filing threshold but below about $20,000 will pay the $95 flat dollar amount, and those with income above about $20,000 will pay 1% of income.
- In 2015, as both the flat dollar amount and the percentage of income increases, those with income above the filing threshold but below about $25,000 will pay $325, while those with income above about $25,000 will pay 2% of income.
- In 2016, those with income above the filing threshold but below about $37,000 will pay the flat dollar amount of $695, while those with income above about $37,000 will pay 2.5% of income.

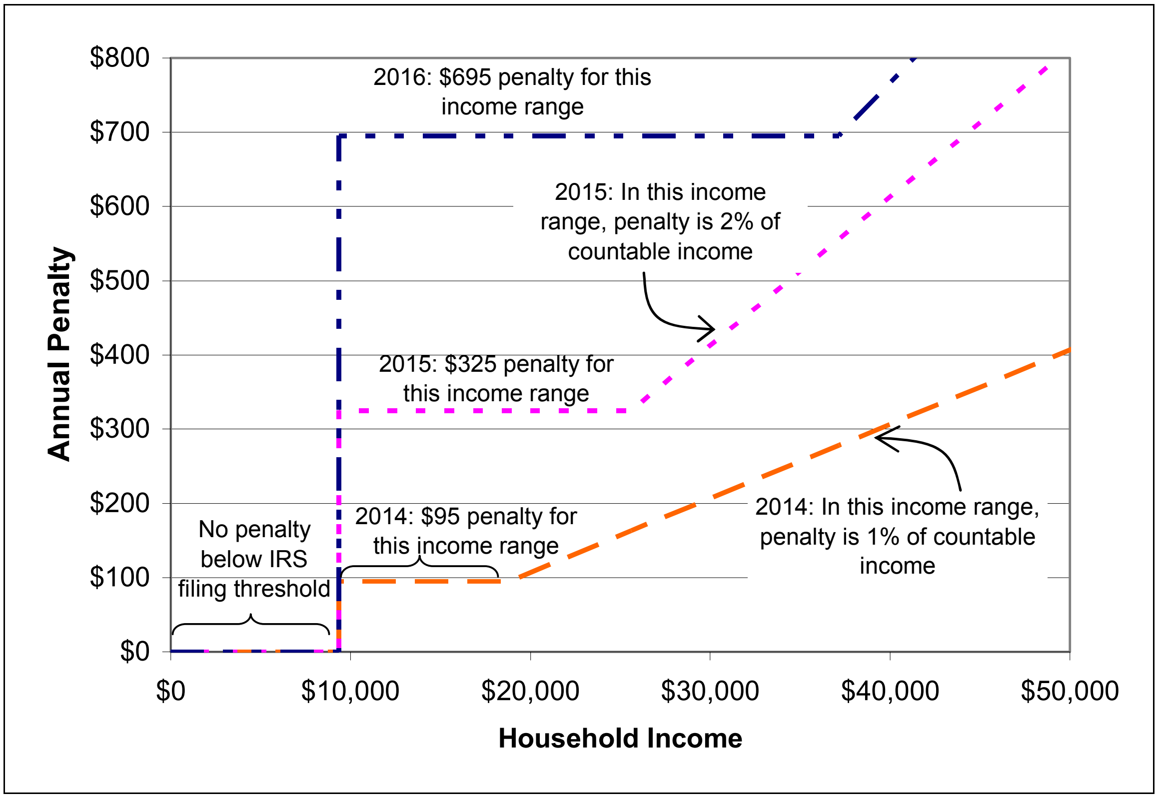
The penalty for an individual will be capped at the national average premium for a bronze-level plan.[37] As shown in the figures, the slope of the line increases each year, reflecting the increase in

[36] The filing threshold for 2010 was $9,350. This threshold is linked to an inflation adjustment based on the CPI-U, and therefore it may be higher in 2014 and subsequent years. For purposes of this illustration, it is held constant at the 2010 dollar amount, so it may somewhat underestimate who might be exempt from the penalty, and also affect when someone's penalty would be based on the flat dollar amount versus a percentage of their income.

[37] The Congressional Budget Office estimated that the cost of a bronze-level plan for an individuals would be between $4,500 and $5,000 in 2016. For this illustration the cost of a single bronze-level plan is held constant at $4,500. To the (continued...)

the percentage of income (1% in 2014, 2% in 2015, and 2.5% in 2016). As a result, each year as the percentage increases, individuals both pay higher penalties and reach the cap at lower income amounts, as shown in **Figure A-2**.

Figure A-1. Illustrative Individual Mandate Penalties for a Single Individual with No Dependents, 2014-2016, with Household Income up to $50,000



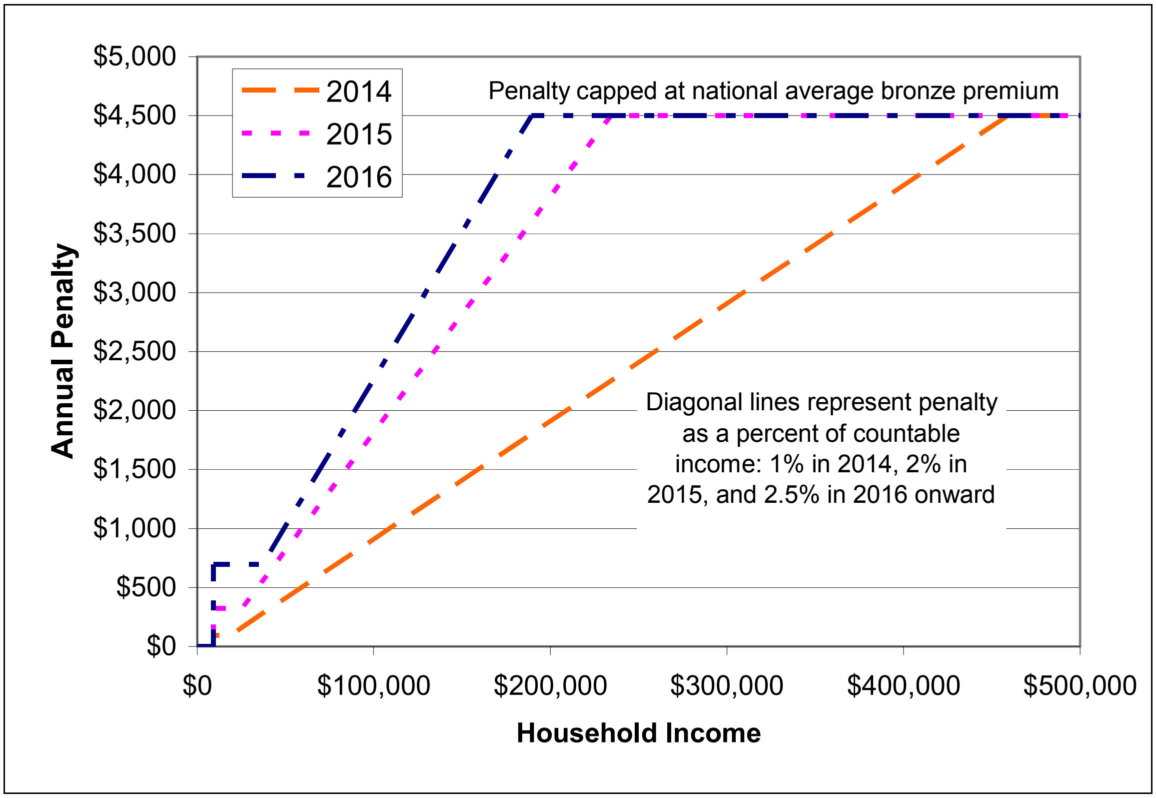
Source: CRS.

Notes: For this figure, the 2010 filing threshold was used, which is $9,350 for a single individual under age 65 with no dependents (single filing status), but will likely be higher when implemented (thus exempting people with slightly higher income) than shown here.

(...continued)

extent this overestimated the cost of premiums, the penalty would cap would be reached at lower levels of income, and if underestimated, the penalty would cap would be reached at a higher level of income.

Figure A-2. Illustrative Individual Mandate Penalties for a Single Individual with No Dependents, 2014-2016, with Household Income up to $500,000



Source: CRS.

Notes: For this figure, the 2010 filing threshold was used, which was $9,350 for a single individual under age 65 with no dependents (single filing status), but will likely be higher when implemented (thus exempting people with slightly higher income) than shown here. The penalty will be capped at the national average premium for bronze-level qualified health plans offered through exchanges, which CBO projects will be $4,500 to $5,000 for single individuals in 2016. For this figure, which covers 2014 through 2016, $4,500 was used. Actual experience may vary.

Penalty for a Family

In calculating the penalty for a family, each of the components of the formula increases for a family, including the filing threshold, flat dollar amount, and the cost of a bronze-level plan. However, the flat dollar amount for a family cannot be greater than three times the amount for an individual. For example, in 2014 the flat dollar amount is limited to three times $95, or $285. The flat dollar amount is one-half for children under 18, so that a married couple with two children under 18, a single parent with four children under 18, as well as larger families are all subject to the same flat dollar maximum amount. However, these families may still pay larger penalties, if they have higher incomes.

Figure A-3 and **Figure A-4** show the amount of the annual penalty for a *family* (in this example a married couple with two children under 18) that does not maintain minimum essential coverage and is not exempt from the mandate. These two figures are identical, except **Figure A-4** shows higher income levels, where the maximum penalty is reached. Penalty amounts are shown for 2014, 2015, and 2016. As shown in the figures, those families below the filing threshold will not pay a penalty.[38] As income levels begin to exceed the filing threshold, the flat dollar amount penalty will apply. Eventually as income increases, the penalty based on percent of applicable income will be a greater amount than the flat dollar amount. As shown in **Figure A-3** and **Figure A-4**:

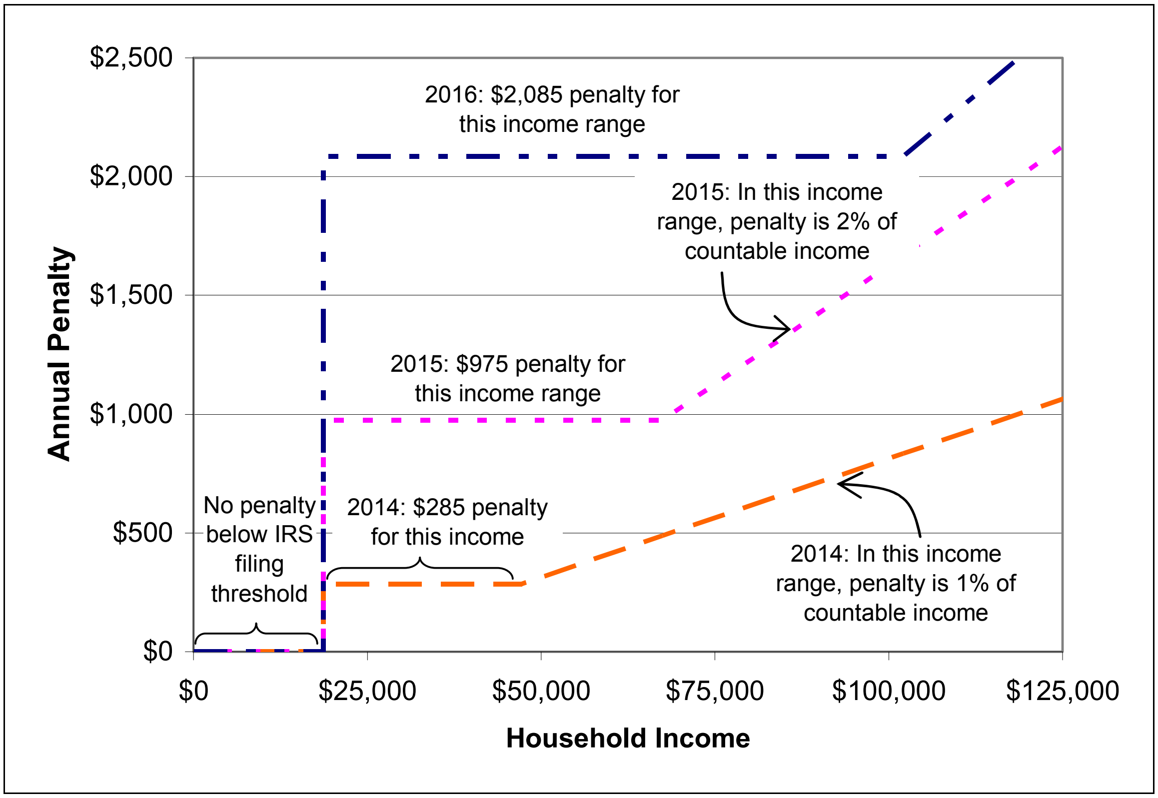
- In 2014, those with income above the filing threshold but below about $55,000 will pay the $285 flat dollar amount and those with income above about $55,000 will pay 1% of income.
- In 2015, as both the flat dollar amount and the percentage of income increases, those with income above the filing threshold but below about $75,000 will pay $975, while those with income above about $75,000 will pay 2% of income.
- In 2016, those with income above the filing threshold but below about $110,000 will pay the flat dollar amount of $2,085, while those with income above about $110,000 will pay 2.5% of income.

The total penalty for a family will be capped at the national average premium for a family bronze level plan.[39] As shown in **Figure A-4**, the slope of the line increases each year, reflecting the increase in the percentage of income (1% in 2014, 2% in 2015, and 3% in 2016). As a result, each year as the percentage increases, families will both pay higher penalties and reach the cap at lower income amounts.

[38] The filing threshold for married couple filing jointly in 2010 was $18,700. This threshold is linked to an inflation adjustment, so it is likely to be higher by 2014, and could also increase each subsequent year. For purposes of this illustration, it is held constant at the 2010, so it may somewhat overestimate the penalty amounts for those at low incomes.

[39] The Congressional Budget Office estimated that the cost of a bronze-level plan for a family would be between $12,000 and $12,500 in 2016. For this illustration, that number is held constant at $12,000. To the extent this overestimated the cost of premiums, the penalty would cap out sooner, and if it underestimated the cost of premiums, the penalty would cap out at a somewhat higher income.

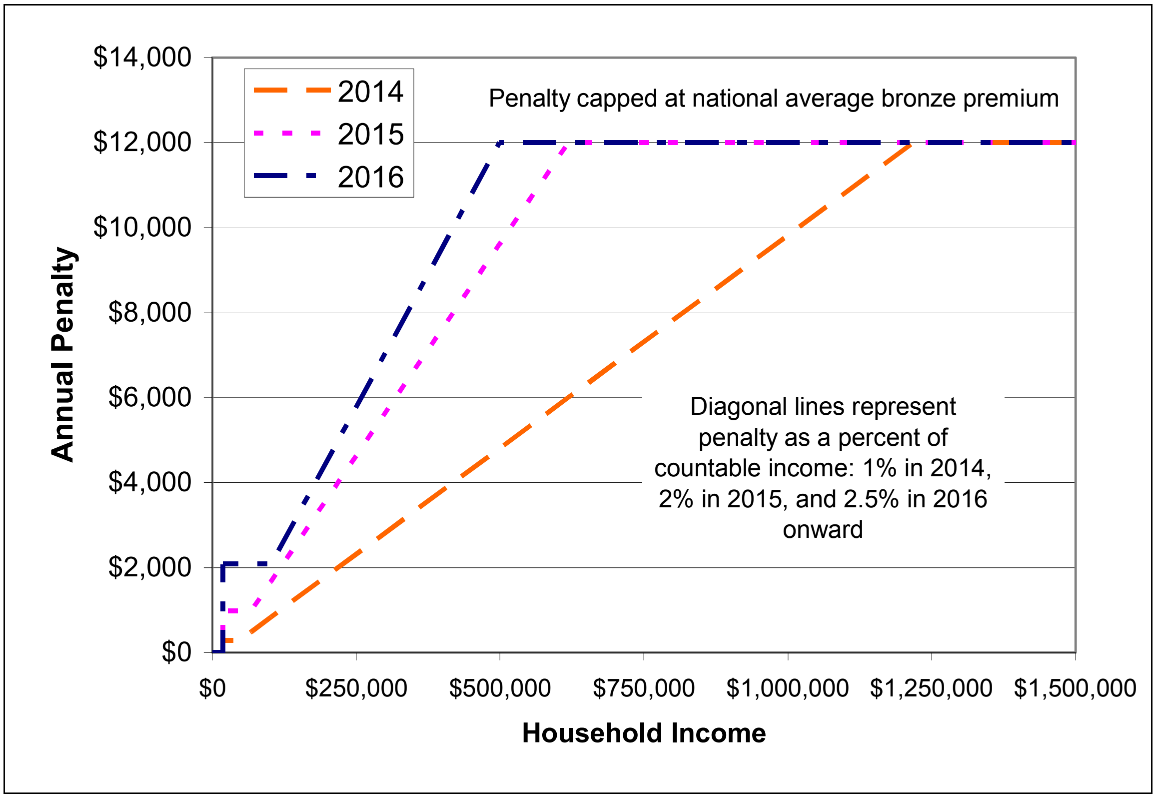
Figure A-3. Illustrative Individual Mandate Penalties for a Family of Four, 2014-2016, with Household Income up to $125,000



Source: CRS.

Notes: For this figure, the 2010 filing threshold was used, which was $18,700 for a married couple under age 65 filing jointly, but will likely be higher when implemented (thus exempting people with slightly higher income) than shown here. This example assumes that the family includes two dependent children under the age of 18.

Figure A-4. Illustrative Individual Mandate Penalties for a Family of Four, 2014-2016, with Household Income up to $500,000



Source: CRS.

Notes: For this figure, the 2010 filing threshold was used, which was $18,700 for a married couple under age 65 filing jointly, but will likely be higher when implemented (thus exempting people with slightly higher income) than shown here. This example assumes that the family includes two dependent children under the age of 18. The penalty will be capped at the national average premium for bronze-level qualified health plans offered through exchanges, which CBO projects will be $12,000 to $12,500 for families in 2016. For this figure, which covers 2014 through 2016, $12,000 was used. Actual experience may vary.

Author Contact Information

Annie L. Mach
Analyst in Health Care Financing
amach@crs.loc.gov, 7-7825

Janemarie Mulvey
Specialist in Health Care Financing
jmulvey@crs.loc.gov, 7-6928

Manon Scales
Research Associate
mscales@crs.loc.gov, 7-4118

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