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Individual Mandate Under ACA

Annie L. Mach
Analyst in Health Care Financing

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Summary

Beginning in 2014, ACA requires most individuals to maintain health insurance coverage or otherwise pay a penalty. Specifically, most individuals will be required to maintain minimum essential coverage, which is a term defined in ACA and its implementing regulations and includes most private and public coverage (e.g., employer-sponsored coverage, individual coverage, Medicare, and Medicaid, among others). 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.

Individuals who do not maintain minimum essential coverage and are not exempt from the mandate will have to pay a penalty for each month of noncompliance with the mandate. The penalty is the greater of a flat dollar amount or a percentage of applicable income. In 2014, the annual penalty is the greater of $95 or 1% of applicable income; the penalty increases in 2015 and 2016 and is adjusted for inflation thereafter. The penalty will be collected through federal income tax returns. The Internal Revenue Service (IRS) can attempt to collect any owed penalties by reducing the amount of an individual's tax refund; however, individuals who fail to pay the penalty will not be subject to any criminal prosecution or penalty for such failure. The Secretary of the Treasury cannot file notice of lien or file a levy on any property for a taxpayer who does not pay the penalty.

Certain individuals will be exempt from the individual mandate and the penalty. For example, individuals with qualifying religious exemptions and those whose household income is below the filing threshold for federal income taxes will not be subject to the penalty. ACA allows the Secretary of Health and Human Services (HHS) to grant hardship exemptions from the penalty to anyone determined to have suffered a hardship with respect to the capability to obtain coverage. The Secretary of HHS has identified a number of different circumstances that would allow individuals to receive a hardship exemption, including an individual not being eligible for Medicaid based on a state's decision not to carry out the ACA expansion and financial or domestic circumstances that prevent an individual from obtaining coverage (e.g., eviction or recent experience of domestic violence).

ACA includes several reporting requirements designed, in part, to assist individuals in providing evidence of having met the mandate. Every person (including employers, insurers, and government programs) that provides minimum essential coverage to any individual must provide a return to the IRS that includes information about the individual's health insurance coverage.

On March 5, 2014, the House of Representatives passed H.R. 4118, Suspending the Individual Mandate Penalty Law Equals (SIMPLE) Fairness Act. H.R. 4118 provides that individuals do not have to pay an individual mandate penalty for any month prior to January 1, 2015, effectively delaying implementation of the individual mandate penalty and maintaining the initial penalty levels until 2015.

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This report describes the individual mandate as established under the 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.

Individual Mandate

Beginning in 2014, ACA requires most individuals to have health insurance coverage 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

In general, individuals who are not exempt from the mandate must maintain minimum essential coverage to avoid the penalty. Minimum essential coverage is defined broadly in statute and is further defined in regulations; the definition includes most types of government-sponsored coverage (e.g., Medicare) as well as most types of private insurance (e.g., employer-sponsored insurance). **Table A-1** provides detailed information about how different types of health insurance coverage relate to the definition of minimum essential coverage and the penalty. 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.[3] 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.[4] The filing threshold comprises the personal exemption

[1] On June 28, 2012, the U.S. 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 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. For more information, see CRS Report WSLG112, *Supreme Court Upholds the Individual Mandate as a Permissible Exercise of Congress' Taxing Power*, by Erika K. Lunder.

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

[3] In the final rule on maintaining minimum essential coverage (78 FR 53646, August 30, 2013), IRS provides that a taxpayer is liable for an individual mandate penalty for his/her dependents regardless of whether the taxpayer claims the dependents for the taxable year. For the purposes of this provision, "dependent" is defined in §152 of the Internal Revenue Code (IRC) and includes qualifying children and qualifying relatives.

[4] 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 (§911 of (continued...)

amount (doubled for those married filing jointly) plus the standard deduction amount,[5]

- 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),[6] assessed for each taxpayer and any dependents;
   - 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.

The penalty for noncompliance cannot exceed the national average premium for bronze-level-qualified health plans offered through exchanges (for the relevant family size).[7] 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.

Illustrative Individual Mandate Penalties

The following examples illustrate the penalty for a single individual and for a family of four. Penalty amounts are shown for 2014, 2015, and 2016. To summarize the penalty (as described above) for those individuals whose household income 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). Individuals below the filing threshold for federal income tax will not pay a penalty.

In the 2014 examples, the 2014 filing threshold is used, which is $10,150 for a single individual under age 65 with no dependents (single filing status) and $20,300 for a married couple filing jointly. The filing thresholds for 2015 and 2016 have not yet been determined, but because they are linked to an inflation adjustment based on the CPI-U,[8] they will likely be higher when implemented in 2015 and 2016. The examples below use estimated filing thresholds for 2015 and 2016.[9] As a result, the numbers for 2015 and 2016 are meant for illustrative purposes only. These

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the IRC) and any amount of tax-exempt interest received or accrued by the taxpayer during the taxable year.

[5] In 2014, the standard deduction is $6,200 and the personal exemption is $3,950, so that generally, the filing thresholds for individuals under age 65 are $10,150 for a single filing status and $20,300 for a married couple filing jointly. The filing threshold is linked to an inflation adjustment based on the CPI-U, and therefore it may be higher in 2015 and 2016.

[6] The inflation adjustment will be based on the cost-of-living adjustment (CPI-U), for the calendar year, with any increase that is not a multiple of $50 rounded to the next lowest multiple of $50.

[7] As of the date of this report, no information has been released as to the national average premiums of bronze-level plans offered through exchanges.

[8] The Consumer Price Index for all Urban Consumers (CPI-U) is a measure of inflation published by the U.S. Bureau of Labor Statistics. One way in which it is used is to calculate annual inflation adjustments to personal income tax brackets.

[9] The estimated filing thresholds for 2015 and 2016 are not based on the formula IRS uses to adjust the filing thresholds; rather, they were calculated using the Congressional Budget Office's CPI-U forecast for 2015 and 2016 and then rounding down the estimates to the nearest $50. The Congressional Budget Office's CPI-U forecast was obtained from *The Budget and Economic Outlook: 2014 to 2024*, http://www.cbo.gov/sites/default/files/cbofiles/attachments/
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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.

Illustrative individual mandate penalties for a single individual with no dependents:

- In 2014, those with income above the filing threshold ($10,150 in 2014) but at or below $19,650 will pay the $95 flat amount, those with income above $19,650 and below the cap at the national average premium for bronze-level coverage will pay 1% of applicable income;
- In 2015, those with income above the filing threshold (estimated to be $10,300 in 2015) but at or below an estimated $26,550 will pay the $325 flat amount, and those with income above an estimated $26,550 and below the cap at the national average premium for bronze-level coverage will pay 2% of applicable income;
- In 2016, those with income above the filing threshold (estimated to be $10,450 in 2016) but at or below an estimated $38,250 will pay the $695 flat amount, and those with income above an estimated $38,250 and below the cap at the national average premium for bronze-level coverage will pay 2.5% of applicable income.

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.

Illustrative individual mandate penalties for a family of four (married couple with two children under age 18):

- In 2014, those with income above the filing threshold ($20,300 in 2014) but at or below $48,800 will pay the $285 flat dollar amount, those with income above $48,800 and below the cap at the national average premium for bronze-level family coverage will pay 1% of applicable income;
- In 2015, those with income above the filing threshold (estimated to be $20,600 in 2015) but at or below an estimated $69,350 will pay the $975 flat dollar amount, those with income above an estimated $69,350 and below the cap at the national average premium for bronze-level family coverage will pay 2% of applicable income;
- In 2016, those with income above the filing threshold (estimated to be $20,900 in 2016) but at or below an estimated $104,300 will pay the $2,085 flat dollar amount, those with income above an estimated $104,300 and below the cap at the national average premium for bronze-level family coverage will pay 2.5% of applicable income.

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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.

Certain categories of individuals will be exempt from the individual mandate, including those with qualifying religious exemptions,[12] those in a health care sharing ministry,[13] individuals not lawfully present in the United States, and incarcerated individuals (except those pending the disposition of charges). No penalty will be imposed on those without coverage for less than three months[14] or members of Indian tribes.[15] Qualifying individuals who would otherwise be subject to the mandate, but who live abroad for at least 330 days within a 12-month period, 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. Any individual whom the Secretary of Health and Human Services (HHS) determines to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan will be exempt (see the text box for more information about the hardship exemption).

The Internal Revenue Service (IRS) issued guidance that provides "transitional relief" from the penalty for individuals (and any dependents) who were eligible for non-calendar year employer-

[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] 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.

[13] A health care 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.

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

[15] 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.

sponsored insurance plans in 2013.[16] For example, consider an individual who was eligible to enroll in his/her employer's health plan, whose plan year began on September 1, 2013, and ends on August 31, 2014. Under the transitional relief, the individual is not liable for the individual mandate penalty for January 2014 through August 2014, as the individual would have had to enroll in the employer-sponsored plan in 2013 in order to be covered by the plan in those months of 2014.

Additionally, the IRS has issued guidance that provides that individuals enrolled in certain types of coverage that are not considered minimum essential coverage will not be liable for a penalty.[17] For example, women who only receive pregnancy-related services under Medicaid do not have minimum essential coverage, but IRS indicates that these women will not be liable for a penalty in 2014. These "exemptions" from the penalty are not discussed in the "Claiming an Exemption" section of this report; however, they are identified in **Table A-1** in the Appendix of this report.

[16] IRS Notice 2013-42.

[17] IRS Notice 2014-10.

Hardship Exemption

Any individual whom the Secretary of HHS determines has suffered a hardship with respect to the capability to obtain health insurance coverage will receive a hardship exemption. Through regulations and guidance, HHS has identified a number of circumstances that would allow individuals to receive a hardship exemption:[18]

(1) an individual experiences financial, domestic, or other circumstances that prevent him/her from obtaining coverage or the expense of purchasing coverage would have caused him/her to experience serious deprivation of food, shelter, clothing, or other necessities;[19]

(2) an individual is unable to afford coverage based on projected household income;

(3) an individual whose income is below the filing threshold (and therefore eligible for the filing threshold exemption), except that the individual claimed a dependent with a filing requirement and had household income exceeding the filing threshold as a result;

(4) an individual is ineligible for Medicaid based on a state's decision not to carry out the ACA expansion;

(5) an individual is identified eligible for affordable self-only employer-sponsored insurance (ESI), but the aggregate cost of the ESI for all the employed members of the family exceeds 8% of household income;

(6) an individual is an Indian eligible for services through an Indian health care provider, but is not eligible for an exemption based on being a member of an Indian tribe, or is eligible for services through the Indian Health Service;

(7) an individual who enrolls in a plan offered through an exchange or the State Children's Health Insurance Program (CHIP) prior to the close of the open enrollment period (March 31, 2014) will be able to claim a hardship exemption for the months prior to the effective date of the individual's coverage;[20] or

(8) an individual has been notified that his/her plan will not be renewed and believes that the available plan options are more expensive than the plan that was not renewed.[21]

Individuals who claim hardship exemptions are eligible to purchase catastrophic plans. Under ACA, catastrophic plans must cover a comprehensive set of benefits, but they do not have to comply with the same cost-sharing requirements with which other plans must comply under ACA. As a result, these plans typically have lower premiums because they have higher cost-sharing. Only individuals who are either under age 30 or eligible for a hardship or affordability exemption from the individual mandate are eligible to enroll in catastrophic plans.[22]

Claiming an Exemption

Individuals can be exempt from the mandate and the penalty based on an individual's characteristics, financial status, or affiliations (e.g., religious affiliations). Some individuals who are exempt will not be expected to take any actions to claim the exemption; others will have to

[18] 45 C.F.R. §155.605(g) and the guidance noted.

[19] HHS provides further guidance on these circumstances in "Guidance on Hardship Exemption Criteria and Special Enrollment Periods" published June 26, 2013, available at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/exemptions-guidance-6-26-2013.pdf.

[20] These circumstances are not described in regulations; the exchange aspect is described in guidance published October 28, 2013, available at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/enrollment-period-faq-10-28-2013.pdf, and the CHIP aspect is described in guidance published March 31, 2014, available at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/shared-responsibility-FAQ-3-30-2014.pdf.

[21] This circumstance is not described in regulations; it is described in guidance published December 19, 2013, available at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cancellation-consumer-options-12-19-2013.pdf.

[22] For more information about catastrophic plans, see CRS Report R43233, *Private Health Plans Under the ACA: In Brief*, by Bernadette Fernandez and Annie L. Mach.

either obtain a certification of exemption from a health insurance exchange or claim the exemption through the tax filing process.

Individuals who live abroad for more than 330 days in a 12-month period and those who are bona fide residents of a U.S. possession do not have to take any action to claim the exemption. Those claiming the short coverage gap, unlawfully present, filing threshold, or affordability exemptions may only do so on their federal income tax return. In order to claim a religious exemption an individual must obtain an exemption certification issued by the exchange serving the area in which the individual resides. Some types of hardship exemptions can be claimed by receiving a certification from an exchange, while other types can only be claimed through the tax filing process.[23] All other exemptions may be certified by an exchange *or* may be claimed on the filer's federal income tax return.[24]

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. **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
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	Not applicable[c]	Retrospective	Annual

Sources: 45 C.F.R. Part 155 and 26 C.F.R. Part 1.

Note: The "exemptions" for qualifying individuals who live abroad for at least 330 days within a 12 month period and bona fide residents of any possession of the United States are not included in this table because individuals who meet one of these criteria do not need to take any action to comply with the individual mandate.

a. Reapplication for the exemption is required when an individual reaches age 21. See 45 C.F.R. §155.605(c).

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

[23] Several different types of hardship exemptions are described in regulations and guidance (see the text box in this report); at least three of the types will be provided exclusively through the tax filing process, not through exchanges.

[24] According to regulations (45 C.F.R. §155.610(h)), 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 31st of the relevant year must do so on their federal tax return.

c. Individuals who qualify for a filing threshold exemption are not required to file a tax return or apply to an exchange to claim the exemption; these individuals are automatically exempt and do not need to take further action to secure an exemption. However, if the individuals choose to file a return they may claim the exemption on the return.

Failure to Pay Penalty

Taxpayers who are required to pay a penalty but fail to do so will receive a notice from 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 for that year or future years. However, individuals who fail to pay the penalty will not be subject to any criminal prosecution or penalty for such failure. The Secretary of the 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 have expanded their Medicaid programs 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.[25] 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.[26]

Reporting Minimum Essential Coverage

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.[27] Every person (including employers, insurers, and government programs) that provides minimum essential coverage to any individual must provide a return to the IRS and a statement to the covered individual.

The person required to provide the return and statement is referred to as the "reporting entity." In general, insurers are the reporting entities for all fully insured health insurance arrangements, and plan sponsors are the reporting entities for all self-insured arrangements.[28] A government agency

[25] 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 U.S. 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. For more information, see CRS Report R43357, *Medicaid: An Overview*, coordinated by Alison Mitchell.

[26] 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.

[27] 26 IRC §6055.

[28] A fully insured plan is one in which the plan sponsor purchases health coverage and the carrier assumes the risk of (continued...)

or unit is the reporting entity for any coverage under a government-sponsored program, including any coverage that is provided through an insurer (e.g., a Medicare Advantage plan). An insurer does not have to provide a return or a statement for any coverage it offers through an individual health insurance exchange, as the exchange is the reporting entity for such coverage; however, insurers that offer small group coverage through a small business health options program (SHOP) exchange are the reporting entities for such coverage.

The return provided to the IRS must include the following:

- the name, address, and employer identification number (EIN) of the reporting entity required to file the return;
- the name, address, and taxpayer identification number (TIN) of the "responsible individual"[29] and each other individual covered under the policy or program;[30]
- the months for which, for at least one day, each individual was covered under the policy or program;
- for coverage provided through the group plan of an employer—
  - the name, address, and EIN of the employer sponsoring the plan;
  - whether the coverage is a qualified health plan (QHP) offered through a SHOP exchange and the SHOP's unique identifier;
- and any other information as specified in forms, instructions, or published guidance issued by the Department of the Treasury.

The reporting entity is also responsible for providing a statement to each responsible individual covered under the policy or program. The statement must include the contact information for the person designated as the reporting entity's contact person; the policy number of the coverage, if any; and the information included in the return to the IRS for the responsible individual and any individuals listed on the return.

Reporting entities were required to begin submitting returns in 2014; however, in July 2013 the Department of Treasury published a notice that delayed the reporting requirement until 2015.[31] Reporting entities that do not file timely and accurate returns and those that do not provide statements to individuals could be subject to penalties.

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providing health benefits to the sponsor's enrolled members. A self-insured plan is one in which an entity (e.g., employer or association) provides coverage for its members directly by setting aside funds and paying for health benefits.

[29] In regulations, the term responsible individual includes, "a primary insured, employee, former employee, uniformed services sponsor, parent, or other related person named on an application who enrolls one more individuals, including him or herself, in minimum essential coverage." 26 C.F.R. §1.6055-1(b)(11).

[30] Regulations provide that a reporting entity is required to make a reasonable effort to obtain the TIN of each individual covered under the plan, but if a TIN is not available, the reporting entity must provide a date of birth for the individual instead.

[31] IRS Notice 2013-45.

Appendix A. Health Insurance Coverage and the Individual Mandate

Table A-1. Types of Health Insurance Coverage as they Relate to the Definition of Minimum Essential Coverage and the Individual Mandate Penalty in 2014

As Identified in Statute, Regulations, and Guidance

Type of Coverage	Is it considered minimum essential coverage in 2014?	If it is an individual's only source of coverage in 2014, is the individual liable for the individual mandate penalty?
Medicare Part A	Yes	No
Medicare Advantage	Yes	No
Medicaid full benefit coverage	Yes	No
Medicaid limited benefit coverage		
Optional coverage of family planning services[a]	No	No
Optional coverage of tuberculosis-related services[b]	No	No
Coverage of pregnancy-related services[c]	No	No
Coverage limited to treatment of emergency medical conditions[d]	No	No
Coverage authorized under §1115(a)(2) of the Social Security Act (SSA)[e]	According to a proposed rule issued by the Internal Revenue Service (IRS), this coverage is not considered minimum essential coverage[f]	No
Medicaid coverage for the medically needy[g]	According to a proposed rule issued by the IRS, this coverage is not considered minimum essential coverage[f]	No
State Children's Health Insurance Program (CHIP)	Yes	No
TRICARE		
Limited benefit TRICARE programs[h]	According to a proposed rule issued by the IRS, this coverage is not considered minimum essential coverage[f]	No
Other coverage offered under TRICARE	Yes	No

Type of Coverage	Is it considered minimum essential coverage in 2014?	If it is an individual's only source of coverage in 2014, is the individual liable for the individual mandate penalty?
VA Health Care Programs[i]		
Medical benefits package authorized for eligible veterans under 38 U.S.C. 1710 and 38 U.S.C. 1705	Yes	No
Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) authorized under 38 U.S.C. 1781[j]	Yes	No
Comprehensive health care program authorized under 38 U.S.C. 1803 and 38 U.S.C. 1821 for certain children of Vietnam Veterans and Veterans of covered service in Korea who are suffering spina bifida	Yes	No
Peace Corps Program	Yes	No
Nonappropriated Fund Health Benefits Program of the Department of Defense	Yes	No
Employer-sponsored health insurance	Yes	No
Individual market health insurance	Yes	No
Qualified health plans (QHP) offered inside and outside exchanges	Yes	No
Grandfathered health plans[k]	Yes	No
Self-funded student health plans[l]	Yes	No
Refugee Medical Assistance supported by the Administration for Children and Families	Yes	No
State high risk pools[m]	Yes	No
Group health plan provided through insurance regulated by a foreign government	Yes[n]	No

Source: CRS analysis of ACA statute, 26 C.F.R. Part 1, and its implementing regulations and guidance.

Notes: ACA allows the Secretary of HHS, in coordination with the Secretary of the Treasury, to recognize arrangements other than those identified in statute as minimum essential coverage. HHS has outlined a procedure by which a sponsor of coverage or a government agency may apply to HHS to have its coverage certified as minimum essential coverage. The process is outlined in 45 C.F.R. §156.604 and in guidance issued by HHS, *CCIIO Sub-Regulatory Guidance: Process for Obtaining Recognition as Minimum Essential Coverage,* on October 31, 2013.

a. As defined in 42 U.S.C. 1396a(a)(10)(A)(ii)(XXI).

b. As defined in 42 U.S.C. 1396a(a)(10)(A)(ii)(XII).

c. As defined in 42 U.S.C. 1396a(a)(10)(A)(i)(V) and 1396a(a)(10)(A)(ii)(IX).

d. As authorized by 42 U.S.C. 1396b(v).

e. In general, §1115 of the Social Security Act (SSA) gives the Secretary of HHS authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. Section 1115(a)(2) of the SSA allows a state to extend benefits to additional populations (expansion populations) that would not otherwise be eligible for Medicaid. The coverage a state extends to expansion populations is not required to be comprehensive and may be limited.

f. While generally not considered minimum essential coverage, to the extent such coverage is comprehensive coverage, the Secretaries of HHS and the Treasury may recognize such coverage as minimum essential coverage. See the proposed rule for more details (78 *Federal Register* 4302, January 27, 2014).

g. As defined in 42 U.S.C. 1396a(a)(10)(C) and 42 C.F.R. 435.300 and following (Subpart D).

h. Specifically, the program providing care limited to the space available in a facility for the uniformed services for individuals excluded from TRICARE coverage under sections 1079(a), 1086(c)(1), or 1086(d)(1) of Title 10, U.S.C., and the program for individuals not on active duty for an injury, illness, or disease, incurred or aggravated in the line of duty under sections 1074a and 1074b of Title 10, U.S.C.

i. P.L. 111-173 amended ACA to clarify that the Secretary of Veterans Affairs, in coordination with the Secretary of HHS and the Secretary of the Treasury, would determine which VA health care programs would be considered minimum essential coverage. The programs outlined in the table are the VA programs the Secretaries have identified as minimum essential coverage; it would seem that coverage under any VA programs other than those specified in the table is not considered minimum essential coverage. 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.

j. For more information on the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), see CRS Report RS22483, *Health Care for Dependents and Survivors of Veterans*, by Sidath Viranga Panangala.

k. 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). 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.

l. Self-funded student health plans are designated minimum essential coverage for plan or policy years beginning on or before December 31, 2014; for coverage beginning after December 31, 2014, sponsors of such plans have to apply to the Secretary of HHS to be recognized as minimum essential coverage via the process outlined in 45 C.F.R. §156.604.

m. State high risk pools are designated as minimum essential coverage for plan or policy years beginning on or before December 31, 2014; for coverage beginning after December 31, 2014, sponsors of high risk pool coverage have to apply to the Secretary of HHS to be recognized as minimum essential coverage via the process outlined in 45 C.F.R. §156.604.

n. According to guidance from HHS, an individual who has coverage under a group health plan provided through insurance regulated by a foreign government has minimum essential coverage if the individual is "physically absent from the United States ..." and if the individual is "physically present in the United States ... while the individual is on expatriate status." For more information see *CCIIO Sub-Regulatory Guidance: Process for Obtaining Recognition as Minimum Essential Coverage*, issued October 31, 2013.

Author Contact Information

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