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Proposed Rules for Minimum Essential Coverage

On January 24, 2014, the Agencies (IRS, DOL and HHS) issued proposed rules regarding the requirement for individuals to maintain Minimum Essential Coverage ("MEC") under the Individual Shared Responsibility (also known as the Individual mandate) rules of the ACA. These rules are essentially "rounding out" the details as they relate to certain types of governmental health programs and whether they qualify as MEC.

Details on Government Sponsored Programs

Medically Needy Coverage

The guidance first deals with certain portions of the Medicaid program that are available to some "medically needy" people but who have too much income to qualify for Medicaid eligibility. States are allowed to set up programs that allow people in this position to conditionally qualify for what amounts to Medicaid supplement programs by spending down their income in a specific "budget period." Since this coverage is not required to be comprehensive, it does not qualify as MEC, unless the Medically Needy coverage actually is comprehensive. Additionally, the guidance identifies two additional types of coverage under Medicaid that does not qualify as MEC – certain optional family planning services, and optional tuberculosis-related services.

Section 1115 Demonstration Programs

Section 1115 programs are pilot programs designed to promote the objectives of the Medicaid program, some of which are provided waivers from certain Medicaid requirements. As with the conclusion on the Medically Needy coverage, to the extent that the Section 1115 program doesn't provide comprehensive coverage, the Agencies have determined that this coverage will not qualify as MEC.

Limited Benefit Coverage under TRICARE

There are two types of limited coverage available under the government's TRICARE program – "Space Available" and "Line of Duty" coverage. Both programs are limited in nature and available only in certain circumstances. As such, they too do not qualify as MEC.

Excepted Benefits

Consistent with a variety of rules published over the last six months or so, the Agencies have reaffirmed again that coverage consisting solely of excepted benefits (dental-only plans, or fixed indemnity plans that qualify as excepted benefits, for example) does not qualify as MEC.

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Exemptions for Individuals who cannot afford coverage

The guidance also addresses the affect of employer contributions to HRAs and Cafeteria Plans with respect to whether or not the coverage being offered represents MEC.

Health Reimbursement Arrangements

If an employer makes contributions to an HRA that is integrated with the group health plan, and those contributions can be used by the employee to pay for a portion of their premiums under the plan, those HRA contributions can be taken into account in determining whether the plan meets the employer's affordability requirement under the employer's Shared Responsibility requirements. In other words, employers can use an HRA to offset the premium cost in order to remain within the 9.5% requirement.

Cafeteria Plan Contributions

The guidance examines two scenarios dealing with Cafeteria Plans – one where an employee elects to reduce their salary to pay for their contribution on a tax-free basis, and one where an employer gives employees an employer contribution to the Cafeteria Plan that cannot be cashed-out on an after-tax basis.

In the first scenario, the guidance indicates that the amount of employee salary reduction is added to the employee's household income for purposes of determining whether the coverage is affordable.

The agencies are asking for public input on the second scenario, which envisions a situation where the employer gives employees one contribution amount if they enroll in one of the group health plan options offered through the Cafeteria Plan, and a different amount (likely lower) if they don't, but also restricts the employee from cashing out the employer contribution.

Wellness Program Initiatives

Next, the guidance turns towards three issues with respect to wellness programs – cases where the employee is eligible for coverage, cases where the employee is not eligible for coverage, and an examination of the "simplified method" previously published in guidance from 2013.

Employee is Eligible for Coverage

This first scenario examines whether a wellness "credit" or reduction in premium costs counts with respect to determining whether the coverage is affordable. Consistent with prior guidance, wellness rewards only help offset the cost of coverage if they are related to tobacco usage.

Employee is Not Eligible for Coverage

Here, the Agencies are taking a wait-and-see approach. This scenario is somewhat convoluted – involving a scenario where an employee is not eligible for coverage under an employer plan, and instead turns to the Exchange for a bronze-level individual plan. At issue is whether an individual wellness plan, presumably associated with the individual health plan, which provides a wellness premium award, would have an affect on whether the coverage is affordable (and therefore whether the individual is eligible for a subsidy.) Once plans of these types are made available through a demonstration project, the Agencies will take a closer look to determine what additional guidance, if any, is required.

The Simplified Method

While listed in the section discussing wellness program initiatives, this portion of the guidance is actually an statement by the Agencies that they continue to seek input from the public regarding how to calculate the applicable premium with respect to measuring affordability in the scenario where an individual cannot find a bronze-level plan on the Exchange that will cover all family members – in other words, if each family member has to secure their own individual bronze-level coverage, is the applicable premium simply the combination of those premiums? Stay tuned on this one.

Hardship Exemptions

The last part of this guidance relates to the hardship exemptions that resulted from the troubled rollout of the federal Exchanges, formalizing the penalty relief for those who enroll through the Exchange during its initial open enrollment but did not secure coverage by January 1, 2014.

Finally, the Agencies also provided a quick tweak to the regulations that clarify that the taxpayer is responsible for the penalties incurred for not maintaining MEC for any given month in which the penalty applies (the regulations said the same thing but used terms that might be construed in a way that would hold each individual taxpayer in the household responsible for the penalty.)

Partial Relief

Concurrent with the release of this guidance, the IRS published Notice 2014-10, available here, which provides relief with respect to people enrolled in the following:

- Family planning services Medicaid
- Tuberculosis-related Medicaid
- Pregnancy-related Medicaid
- Emergency-related Medicaid

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- Certain Section 1115 Demonstration Programs
- Coverage for medically-needy individuals
- Space-available Care
- Line of duty Care

This relief from the Shared Responsibility Penalty is necessary due to the late release of the guidance; some people have enrolled in the aforementioned programs presuming they do represent MEC. As this is no longer the case, they will need to seek alternative solutions for their MEC coverage. However, for months in 2014 where they have coverage under one of these plans, they will not be penalized.