



February 13, 2013

Health Care Reform: Dependent Coverage Affordability Rule under Employer Plans

On February 1, 2013, the Internal Revenue Service (IRS) adopted a **final rule** under the Patient Protection and Affordable Care Act (PPACA or ACA) about the affordability of employer health coverage offered to families of employees. The rule could inadvertently deny federal financial assistance in the form of premium tax credits (PTCs) to many family members of employees with modest incomes who cannot afford the family coverage offered by their employers.

In determining whether an employer's health plan is "affordable" for "related individuals" (i.e., spouses and children of a covered employee) for purposes of determining eligibility for the PTC, the IRS will look at the cost of coverage only for an *individual employee*—not for the family. *Even if employer health coverage is unaffordable to an employee's family at the family-coverage level, family members will not be eligible for PTCs to purchase coverage through the ACA's health insurance exchanges (Exchanges) as long as the employee-only cost of the offered employer coverage is less than 9.5% of household income.* In cases where family coverage is prohibitively expensive and the employee declines employer-provided coverage of his or her dependent children or spouse, PTCs would still not be available to help the family purchase insurance for children or the spouse through an Exchange. There is an additional consideration regarding spouses because employers are not required to offer spouse coverage, which is explained below.

Family members denied PTCs on this basis, however, will not face penalties under the ACA's individual mandate (Individual Mandate), described **here** for not having health coverage. This is an important exemption, although little consolation for families that cannot afford coverage under an employer plan and do not qualify for PTC-assistance on an Exchange. The definition of affordable employer coverage with respect to the Individual Mandate differs slightly, as explained below.

The Basic Rule for Employees

Under the ACA, an individual will not qualify for a PTC when he or she has an offer of affordable employment-based coverage. This means that the individual will not receive any federal assistance in the form of a PTC to purchase a health insurance plan on an Exchange, even if his or her household income is below 400% of the federal poverty level (FPL, the income threshold for federal PTCs). Affordable employer coverage for this purpose (PTC eligibility) is defined by the ACA as coverage for which the employee is not required to pay more than 9.5% of his or her household income (which is defined as modified adjusted gross income or MAGI¹).

¹ For purposes of the ACA, MAGI is defined under §36B of the Internal Revenue Code (Code) as a taxpayer's adjusted gross income (AGI) as defined under Code §62, increased by three components: (1) any amount excluded from gross income under Code §911 (i.e., foreign earned income); (2) any amount of tax-exempt interest received or accrued by the taxpayer during the tax year; and (3) the amount of the taxpayer's Social Security benefits that are excluded from gross income under Code §86 for the tax year. [In general, AGI can be found on the last line (line 37) of Page 1 of taxpayers' *Form 1040*.]

Example 1: In 2014, Rev. Ryan has MAGI of \$47,000 (total compensation of \$60,000, less \$10,000 under the housing exclusion and \$3,000 that Ryan contributes pre-tax to the United Methodist Personal Investment Plan [UMPIP]). Ryan is an “employee” (for this purpose) of First United Methodist Church (FUMC), which offers its employees health coverage through its annual conference plan and requires Ryan to contribute \$1,800 annually for self-only coverage for 2014 (this is 3.8% of Ryan’s MAGI). Because Ryan’s required contribution for self-only coverage does not exceed 9.5% of MAGI, FUMC’s plan is defined as affordable for Ryan; therefore Ryan is eligible for “*minimum essential coverage*” in 2014. This means that if Ryan decided to seek health insurance coverage on his state’s Exchange, he would be denied PTCs toward that coverage, even if he might otherwise qualify based on MAGI.

An **earlier final regulation** on the PTC, however, had left open the question of what would happen if an employed individual can afford self-only coverage for 9.5% of MAGI or less, but cannot afford the higher-priced family coverage. *Would the family, or at least the family members other than the employee, be able to forgo the employer coverage and qualify for PTCs?*

New Finalized PTC Rule

The February 1 IRS **final rule** determined when an employer-sponsored plan is considered *affordable* for an individual related to the employee, i.e., spouses and dependents, for purposes of the PTC. The final rule clarifies that beginning January 1, 2014, “an eligible employer-sponsored plan is *affordable* for related individuals if the portion of the annual premium the employee must pay for *self-only* coverage (the required contribution percentage) does not exceed 9.5% of the employee’s [MAGI].”

Essentially, the rule requires only that employers pay a significant portion of the cost to cover the employee. The rule allows employers to charge employees higher amounts for covering dependents without worrying that the employee will opt out of the employer coverage and seek PTCs for Exchange coverage (which could cause a penalty to accrue to the employer under the employer mandate in some circumstances). This rule may result in employers shifting ever more of the cost for spouse and dependent coverage to employees.

Example 2: In 2014, Reverend Beverly has MAGI of \$47,000. Beverly is an “employee” of FUMC, which offers employees health coverage through the annual conference plan. Beverly is married to Gerry. FUMC’s plan covers dependents of employees and requires Beverly to contribute \$6,000 for coverage of herself and Gerry. This amount is equal to 12.8% of Beverly’s MAGI (household income). However, FUMC’s plan would require Beverly to contribute only \$2,400 for *self-only* coverage. Because the \$2,400 required contribution for self-only coverage does not exceed 9.5% of MAGI (\$2,400 is 5.1% of Beverly’s MAGI), FUMC’s plan is considered *affordable* for Beverly *and* Gerry (despite that the actual cost of covering both individuals is 12.8% of MAGI). Therefore, Beverly and Gerry are considered eligible for *minimum essential coverage* from the FUMC employer plan, and both are precluded from obtaining a PTC on an Exchange. This is true even if Beverly declines coverage for Gerry because he was offered affordable employer coverage under the ACA’s PTC affordability rule.

How PTC Rule Fits with the Individual Mandate

This final rule about the PTCs relates to several other provisions of the ACA. The IRS issued a rule about the Individual Mandate, under which it proposes requiring an employee who is offered self-only coverage by an employer that costs the employee 8% of MAGI or less to accept that coverage in order to avoid the Individual Mandate’s tax penalty. The definition of affordable employer coverage differs under the Individual Mandate from the PTC Rule in a few important respects. Under the Individual Mandate rule, the employee’s dependents would not be penalized for refusing to purchase (enroll in) family coverage under an employer plan if that family coverage costs more than 8% of MAGI. For purposes of applying this exemption from the Individual Mandate in the case of “related individuals,” the required contribution is based on the premium the employee would pay for employer-sponsored family coverage rather than self-only coverage.

Examples 1 and 2: In our examples above, Ryan (for whom self-only employer coverage would cost 3.8% of MAGI) would be required to accept the employer coverage in order to avoid the penalty under the Individual Mandate. Beverly and Gerry, on the other hand, would have a more complicated calculus. Beverly would be required to accept her employer's offer of coverage to avoid the Individual Mandate's penalty because she was offered self-only coverage that would cost her less than 8% of her MAGI (self-only would cost her 5.1% of MAGI).

However, because the coverage offered by FUMC to cover Beverly and Gerry together (family coverage) would cost Beverly and Gerry more than 8% of MAGI, they have a choice. Gerry could decline the FUMC coverage if he and Beverly think it is too expensive. As a result, Gerry would not be subject to a penalty under the Individual Mandate, because the family coverage offered by FUMC would cost them more than 8% of their MAGI. However, because the FUMC plan is affordable for Beverly with respect to the PTC rule (i.e., self-only coverage costs less than 9.5% of MAGI), Gerry will not qualify for a PTC to assist in purchasing coverage from an Exchange. He may go without coverage.

How the PTC Rule Fits with the Employer Mandate

In its **proposed rules** about the employer shared responsibility provision (Employer Mandate), the IRS proposed that the statutory requirement that an employer offer coverage to employees "and their dependents" be interpreted so that employers must offer coverage to each employee as well as an employee's children, *but is not required to offer such coverage to an employee's spouse*. The IRS further proposed that an employer should not be penalized under the Employer Mandate for offering unaffordable coverage if the employer complies with one of three safe harbors, all of which hinge upon the employer offering affordable self-only coverage (i.e., costs less than 9.5% of MAGI, similar to the definition under the PTC Rule), rather than affordable family coverage.

The fact that employers are not required to offer coverage at all to an employee's spouse is significant. Employers could rely on these rules to quit offering coverage to employees' spouses. In some cases, this action could free spouses of employed individuals to seek Exchange coverage and qualify for a PTC. This also may lead to more married couples getting coverage for each spouse through his or her own employer, where that is an option. Alternatively, more spouses that do not have an offer of their own employer coverage may obtain coverage through the Exchanges.

Example 3: Reverend Scott works as an associate pastor for Grace United Methodist Church (GUMC). GUMC is a large employer subject to the Employer Mandate. GUMC has decided to avoid the penalty under the Employer Mandate by offering its employees and their children a health plan, but has decided to encourage employees' spouses to find coverage through their own employers and therefore does not cover spouses in its plan. Scott is married to Halle and they have two children. Scott and Halle have MAGI of \$47,000. GUMC requires Scott to pay \$1,200 annually for self-only coverage (2.6% of his MAGI), but family coverage (for Scott and the children) would cost Scott \$6,600 annually. Under the Individual Mandate rules, Scott would be required to enroll in GUMC coverage for himself because the self-only coverage costs less than 8% of MAGI—or pay a penalty. However, he would not be required to enroll the children because the family coverage would cost more than 8% of MAGI (it would cost 14% of MAGI).

Halle cannot enroll in the GUMC plan because of its exclusion of spouses. Halle must find other health coverage or else pay a penalty under the Individual Mandate. Given the final rule for PTCs, because Halle was not offered coverage under the GUMC plan that is affordable for Scott and as long as Halle does not have an offer of affordable coverage from her own employer (if any), it appears she could shop for a plan on the Exchange and receive a PTC based on the couple's MAGI to help purchase that coverage. The children, however, would not be eligible for PTCs because they were offered coverage under the GUMC plan that was affordable (because *self-only coverage* costs Scott less than 9.5% of his MAGI).

Scott and Halle would have to choose whether to cover the children in the GUMC plan and pay the high cost of that coverage, or leave the children uncovered. Under the Individual Mandate, the children would not be penalized for not having coverage because the GUMC family coverage would cost more than 8% of MAGI.

Bottom Line

The bottom line seems to be that even though an employer must offer coverage to an employee and the employee's children (though not necessarily the employee's spouse), the employer will not be penalized under the Employer Mandate if *family coverage* is unaffordable as long as *self-only* coverage is affordable (less than 9.5% of MAGI). If self-only coverage is affordable, the employer will have satisfied the Employer Mandate under the ACA, even though family coverage is unaffordable. In addition, as long as the employer-offered coverage costs the employee less than 9.5% of MAGI for self-only coverage, then *no matter what the employer charges to cover the employee's dependents, those dependents offered coverage will be precluded from seeking government-subsidized coverage on the Exchanges*. Dependents who decline employer-provided coverage that they cannot afford will not be penalized under the Individual Mandate if the cost of the family coverage exceeds 8% of MAGI. And, presumably, spouses of employees can qualify for PTCs if they are not offered employer coverage at all.

In 2012, according to an annual survey by the Kaiser Family Foundation, total premiums for employer-sponsored health insurance averaged across the U.S. \$5,615 a year for self-only coverage and \$15,745 for family coverage. The employee's share of the premium averaged \$951 for self-only coverage and nearly \$4,316, for family coverage. Under the final rule, such costs would be considered "affordable" for a family making \$35,000 a year, even though the family would have to spend 12% of its MAGI for that family coverage.

What it May Mean for Annual Conference Health Plans

United Methodist annual conferences will need to consider the premium cost-sharing provisions of their plans carefully. Some annual conferences set mandatory cost-sharing percentages for clergy and dependent coverage; others establish suggested policies for charge conferences and local churches; and still others leave such cost-sharing policies to the local churches. In any case, these rules have significant meaning to clergy, lay employees and their dependents across the Connection. Covered individuals at local churches in annual conference plans will need access to information about the health plan premiums (contributions) attributable to self-only coverage and family coverage. Conferences that use "blended rates" regardless of a clergyperson's family size or pass on the costs of coverage through apportionments will have to begin providing local churches and participants additional information about actual costs of coverage.

Questions and Information

If you have questions or would like additional information, please send your inquiries to healthcarereform@gbophb.org. General information about health care reform is available from the federal government at www.healthcare.gov.

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