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Exchange Health Insurance Subsidies

The Affordable Care Act (ACA) calls for the creation of state-based competitive marketplaces, known as **Affordable Health Insurance Exchanges** (Exchanges), for individuals and small businesses to purchase private health insurance. According to the Department of Health and Human Services (HHS), the Exchanges will allow for direct comparisons of private health insurance options on the basis of price, quality and other factors, and will coordinate eligibility for premium tax credits and other affordability programs.

The ACA created health insurance subsidies, in the form of premium tax credits and cost-sharing reductions, to help eligible individuals and families purchase health insurance through an Exchange. By reducing a taxpayer's out-of-pocket premium costs, the subsidies are designed to make coverage through an Exchange more affordable.

Subsidies will be available **beginning in 2014**, at the same time the Exchanges are scheduled to become operational. Enrollment in Exchanges began on Oct. 1, 2013.

OVERVIEW OF THE EXCHANGE HEALTH INSURANCE SUBSIDIES

There are two federal health insurance subsidies available with respect to coverage through an Exchange—**premium tax credits** and **cost-sharing reductions**. Both of these subsidies vary in amount based on the taxpayer's household income and reduce the out-of-pocket costs of health insurance for the insured.

- Premium tax credits are available for people with somewhat higher incomes (up to 400% of FPL), and reduce **out-of-pocket premium costs** for the taxpayer.
- Reduced cost-sharing is available for individuals with lower incomes (up to 250% of FPL). Through cost-sharing reductions, these individuals will be eligible to enroll in plans with higher actuarial values and have the plan, on average, pay a greater share of covered benefits. This means that coverage for these individuals will have lower **out-of-pocket costs at the point of service** (for example, lower deductibles and copayments).

For purposes of determining eligibility for these subsidies, and the amount of any subsidy available, household income is determined using the taxpayer's **federal income tax return for that year**. However, because these subsidies are provided when the individual purchases insurance, the Exchanges will generally have to determine household income well before the individual files his or her tax return for that year.

To aid the Exchanges in making these determinations, HHS released an application for insurance that asks applicants to provide specific information about their current income.

- If the applicant's current income is not steady or if they expect it to change, the application asks them to project their 2014 income.
- If the applicant provides no financial information, the Exchange will rely on the individual's federal income tax return from the previous year.

At the end of the year, the subsidy amount will be recalculated using the taxpayer's household income as reported on his or her tax return, and any difference in the amounts will be reconciled. If the taxpayer's income has increased from the amount that he or she reported to the Exchange, and as a result received a larger subsidy than he or she

was entitled to, that individual **may have to repay part of their subsidy**. This could result in a smaller tax refund or a tax payment due for that individual.

ELIGIBILITY FOR PREMIUM TAX CREDITS

The ACA requires Exchanges to provide information to prospective enrollees about their eligibility for premium tax credits. To receive the premium assistance, a taxpayer must enroll in one or more qualified health plans (QHPs) through an Exchange. Also, to be eligible for the premium tax credit, a taxpayer:

- Must have household income for the year between 100 percent and 400 percent of the federal poverty line (FPL) for the taxpayer's family size;
- May not be claimed as a tax dependent of another taxpayer; and
- Must file a joint return, if married.

For purposes of the subsidies, "household income" means the sum of:

- A taxpayer's modified adjusted gross income; plus
- The aggregate modified adjusted gross income of all other individuals who:
    - Are included in the taxpayer's family (meaning the individuals for whom a taxpayer properly claims a deduction for a personal exemption for the taxable year); and
    - Are required to file a tax return for the taxable year.

To be eligible for the tax credit, the taxpayer **cannot be eligible for minimum essential coverage** (such as coverage under a government-sponsored program or an eligible employer-sponsored plan). Employees who may enroll in an employer-sponsored plan, and individuals who may enroll in the plan because of a relationship with an employee, are generally considered eligible for minimum essential coverage if the plan is **affordable** and provides **minimum value**.

> *Employees who are eligible for minimum essential coverage (that is affordable and provides minimum value) through an employer-sponsored plan are not eligible for the premium tax credit. This is significant because the ACA's shared responsibility penalty for large employers is triggered when a full-time employee receives a premium tax credit for coverage under an Exchange. An employee who is not eligible for a tax credit may still be eligible to enroll in a QHP through an Exchange. However, this would not result in a shared responsibility penalty for the employer.*

Also, for purposes of the premium assistance, the requirements of affordability and minimum value do not apply if an employee actually enrolls in any employer-sponsored minimum essential coverage, including coverage provided through a cafeteria plan, a health FSA or an HRA, but only if the coverage does not consist solely of excepted benefits. If an employee enrolls in any employer-sponsored minimum essential coverage, the employee is ineligible for the premium assistance.

Continuation Coverage

A special rule applies to individuals eligible for continuation coverage under federal law or a state law that provides comparable continuation coverage, such as COBRA. In May 2012, the IRS issued a final rule providing that individuals who are eligible for continuation coverage are treated as being eligible for minimum essential coverage only for months that they are actually enrolled in the coverage.

However, on May 3, 2013, the IRS issued a proposed rule that revises this guidance by limiting the application of the special rule to former employees. The proposed rule may be applied for taxable years ending before Jan. 1, 2015.

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Under the proposed rule:

- A former employee who is eligible to enroll in continuation coverage is considered eligible for minimum essential coverage only for months that the individual is enrolled in the coverage. The same rule applies to retirees eligible for retiree coverage.
- Active employees eligible for continuation coverage as a result of reduced hours are subject to the same eligibility rules for the premium tax credit as other active employees. Thus, active employees who are eligible for continuation coverage that is affordable and provides minimum value will not be eligible for a premium tax credit.

Affordability Determination

To determine an individual's eligibility for a tax credit, the ACA provides that employer-sponsored coverage is not considered affordable if the employee's cost for self-only coverage exceeds **9.5 percent** of the employee's household income for the tax year. The IRS confirmed that for purposes of the pay or play rules, the affordability determination for families is based on the cost of **self-only coverage**, not family coverage.

Although the ACA measures affordability based on household income, the proposed regulations include three safe harbor approaches for assessing whether an employer's coverage is affordable. These safe harbors allow an employer to measure affordability based on:

- The employee's **W-2 wages**;
- The employee's **rate of pay**; or
- The **federal poverty level for a single individual**.

Premium credit eligibility will still be based on household income, but the employer will not be subject to a penalty for that employee, even if he or she ultimately receives a premium credit.

Minimum Value Determination

The ACA provides that a plan fails to provide minimum value if the plan's share of total allowed costs of benefits provided under the plan is less than **60 percent** of those costs.

On Feb. 25, 2013, HHS issued a final rule that outlines the following approaches for determining whether an employer's health coverage provides minimum value:

- ***Approach One: Calculator –*** HHS has released an MV Calculator that permits an employer to enter information about its health plan's benefits, coverage of services and cost-sharing terms to determine whether the plan provides minimum value.
- ***Approach Two: Checklists –*** HHS and the IRS have indicated that they will provide an array of design-based safe harbors in the form of checklists that employers can use to compare to their plan's coverage. If a plan's terms are consistent with or more generous than any one of the safe harbor checklists, the plan would be treated as providing minimum value. In May 2013, the IRS specified three safe harbor plan designs that satisfy minimum value and stated that they expect to release more in future guidance.
- ***Approach Three: Actuarial Certification –*** An employer-sponsored plan may seek certification by an actuary to determine the plan's minimum value if the plan contains nonstandard features that preclude the use of the MV Calculator and safe harbor checklists.

In addition, a plan in the small group market that meets any of the "metal levels" of coverage (that is, bronze, silver, gold or platinum) provides minimum value.

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AMOUNT OF THE PREMIUM TAX CREDITS

The amount of the premium tax credit that an individual can receive generally is the difference between the cost of the premium for the "benchmark plan" and the amount the individual should be able to pay for premiums (expected contribution).

- The "**benchmark plan**" is the second lowest cost silver plan in the Exchange and area where the individual is eligible to purchase coverage. A **silver plan** is a plan that provides the essential benefits and has an actuarial value of 70 percent (that is, the plan, on average, pays 70 percent of the cost of covered benefits).
- The "**expected contribution**" is calculated as a specified percentage of the taxpayer's household income for the year, based on the taxpayer's FPL. The percentage increases as income increases, as follows:

INCOME LEVEL	EXPECTED CONTRIBUTION
Up to 133% FPL	2% of income
133 – 150% FPL	3 – 4% of income
150 – 200% FPL	4 – 6.3% of income
200 – 250% FPL	6.3 – 8.05% of income
250 – 300% FPL	8.05 – 9.5% of income
300 – 400% FPL	9.5% of income

The ACA also established new eligibility rules for Medicaid, giving states the option of extending Medicaid coverage to most people with incomes under 138 percent of federal poverty. In states that expand Medicaid, tax credits are available through the Exchange for individuals with incomes between 139 percent and 400 percent of federal poverty who do not have access to employer-sponsored or public coverage, as follows:

INCOME LEVEL	TYPE OF COVERAGE	EXPECTED CONTRIBUTION
Up to 138% FPL	Medicaid	No premiums
139 – 150% FPL	Exchange	3 – 4% of income
150 – 200% FPL	Exchange	4 – 6.3% of income
200 – 250% FPL	Exchange	6.3 – 8.05% of income
250 – 300% FPL	Exchange	8.05 – 9.5% of income
300 – 400% FPL	Exchange	9.5% of income

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If an individual enrolls in a QHP that is cheaper than the benchmark plan, the actual amount the individual will pay for coverage will be less than the expected contribution. However, an individual that wants to purchase a QHP that is more expensive would have to pay the **full difference** between the cost of the benchmark plan and the plan they wish to purchase. The credit is capped at the premium for the plan the individual chooses (so that no one receives a credit that is larger than the amount they actually pay for their plan).

PREMIUM TAX CREDIT PAYMENTS

The premium tax credits are both refundable and advanceable. A refundable tax credit is one that is available to an individual even if he or she has no tax liability. An advanceable tax credit allows an individual to receive assistance at the time that they purchase insurance, rather than paying their premium out of pocket and waiting to be reimbursed when filing their annual income tax return.

Advance payments would be made directly to the insurance company on the family's behalf. At the end of the year, the advance payments are **reconciled** against the amount of the family's actual premium tax credit, as calculated on the family's federal income tax return. Any repayment due from the taxpayer is subject to a cap for taxpayers with incomes under 400 percent of FPL.

COST-SHARING REDUCTIONS

In addition, individuals with household incomes of **up to 250 percent of FPL** may also be eligible for reduced cost-sharing (that is, coverage with lower deductibles and copayments). These cost-sharing reductions are intended to protect lower income individuals from high out-of-pocket costs by ensuring that the plan, on average, pays a greater share of covered benefits. In order to receive the reductions, an individual must enroll through an Exchange in a QHP in the **silver level of coverage**.

On March 11, 2014, HHS published its 2015 Notice of Benefit and Payment Parameters Final Rule, which includes reductions in the maximum annual limitation on cost-sharing for enrollees in 2015. The following table shows the reductions:

INCOME LEVEL	REDUCED MAXIMUM ANNUAL LIMITATION ON COST-SHARING FOR SELF-ONLY COVERAGE FOR 2015	REDUCED MAXIMUM ANNUAL LIMITATION ON COST-SHARING FOR FAMILY COVERAGE FOR 2015
100-150% FPL	$2,250	$4,500
150-200% FPL	$2,250	$4,500
200-250% FPL	$5,200	$10,400

APPEAL RIGHTS

For Individuals

Individuals have the right to appeal determinations of their eligibility to purchase health insurance through an Exchange, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions that they are eligible for. Under the federally-facilitated Exchange, individuals will first have the opportunity for a preliminary case review by appeals staff, referred to as "informal resolution." If the individual is satisfied by the outcome of the informal resolution, the decision stands as an official appeal decision. If the individual is dissatisfied with the outcome of the informal resolution, he or she retains the right to a hearing.

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State-based Exchanges have the flexibility to implement their own appeals processes in accordance with federal guidelines. Like the federal appeals process, state-based appeals processes may also include an informal resolution process. However, individuals have the right to escalate their appeals to the federal process managed by HHS if they remain dissatisfied following the state-based appeals process.

For Employers

Beginning in 2014, large employers may be subject to penalties if they do not offer coverage to full-time employees, or if the health coverage does not meet certain standards. These penalties are triggered when a full-time employee receives a premium tax credit or cost-sharing reduction for purchasing health insurance through an Exchange. When an employee receives a federal premium subsidy, the employer will be notified of the determination and their potential liability for a shared responsibility penalty.

The federally-facilitated Exchange will include an appeals process for employers that wish to contest an Exchange determination that the employer does not provide minimum essential coverage that meets both minimum value and affordability standards. Through this appeals process, the employer can correct any information the Exchange received from an employee's application regarding the employer's offer of coverage. This appeal is separate from the IRS' process for determining whether an employer is liable for a shared responsibility penalty.

State-based Exchanges have the flexibility to implement their own appeals processes in accordance with federal standards. For Exchanges that do not establish their own process, HHS will provide an employer appeals process.

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