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Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA) in 2015

(name redacted)
Specialist in Health Care Financing

March 18, 2015

Congressional Research Service
7-....
www.crs.gov
R43945

CRS REPORT
Prepared for Members and
Committees of Congress

Summary

New federal tax credits, authorized under the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), first became available in 2014 to help certain individuals pay for health insurance. The tax credits apply toward premiums for private health plans offered through *exchanges* (also referred to as health insurance *marketplaces*). The ACA also established subsidies to reduce cost-sharing expenses.

Health insurance exchanges operate in every state and the District of Columbia (DC), per the ACA statute. Exchanges may be established and administered by states, the federal government, or a combination of both. Exchanges are not insurers, but they provide eligible individuals and small businesses with access to private health insurance plans. Generally, plans offered through the exchanges provide a comprehensive set of health services and meet all of the ACA's insurance market reforms, as applicable.

The new premium credits established under the ACA are advanceable and refundable, meaning tax filers need not wait until the end of the tax year to benefit from the credit and may claim the full credit amount even if they have little or no federal income tax liability. Premium tax credits generally are available to individuals who enroll in an exchange plan; are part of a tax-filing unit; have household income between specified amounts; are not eligible for other forms of comprehensive health coverage; and are U.S. citizens or lawfully present residents. This report provides examples of hypothetical individuals and families that qualify for the premium credits. The examples use actual 2015 exchange premiums.

The amounts received in premium credits are based on federal income tax returns. These amounts are reconciled after individuals file their returns and can result in overpayment of premium credits if income increases, which must be repaid to the federal government. The ACA limits the amount of required repayments for lower-income enrollees.

In addition to premium credits, the ACA authorized new cost-sharing subsidies. Certain premium credit recipients also are eligible for reductions in their annual cost-sharing limits. Moreover, certain low-income individuals receive additional subsidies in the form of reduced cost-sharing requirements (e.g., lower deductibles).

Contents

Figures

Tables

Contacts

New federal tax credits were authorized in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), to help certain individuals pay for health insurance coverage, beginning in 2014.[1] The tax credits apply toward premiums for private health plans offered through *exchanges* (also referred to as *health insurance marketplaces*). The ACA also authorized subsidies to reduce cost-sharing expenses.

This report describes the eligibility criteria applicable to the premium tax credits and cost-sharing subsidies, and the calculation method for the credit and subsidy amounts. It also highlights selected issues addressed in the final regulation and guidance on premium credits and indicates the status of implementation, where relevant data is available.

Exchanges and Premium Credits

Health insurance exchanges operate in every state and the District of Columbia (DC), per the ACA statute. Exchanges may be established and administered by states, the federal government (administered through the Department of Health and Human Services [HHS]), or a combination of both.[2] Exchanges are not insurance companies; rather, they are *marketplaces* that offer private health plans to qualified individuals[3] and small businesses.[4] Generally, exchange plans provide a comprehensive set of health services and meet all of the ACA's insurance market reforms, as applicable.[5] In addition, most exchange plans comply with a requirement that measures how much a given plan will pay for a group of individuals (who vary in terms of medical use and expenses); that measure is referred to as actuarial value (AV).[6] Most exchange plans meet a specific AV, with each AV designated by a precious metal: bronze (actuarial value of 60%), silver (70%), gold (80%), and platinum (90%). For AVs, the higher the percentage, the lower the cost sharing, *on average*.[7]

[1] §1401 of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), new §36B of the Internal Revenue Code of 1986 (IRC).

[2] For information about types of exchanges, see Kaiser Family Foundation, "State Health Insurance Marketplace Types, 2015," at http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/.

[3] Enrollment in an exchange plan is voluntary; see §1312(d)(3) of the ACA. This also applies to Members of Congress and their personal staff who may only be offered coverage by the federal government that is created under the ACA or offered through an exchange, per the ACA §1312(d)(3)(D). Although the federal government may make only certain plans available to applicable Members and staff, such individuals may enroll in any plan that is available to them. For a comprehensive discussion about these issues, see CRS Report R43194, *Health Benefits for Members of Congress and Certain Congressional Staff*.

[4] Before 2016, states will have the option to define *small employers* either as those with (1) 100 or fewer employees, or (2) 50 or fewer employees. Beginning in 2016, small employers will be defined as those with 100 or fewer employees. Beginning in 2017, large groups may participate in exchanges, at state option.

[5] See CRS Report R42069, *Private Health Insurance Market Reforms in the Affordable Care Act (ACA)*.

[6] Actuarial value (AV) is a summary measure of a plan's generosity, expressed as the percentage of medical expenses estimated to be paid by the insurer for a standard population and set of allowed charges. AV is *not* a measure of premiums or the benefits package. Two plans with the same AV may have different premiums and different sets of covered benefits.

[7] Since actuarial value is calculated based on a population, this measure indicates plan generosity for a group. It does *not* indicate the share of medical expenses that the plan will pay for *each* individual enrolled in a plan. The utility of AV is that it facilitates comparisons across plans, so that an individual/family may use this plan characteristic (along with other factors) to decide on the most appropriate plan given anticipated health care needs and disposable income.

Given that the ACA specifically requires exchanges to offer insurance options to individuals and small businesses, the ACA requires exchanges to be structured to assist these two different types of "customers." Consequently, there is an exchange to serve individuals and families, and another to serve small businesses (SHOP exchanges[8]) within each state. However, the ACA gives states the option to provide one exchange to serve both individuals and small businesses.[9]

Certain enrollees in the *individual* exchanges are eligible for premium assistance in the form of federal tax credits.[10] Such credits are not provided through the SHOP exchanges. The premium credit is an advanceable, refundable tax credit, meaning tax filers need not wait until the end of the tax year to benefit from the credit and may claim the full credit amount even if they have little or no federal income tax liability. Receiving the credits as advanced payments means that monthly insurance premiums will be automatically reduced by the credit amount. Therefore, the direct cost of insurance to an individual/family *generally* will be lower than the "advertised" cost for a given exchange plan.[11]

The Treasury Department (Treasury) promulgated final regulation on the premium credits on May 23, 2012.[12] The final regulation confirmed certain eligibility and other requirements, as specified in statute; such requirements are discussed in applicable sections of this report. In addition, the Internal Revenue Service (IRS) has issued guidance and other documentation (such as Q&As) relevant to premium credits.[13]

[8] See CRS Report R43771, *Small Business Health Options Program (SHOP) Exchange*.

[9] The ACA statute does not specify the features of such an exchange, except that the exchange must have "adequate resources" to provide assistance to both types of customers. See §1401(b)(2) of the ACA.

[10] For tax years beginning after December 31, 2013, 31 U.S.C. 1324 appropriates necessary amounts to the Treasury Secretary for disbursements due under §36B of the IRC. This permanent appropriation means that the premium credits do not require annual appropriations.

[11] The formula for calculating the premium credit amount is such that it is possible for a higher-income person who is technically eligible for a credit to end up receiving no credit to offset the cost of buying insurance. For additional information about this issue, see the discussion under the "Required Premium Contributions and Premium Credit Calculations" section of this report.

[12] 77 *Federal Register* 30377, May 23, 2012.

[13] See the IRS's "Affordable Care Act (ACA) Tax Provisions" webpage for links to such documents at http://www.irs.gov/Affordable-Care-Act.

King vs. Burwell

On March 4, 2015, the Supreme Court heard oral arguments in *King vs. Burwell*.[14] At issue in *King* and other similar legal challenges is whether the statutory language of the ACA allows the IRS to provide premium tax credits to residents of states that declined to establish health insurance exchanges. The issue is considered a significant one, not only because a majority of states have exchanges that were not established by the states, and millions of individuals residing in those states receive credits, but also because of the far-reaching implications of a potential loss of credits on the private market more broadly and implementation of other ACA provisions. For additional information about *King* and potential implications of the Supreme Court's decision, see CRS Report R43833, *Premium Tax Credits and Federal Health Insurance Exchanges: Questions and Answers*.

Premium Credit Eligibility

The ACA specifies that premium credits will be available to "applicable taxpayers" in a "coverage month."[15]

An *applicable taxpayer* is an individual who

- is part of a tax-filing unit;
- is enrolled in a plan through an individual exchange; and
- has household income at or above 100% of the federal poverty level (FPL), but not more than 400% FPL.[16]

A *coverage month* refers to a month in which the applicable taxpayer paid for coverage offered through an exchange, not including any month in which the taxpayer was *eligible* for "minimum essential coverage" with exceptions.

These eligibility criteria are discussed in greater detail below.[17]

Part of a Tax-Filing Unit

Premium assistance is provided in the form of tax credits, which are administered through the tax system (although advance payments go directly to insurers).[18] The premium credit process

[14] 759 F.3d 358, (4th Cir. 2014), cert. granted, 83 U.S.L.W. 3286 (U.S. November 7, 2014) (No. 14-114).

[15] §1401(a) of the ACA, new §36B(c)(1) of the IRC.

[16] The guidelines that designate the federal poverty level are used in a variety of federal programs for eligibility purposes. The poverty guidelines vary by family size, and by whether the individual resides in the 48 contiguous states and the District of Columbia, Alaska, or Hawaii. Office of the Assistant Secretary for Planning and Evaluation, "Frequently Asked Questions Related to the Poverty Guidelines and Poverty," http://aspe.hhs.gov/Poverty/faq.cfm#programs.

[17] Consumers Union's Tax Credit Brochures are available to help tax filers determine their eligibility for premium tax credits. See "Cut the Cost of Health Insurance," http://www.consumersunion.org/tax_credit_brochure.

[18] As specified under §1412(a)(3) of the ACA, advanced credits are provided from the Treasury Department to insurers. The Department of Health and Human Services (HHS) provides payment information to Treasury. Treasury then processes the Electronic File Transfer and sends credit payments directly to the insurer's financial institution. See FAQs 463 and 500, https://www.regtap.info/.

requires qualifying individuals to file federal tax returns, even if their incomes are at levels that normally do not necessitate the filing of tax returns.

Married couples are required to file joint tax returns to claim the credit.[19] The final regulation includes special rules relating to the calculation and allocation of credit amounts due to changes in filing status during a given tax year (e.g., taxpayers who marry or divorce). The final regulation acknowledges that certain circumstances may make filing jointly a challenge (e.g., domestic abuse, abandonment, etc.); it states that the IRS will propose additional rules to address these kinds of circumstances.

Enrolled in an Individual Exchange

Premium credits are available only to individuals and families enrolled in a plan offered through an individual exchange; premium credits are *not* available through the small business (SHOP) exchanges. Individuals may enroll in a plan through their state's exchange if they are (1) residing in a state in which an exchange was established; (2) not incarcerated, except individuals in custody pending the disposition of charges; and (3) "lawfully present" residents.[20]

Only lawful residents are allowed to obtain exchange coverage. Undocumented individuals are prohibited from purchasing coverage through an exchange, even if they could pay the entire premium without a subsidy.[21] Because the ACA prohibits undocumented individuals from obtaining exchange coverage, they are *not* eligible for premium credits.

The final regulation clarifies the potential credit eligibility for family members of individuals who themselves are *not* eligible to enroll in an exchange due to incarceration or legal status. For example, while the final regulation restates the ACA's prohibition on incarcerated individuals enrolling in exchange plans, the rule confirms that family members (of incarcerated individuals) who enroll in exchange plans may receive premium credits, as long as the family members meet all eligibility criteria.[22]

Household Income Is 100%-400% of Federal Poverty Level

Individuals generally must have household income within statutorily defined guidelines (based on the federal poverty level [FPL][23]) to be eligible for premium credits, with some exceptions. For

[19] On June 26, 2013, in United States v. Windsor, the U.S. Supreme Court struck down Section 3 of the Defense of Marriage Act (DOMA), finding that it violated the equal protection guarantees of the Fifth Amendment. Section 3 had required that, for purposes of federal enactments, marriage be defined as the union of one man and one woman. In light of this ruling, HHS issued guidance which stated that same-sex spouses will be treated just like opposite-sex spouses for premium credit eligibility purposes. See Centers for Medicare & Medicaid Services, "Guidance on Internal Revenue Ruling 2013-17 and Eligibility for Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions," September 27, 2013, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/marketplace-guidance-on-irs-2013-17.pdf.

[20] §1401(a) of the ACA, new §36B of the IRC.

[21] §1312(f)(3) of the ACA.

[22] See discussion under "Individuals not lawfully present or incarcerated," 77 *Federal Register* 30377, May 23, 2012.

[23] The poverty guidelines are updated annually, at the beginning of the year. However, premium credit calculations are based on the prior year's guidelines to provide individuals with timely information as they compare and enroll in exchange plans during the open enrollment period (which occurs prior to the beginning of the plan year). For the poverty guidelines used to calculate the credit amounts for 2015, see "Annual Update of the HHS Poverty Guidelines," (continued...)

purposes of premium credit eligibility, household income is measured according to the definition for modified adjusted gross income (MAGI).[24] An individual whose MAGI is at or above 100% FPL up to and including 400% FPL may be eligible to receive premium credits.[25]

Table 1 displays the income levels at 400% FPL, the amount *beyond* which individuals and families would *not* be eligible for premium credits in 2015 (using 2014 HHS poverty guidelines).[26]

Table 1. Income Levels at 400% FPL Applicable to 2015 Premium Credit Eligibility

(based on 2014 HHS poverty guidelines)

Number of Persons in Family	48 Contiguous States and DC	Alaska	Hawaii
1	$46,680	$58,320	$53,680
2	$62,920	$78,640	$72,360
3	$79,160	$98,960	$91,040
4	$95,400	$119,280	$109,720
5	$111,640	$139,600	$128,400
6	$127,880	$159,920	$147,080
7	$144,120	$180,240	$165,760
8	$160,360	$200,560	$184,440

Source: Congressional Research Service computations based on "Annual Update of the HHS Poverty Guidelines," 79 *Federal Register* 3593, January 22, 2014, http://www.gpo.gov/fdsys/pkg/FR-2014-01-22/pdf/2014-01303.pdf.

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79 *Federal Register* 3593, January 22, 2014, http://www.gpo.gov/fdsys/pkg/FR-2014-01-22/pdf/2014-01303.pdf.

[24] In §2002(a) and §1401(a) of the ACA, household income is defined to be MAGI, in compliance with the Internal Revenue Code (IRC). Under the IRC, gross income is total income minus certain exclusions (e.g., public assistance payments, employer contributions to health insurance payments). From gross income, adjusted gross income (AGI) is calculated to reflect a number of deductions, including trade and business deductions, losses from sale of property, and alimony payments. MAGI is defined as AGI plus certain foreign earned income and tax-exempt interest. However, for premium credit eligibility purposes, the definition of MAGI will also include nontaxable Social Security benefits (as amended by P.L. 112-56). For additional discussion about the use of MAGI with respect to the ACA premium credits, see CRS Report R43861, *The Use of Modified Adjusted Gross Income (MAGI) in Federal Health Programs*.

[25] There are exceptions to the lower bound income threshold at 100% FPL. One exception relates to the state option under the ACA to expand Medicaid for individuals with income up to 133% FPL (with a 5% income disregard). If a state chooses to undertake the ACA Medicaid expansion (or has already expanded Medicaid above 100% FPL), eligibility for premium credits would begin above the income level where Medicaid eligibility ends in such a state. (Note that in states that do not expand Medicaid to at least 100% FPL, some low-income state residents are *in*eligible for both premium credits and Medicaid.) Another exception is for lawfully present aliens with income below 100% FPL, who are *not* eligible for Medicaid for the first five years that they are lawfully present. The ACA established section 36B(c)(1)(B) of the IRC to allow such lawfully present aliens to still be eligible for premium credits. Likewise, the final regulation on premium credits provided a special rule for credit recipients whose income at the end of the tax year end up being less than 100% FPL. Such individuals will continue to be considered "applicable taxpayers" for premium credit eligibility purposes. For regulatory language applicable to lawfully present aliens and individuals whose incomes are below 100% FPL at the end of the tax year, see 26 C.F.R. 1.36B-2(b)(5), (6), and (7).

[26] See Internal Revenue Service, "Questions and Answers on the Premium Tax Credit," Q&A #6, http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-the-Premium-Tax-Credit.

Notes: For 2015, the income levels used to calculate premium credit eligibility and amounts are based on 2014 Department of Health and Human Services (HHS) poverty guidelines. The poverty guidelines are updated annually for inflation. FPL = federal poverty level; DC = District of Columbia.

Not Eligible for "Minimum Essential Coverage"

To receive a premium credit, an individual may *not* be *eligible* for "minimum essential coverage," with exceptions (described below). The ACA broadly defines minimum essential coverage to include Medicare Part A; Medicare Advantage; Medicaid (with exceptions); the State Children's Health Insurance Program (CHIP); Tricare; Tricare for Life, a health care program administered by the Department of Veterans Affairs (VA);[27] the Peace Corps program; any government plan (local, state, federal) including the Federal Employees Health Benefits Program (FEHBP); any plan offered in the individual health insurance market; any employer-sponsored plan (including group plans regulated by a foreign government); any grandfathered health plan;[28] any qualified health plan offered inside or outside of exchanges; and any other coverage (such as a state high risk pool) recognized by the HHS Secretary.[29]

Exceptions to Minimum Essential Coverage Eligibility

The ACA provides certain exceptions regarding eligibility for minimum essential coverage and receipt of premium credits:

- An individual who is only eligible to obtain coverage through the individual (nongroup) health insurance market[30] may be eligible to receive a premium credit.
- An individual eligible for an employer-sponsored plan may still be eligible for premium credits if the employer's coverage is either (1) not affordable; that is, the employee's premium contribution toward the employer's self-only plan exceeds 9.56% of household income;[31] or (2) does not provide minimum value;

[27] The IRS final regulation on premium credits stated that for premium credit eligibility purposes, a person would be considered "eligible" for a VA health program only if that person is actually enrolled in such a program. Therefore, individuals who could enroll in such programs, but choose not to enroll, may be eligible for premium credits, providing they meet all other eligibility criteria. See discussion under "Special rule for coverage for veterans and other individuals under chapter 17 or 18 of Title 38, U.S.C.," 77 *Federal Register* 30377, May 23, 2012.

[28] A grandfathered health plan is a group health plan or health insurance coverage (including coverage from the individual health insurance market) in which a person was enrolled since the date of enactment of the ACA. For additional information about grandfathered plans, see CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (ACA)*.

[29] The IRS final regulation on premium credits addresses various circumstances when individuals transition between exchange coverage and public coverage, such as Medicaid. For example, the regulation discusses the process and time period applicable to an individual who becomes eligible for "government-sponsored coverage," and therefore becomes ineligible for premium credits. See discussion under "Government-Sponsored Coverage" and "Determination of Medicaid or Children's Health Insurance Program (CHIP)," 77 *Federal Register* 30377, May 23, 2012.

[30] The private health insurance market continues to exist outside of the ACA exchanges. Moreover, almost all exchange plans are allowed to be offered in the market outside of exchanges.

[31] The IRS final regulation on premium credits confirms that an employee safe harbor will be provided to an individual who initially is determined to be eligible for premium credits because the employer plan is unaffordable to that individual, but later in the year the individual has access to an affordable employer plan and technically is not eligible for credits. The employee safe harbor allows such individuals to continue to be eligible for credits for the rest of the year. Moreover, the employer would not be subject to a penalty because a full-time employee receives a premium credit (continued...)

that is, the plan's payments cover less than 60% of total allowed costs on average.[32]

- An individual who is eligible for limited benefits under Medicaid may still be eligible for premium credits (see "Medicaid" section below for additional information).

Employer Contribution Toward Coverage in SHOP Exchanges

Certain small employers (and in later years, large employers at state option) may offer and contribute toward coverage through SHOP exchanges. If an individual is enrolled in an exchange through an employer who contributed toward that coverage, the individual will *not* be eligible for premium credits.[33]

Medicaid

The ACA's Medicaid expansion provisions have the potential for affecting eligibility for premium credits if certain low to middle income individuals and families seek health insurance through the exchanges.[34] Under the ACA, states have the option to expand Medicaid eligibility to include all non-elderly, non-pregnant individuals (i.e., childless adults and certain parents, except for those ineligible based on certain non-citizenship status) with income up to 138% FPL.[35] (The ACA does not change noncitizens' eligibility for Medicaid.[36]) States that have chosen to implement the ACA Medicaid expansion have received substantial federal subsidies. If a person who applied for premium credits in an exchange is determined to be eligible for Medicaid, the exchange must have them enrolled in Medicaid.[37] Therefore, in states that have expanded Medicaid eligibility to include persons with incomes at or above 100% FPL (or any state that currently includes such individuals), premium credit eligibility begins at the income level where Medicaid eligibility ends.

In general, a person may be eligible for only one subsidized health coverage program at a time. However, exceptions are made for individuals who are eligible only for limited benefits under Medicaid; limited benefits include the pregnancy-related benefits package, treatment of emergency medical conditions only, and other limited benefits. Individuals who have access to

(...continued)

under the safe harbor.

[32] §1401(a) of the ACA, new §36B(c)(2)(C) of the IRC.

[33] §1401(a) of the ACA, new §36B(c)(2)(A)(ii) of the IRC.

[34] See CRS Report R43564, *The ACA Medicaid Expansion*.

[35] The ACA specifies that the Medicaid expansion increases eligibility for individuals with incomes up to 133% FPL, with an income disregard of 5%. Thus, the *effective* minimum income eligibility threshold for such individuals in this new Medicaid eligibility group will be 138% FPL.

[36] As under law prior to the ACA, certain lawfully present aliens are eligible for full Medicaid benefits (e.g., refugees, asylees, and some legal permanent residents [LPRs] who have been here at least five years), whereas others are not (e.g., certain LPRs who have been here less than five years).

[37] §§1311(d)(4) and 1413(a) of the ACA. Nonetheless, nothing in the ACA prohibits a Medicaid-eligible individual from enrolling in an exchange on his/her own. However, that individual will be responsible for the entire cost of exchange coverage, which will likely be prohibitive for a low-income individual.

specified limited benefits under Medicaid may qualify for premium credits if such individuals enroll in exchanges.[38]

Required Premium Contributions and Premium Credit Calculations

The amount of the premium tax credit varies from person to person; the credit is based on the household income of the tax filer (and dependents), the premium for the exchange plan in which the tax filer (and dependents) is (are) enrolled, and other factors. In certain instances, the credit amount may cover the entire premium and the tax filer pays nothing toward the premium. In other instances, the tax filer may pay part (or all)[39] of the premium.

The credit amount is based on a comparison of two amounts that result from two different scenarios. The first scenario (and amount) is straightforward: the premium for the exchange plan in which the person/family enrolls. The second scenario is more complicated, involving a formula that considers the premium for a reference plan in the local area in which the person/family resides, and an amount that the person/family may be required to contribute toward the premium. Based on a comparison of the amounts resulting from each scenario, the premium credit will be the lesser amount. The following text box, "Calculation of the Premium Credit Amount," discusses these two scenarios in more detail.

Calculation of the Premium Credit Amount

The premium credit amount will be the *lesser* amount resulting from either:

Scenario A: The cost of the exchange plan that the tax filer (and dependents) is (are) enrolled in;

Or

Scenario B: The excess, if any, resulting from the following formula:

The age-adjusted premium for the second-lowest-cost silver plan in the tax filer's area (*reference plan*),

Minus

The product of the tax filer's household income and the *applicable percentage* (explained in greater detail below), based on the tax filer's household income relative to the federal poverty level.

[38] See Health Reform GPS, "When Does Medicaid Coverage Amount to Minimum Essential Coverage Under the Affordable Care Act? An Update on the Treasury/IRS Rules Defining Minimum Essential Coverage," February 11, 2014, http://www.healthreformgps.org/resources/when-does-medicaid-coverage-amount-to-minimum-essential-coverage-under-the-affordable-care-act-an-update-on-the-treasuryirs-rules-defining-minimum-essential-coverage/.

[39] The formula for calculating the premium credit amount is such that it is possible that the result may be a credit of zero dollars, meaning the person/family pays the entire exchange premium. See the text box "Calculation of the Premium Credit Amount" for additional information.

Enrollee Premium Contribution

The enrollee premium contribution will be based on the lesser amount calculated above.

Scenario A: If the premium credit is based on the amount calculated under Scenario A, then the tax filer (and dependents) pay(s) nothing toward the premium for exchange coverage.

Scenario B: If the premium credit is based on the amount calculated under Scenario B, then the tax filer (and dependents) pay(s) some amount toward the premium for exchange coverage.

Choice of Exchange Plan Enrollment

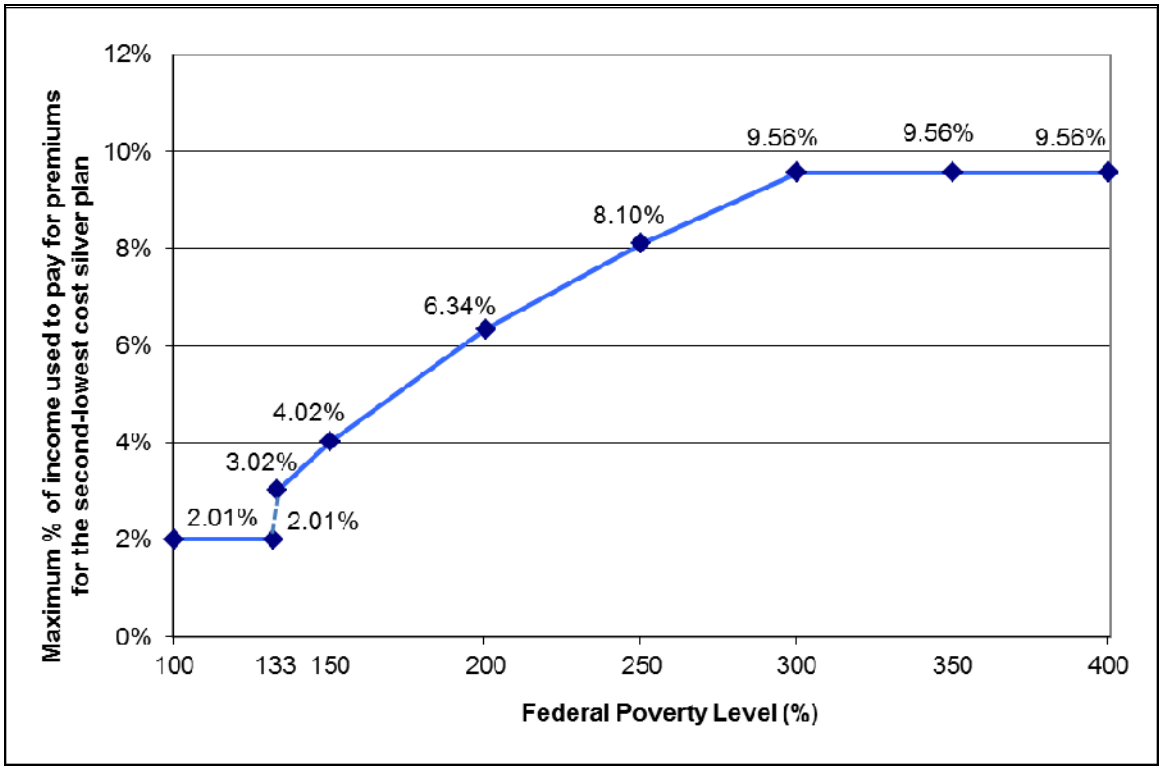
While the calculation in Scenario B is based on the second-lowest-cost silver plan in the tax filer's local area, the qualifying individual/family may enroll in any tiered plan in an exchange and still be eligible for a tax credit. However, if the individual/family enrolls in a plan with a premium that exceeds the premium for the reference plan, the individual/family is responsible for paying that additional amount.

Under Scenario B, the amount that a tax filer who receives a premium credit is required to contribute toward the premium (for the reference plan) is capped as a percentage of household income; that is, the *maximum premium contribution* is the product of the tax filer's household income and the "applicable percentage," as specified in the ACA. In general, the applicable percentage is less for those with lower incomes compared with those with higher incomes; where income is measured relative to the federal poverty level. Under Scenario B, the amount that tax filers with income between 100% FPL and 133% FPL may be required to contribute toward the reference plan's premium is capped at 2.01% of household income for 2015. For tax filers with income 300%-400% FPL, their premium contribution is capped at 9.56% of income. The IRS further specifies the applicable percentages, for tax filers whose incomes are between those two income bands[40] (see **Figure 1**).

[40] See IRS Revenue Procedure 2014-37, http://www.irs.gov/pub/irs-drop/rp-14-37.pdf.

Figure 1. Maximum Percentage of Household Income to Go Toward 2015 Premiums for the Second-Lowes Cost Silver Plan, by Percentage of the Federal Poverty Level

(applicable to premium tax credit recipients)



Source: IRS Revenue Procedure 2014-37, http://www.irs.gov/pub/irs-drop/rp-14-37.pdf.

Note: The Patient Protection and Affordable Care Act (ACA) statute specifies the maximum percentages of income, as measured relative to the federal poverty level (FPL), to calculate the tax filer's required premium contribution. The ACA specified the "applicable percentages" at the following FPLs: 133%, 150%, 200%, 250%, 300%, and 400%. The percentages jump at 133% FPL; the dotted line in the graph illustrates the cliff effect of the statutory requirements.

The line graph shows the "applicable percentage" used to calculate the tax filer's required premium contribution at each income level, as measured relative to the federal poverty level. The ACA statute specifies the applicable percentage at certain incomes (income at 100% FPL, 133% FPL, 150% FPL, etc.) beginning in 2014 and indexed in later years. At each of those incomes, the line changes slope. Specifically, at and above 133% FPL up to 300% FPL, the applicable percentage increases *incrementally* as income increases. For example, a person with income at 150% FPL may be required to pay a maximum of 4.02% of household income toward exchange coverage in the reference plan. A 1% increase in income (i.e., person has income at 151% FPL) results in a maximum premium contribution equal to 4.07% of income.[41] In contrast to this gradual change in the maximum premium contribution for incomes between 133% and 300% FPL, there is a "cliff" for a person/family with income below 133% FPL. Instead of the incremental change discussed above, the contribution amount jumps when you compare income just *below* 133% FPL with income *at* 133% FPL. This cliff reflects statutory requirements.[42]

[41] The formula to calculate "applicable percentages" is discussed in 26 C.F.R. 1.36B-3.

[42] See the ACA, §1401(a), new §36B(b)(3)(A) of the IRC; and 26 C.F.R. 1.36B-3.

Given that calculation of the premium credit amount (under Scenario B) is the arithmetic difference after subtracting the tax filer's required premium contribution from the premium for the second-lowest-cost silver plan (*reference plan*), it is theoretically possible that a person's required premium contribution could be equal to or exceed the reference plan's premium. Such a scenario would leave that tax filer with a premium credit of zero.[43] Moreover, while the credit amount under this scenario is based on the reference plan, the individual/family may enroll in any metal-tier plan and still be eligible for credits. However, when a premium credit recipient enrolls in a plan that is more expensive than the reference plan, that person must pay the additional premium amount.

Premium Credits in 2015

For 2015, **Table 2** displays selected annual income levels used in the calculation of premium credit amounts and required premium contributions, as discussed above.

Table 2. Selected Annual Income Levels Applicable to 2015 Premium Credits

(based on 2014 HHS poverty guidelines for the 48 contiguous states and the District of Columbia)

Percentage of Federal Poverty Line (FPL)	Family Size			
	1 person	2 persons	3 persons	4 persons
100%	$11,670	$15,730	$19,790	$23,850
133%	$15,521	$20,921	$26,321	$31,721
150%	$17,505	$23,595	$29,685	$35,775
200%	$23,340	$31,460	$39,580	$47,700
250%	$29,175	$39,325	$49,475	$59,625
300%	$35,010	$47,190	$59,370	$71,550
350%	$40,845	$55,055	$69,265	$83,475
400%	$46,680	$62,920	$79,160	$95,400

Source: CRS computations based on "Annual Update of the HHS Poverty Guidelines," 79 *Federal Register* 3593, January 22, 2014, http://www.gpo.gov/fdsys/pkg/FR-2014-01-22/pdf/2014-01303.pdf.

Notes: For 2015, the income levels used to calculate premium credit eligibility and amounts are based on 2014 Department of Health and Human Services (HHS) poverty guidelines. Different income levels, as measured against the federal poverty level, apply separately to Alaska and Hawaii (see **Table 1**).

Table 3 displays the maximum *monthly* premium contributions for individuals and families who receive premium tax credits, provided that they enroll in the applicable reference plan.

[43] For an illustrative example, see hypothetical person "C" and table note "c" in **Table 4** of this report.

Table 3. Maximum Monthly Premium Contributions for Tax Credit Recipients Enrolled in the Second-Lowest-Cost Silver Plan, by Income, 2015

(based on 2014 HHS poverty guidelines for the 48 contiguous states and the District of Columbia)

Federal Poverty Line (FPL)	Maximum Premium Contribution based on a Percentage of Income (Applicable Percentages)	1 person	2 persons	3 persons	4 persons
100%	2.01%	$20	$26	$33	$40
132.99%	2.01%	$26	$35	$44	$53
133%	3.02%	$39	$53	$66	$80
150%	4.02%	$59	$79	$99	$120
200%	6.34%	$123	$166	$209	$252
250%	8.10%	$197	$265	$334	$402
300%	9.56%	$279	$376	$473	$570
350%	9.56%	$325	$439	$552	$665
400%	9.56%	$372	$501	$631	$760

Source: CRS computations based on "Annual Update of the HHS Poverty Guidelines," 79 *Federal Register* 3593, January 22, 2014, http://www.gpo.gov/fdsys/pkg/FR-2014-01-22/pdf/2014-01303.pdf.

Notes: For 2015, the income levels used to calculate premium credit eligibility and amounts are based on 2014 Department of Health and Human Services (HHS) poverty guidelines. If individuals enroll in more expensive plans than the second-lowest-cost silver plan in their respective areas, they would be responsible for the additional premium amounts. If the required premium contribution exceeds the actual premium amount, individuals would pay the entire premium for exchange coverage. The premium contributions have been rounded up to the nearest dollar amount.

Both **Figure 1** and **Table 3** illustrate the cliff effect that occurs at 133% FPL. For individuals with income *below* 133% FPL, the credit formula ensures that such individuals pay no more than 2.01% of their income for the second-lowest-cost silver plan. For incomes *at* 133% FPL, individuals and families may pay 3.02% of their income toward premiums for the reference plan. For example, an individual with income at 132.99% FPL (annual income of $15,520) may be required to pay $26 in monthly premiums for the second-lowest-cost plan in 2015 (see **Table 3**). With one additional dollar of income (annual income of $15,521, equivalent to 133% FPL), this person may be required to pay $39 in monthly premiums. Therefore, the additional $1 in annual income may lead to an additional $156 in premium contributions for this hypothetical person in 2015. Nevertheless, some might observe that prior to implementation of the ACA premium credits in 2014, there were no federal subsidies for health coverage for individuals with income at this level and above, except for some narrowly defined groups. Thus, more individuals overall may be eligible for subsidized private coverage under the ACA, than before enactment of the law.

Premium Credit Examples: Self-Only and Family Coverage

The following hypothetical examples use actual exchange information about premiums, enrollee contributions, and estimated premium credit amounts; the information was compiled using the plan finder tool at healthcare.gov.[44] To facilitate comparisons across hypothetical individuals and

[44] To find local plan information, premiums, and estimated tax credit amounts in federally facilitated exchanges (no (continued...)

families, the premium and estimated tax credit amounts apply to the same zip code: 60647 (the same zip code used as an example in the plan finder tool at https://www.healthcare.gov/see-plans/). The examples in **Table 4** assume that the hypothetical individual (or family) is enrolled in the reference plan (second-lowest-cost silver plan). As the 2015 premium data indicate, individuals at the same income level will face different (pre-credit) premiums based on age. This reflects the limited age rating allowed for health insurance policies, including those offered in the individual exchanges.[45] The practical effect of the ACA's age rating requirements means that, for any given metal-tier plan in a specific geographic area, premiums vary for adults between 21 and 64+ years of age by a 3:1 ratio. (For examples that illustrate the 3:1 ratio for adults, see hypothetical persons A, B, C, and D in **Table 4** and the following analysis included under "Discussion of Self-Only Coverage Examples.") Moreover, the premium credit amounts are greater for those with lower incomes, compared with higher-income individuals of the same age, reflecting the income-based structure of the premium credits.

Table 4. Premium Contributions and Credit Amounts for the Second-Lowest-Cost Silver Plan in 2015, by Selected Coverage Tiers

(applicable to zip code 60647)

Coverage Tier	Hypothetical Person or Family (Letter Designation)	Annual Income	Federal Poverty Level (FPL)	Maximum Premium Contribution as a % of Income	Age of Adult(s)[a]	Monthly (Pre-Credit) Premium for the Second-Lowest-Cost Silver Plan[b]	Monthly Premium Contribution from Enrollee(s)	Monthly Credit Amount
Self-Only	A	$17,505	150%	4.02%	21	$168	$59	$109
	B	$17,505	150%	4.02%	64	$506	$59	$447
	C	$40,845	350%	9.56%	21	$168	$168[c]	$0
	D	$40,845	350%	9.56%	64	$506	$325	$181
Family of Three[d]	E	$29,685	150%	4.02%	40	$538	$99	$439
	F	$29,685	150%	4.02%	60	$1,022	$99	$923
	G	$69,265	350%	9.56%	40	$538	$538[e]	$0
	H	$69,265	350%	9.56%	60	$1,022	$552	$470

Sources: Income levels and poverty levels from "Annual Update of the HHS Poverty Guidelines," 79 *Federal Register* 3593, January 22, 2014, http://www.gpo.gov/fdsys/pkg/FR-2014-01-22/pdf/2014-01303.pdf. Health plan premiums and estimated credit amounts were compiled using the health plan finder tool at https://www.healthcare.gov/see-plans/. The zip code used for these hypothetical persons/families is the same zip code used as an example in the plan finder tool.

Notes: For 2015, the income levels used to calculate premium credit eligibility and amounts in this table are based on 2014 HHS poverty guidelines for the 48 contiguous states and the District of Columbia.

(...continued)

registration necessary), see https://www.healthcare.gov/see-plans/. Residents in states with state-based exchanges may go directly to such exchanges, or can input a zip code at https://www.healthcare.gov/see-plans/ and be redirected to the relevant state-based exchange website.

[45] For additional information about age rating under the ACA, see the "Rating Restrictions" section in CRS Report R42069, *Private Health Insurance Market Reforms in the Affordable Care Act (ACA)*.

Notes:

a. Premiums for exchange plans are age-adjusted to allow for a maximum 3:1 variation for adults between 21 and 64+ years of age. For additional information about this and other rating restrictions, see CRS Report R42069, *Private Health Insurance Market Reforms in the Affordable Care Act (ACA)*.

b. The premiums for the plans that are currently being offered through exchanges vary according to metal tier, geographic location, family size, age, and other factors.

c. The maximum premium contribution for an individual whose income is $40,845 in 2015 is approximately $325 per month. However, the monthly premium in this example is $168, which is a lower amount than the maximum premium contribution for the second-lowest-cost silver plan. Given this, hypothetical person C pays the entire premium for coverage in this plan, and the credit amount is zero.

d. Premiums for exchange plans are allowed to vary based on family size. In this table, hypothetical families E through H are each composed of two adults of the same age and one child who is age 19. Insurance rates for children are calculated by considering individuals under age 21 as one group. For example, if one child who is age 5 and another child who is age 19 enrolled in the same metal-tier plan, their (pre-credit) premiums would be the same amount.

e. The maximum premium contribution for a family of three whose income is $69,265 in 2015 is approximately $552 per month. However, the monthly premium in this example is $538, which is a lower amount than the maximum premium contribution for the second-lowest-cost silver plan. Given this, hypothetical family G pays the entire premium for coverage in this plan and the credit amount is zero.

Discussion of Self-Only Coverage Examples

As indicated **Table 4** the monthly (pre-credit) premiums for self-only coverage in the second-lowest-cost silver plan in zip code: 60647, are $168 for a 21-year-old individual and $506 for a 64-year-old individual.[46] Given the 3:1 age-rating among adults between 21 and 64+ years of age, it follows that the premium for the same plan in the same county is approximately three times greater for the older adults (hypothetical persons B and D), than it is for the younger adults (hypothetical persons A and C). That is, hypothetical persons A and C (both of whom are 21 years of age) have a pre-credit premium of $168, compared to hypothetical persons B and D (both of whom are 64 years of age) who have a pre-credit premium of $506.

However, for premium credit recipients, age does *not* determine the amount that a given person contributes toward the premium. The formula for calculating premium contributions from enrollees is based on income (see **Table 3**), and such contributions are calculated prior to determining the credit amount. Therefore, the actual amount that tax credit recipients will pay toward exchange premiums may be the same for individuals with the same income levels, regardless of age. For example, persons A and B are very different in age but have the same income level; therefore, their required monthly contributions toward premiums are the same amount ($59). Person C is an example of the exception to this general rule. Persons C and D have the same income level, so you would expect their premium contributions to be the same amount ($325, see **Table 3**). However, person C's pre-credit premium ($168) is lower than the maximum premium contribution allowed for an enrollee at that income level ($325). Therefore, person C

[46] As discussed in the text box "Calculation of the Premium Credit Amount" in this report, the actual credit amount will either be the premium of the exchange plan in which the tax filer is actually enrolled (Scenario "A"), or the amount derived from the formula based on the second-lowest-cost silver plan (Scenario "B"). Given this requirement, the examples included in this report assume that the hypothetical individuals/families enroll in the reference plan, even though credit recipients are allowed to enroll in any metal tier plan.

pays the entire premium amount for the second-lowest-cost silver plan available in that zip code.[47]

Discussion of Family Coverage Examples

The rules applicable to self-only coverage regarding age-rating for adults and calculation of enrollee premium contributions based on income likewise apply to family coverage. **Table 4** includes 2015 examples for hypothetical families comprised of two adults of the same age and one child who is age 19. Similar to the self-only coverage examples, the families with the older adults (families F and H) face a larger pre-credit premium than the families with the younger adults (families E and G). However, the families with the same income pay the same amount toward premiums (see families E and F), unless the maximum premium contribution exceeds the pre-credit premium (see family G).

Reconciliation of Premium Credits

Under the ACA, the amount received in premium credits is based on the prior year's income tax returns. These amounts are reconciled when individuals file tax returns for the actual year in which they receive premium credits. If a tax filing unit's income decreases during the tax year, and the filer should have received a larger tax credit, this additional credit amount will be included in the tax refund for the year. On the other hand, any excess amount that was overpaid in premium credits will have to be repaid to the federal government as a tax payment. However, the ACA imposes limits on the excess amounts to be repaid under certain conditions. For households with incomes below 400% FPL, the law includes specific limits that apply to single and joint filers separately—limits that will be indexed by inflation in future years.[48]

Since the enactment of the ACA, these limits have been legislatively amended twice: first under the Medicare and Medicaid Extenders Act of 2010 (P.L. 111-309), and then under the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayment Act of 2011 (P.L. 112-9). The current repayment limits vary by income band (see **Table 5**). For example, say a family received overpayments for the tax credits they should have received in a given tax year. They will have to repay the excess when they file federal income taxes for that year. However, if such a family has income below 200% FPL, the IRS may only require them to repay up to $600 (for tax credit overpayments during that tax year). In other words, while such a family may technically owe a larger amount, repayment is limited to a maximum of $600 for a family with income below 200% FPL.

[47] Although person C is responsible for paying the entire premium, the premium contribution equals approximately 4.9% of income. This contrasts with person D, who has the same income level as person C, but whose premium contribution equals the maximum 9.56% of income.

[48] Revenue Procedure 2014-61 indicates that the dollar limits indicated in **Table 5** of this report still apply in 2015. See IRS Rev. Proc. 2014-61, http://www.irs.gov/pub/irs-drop/rp-14-61.pdf.

Table 5. Limits on Repayment of Excess Premium Credits Enacted by the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayment Act of 2011 (P.L. 112-9)

If Household Income (Expressed as a Percentage of the Federal Poverty Level) Is	Then the Applicable Dollar Limit for Joint Filers Is
Less than 200%	$600
At least 200% but less than 300%	$1,500
At least 300% but less than 400%	$2,500

Note: The applicable dollar limit for single filers is 50% of the joint-filer limit.

Limited Tax Relief for Certain Premium Credit Recipients

On January 26, 2015, the IRS announced that premium credit recipients who owe a payment on their 2014 tax return, as a result of the tax credit reconciliation process, may receive limited tax relief.[49] For the 2014 tax year only, taxpayers who meet specified eligibility criteria will be given relief from penalties related to the following scenarios: (1) late payment of taxes owed[50] and (2) underpayment of taxes owed.[51] In other words, this relief for 2014 only applies to penalties related to late payment or underpayment of taxes; the relief does not negate the taxpayer's obligation to pay back excess premium credit amounts calculated under the reconciliation process. Moreover, this limited relief does not provide taxpayers with an extension to file their return, nor does it provide relief from any underpayment related to the penalty for not complying with the ACA's individual mandate.[52]

To qualify for penalty relief under the first scenario, taxpayers must otherwise be in compliance with other tax filing and payment requirements; owe a tax payment as a result of premium credit overpayments that were advanced during the 2014 tax year; and report the excess amount of advanced credit payments on their timely filed 2014 tax return. To qualify for penalty relief under the second scenario, taxpayers must otherwise be in compliance with other tax filing and payment requirements and report the excess amount of advanced credit payments on their timely filed 2014 tax return.

Exchange Plan Selection and Premium Credits

On March 10, 2015, HHS announced that nearly 11.7 million persons selected a metal plan through the individual exchanges, with 86% determined to be eligible for premium tax credits.[53]

[49] See IRS Notice 2015-9, http://www.irs.gov/pub/irs-drop/n-15-09.pdf.

[50] This penalty was in effect prior to the ACA. See IRC §6651(a)(2).

[51] This penalty was in effect prior to the ACA. See IRC §6654(a).

[52] For information about the individual mandate, see CRS Report R41331, *Individual Mandate Under ACA*.

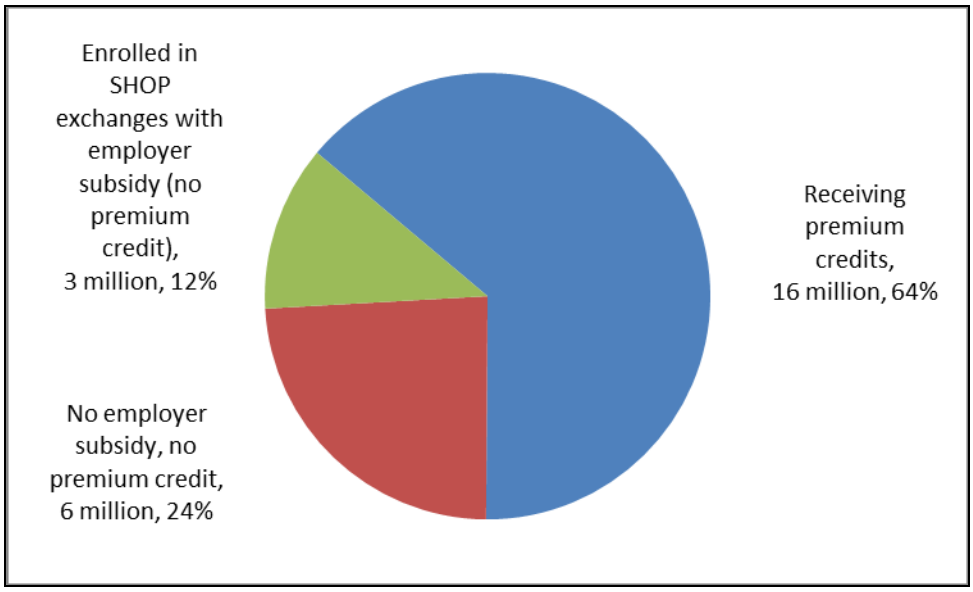
[53] The plan selection count does not consider payment of premiums; therefore, it is not equivalent to a final enrollment count. The data point referring to premium credit eligibility is based only on plan selections for which such information is available. Office of the Assistant Secretary for Planning and Evaluation, Appendix Table A1, "Health Insurance Marketplace 2015 Open Enrollment Period: March Enrollment Report," March 10, 2015, http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf

These data reflect exchange plan selections through the standard open enrollment period as well as the special enrollment period (SEP) that ended on February 22, 2015.[54]

For 2015 exchange enrollment, HHS is providing another special enrollment period. This SEP is for individuals residing in states in which the federal government administers the exchanges who were uninsured in 2014 and are subject to the penalty for noncompliance with the individual mandate. Individuals who meet the requirements specified in the SEP announcement[55] will be allowed to enroll in an exchange plan during the SEP (March 15, 2015, through April 30, 2015).

In its past and current estimates of the ACA's health coverage provisions, the Congressional Budget Office (CBO) projects exchange enrollment to be modest in the first few years, then increase significantly afterwards. Likewise, the estimates of federal outlays for premium credits are relatively moderate initially, but increase rapidly after the first few years. According to its latest estimates, CBO projects exchange enrollment in 2015 to total 12 million persons: 11 million and 1 million persons enrolled in the individual and SHOP exchanges, respectively. By 2025, CBO estimates that 25 million individuals will be enrolled in exchange coverage. Of those exchange enrollees who are enrolled in the individual exchanges (22 million), 16 million are projected to receive premium credits (see **Figure 2**). CBO estimates that federal outlays for premium credits will total $599 billion from FY2016 through FY2025.[56]

Figure 2. Total Estimated Exchange Enrollment, 2025



Source: U.S. Congressional Budget Office, "Insurance Coverage Provisions of the Affordable Care Act—CBO's March 2015 Baseline," March 2015, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf.

[54] While the 2015 open enrollment period ended on February 15, HHS provided a one-week special enrollment period for individuals who experienced technical problems or long call center waits related to enrollment through healthcare.gov. Also, individuals who experience a qualifying life event may qualify for a special enrollment period.

[55] "CMS Announces Special Enrollment Period for Tax Season," February 20, 2015, http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-02-20.html.

[56] U.S. Congressional Budget Office, "Insurance Coverage Provisions of the Affordable Care Act—CBO's March 2015 Baseline," March 2015, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf.

Notes: The estimate for individuals receiving premium credits includes individuals who were determined to be eligible for such credits because their employer plan was either unaffordable or did not provide minimum value ("inadequate"), per the ACA statute. The latest CBO projections for the ACA's insurance coverage provisions estimated that individuals with unaffordable or inadequate employer coverage was less than 1 million total; therefore, counts for those individuals were not published separately from other individuals who received premium credits through the standard eligibility process.

Cost-Sharing Subsidies

In addition to the premium credits, the ACA established subsidies that are applicable to cost-sharing expenses. An individual who qualifies for the premium credit *and* is enrolled in a silver plan (actuarial value of 70%) through an exchange is also eligible for cost-sharing assistance.[57] The assistance is provided in two forms, and both forms are based on income (see descriptions below). Individuals who receive cost-sharing subsidies may receive both types, as long as they meet the applicable eligibility requirements.

The ACA requires each metal tier plan to limit the total amount an enrollee will be required to pay out of pocket for use of covered services in a year (referred to as an annual cost-sharing limit in this report), and establishes separate limits for self-only coverage and family coverage. For 2015, the annual cost-sharing limit for self-only coverage is $6,450; the corresponding limit for family coverage is $12,900.[58] Given that tiered plans will already be required to comply with those annual cost-sharing limits, one form of cost-sharing assistance reduces such limits (see **Table 6**). The cost-sharing assistance reduces the annual limit faced by eligible individuals with income between 100% and 250% FPL; greater reductions are provided to those with lower incomes. In general, this cost-sharing assistance targets individuals and families who use a great deal of health care in a year and, therefore, have high cost-sharing expenses. Enrollees who use very little health care do not generate enough cost-sharing expenses to reach the annual limit.

Table 6. ACA Cost-Sharing Subsidies: Annual Cost-Sharing Limits, by Household Income Tier, 2015

Household Income Tier, by Federal Poverty Level	Annual Cost-Sharing Limits	
	Self-Only Coverage	Family Coverage
100% - 150%	$2,250	$4,500
Greater than 150% - 200%	$2,250	$4,500
Greater than 200% - 250%	$5,200	$10,400

Source: "HHS Notice of Benefit and Payment Parameters for 2015," 79 *Federal Register* 13744, March 11, 2014, http://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2-14-05052.pdf.

Note: The cost-sharing limits applicable to tiered plans established under the ACA use existing limits applicable to high-deductible health plans (HDHPs) that qualify to be paired with health savings accounts (HSAs). For 2015,

[57] The ACA establishes different eligibility criteria for cost-sharing subsidies for certain American Indians and Alaska Natives. For more information, see CRS Report R41152, *Indian Health Care: Impact of the Affordable Care Act (ACA)*.

[58] The cost-sharing limits established under this ACA provision uses existing limits applicable to high-deductible health plans (HDHPs) that may be paired with health savings accounts (HSAs). Therefore, the annual cost-sharing limits that apply to a given metal tier plan is based on the cost-sharing limits applicable to HSA-qualified HDHPs. See Internal Revenue Service, "Revenue Procedure 2014-30," http://www.irs.gov/pub/irs-drop/rp-14-30.pdf.

the cost-sharing limits for HSA-qualified HDHPs are $6,450 for self-only coverage, and $12,900 for family coverage. The cost-sharing subsidy reduces these annual limits based on income.

The second form of cost-sharing assistance also applies to individuals with income between 100% and 250% FPL. For eligible individuals, the cost-sharing requirements (in the plans they have enrolled) have been reduced to ensure that the plan covers a certain percentage of allowed health care expenses, on average. The practical effect of this cost-sharing assistance is to increase the actuarial value (AV)[59] of the exchange plan in which the person is enrolled (**Table 7**), so enrollees face lower cost-sharing requirements than they would have without this assistance. Given that this form of cost-sharing assistance directly affects cost-sharing requirements (e.g., lower deductible), both enrollees who use minimal health care and those who use a great deal of services may potentially benefit from this assistance.

Table 7. ACA Cost-Sharing Subsidies: Actuarial Values, by Household Income Tier

Household Income Tier, by Federal Poverty Level	New Actuarial Values for Cost-Sharing Subsidy Recipients
100%-150%	94%
Greater than 150%-200%	87%
Greater than 200%-250%	73%

Source: 45 C.F.R. §156.420.

To be eligible for cost-sharing subsidies, an individual must be enrolled in a silver plan, so that coverage already has an AV of 70%. For an individual who receives the subsidy referred to in **Table 7**, the health plan imposes a set of different cost-sharing requirements, so the "silver" plan will meet the new applicable AV. The ACA statute does not specify how a plan reduces cost-sharing requirements to increase the AV from 70% to one of the higher AVs. Through regulations, HHS requires each insurance company that offers a plan that is subject to these cost-sharing reductions to develop variations of its silver plan; these silver plan variations must comply with the higher levels of actuarial value (73%, 87%, and 94%).[60] When an individual is determined by an exchange to be eligible for a cost-sharing subsidy, the person is enrolled in the plan variation that corresponds with that person's income (as indicated in **Table 7**). This approach allows an individual to benefit automatically from this type of assistance, as soon as he or she uses health care that is covered under the exchange plan.

The HHS Secretary will provide full reimbursements to exchange plans that provide cost-sharing subsidies.[61] A given health plan is required to submit to HHS estimates of the amount of cost-sharing assistance it will provide in a year. Such estimates must be submitted prior to that year to

[59] Actuarial value (AV) is a summary measure of a plan's generosity, expressed as the percentage of medical expenses estimated to be paid by the insurer for a standard population and set of allowed charges. In other words, the higher the percentage, the lower the cost-sharing, on average. AV is not a measure of premiums or the benefits package. Two plans with the same AV may have different premiums and different sets of covered benefits.

[60] See 45 C.F.R. § 156.420.

[61] The ACA did not explicitly provide appropriations for the cost-sharing subsidies. The Administration is currently funding these subsidies through the financing mechanism used for the premium tax credits. The House of Representatives has filed a lawsuit challenging the Administration's action, arguing that the Administration lacks the authority to disburse the money for the subsidies that they are providing. See *House of Representatives v. Burwell*, No. 14-cv-01967, (D.D.C., filed November 21, 2014), http://www.speaker.gov/sites/speaker.house.gov/files/HouseLitigation.pdf.

receive advance payments for the estimated amount of cost-sharing assistance. A plan also must submit to HHS actual amounts of cost-sharing assistance provided. The actual amounts will be periodically reconciled with the amounts received by the plan in advance payments.[62] CBO estimates that federal outlays for the cost-sharing subsidies will total $136 billion from FY2016 through FY2025.[63]

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[62] For additional information about these submission and payment processes, see 45 C.F.R. §156.430.

[63] U.S. Congressional Budget Office, "Insurance Coverage Provisions of the Affordable Care Act—CBO's March 2015 Baseline," March 2015, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf.