CHAPTER 4: ELIGIBILITY FOR ADVANCE PREMIUM TAX CREDIT & COST SHARING REDUCTIONS

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A. Overview of Advance Premium Tax Credits and Cost Sharing Reductions

Premium tax credits and Cost Sharing Reductions (CSRs) are subsides made available by the federal government to help individuals and families pay for the cost of health insurance coverage purchased through HealthSource RI. To be eligible for a premium tax credit or CSR, an individual must:

- Be part of a household that files (or will file) taxes and meets financial eligibility standards; if married, household must file taxes jointly
- Enroll in a Qualified Health Plan (QHP) through HealthSource RI; and
- Be without access to an affordable alternative source of coverage that meets basic standards, i.e., "minimum essential coverage" (MEC).

A premium tax credit becomes available at the end of the tax year, when a household files its annual tax return and reports the coverage the household purchased during the preceding year.

A premium tax credit also may be paid in advance on a monthly basis to provide immediate financial assistance to households to help them purchase a QHP. When the tax credit is paid in advance, it is called an Advance Premium Tax Credit (APTC). For households eligible for APTCs, this assistance is sent to the insurance carrier on their behalf to offset each monthly bill. The amount of APTCs that the household receives will appear on monthly billing invoice sent by HealthSource RI.

This Chapter focuses on initial eligibility for APTCs and CSRs. Information on the redetermination of eligibility and enrollee obligations to report changes that occur throughout the year are not included in this Chapter, nor is information regarding the reconciliation process. For information on redeterminations of eligibility, please see Chapter 8. For more information about the reconciliation process, please see Chapter 5.

HealthSource RI is obligated to transmit individual market eligibility and enrollment information to the Federal government as necessary for the Federal government to begin, end, or change APTCs or CSRs.[1] HealthSource RI will transmit individual eligibility and enrollment information to the Carriers as necessary for them to calculate the amounts they should collect from the Federal government on behalf of covered individuals/households who qualify for APTCs and CSRs, including initial determinations, mid-year changes, and annual changes in eligibility.

1) Advance Premium Tax Credits

APTCs are available to households based on eligibility criteria, including household size and annual income, they are intended to help offset some of the cost associated with purchasing health insurance. To calculate a household's APTC eligibility, HealthSource RI will first identify the **second** lowest cost silver plan that is available in that policy year, called the "benchmark plan." The amount of tax credit the household is eligible for is equal to the total cost of the benchmark plan (or plans) that would cover the family, minus the household's expected contribution for coverage. The expected contribution is based on the Federal Poverty Level (FPL) and uses on a sliding scale; it varies from 2% of income for households at 100% of the FPL to 9.5% of income for those at 400% of the FPL.[2]

[1] as required by 45 C.F.R. § 155.340

APTC eligible customers can use their APTCs to buy any category of health plan offered through HealthSource RI Their monthly payment may increase or decrease based on their plan selection.[3] After a customer enrolls in a plan and pays for the first month of coverage, the customer's health insurance company will start to directly apply the customer's APTCs to the customer's monthly health insurance bill. Households can apply tax credits toward the purchase of any available QHP sold through HealthSource RI except a catastrophic plan.[4]

2) Cost Sharing Reductions

Cost-sharing reductions (CSRs) are available to households who earn up to 250% of the FPL AND enroll in a silver-level QHP plan through HealthSource RI. CSRs are also available to American Indian and Alaska Native households who enroll in any level QHP (See "Eligibility for Cost Sharing Reductions, American Indian/Alaska Native Population"). CSRs are used to reduce the out-of-pocket costs of medical care such as deductibles, co-payments, and coinsurance for covered services. Similar to APTCs, the federal government sends CSR subsidies directly to health insurance companies on behalf of CSR-eligible households. There are three different levels of CSRs available, eligibility for each depending on a household's FPL.

B. APTC Eligibility

1) Overview of APTC Eligibility

a) Eligibility Criteria

Households are eligible for an APTC in a given coverage month if they:[5]

- Anticipate having an annual household income of 138% to 400% of the FPL[6] (with an exception for non-citizens with income below 138% of FPL who are lawfully present and ineligible for Medicaid due to immigration status[7]).
- Plan to file a federal tax return and, if married, plan to file a joint return[8]. Married same-sex couples must also plan to file jointly.
- Cannot be claimed as a dependent on someone else's tax return.[9]
- Meet other eligibility requirements to enroll in a QHP (See Chapter 1).

In any given month, individuals can qualify for an APTC on behalf of themselves and any eligible household members who:

- Enroll in a QHP,[10] and
- Lack access to other MEC, such as employer-based coverage, employer-based coverage through the SHOP Exchange, Medicare, Medicaid, or CHIP. (See "Minimum Essential Coverage" below.)

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[3] If a household is eligible for APTCs in excess of the cost of the QHP in which they enroll, and a child or children under the age of 19 in that household enrolls in a stand-alone dental plan, then any amounts of the APTC in excess of the cost of the QHP, up to the cost of the EHB portion of the pediatric stand---alone dental plan, may be claimed as a premium tax credit at the end of the year, see 26 CFR 1.36B-3(k). HealthSource RI cannot apply advances on premium tax credits towards stand-alone dental coverage in these circumstances.

[4] 45 CFR 156.440

[5] 45 CFR 155.305(f); 26 CFR 1.36B--2

[6] The FPL level is updated annually by the Secretary of Health and Human Services. For purposes of APTC eligibility, use the most recently published FPL on the first day of the annual open enrollment period.

[7] 45 CFR 155.305(f)(2); § 1.36B-2(b)(5)

[8] 45 CFR 155.300(a), § 1.36B-2(b)(2)

[9] 26 CFR 1.36B-2(b)(2)(3). Even if the taxpayer who could claim the APTC applicant as a dependent is expected not to do so, the applicant still is ineligible for an APTC. An APTC cannot be provided to an individual for whom a dependent deduction is "allowable to another taxpayer."

[10] 26 CFR 1.36B-2(c). The enrollment must be as of the first day of the month; if an individual enrolls in a QHP in the middle of a month, he or she cannot receive an APTC for that month.

b) Treatment of Households in Which Some Individuals Are Not Eligible for an APTC

An individual who is not eligible to purchase a QHP can still receive an APTC for other household members.[11] For example, a father who is not lawfully residing in the United States or who is incarcerated (and therefore ineligible to purchase a QHP) may still receive an APTC on behalf of his wife and children if the wife and children meet eligibility requirements. If an individual is not applying for coverage for him or herself, he or she must still provide the income and household information required to evaluate eligibility for other household members.

c) Special Rule for Lawfully Present Individuals Below 100% of the FPL

In general, households must have income between 138% and 400% of the FPL to be eligible for an APTC.[12]. However, lawfully present immigrants who are ineligible for Medicaid based on their immigration status[13] and whose household income falls below 138% of the FPL still may be eligible for an APTC. Such individuals must be lawfully present and must meet all of the other APTC eligibility criteria that apply to individuals with income at or above 138% of the FPL.

2) Household Composition and Size

To determine whether an applicant meets the financial eligibility criteria for an APTC, HealthSource RI must "construct" the applicant's household, i.e., identify the members of the applicant's family who are considered part of the household for APTC purposes.[14] After the household is constructed, HealthSource RI determines the household's income and compares it to the FPL for a household of the appropriate size.

For APTC purposes, an applicant's household consists of the family members who will file taxes together. Specifically, a household includes individuals for whom a taxpayer may claim a deduction for a personal exemption,[15] including tax dependents even if they live outside the home for some period of time. For assessing Medicaid eligibility, the same household is generally used except when alternative relationship-based household rules apply (see Chapter 6).

In the case of a dispute between parents as to who is eligible to claim a child or children as tax dependents, HealthSource RI will not provide any assistance nor make a determination. HealthSource RI will only accept a court order as proof of which parent is authorized to claim a child or children as tax dependents for purposes of determining a household's eligibility for APTCs or CSRs.

Example: Consider two adults who are divorced with a child. The mother and child live together and the father lives separately. The father claims a personal exemption deduction for the child, so the child is included in the father's taxpayer household for the purpose of determining eligibility for an APTC. The father's taxpayer household size is two: the father and the child. The child is *not* included in the mother's taxpayer household for determining eligibility for an APTC, even if the child lives with the mother. The mother has a taxpayer household size of one for the purpose of assessing eligibility for an APTC.

[11] 45 CFR 155.305(f); 26 CFR 1.36B-2
[12] 45 CFR 155.305(f)(2); 26 CFR 1.36B-2(b)(5)
[13] See DHS Medical Assistance Policy Manual, Technical Eligibility Requirements: 0304.05.15.05; https://www.policy.dhs.ri.gov/0300.htm#_Toc359220686
[14] 26 CFR 1.36B-1(d)
[15] 45 CFR 155.305(f)(ii); 26 CFR 1.36B-2

a) Situations in which Multiple Taxpayer Households Enroll in One QHP

Multiple-taxpayer households receiving separate APTCs may enroll together in one QHP.[16] For example, a 25-year old expecting to file taxes separately from her parents may choose to enroll in the same QHP as her parents. In this situation, the APTC is calculated separately for each taxpayer household, and both APTCs are applied to the same plan.

3) Household Income

In order to be eligible for an APTC, an applicant's projected annual household income must be between 138% of the FPL to 400% of the FPL[17] or, as explained below, less than 138% of the FPL for lawfully-present immigrants.[18] Household income is also included in the calculation to determine the total amount of a household's APTC (see section on "Formula for Calculating the Size of an APTC").

a) Whose Income is Counted

The income of all individuals in the taxpayer's household who are required to file taxes must be included in household income.[19] For example, a married couple with a teenage son who works part-time must include his income, but only if he earns enough income to require him to file taxes. For more information on who is required to file taxes, and what the appropriate tax filing thresholds are, see IRS Publication 501.[20]

Example: Consider a married couple expecting to file Federal taxes jointly who claim a personal exemption deduction for their 16-year old daughter. The QHP household size is three: the mother, father, and daughter. Both parents are employed and their daughter also earns $300 per year through babysitting jobs. When determining their household income, the parents' income is included, but the daughter's income is not included because her earned income is below the tax filing threshold. She is not required to file her own tax return. If, however, she anticipates taking on an additional job that would pay enough money to put her over the tax-filing threshold, she would be required to file her own tax form and her earnings would be included in the household's income.[21]

b) Use of Projected Income

HealthSource RI applies a household's "projected" annual income to assess its eligibility for APTCs.[22] Projected annual income is the applicant's best estimate for the household's income during the year the applicant hopes to enroll in coverage. Projected income must be based upon reasonable and verifiable expectations (see Chapter 7), such as past year's income and expected changes to income based on factors such as a planned job change, a promotion, planned retirement, or expected re-entry into the work force. While HealthSource may assist customers with the math portion of estimating annual household income, HSRI are not tax professionals and customers are ultimately responsible for the projected annual income number that they report. Customers should consult with a tax professional if they have questions regarding how to best project their annual income.

[16] 26 CFR 1.36B-3(h)
[17] 45 CFR 155.305(f)(i); 26 CFR 1.36B-2(b)
[18] 45 CFR 155.305(f)(B)(2)
[19] 45 CFR 155.305(f); 26 CFR 1.36B-1(e)
[20] IRS Publication 501 is available at: http://www.irs.gov/publications/p501/ar02.html#en_US_2012_publink1000220851
[21] 26 CFR 1.36B-1(e)(ii)(B)
[22] 45 CFR 155.305(f)(i); 26 CFR 1.36B-2(b)

Households which end up reporting a different amount of income for the year on their federal tax forms than they actually earn during that year may either be responsible for repaying excess APTCs received to the IRS, or may be entitled to a refund for underpayments of APTCs for which the household was eligible. See Chapter 5 for additional information.

Example: A Rhode Island man loses his job in June and applies for coverage through HealthSource RI on July 1. To evaluate his eligibility for APTCs, HealthSource RI needs to calculate his expected income for the entire year, because APTCs are calculated based on an **annual** income. To do this, HealthSource RI will combine his earnings for the first half of the year while employed with any unemployment income he might have beginning in June for the rest of the year.

If he earned $20,000 during the first half of the year and expects to receive $10,000 in unemployment benefits through December 31, his projected annual income would be $30,000 ($20,000 for January through June plus $10,000 for July through December). HealthSource RI does NOT simply look at his expected income for the remainder of the year.

c) What Counts as Household Income

For calculating household income as it relates to assessing APTC eligibility, HealthSource RI uses a measure of income known as "Modified Adjusted Gross Income" or "MAGI."[23] MAGI is based on the IRS definition of what counts as income after selected deductions are taken into account. MAGI consists of the following types of income, as defined by the IRS:[24]

- **Adjusted Gross Income**

Adjusted gross income is gross income adjusted by "above-the-line" deductions.[25] For most tax payers, wages and salaries will constitute the majority of their gross income. However, as discussed in more detail below, gross income also includes income from a broad array of other sources, such as unemployment benefits, taxable interest, and capital gains. "Above-the-line" deductions refer to the adjustments that people can make to their gross income. These include alimony payments, interest on student loans, and other items that appear on page one of Form 1040. However, they do not include charitable contributions, mortgage interest and other "below-the-line" deductions.

- **Social Security Benefits Not Included in Adjusted Gross Income**

For federal income tax purposes, the federal government only taxes Social Security benefits for people who meet certain income criteria and, then, only a share of their benefits are taxed.[26] However, all Social Security benefits are included in MAGI, regardless of whether they are considered taxable or non-taxable income for federal tax purposes.

[23] 26CFR1.36B-1(e)
[24] 26CFR1.36B-1(e)(2)
[25] 26 USC § 62
[26] 26CFR1.36B-1(e)

- **Tax-Exempt Interest**

Most of the interest that tax payers receive from bank accounts, money market accounts, certificates of deposit, and deposited insurance dividends is considered taxable income. However, interest on some bonds issued by, and used to finance, state and local government operations is not taxable at the federal level. This tax-exempt interest is considered as part of MAGI.[27]

- **Foreign Earned Income**

While foreign earned income generally is not subject to taxation, it is included in MAGI.[28] It is the income received from sources within a foreign country or countries that constitute earned income attributable to services performed by the individual when they were:

- A U.S. citizen and a bona fide resident of a foreign country for an uninterrupted period of time, which includes an entire taxable year; or
- A U.S. citizen or resident and who, during any period of 12 consecutive months, is present in a foreign country for at least 330 full days during that period.

d) Determining Modified Adjusted Gross Income (MAGI)

MAGI is rooted in the IRS definition of income developed to help tax payers file their annual returns. However, APTCs are based on a household's projected annual income during the month in which it is applying for coverage. HealthSource RI will assist households in generating their projected annual MAGI based on their circumstances at the time of application. In practice, there are two ways HealthSource RI can help applicants determine their household's projected annual MAGI:

- **Use a prior year's federal tax return**

This method requires pulling "adjusted gross income" off the appropriate line of the tax form and making a few additions, if applicable, for foreign earned income, tax-exempt interest, and any untaxed Social Security benefits. This method works if an applicant's circumstances haven't changed notably since the applicant's last tax filling.

- **"Construct" MAGI**

This method requires gathering detailed information on an applicant's income from various sources, and adjusting that income to take into account the "above-the-line" deductions. This approach can be used if an applicant's circumstances have changed since tax time or if the applicant anticipates significant changes during the course of the coverage year.

Both methods, described in more detail below, rely on identical IRS definitions of what constitutes income and allowable deductions. Using a prior year's tax return allows HealthSource RI to estimate based on the work that already has been done by the applicant to report his or her data and deductions in accordance with IRS rules. If the prior year's tax return is no longer relevant, HealthSource RI must help to construct the projected MAGI for the year

[27] 26 CFR 1.36B-1(e); IRS-Income Received, available at: http://www.irs.gov/taxtopics/tc403.html
[28] 26 USC § 9

in which the household is applying for an APTC or CSR using the same IRS definitions and rules.

i) Use of the prior year's federal tax return.

If the household's circumstances have not changed substantially, HealthSource RI can use the adjusted gross income amount on the household's prior year's tax return as the primary basis for MAGI. This adjusted gross income amount can be found at:[29]

- IRS Form 1040EZ: Line 4
- IRS Form 1040A: Line 21
- IRS Form 1040: Line 37

If applicable, HealthSource RI will then add the following sources of income from the tax form to transform the household's "adjusted gross income" into "modified adjusted gross income":

- Any Social Security benefits not already included in adjusted gross income (Line 20a of IRS Form 1040).
- Foreign earned income excluded from gross income (include on Line 7 of IRS Form 1040 based on Line 26 of IRS Form 2555 or Line 17 of IRS Form 2555-EZ), and
- Tax-exempt interest the taxpayer expects to receive or accrue during the year (Line 8b of last year's Federal tax return IRS Form 1040).

ii) Constructing MAGI.

When a household has experienced a substantial change in circumstances since filing its tax return (or anticipates such a change will occur during the current calendar year), HealthSource RI will help the household "construct" its projected annual modified adjusted gross income. As a first step, HealthSource RI will determine the household's gross income. The types of income that count and do not count are identified in Table 1 below.[30]

[29] For federal tax purposes, "above-the-line" deductions can only be used by individuals who file a Form 1040 or Form 1040A. They cannot be claimed by someone who relies on the Form 1040EZ because the form is not designed to capture them. In the context of APTC eligibility, however, the deductions are available to all households who are not relying on their prior year federal tax form as the sole basis for establishing their projected annual household income.

[30] For additional information on adjusted gross income, see IRS Publication 17, available at: http://www.irs.gov/publications/p17/. For IRS income types, please visit: http://www.irs.gov/taxtopics/tc400.html.

Table 1. Examples of What Income Counts & Does Not Count Under MAGI[31]

Income that counts towards MAGI
Taxable wages/salary (before taxes are taken out) *Note that pre-tax contributions to dependent care accounts, health insurance premiums, flexible spending accounts, retirement accounts and commuter expenses are NOT included as income*[32]
Self-employment (profit once business expenses are paid)[33]
Social Security benefits
Unemployment benefits
Alimony received
Most retirement benefits
Interest (including tax-exempt interest)
Net capital gains (profit after subtracting capital losses)
Most investment income, such as interest and dividends
Rental or royalty income (profit after subtracting costs)
Other taxable income, such as canceled debts, court awards, jury duty pay not given to an employer, cash support, and gambling, prizes, or awards
Foreign earned income
Income that does NOT count
Child support received
Supplemental Security Income (SSI)
Worker's compensation payments
Veterans benefits
Gifts

a. Accounting for "Above-the-Line" Income Deductions

As a second step, an applicant's gross income must be adjusted by the above-the-line deductions discussed above.[34] Some of the tax deductions include:

- Certain self-employment business expenses
- Portion of interest on student loans
- Alimony paid
- Most contributions to retirement accounts[35]
- Tuition and fees[36]
- Health savings account contributions[37]
- Penalties on the early withdrawal of savings[38]

[31] For additional information, please refer to 26 USC 61. The list presented here is based on the Centers for Medicare and Medicaid Services' description of the types of income that count toward "gross income" for purposes of MAGI. See also Centers for Medicare & Medicaid Services Single Streamlined Application, Attachment A: List of Items in the Online Application to Support Eligibility Determinations for Enrollment through the Health Insurance Marketplace and for Medicaid and the Children's Health Insurance Program.
[32] Czajka, John. May 2013. Translating Modified Adjusted Gross Income (MAGI) to Current Monthly Income. State Health Access Reform Evaluation. Available at: http://www.shadac.org/files/shadac/publications/TranslatingMAGItoCurrenlyMonthlyIncome.pdf.
[33] 26 USC 1402
[34] A comprehensive list of these deductions can be found at: http://www.law.cornell.edu/uscode/text/26/62 with additional information at the IRS website at http://www.irs.gov/Credits---&---Deductions.
[35] 26 USC § 219.
[36] 26 USC § 222.
[37] 26 USC § 223.
[38] 26 USC § 165.

- Educator expenses[39]
- Moving expenses related to a job change[40]
- Certain business expenses of performing artists, reservists, and fee-basis government officials[41]

The above-the-line deductions potentially most common among low- and moderate-income households include certain self-employment expenses, most contributions to retirement accounts, alimony paid, tuition and student fees, and a portion of student loan interest.[42]

b. Deductions for Certain Self-Employment Expenses

Most deductions for self-employed business expenses are included in net income (the profit once business expenses are paid), but additional deductions can be taken for the deductible part of self-employment tax,[43] self-employed SEP, SIMPLE, qualified plans,[44] and self-employed health insurance deductions.[45,46]

c. Alimony Payment

Alimony is a payment to a spouse or former spouse under a divorce or separation agreement.[47]

d. Portion of Student Loan Interest

Households may be able to deduct a portion of the interest they expect to pay on a qualified student loan.[48] Box 1 of the 1098-E Form shows the interest paid for the prior year, which may be helpful in projecting student loan interest that will be paid during the year.

e) Comparing Household Income to the Federal Poverty Level

To assess financial eligibility for APTCs, HealthSource RI will compare a household's projected annual income to the FPL guidelines for the appropriate household size.[49] HealthSource RI will use the most recently published FPL guidelines available as of the first day of the annual open enrollment period for coverage by a QHP offered through HealthSource RI for a calendar year.[50,51]

The FPL used to determine APTC eligibility may be different than the FPL used for Medicaid eligibility. Medicaid uses FPL levels in accordance with the rules set forth by their agency.[52] (see Chapter 6).

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[39] 26 USC § 162.
[40] 26 USC § 217.
[41] 26 USC § 162.
[42] Czajka, John. May 2013. Translating Modified Adjusted Gross Income (MAGI) to Current Monthly Income. State Health Access Reform Evaluation. Available at: http://www.shadac.org/files/shadac/publications/TranslatingMAGItoCurrenlyMonthlyIncome.pdf.
[43] IRS Self-Employment Tax. http://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Self-Employment-Tax-Social-Security-and-Medicare-Taxes
[44] IRS Self-Employment Tax. http://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Self-Employment-Tax-Social-Security-and-Medicare-Taxes
[45] 26 USC § 162.
[46] For additional information see IRS Publication 334, Tax Guide for Small Business.
[47] 26 USC 215; IRS-Alimony Paid, available at: http://www.irs.gov/taxtopics/tc452.html.
[48] 26 USC § 221; IRS---Student Loan Interest Deduction, available at: http://www.irs.gov/taxtopics/tc456.html.
[49] The FPL level is updated annually by the Secretary of Health and Human Services.
[50] 45 CFR 155.300(a)
[51] The initial open enrollment extended from October 1, 2013 through March 31, 2014, which meant the 2013 FPL levels were used for the initial open enrollment period. For the 2015 coverage year, the annual open enrollment period extended from November 15 to February 15, and 2014 FPL levels were used. In subsequent years, the open enrollment period will extend from October 1 through December 15.
[52] 42 CFR 435.4

4) Ineligibility Based on Access to Minimum Essential Coverage

In general, people are ineligible for an APTC if they have sufficient income to secure adequate coverage (i.e., "minimum essential coverage" or MEC) through a source other than HealthSource RI.[53] This federal requirement is designed to reserve the availability of APTCs to households who do not have alternative affordable coverage options through their jobs, government programs, or other sources.

a) Definition of MEC for Purposes of APTC Eligibility[54]

For purposes of APTC eligibility, the term "minimum essential coverage" (MEC) means coverage under any of the following:

- Most government-sponsored insurance,
- Eligible employer-sponsored insurance,
- Grandfathered health plans,[55] and
- Other coverage that is recognized as MEC by the Secretary of Health and Human Services, including foreign health coverage and self-funded student health coverage.

Some types of very limited coverage are not considered "MEC". These "excepted benefits" policies include the following:[56]

- Accidental death and dismemberment coverage
- Disability insurance
- General liability insurance
- Automobile liability insurance
- Workers' compensation
- Credit-only insurance (e.g. mortgage insurance)
- Coverage for employer-provided on-site medical clinics
- Limited-scope dental or vision benefits
- Long-term care benefits
- Benefits provided under most health flexible spending arrangements
- Policies that cover only a specified disease or illness (e.g. cancer-only policies)
- Supplemental coverage, such as Medicare supplemental policies, TRICARE supplemental policies, and similar supplemental coverage to coverage under a group health plan.

[53] 45 CFR 155.305(f), 26 CFR 1.36B---2(c)

[54] 26 USC 5000A(f); Proposed 26 CFR 1.5000A-2; Proposed 45 CFR 156.602. Note that the concept of MEC also is used to determine who may be exempt from a shared responsibility payment. For this purpose, the list of coverage that constitutes MEC is slightly different as discussed in Chapter X.

[55] A grandfathered health plan is a group health plan or group health insurance coverage that was already in existence on March 23, 2010, when the Affordable Care Act was signed into law. Grandfathered status excludes plans from certain mandates under the law (ACA Section 1251; Proposed 26 CFR 1.5000A-2(e)).

[56] 26 USC 5000A(f)(3)

b) Government-Sponsored MEC

A household is considered eligible for government-sponsored MEC - and therefore ineligible for an APTC - if it meets the eligibility criteria for coverage under the programs listed below.[57] Unless otherwise noted, it is eligibility for the program – not actual enrollment in it – that makes a household member ineligible for an APTC. Government-sponsored MEC includes the following coverage:[58]

- Enrolled in Medicare Part A not requiring paying a Part A premium[59] (most Medicare beneficiaries do not need to pay Part A premiums and are automatically considered eligible for MEC)
- Medicare Advantage plans (Medicare Part C),
- Medicaid, **other than** for:
  - Optional coverage of family planning services
  - Optional coverage of tuberculosis-related services
  - Coverage of pregnancy-related services
  - Coverage of emergency medical services
- CHIP[60]
- Enrolled in TRICARE
- Enrolled in veterans' health coverage[61]
- Peace Corps volunteer program
- Refugee medical assistance supported by the Administration for Children and Families
- Enrolled in a student health plan[62]
- Enrolled in State high risk pool coverage[63]

i) Time of Eligibility

An individual is treated as eligible for a government-sponsored program on the first day of the first full month in which he or she may actually begin receiving benefits under the program.[64] This means that an individual is **not** treated as eligible for a government-sponsored program (and therefore **is** eligible to receive APTCs) during:

- The time required for application processing (i.e., the period of time between application submission and approval), and
- Any interim period between when a person is found eligible for a government- sponsored program and the date when he or she can begin receiving benefits (i.e., the period of time between application approval and the effective date of coverage).

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[57] 26 CFR 1.36B-2(c)(2)(i)
[58] 26 CFR 5000A(f)(1); 26 CFR 1.36B-2(c)(2)(i); Proposed 26 CFR 1.5000A-2(b); Proposed 45 CFR 156.602
[59] Proposed IRS Notice 2013-41, issued on June 26, 2013. Available at: http://op.bna.com/dt.nsf/id/sdoe--992kz2/$File/Notice%202013-41.pdf.
[60] Children age one and above who lose CHIP coverage due to a failure to pay premiums and who may not re-enroll in CHIP for four months are treated as eligible for CHIP and do not qualify for an APTC during that time period.
[61] The veterans' health coverage programs that represent MEC for those who are enrolled include the medical benefits package authorized for eligible veterans under 38 U.S.C. 1710 and 38 U.S.C. 1705; the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) authorized under 38 U.S.C. 1781; comprehensive health care program authorized under 38 U.S.C. 1803 and 38 U.S.C. 1821 for certain children of Vietnam Veterans and Veterans of covered service in Korea who are suffering from spinal bifida; and the Non-appropriated Fund Health Benefits Program of the Department of Defense (*Proposed 26 U.S.C. 1.5000A---2(b)(5) and (7))*.
[62] Proposed IRS Notice 2013-41, issued on June 26, 2013. Available at: http://www.irs.gov/pub/irs-drop/n-13-41.pdf
[63] The proposed rule designates state high-risk pools as MEC subject to further review by the Secretary (*Proposed 45 CFR 156.602(e)*). HHS specifically notes that it "reserves the right to review and monitor the extent and quality of coverage, and in the future to reassess whether they should be designated minimum essential coverage or should be required to go through the same [designation] process outlined in 156.604" of the proposed rule (*Preamble 7361*). The proposed IRS notice 2013-41 issued on June 26, 2013 states that individuals are eligible for MEC for purposes of APTC eligibility if they are enrolled in high-risk pool coverage. Available at: http://www.irs.gov/pub/irs---drop/n-13-41.pdf
[64] 26 CFR 1.36B-2(c)(2)(i)

Example: Consider a taxpayer who applies for coverage under a government-sponsored health care program. The individual's application is approved on July 12, but her coverage is not available until September 1. The individual is considered eligible for government-sponsored MEC on September 1 [65] and if meeting all other applicable criteria for APTC, would be considered APTC eligible through August 31.

ii) Obligation to complete administrative requirements to obtain coverage

Individuals eligible for a government-sponsored program, but who do not apply for such coverage, are still excluded from APTC eligibility after they have exceeded the deadline to apply for coverage (with the exception discussed below for people eligible for veterans health coverage programs or for certain individuals eligible but not enrolled for Medicare Part A). Individuals who meet the eligibility criteria for a government-sponsored program are expected to apply by the last day of the third full calendar month following the event that establishes their eligibility, such as loss of a job that makes the individual eligible for Medicaid.[66] If they do not apply by that date, they nevertheless will be treated as eligible for MEC (and thereby ineligible to receive APTCs) beginning on the first day of the fourth calendar month following the qualifying event.[67]

Example: Consider an individual who turns 65 on June 3, and becomes eligible for Medicare. In compliance with requirements necessary to receive benefits, the individual enrolls in Medicare in September, the last month of his initial enrollment period, and is able to receive Medicare benefits beginning on December 1. Because he completed necessary requirements by the last day of the third full calendar month after the event that established his eligibility (i.e., turning 65), the individual is treated as eligible for government-sponsored MEC on December 1 (the first full month he may receive benefits under the program).[68]

Example: Consider the same scenario, except that the individual fails to enroll in the Medicare coverage during his initial enrollment period. In this instance, the individual is treated as eligible for government-sponsored MEC as of October 1, 2015 (the first day of the fourth calendar month following the event that established his eligibility).69

iii) Special rule for veterans coverage programs

An individual is treated as eligible for MEC through a veterans health care program under Chapter 17 or 18 of Title 38, U.S.C. only if the individual is actually enrolled in the program.[70]

iv) Retroactive eligibility

Retroactive eligibility means eligibility covering a period of time in the past. If an individual is determined to be eligible for government-sponsored MEC on a retroactive basis (such as Medicaid), this does not affect his or her eligibility for APTC during the retroactive period. Individuals found eligible for Medicaid are only excluded from APTC eligibility on a prospective basis. They will be treated as eligible for MEC no earlier than the first day of the first

[65] 26 CFR 1.36B-2(c)(2)(vi)
[66] 26 CFR 1.36B-2(c)(2)(ii)
[67] 26 CFR 1.36B-2(c)(2)(ii)
[68] 26 CFR 1.36B-2(c)(2)(vi)
[69] 26 CFR 1.36B-2(c)(2)(vi)
[70] 26 CFR 1.36B-2(c)(2)(iii)

calendar month beginning after the approval of the Medicaid application, as discussed above.[71]

Example: Consider an individual who in November enrolls in a QHP for the upcoming coverage year and receives APTCs to help pay for the cost of the plan. Subsequently, the individual loses her part-time employment and on April 10 applies for coverage under the Medicaid program. Her application is approved on May 15, and her Medicaid coverage is effective as of April 1. The individual is treated as eligible for government-sponsored MEC on June 1.[72]

v) Failure to Reconcile

An enrollee shall not be eligible for APTCs if:[73]

(1) enrollee (and spouse, if applicable) did not comply with the requirement to file an income tax return for the prior year(s), as required by Sections 6011 and 6012 of IRC (26 USC §§ 6011, 6012) and implementing regulations; or
(2) The APTC was not reconciled for that period.

The HealthSource RI application includes a tax filing related question. This question will display on all applications and allow enrollees who received APTCs for the prior year to attest, under the penalty of perjury, to having filed their tax return for the applicable prior year and reconciling their APTCs.

After filing and reconciling the applicable prior year's APTCs, attesting to having filed a tax return on the application will allow the enrollee to maintain eligibility for APTC even if IRS' data has not yet been updated. Enrollee's whose IRS data has not been updated but have filed a tax return and reconciled APTCs for the prior year must attest to having filed and reconciled on the application and select a plan by December 15 in order to maintain APTC eligibility for coverage effective January 1.

c) Employer-sponsored MEC

An individual who may enroll in an eligible employer-sponsored plan, either as an employee or as an individual who may enroll in the plan because of a relationship to an employee (i.e., a "related individual"), is treated as eligible for employer-sponsored MEC if the plan is:

- "Affordable"[74] and
- Provides "minimum value"(MV).[75]

Employer-sponsored coverage includes coverage offered by a small business through the SHOP.

As described in more detail below, an eligible employer-sponsored plan is considered affordable for an individual if the annual premium she must pay to purchase coverage for herself does not exceed a specified percentage of household income.[76] A plan is considered to provide minimum value (MV) only if the plan's share of the total allowed costs of benefits provided to the employee and related individuals is at least 60% of such costs.[77]

[71] 26 CFR 1.36B-2(c)(2)(iv)
[72] 26 CFR 1.36B-2(c)(2)(vi)
[73] 45 CFR 155.305(f)(4); 26 U.S.C. 6011, 6012.
[74] 26 CFR 1.36B-2(c)(3)(i)
[75] 26 CFR 1.36B-2(c)(3)(i)
[76] 26 CFR 1.36B-2(c)(3)(v)(A)
[77] 26 CFR 1.36B-2(c)(3)(vi)

i) Affordable coverage

An eligible employer-sponsored plan is considered "affordable" for an employee if the portion of the annual premium he or she must pay for self-only coverage is less than a certain percentage of their household income. Each year, the required contribution percentage will be adjusted by the federal government to reflect growth in health care costs relative to other measures of economic growth and inflation.[78,79] The calculation of affordability for an employee's household members does not take into account the cost of providing household-based insurance. The "affordability" of employer-based insurance for related individuals is based **solely** on the cost of coverage for the **employee only**.

Example: Consider a woman who in 2016 has a household income of $47,000. Her employer offers a health insurance plan that requires a contribution of $3,450 for self-only coverage for 2016 (which represents 7.3% of her household income). Because her required contribution for self-only coverage does not exceed 9.66% of household income, the plan is considered affordable and the individual is treated as eligible for employer-sponsored MEC for all months in 2016[74]

Example: Consider the same scenario, except that in this case she is married and her employer offers dependent coverage. Her required contribution to purchase coverage for her household (which includes herself, her husband and their child) was $8,250 (representing 17.5% of her household income). Because the cost of purchasing coverage for her family is not taken into account in the affordability test and her required contribution for self-only coverage does not exceed 9.66% of household income, **the plan is still considered affordable**. Accordingly, the individual is determined to have a source of affordable employer-sponsored coverage, and thus ineligible to receive APTCs on behalf of herself and/or members of her household.

- **Treatment of Wellness Incentives and Employer Contributions to Health Reimbursement Arrangement (HRA) in Determining Affordability**

With the exception of wellness programs designed to prevent or reduce tobacco use, non-discriminatory wellness program incentives offered by an eligible employer-sponsored plan that affect premiums **will not** be treated as increasing the affordability of coverage (i.e., affordability will be determined assuming that the employee fails to satisfy the requirements of the wellness program). In circumstances involving tobacco cessation wellness programs, the affordability of plans for tobacco users will be determined based on the premiums charged to those users who complete a tobacco program (i.e., affordability will be determined assuming that the employee satisfies the requirements of the wellness program).[80] See Table 2 below.

[78] 26 CFR 1.36B-2(c)(3)(v)(A)
[79] In 2014, the affordability percentage was 9.5% of household income for individual coverage and in 2015 the percentage was increased to 9.56%.
[80] 26 CFR 1.36B-2(c)(3)(v)(A)(4)

Example: Consider an employer that offers an eligible employer-sponsored plan with a non-discriminatory wellness program that reduces premiums by $300 for employees who do not use tobacco products or who complete a smoking cessation course. Premiums are reduced by $200 if an employee completes cholesterol screening within the first six months of the plan year. One employee (Employee A) does not use tobacco and the cost of his premiums is $3,700. Another employee (Employee B) uses tobacco and the cost of her premiums is $4,000. Only the incentives related to tobacco use are counted toward the premium used to determine the affordability of the employer's plan. Accordingly, Employee B is treated as having earned the $300 incentive for attending a smoking cessation course. Thus, the employee's required contribution to premium for determining affordability for both Employees A and B is $3,700. The $200 incentive for completing the cholesterol screening is disregarded.[81]

Amounts made newly available under an HRA that is integrated with an employer-sponsored plan **can** be taken into account to determine affordability (i.e., can be considered as available to increase the affordability of employee coverage) provided that employees can use the amounts only for premiums, or for either premiums or cost sharing.[82]

Because Health Savings Account (HSA) funds typically cannot be used to pay insurance premiums, these amounts do not affect the determination of affordability. See Table 2 below.

Table 2. Treatment of Wellness Incentives & Employer Contributions to HRA in Determining Affordability

Applicability of Incentive/Amount to Premiums In Order to Determine Affordability	
Wellness Program – Non-Tobacco Cessation	No. Affordability determined assuming employee fails to earn incentive/complete program.
Wellness Program – Tobacco Cessation	Yes. Affordability determined assuming employee earns incentive/completes program.
Employer HSA Contribution	No. HSA funds generally cannot be used to pay premiums.
HRA Contribution	Yes, provided that employee can use HRA amounts to (1) reduce premiums or (2) for either reducing premiums or cost-sharing.

ii) Minimum value and methods for determining MV

An eligible employer-sponsored plan provides MV only if the plan's share of the total allowed costs of benefits provided to the employee under the plan (as determined by HHS) is at least 60%.[83] The MV of a specific eligible employer-sponsored plan is calculated by dividing the anticipated covered medical spending for EHB coverage for the population covered by a typical self-insured group health plan. This is computed in accordance with the specific group health plan's cost sharing by the total anticipated allowed charges for EHB coverage for a typical self-insured group health plan population.[84]

[81] 26 CFR 1.36B-2(c)(3)(v)(D)
[82] 26 CFR 1.36B-2(c)(3)(v)(A)(5)
[83] 26 CFR 1.36B-2(c)(3)(vi)
[84] Proposed 26 CFR 1.36B-6(c)(1)

Table 3. Calculation of Minimum Value (MV)

$$\text{Minimum Value} = \frac{\text{Anticipated EHB Costs Reimbursed by Plan}}{\text{Anticipated EHB Costs Covered by "Standard" Self} - \text{Insured Plan}}$$

Any one of the following methods can be used to determine whether an eligible employer-sponsored plan provides MV, [85] including use of:

- The MV Calculator made available by HHS and IRS on the HHS website;[86]
- One of the safe harbor plan designs established by HHS and IRS and described below; or
- For non-standard plans, actuarial certification from a member of the American Academy of Actuaries.

Plans in the small group market also meet MV requirements if they provide a bronze level plan.[87]

Individuals seeking advice as to whether the employer-sponsored insurance available to them meets the MV standard should seek guidance from their employer and/or insurance carrier.

Safe Harbors for Determining MV[88]

As an alternative to using the MV Calculator, an employer-sponsored plan could use one of three design-based safe harbors published by HHS and the IRS in the form of checklists to determine whether the plan provides MV. These include:

- A plan with a $3,500 integrated medical and drug deductible, 80% plan cost- sharing and a $6,000 maximum out-of-pocket limit;
- A plan with a $4,500 integrated medical and drug deductible, 70% plan cost-sharing, a $6,400 maximum out-of-pocket limit and a $500 employer contribution to an HSA; or
- A plan with a $3,500 medical deductible, $0 drug deductible, 60% medical cost sharing, 75% drug cost-sharing, a $6,400 maximum out-of-pocket limit,
  $10/$20/$50 copay tiered drug plan, and a 75% coinsurance for specialty drugs.

[85] 26 CFR 1.36B-6(d)
[86] The calculator is available at the following web site as of July 2013: http://www.cms.gov/cciio/Resources/Regulations-and-Guidance/index.html.
[87] 26 CFR 1.36B-6(d)(4)
[88] 26 CFR 1.36B-6(d)

A summary of this information is in the following Table 4.

Table 4: Safe Harbors for Determining Minimum Value

Individual Out---of-Pocket Limit	Individual Deductible		Coinsurance	Prescription Drug Copayments	Employer Individual Annual HSA Contribution
	Medical	*Prescription Drug*			
$6,000	$3,500 integrated medical and drug		80% of all services	N/A	N/A
$6,400	$4,500 integrated medical and drug		70% of all services	N/A	$500
$6,400	$3,500	$0	60% medical 75% drug	$10/$20/$50 Specialty drugs at 75%	N/A

Treatment of Wellness Incentives and Employer Contributions to HRAs and Health Savings Accounts (HSAs) in Calculating MV

In some instances, wellness programs and employer contributions to HRAs and HSAs may be taken into account when determining a plan's MV percentage. See Appendix A for details on related requirements.

iii) Treatment of Open Enrollment Periods and Special Enrollment Periods

As with government programs, people are excluded from APTC eligibility if they could enroll in an employer-sponsored plan that meets affordability and minimum value criteria, regardless of whether or not they actually do so. As a result, people must be treated as eligible for employer-sponsored MEC for any months in a plan year during which they could have enrolled via an open or special enrollment period[89] (See Chapter 3 for information on special enrollment periods.) It is important to note that people will not be treated as eligible for employer-sponsored MEC during any required waiting period before the coverage becomes effective.[90]

Example: Consider an individual whose employer offers its employees a health insurance plan that has a plan year from October 1 through September 30. Employees may enroll during an open season from August 1 to September 15. In this scenario, the employee chooses not to enroll in the employer's plan for the October 1, 2014 – September 30, 2015 plan year and, in November 2014, she enrolls in a QHP through HealthSource RI for calendar year 2015. Because she could have enrolled in her employer's plan during the August 1 to September 15 open enrollment period, unless the plan is not affordable or does not provide minimum value, this individual is treated as eligible for employer-sponsored MEC for those months that she is enrolled in the QHP during her employer's plan year (i.e., from January through September 2015).[91]

[89] 26 CFR 1.36B-2(c)(3)(iii)
[90] 26 CFR 1.36B-2(c)(3)(iii)
[91] 26 CFR 1.36B-2(c)(3)(iii)(C)

iv) Continuation Coverage (e.g., COBRA)

An individual who may enroll in continuation coverage required under Federal (e.g., COBRA) or State law that provides comparable continuation coverage is treated as eligible for employer-sponsored MEC only for months that the individual is actually enrolled in the coverage.[92] If someone is provided with an offer to sign up for COBRA coverage, but opts not to do so, this does not adversely affect his or her potential eligibility for an APTC.

v) Enrollment in an Eligible Employer-Sponsored Plan

If a person is enrolled in employer-based coverage, it is deemed to be MEC regardless of whether it meets the affordability and minimum value standards.[93] However, for instances in which an employee is automatically enrolled in an employer-sponsored plan, the employee will be treated as not enrolled in the plan if he/she terminates coverage before the later of either: (1) the second full calendar month of that plan year or other period of automatic enrollment; or (2) the last day of any permissible opt-out period provided by the employer-sponsored plan or in regulations to be issued by the Department of Labor.[94]

Example: Consider an individual whose required contribution for self---only employer coverage exceeded 9.5% of her 2014 projected annual household income. The individual enrolls in her employer's calendar year plan for 2014. The individual was treated as eligible for MEC for 2014 because she was enrolled in an eligible employer-sponsored plan for 2014.[95]

Example: Consider the same scenario, except that now the individual's employer automatically enrolled her in the plan for calendar year 2015. The individual terminates this coverage on January 20, 2015. The individual is treated as not eligible for MEC under her employer's plan for January 2015.[96]

d) Related Individual Not Claimed as a Personal Exemption Deduction

If an individual who may enroll in MEC due to a relationship to another person who is eligible for coverage (e.g., a child of a parent whose employer offers family coverage) is claimed as a dependent on the tax form of the person with primary access to the coverage, the related individual is treated as eligible for MEC regardless of whether he or she is actually enrolled in the coverage. However, if the related individual is **not** claimed as a dependent on the tax form of the person with primary access to the coverage, he or she will be treated as eligible for MEC under such coverage only for months in which the related individual is actually enrolled.

Example: Consider parents of a 25-year old daughter. If the parents expect to claim a personal exemption deduction for her, she is treated as eligible for MEC through her parent's employer-sponsored coverage (assuming it is affordable and meets minimum value). However, if the parents do not expect to claim a personal exemption for her, she would be treated as eligible for employer-sponsored MEC only for any months during which she is actually enrolled in her parents' plan. Thus, if she chooses to purchase coverage on her own via HealthSource RI, she is potentially eligible for an APTC (i.e., she is not excluded based on having minimum essential coverage through her parents, but she still must meet the other eligibility criteria for an APTC).

[92] 26 CFR 1.36B-2(c)(3)(iv)
[93] 26 CFR 1.36B-2(c)(3)(vii)(A)
[94] 26 CFR 1.36B-2(c)(3)(vii)(B)
[95] 26 CFR 1.36B-2(c)(3)(vii)(C)
[96] 26 CFR 1.36B-2(c)(3)(vii)(C)

C. Calculation of APTC

1) Overview of APTC Calculation

The concept behind the APTC calculation is that households below 400% FPL are expected to contribute a limited share of their income toward purchasing a QHP. The share varies from 2% of income for households at 100% FPL to 9.5% of income for those at 400% FPL.[97] After they contribute this amount, the APTC "fills the gap" and provides enough of a subsidy that the household can afford to purchase the second lowest cost silver-level QHP or "benchmark plan" (described below).

A household may use the APTC to a buy a QHP that is more or less expensive than the benchmark plan. If someone buys a more expensive plan, the person must contribute more of his or her own funds toward the cost of coverage. If the person buys a less expensive plan, the APTC will cover a greater share of the cost of the plan. Under no circumstances, however, may a household receive an APTC that exceeds the actual cost of the coverage that is purchased.

The APTC is based on the cost of purchasing essential health benefits and it is only for such benefits. It cannot be used to subsidize additional benefits. (See "Treatment of Non-Essential Health Benefits below.)

2) Formula for Calculating the Size of an APTC

The size of a taxpayer's APTC is calculated by taking the amount a household must spend to purchase the silver-level plan for eligible household members and subtracting the amount that the household is expected to contribute toward its own health insurance ("contribution amount").[98] The remaining amount – or the gap between the cost of the benchmark plan and the household's contribution amount – determines the maximum APTC that a person may receive.

Actual monthly premium costs paid for QHP(s)

When an individual files taxes, the Internal Revenue Service reconciles the amount of APTC that the person received with the amount he is eligible to receive based on his tax return information.[99] Please see Chapter 5 for a further discussion of the reconciliation process.

a) Cost of the "Benchmark Plan"

The cost of the "adjusted premium for the applicable benchmark plan" (referred to in this document as the "benchmark plan") is based on the Second Lowest Cost Silver Plan (SLCSP) offered through HealthSource RI that can be used to cover the household members who are enrolling in a QHP.[100] In situations where some household members are enrolling in a QHP through HealthSource RI and other household members are either enrolling in Medicaid or are not enrolling in any coverage, the SLCSP is based only on the household members who are APTC-eligible and enrolling in a QHP.

[97] ACA Sec. 1401/Sec. 36B (b); 26 CFR 1.36B-3(g)
[98] 26 CFR 1.36B-3(d)

[99] 26 CFR 1.36B-4
[100] 26 CFR 1.36B-3(e)

Example: Consider a household with two parents and two children with projected annual household income of 210% FPL. The children are eligible for Medicaid and the parents are eligible for a QHP and APTCs on HealthSource RI. The eligibility for APTC's would be based on the cost of the second lowest cost silver QHP that will cover only the parents. The cost of covering the children is *not* included in calculation of APTCs

i) Treatment of families that need more than one QHP to cover all members[101]

If a single plan is not available that can cover an applicant's entire household, then the benchmark plan is based on the cost of the multiple plans it would require to cover all eligible household members. These must be reviewed on a case-by-case basis and be handled by calling the contact center.

Example: Consider a household consisting of a woman taking care of her disabled aunt. If she expects to claim her aunt as a dependent on her Federal tax return then she is eligible to receive an APTC on her aunt's behalf. If there is no QHP available that will allow the woman to enroll in a single family plan that covers both her and her aunt, HealthSource RI must combine the cost of the benchmark plan available to the woman as a single adult, and the benchmark plan available to her aunt as a single adult, to determine the cost of the benchmark plan.

b) Contribution amount

The contribution amount is the amount a household is expected to contribute toward the cost of the benchmark plan. It is determined by a formula delineated in the ACA.[102]

Table 6. Premium Contribution Applicable Percentage by Income for 2016

% of Federal Poverty Line	Premium Contribution	Premium Contribution Final Percentage
Less than 133%	2.03%	2.03%
133-150%	3.05%	4.07%
150-200%	4.07%	6.41%
200-250%	6.41%	8.18%
250-300%	8.10%	9.56%
300-350%	9.66%	9.66%
350-400%	9.66%	9.66%

c) Special expected contribution rules for households with members who are not lawfully present

The ACA adjusts the expected contribution of households with members who are not lawfully present to reflect that some members are ineligible for enrollment in QHPs, as well as for APTCs.[103] In effect, the adjustments lower the expected contribution of such households because not all of their members can be enrolled in a QHP.

[101] 26 CFR 1.36B-3(f)(ii)(2)

[102] 26 CFR 1.36B-3(g)

[103] 26 CFR 1.36B-2; 26 CFR 1.36B-3

d) Actual premium costs

The amount of APTC that a household is eligible for in any given month cannot exceed the total monthly premium price of the coverage in which the eligible household members are enrolled.104 QHPs may have a non-essential health benefit (EHB) portion of the premium that is not eligible for a premium tax credit. In other words, the APTC cannot be used to cover certain health benefits that do not fall within the ACA's definition of EHB, however some plans have a $0 non-EHB benefit.

Example: Consider a household that qualifies for a $1,000 APTC, but elects to purchase a very inexpensive bronze plan for $800 a month with $798 covering the essential health benefits. Given the actual cost of its QHP, the household can use only $798 of its $1,000 APTC and pay $2 a month out of pocket. Therefore, $202 of the APTC would go unused (unless, as discussed below, it spends some of the extra unused APTC on a separate pediatric dental plan).

i) Premiums paid by another person

If an individual or entity pays premiums on behalf of a household, those payments are offset against the premium costs incurred by the household. For example, premiums paid by a Tribe on behalf of a tribal member or by a non-custodial parent on behalf of a child count toward the actual premiums paid. [105]

ii) Allocation of actual premium costs when multiple tax households purchase a plan together

In some instances, a household may buy a plan together even if not all of the household members are part of the same tax household for APTC purposes. When this occurs, a formula is used to allocate the premium costs among the tax households to ensure that none is receiving a premium assistance credit in excess of actual costs. The premium costs are apportioned based on the relative cost of the benchmark plans used to determine the APTC of each tax household within the household. [106]

Example: Consider a couple whose 22-year old son is living with them even though he is employed and will need to file his own taxes. Assume that the benchmark plan for the couple costs $12,000 and $4,000 for the son. When assessing whether the couple would otherwise receive an APTC in excess of its actual premium costs, HealthSource RI must assume that it pays for three-quarters of the cost of any plan that the family purchases together ($12,000 / ($12,000 + $4,000) = 3/4ths). Even if the couple pays for the entire plan, its APTC is limited to 3/4ths of the cost of the purchased QHP. Similarly, the son is treated as paying for 1/4th of the cost of any QHP ($4,000 / ($12,000 + $4,000) = 1/4th) regardless of how much money he contributes toward the cost of the QHP. If the family bought a $10,000 plan, the couple would be treated as spending $7,500 on the plan (limiting its premium assistance credit to $7,500) and the son would be treated as spending $2,500 (limiting his premium assistance credit to $2,500).

[104] 26CFR1.36B(3)
[105] 26CFR1.36B-3(c)(2)
[106] 26CFR1.36B-3(h)

3) Treatment of Non-Essential Health Benefits

As mentioned earlier in this Chapter, APTCs are available only to support the cost of purchasing essential health benefits.[107] APTCs may not be used to subsidize the cost of optional benefits, including elective abortions.[108] As a result, when determining the cost of the benchmark plan and actual premiums paid, only the portion of QHP costs attributable to essential health benefits is counted.

Example: A household selects a QHP that includes several optional non-essential health benefits, such as adult dental coverage. The cost of the household's QHP is $15,000, but $1,000 is attributable to the cost of the adult dental coverage and the other non-essential health benefits. When assessing whether the household's APTC exceeds actual premium costs, HealthSource RI would treat the household as having only $14,000 in actual premium costs. Similarly, when identifying the applicable benchmark plan, HealthSource RI would take into account only the cost of the essential health benefits offered by silver-level QHPs.

4) Treatment of Pediatric Dental Benefits

Pediatric dental benefits are considered part of EHBs and therefore their cost can be offset by APTCs.[109] However, some special rules apply to pediatric dental benefits and their role in the APTC calculation. Specifically, IRS regulations treat differently the cost of pediatric dental coverage when it is embedded in a QHP versus when it is provided through a separate dental-only plan. If embedded in a QHP, the cost of pediatric dental coverage **is** counted toward the cost of the applicable benchmark plan used to determine the size of a family's APTC. This has the effect of increasing the size of the family's APTC and subsidizing its purchase of dental coverage. On the other hand, if pediatric dental coverage is not embedded in the second-lowest-cost silver plan (SLCSP) available on HealthSource RI, then the cost of stand-alone dental **is not** added to the cost of the family's applicable benchmark plan.

These special rules apply when HealthSource RI is determining the cost of a family's applicable benchmark plan, but not when it is assessing whether a family's APTC falls below its actual premium costs. As a result, if a family elects to purchase a QHP but does not need to use the entire APTC to cover the purchase of the plan, it can apply some or all of the "excess" APTCs toward the cost of the dental plan.

Example: Consider a single mom with two kids who purchases a QHP that costs $400 a month and a stand-alone dental plan for both of her children that costs a total of $50 a month. When evaluating the cost of the applicable benchmark plan for her family (and, thus, the size of her tax credit), HealthSource RI cannot take into account the cost of her children's dental coverage. If, however, she purchases a QHP for $450 that includes pediatric dental coverage embedded in it, the applicable benchmark plan used to calculate her APTC will be based on the cost of the second lowest cost silver plan that includes pediatric dental benefits.

[107] 26CFR1.36B-3(j)
[108] ACA Section 1303; 45 CFR 156.280.
[109] 26CFR1.36B-3(k)

D. Eligibility for Cost Sharing Reductions (CSRs)

Households with a projected annual income of up to 250% of the FPL - with exceptions for American Indian and Alaska Native applicants (AI/AN) - are eligible for cost sharing reductions (CSRs) that reduce out-of-pocket spending.110 Households with lower incomes within this range will receive more financial assistance with out-of-pocket spending on health benefits while those at the higher end of the range receive less assistance. To be eligible for CSRs, applicants must enroll in a silver-level QHP111 (with exceptions for AI/AN applicants). CSRs allow households and individuals to enroll in "variations" of silver-level QHPs that have a higher "actuarial value." The actuarial value of a plan is the share of covered health care expenses that a QHP can be expected to cover for a standard population given its deductible, maximum limit on out-of- pocket costs, and other cost-sharing polices. As shown in Table 5 below, there are three major tiers of cost-sharing reductions.

Table 5. Tiers of Cost-Sharing Reductions Available to Households Enrolling in a Silver-Level Plan

Tier	Population	Silver-Level Plan Actuarial Value
Tier 1	100% FPL – 150% FPL (plus special populations below 100% FPL)	94%
Tier 2	150% FPL – 200% FPL	87%
Tier 3	200% FPL – 250% FPL	73%

In addition, as discussed in more detail below, AI/AN applicants are eligible for special cost sharing reductions.[112] AI/AN applicants under 300% of the FPL receive 100% cost sharing reductions for any level QHP in which they enroll.[113]

QHP issuers are required to submit to HealthSource RI annually prior to each benefit year the following plan variations (as well as variations for AI/AN enrollees):

- Silver-level plan QHP <150% FPL
- Silver-level plan QHP 150%-200% FPL
- Silver-level plan QHP 200%-250% FPL

The variations reflect differences in the cost-sharing charges associated with a plan; issuers must cover the same benefits and offer the same provider network to individuals enrolled in the CSR variations as they provide to individuals under the standard silver-level QHP. HealthSource RI assigns applicants to one of the silver-level QHP variations based on income, subject to the special rule on family policies[114].

1) Eligibility for Cost Sharing Reductions (CSR)

People who apply for financial assistance are automatically assessed for CSR eligibility and do not have to complete a separate application. Individuals are eligible for a CSR if they:[115]

[110] 45 CFR 155.305(g)(C)
[111] 45 CFR 155.305(g)(C)(ii)
[112] 45 CFR 155.350
[113] 45 CFR 155.350(a)(2)

[114] 45 CFR 156.410(b)(1)
[115] 45 CFR 305(g)

- Meet the eligibility criteria for an APTC, including QHP requirements[116] (See Chapter 2)
- Anticipate having annual household income at or below 250% FPL[117] (with exceptions for AI/AN applicants)
- Enroll in a silver-level QHP (with exceptions for AI/AN applicants).[118]

CSRs are not available for catastrophic plans or stand-alone pediatric dental plans.[119,120]

Example: Consider a household of two parents and two children with projected annual household income of 210% FPL. The children are eligible for Medicaid and the parents are eligible for APTCs. The parents receive an APTC and choose to enroll in a silver-level QHP. The parents must be assigned to the silver-level QHP variation for families with incomes 200%-250% FPL if they want to take advantage of the CSR benefit.

Example: Consider the same example, except that the parents choose to enroll in a gold-level QHP. As a result, they're not eligible for a CSR because they're not in a silver-level QHP.

2) Changes in Eligibility for Cost-Sharing Reductions

If HealthSource RI notifies a Carrier of a change in an Enrollee's eligibility for CSRs, the Carrier must change the Enrollee's assignment such that the Enrollee is assigned to the applicable standard plan or plan variation as required under 45 C.F.R. § 156.410(b) as of the effective date of eligibility required by HealthSource RI.[121]

In the case of assignment to a new silver plan (or standard plan without cost-sharing reductions) of the same QHP during the course of a coverage year, the Carrier must ensure that any cost sharing paid by the covered individual or household under previous plan variations (or standard plan without cost-sharing reductions) applicable to that coverage year is taken into account in the new plan (or standard plan without cost-sharing reductions) for the purposes of calculating cost sharing based on aggregate spending by the covered individual/household, such as for deductibles and annual out-of-pocket limitations on cost sharing.[122] Meaning, if eligibility for cost sharing reduction plans shifts from one tier to another mid-year, any out of pocket contributions already paid towards health costs such as the deductible will carry over between plans.

In the case of assignment to a new silver plan variation (or standard plan without cost-sharing), the Carrier shall within 10 (ten) business days send the covered individual/household written notice explaining the new cost-sharing now applicable for the Enrollee.

The Carrier shall not be required to send a new member ID card to the covered individual/household to reflect new cost-sharing, except upon an annual renewal during which any elements of cost sharing displayed on the member ID card will be different than it was in the prior year

[116] 45 CFR 155.305(g)(A)
[117] 45 CFR 305(g)(C)
[118] 45 CFR 155.305(g)(C)(ii)
[119] 45 CFR 156.440
[120] 45 CFR 156.440
[121] 45 C.F.R. § 156.425(a)
[122] 45 C.F.R. 156.425(b)

3) Special Rules

There are special CSR rules for non-citizens who are lawfully present and ineligible for Medicaid due to immigration status and for families that include individuals qualifying for different CSR levels.

a) Non-Citizens Lawfully Present Who Are Ineligible for Medicaid Due to Immigration Status

Lawfully present non-citizens with anticipated annual household income of less than 100% FPL who are ineligible for Medicaid due to immigration status are eligible for CSRs.[123] For purposes of assigning them to a silver-level QHP variation, they are treated as if their incomes are within the 100-150% FPL income range and are assigned to the silver-level QHP variation for families in this range.

b) Special Rule for Families That Include Individuals Qualifying for Different CSR Levels

In some instances, families purchasing a plan together will include individual members who qualify for different levels of CSR. For example, a family might include both a Native member and a non-Native member. In these instances, a "least common denominator" rule applies under which the family can only enroll in the CSR variation available to the member who qualifies for the least generous CSR. When at least one family member is entirely ineligible for a CSR, the family must forego a CSR if it wants to purchase coverage together.[124]

Example: Consider a couple with projected annual household income of 260% FPL in which the woman is a tribal member while her husband is not. If the couple purchases a QHP together, they would not be eligible for any CSRs because he does not qualify for a CSR.

4) American Indian/Alaska Native (AI/AN) Population

There are special CSR rules for American Indians and Alaska Natives.[125] An American Indian is a person who is a member of an Indian tribe, band, nation, or other organized group or community, including Alaska Natives, which is recognized as eligible for special programs and services provided to Indians.[126] Information about verifying Indian status can be found in Chapter 7.

a) No Cost Sharing Obligation for AI/AN < 300% FPL

AI/AN applicants who enroll in a QHP, are eligible for an APTC, and have projected annual household income below 300% FPL may enroll in a QHP with no cost sharing obligations (known as a "zero cost sharing plan").[127] Unlike other CSR-eligible individuals, AI/AN are not required to enroll in a silver-level QHP to qualify for a CSR. They are permitted to enroll in any level QHP and have no cost sharing obligations.[128]

[123] 26 CFR 1.36B-(c)(1)(B)
[124] 45 CFR 155.305(g)(3))
[125] 45 CFR 155.155.350; 45 CFR 156.410(b)(2)&(3))
[126] 25 USC § 450(b).
[127] 45 CFR 155.350(a)(ii)
[128] 45 CFR 155.350(a)(ii)(2)

b) Limited Cost Sharing Obligation for All Other AI/AN

All other AI/AN QHP applicants (i.e., those above 300 percent of the FPL and those who elect not to apply for an insurance affordability program) are automatically enrolled in the "limited cost sharing plan" variation (unless they are part of a family with non-Indians as explained above under the special family policy rule) of any QHP level that they select.[129] Under a limited cost-sharing plan, households have no cost-sharing obligation for items or services furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services.[130]

Example: An AI/AN household with projected annual household income of 200% FPL is found eligible for an APTC and eligible for CSRs. The household enrolls in a gold-level QHP. The household is assigned to the zero cost sharing bronze QHP variation and has no cost sharing obligations.

Example: An American Indian household has projected income of 500% FPL and enrolls in a gold-level QHP. The household is assigned a limited cost sharing gold QHP variation under which it cannot be charged cost-sharing for using services provided by the Indian Health Service and selected other AI/AN providers.

E. Appendix

1) Appendix A. Treatment of Wellness Incentives and Employer Contributions to HRAs and Health Savings Accounts (HSAs) in Calculating MV

With the exception of wellness programs designed to prevent or reduce tobacco use, nondiscriminatory wellness program incentives offered by an eligible employer---sponsored plan that reduce cost---sharing are **not** considered to count toward determining the plan's MV percentage (i.e., MV will be determined assuming that all employees fail to satisfy the requirements of the wellness program). In circumstances involving tobacco cessation programs, incentives are considered to count toward determining the plan's MV percentage (i.e., MV will be determined assuming that each employee satisfies the requirements of the wellness program).[131]

Example: Consider an employer that offers an eligible employer-sponsored plan with a nondiscriminatory wellness program that reduces premiums by $300 for employees who do not use tobacco products or who complete a smoking cessation course. Premiums are reduced by $200 if an employee completes cholesterol screening within the first six months of the plan year. One employee (Employee A) does not use tobacco and the cost of his premiums is $3,700. Another employee (Employee B) uses tobacco and the cost of her premiums is $4,000.

Only the incentives related to tobacco use are considered in determining the plan's actuarial value percentage. Accordingly, Employee B is treated as having earned the $300 incentive for attending a smoking cessation course. Thus, the deductible for determining the MV percentage for both Employees A and B is $3,700. The $200 incentive for completing the cholesterol screening is disregarded.[132]

All employer contributions for the current plan year to an HSA will be taken into account in that plan year towards the plan's MV percentage (i.e., employer contributions are taken into account in determining the plan's share of costs for

[129] 45 CFR 156.410(b)(3)
[130] 45 CFR 155.350(b); 45 CFR 156.410(b)(2)
[131] 26 CFR 1.36B-6(c)(2)(i)
[132] 26 CFR 1.36B-6(c)(2)(ii)

MV and treated like amounts available for first dollar coverage).[133] Similarly, amounts made newly available under an HRA that is integrated with an eligible employer-sponsored are taken into account for that plan year towards the plan's MV percentage provided that employees can only use the amounts to reduce cost-sharing (not pay premiums).[134]

Table A-1. Applicability of Incentive/Amount to Premiums In Order to Determine MV

Wellness Program – Non-Tobacco Cessation	No. MV determined assuming employee fails to earn incentive/complete program.
Wellness Program – Tobacco Cessation	Yes. MV is determined assuming employee earns incentive/completes program.
Employer HSA Contribution	Yes.
HRA Contribution	Yes, but only if HRA amounts cab be used only for reduced cost sharing.

2) Appendix B: Expected Premium Contribution by Family Size

The expected premium contribution for households is subject to change each year. Applicable percentages for 2015 coverage are available at: www.irs.gov/pub/irs-drop/rp-14-37.pdf. Please visit the IRS website for the most current listings of applicable percentages.

[133] 26 CFR 1.36B-6(c)(3)
[134] Proposed 26 CFR 1.36B-6(c)(4)