October 31, 2011

CC:PA:LPD:PR (REG–131491–10)
Room 5203
Internal Revenue Service
PO Box 7604
Ben Franklin Station, Washington, DC 20044

Re: NPRM on Health Insurance Premium Tax Credit, (REG-131491-10)

Dear Secretary Geithner and Commissioner Schulman:

We appreciate the opportunity to comment on the proposed rule implementing the Patient Protection and Affordable Care Act's health insurance premium tax credits.

Georgetown University's Center for Children and Families (CCF) is an independent, nonpartisan policy and research center whose mission is to expand and improve health coverage for America's children and families. Central to our work is providing research and policy assistance to state administrators and state-based organizations on strategies for covering children and their families through public insurance affordability programs. We also conduct research and analysis to inform federal and state policymakers about issues impacting children and families in health care reform and to improve Medicaid and CHIP, particularly around streamlining enrollment and renewal systems.

CCF submits the comments below on the Treasury Department's August 17th proposed rule on the health insurance premium tax credit. We also are submitting related comments on the proposed rules issued by the Department of Health and Human Services regarding Medicaid and Exchange eligibility determinations. Before providing more detailed comments by section of the proposed regulation, we highlight our two biggest concerns with the Treasury Department's proposed rule.

1. **Family penalty in the affordability test.** We are deeply concerned that the proposed Treasury rule excludes families from advance premium tax credits if they have access to employer-based coverage even when such coverage would cost more than 9.5 percent of income. If included in the final rule, this policy would cause millions of families to face the unreasonable expectation that they can purchase coverage that is clearly unaffordable under the standards created by the Affordable Care Act. In many instances, children in these families may be able to secure coverage through Medicaid and CHIP, but, as you well know, funding for CHIP is not assured after 2015. Moreover, not all affected children have access to a backup option, and even those who do may have parents who remain uninsured. When parents lack coverage, it affects their own health, the financial stability of their entire family, and the health and well-being of their children.

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2. **Families with children facing multiple premium obligations.** The proposed rule leaves many families with children to face multiple, additive obligations when it comes to buying subsidized coverage on an Exchange if they happen to have a child eligible for CHIP or, in some cases, Medicaid. These families are expected to pay for subsidized coverage through an Exchange *and* CHIP premiums for their children. The amount they are expected to pay for their subsidized Exchange coverage is not adjusted in any way to reflect that they also have premium obligations for their children in CHIP. As a result, many low and moderate-income families with children would, in effect, face premium costs in excess of the affordability thresholds established by the Affordable Care Act.

From the perspective of families with children, we believe it is particularly critical to address these two issues in your final rule. The Affordable Care Act will not be a success if it results in families being expected to purchase employer-based coverage that is unaffordable or a combination of Exchange and public coverage that is unaffordable. Fortunately, as outlined in more detail in our comments below, we believe that there are options available to you for resolving these issues.

For questions or further information on any of CCF's comments on the proposed rule, please contact Jocelyn Guyer at jag99@georgetown.edu or 202-784-4077.

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Internal Revenue Service
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Health Insurance Premium Tax Credit

1.36B-2 Eligibility for premium tax credit

1.36B-2(6) Special rule for taxpayers with household income below 100 percent of the federal poverty line for the taxable year

We support the special rule that allows for a taxpayer or family member to be eligible for a premium tax credit if the taxpayer or family member enrolls in a qualified health plan through an Exchange, an Exchange estimates that the taxpayer's household income will be between 100 and 400 percent of the federal poverty level for the taxable year, and advance credit payments are authorized and paid for one or more months during the taxable year. The special rule uses the Treasury Department's regulatory powers to fill in a gap in the statute to make sure the intent of the law is fulfilled in providing access to coverage to all individuals with household income under 100 percent of the federal poverty level. The ACA clearly expands Medicaid eligibility to 133 percent of the federal poverty level and provides a special rule for recent immigrants ineligible for Medicaid who have household income under 100 percent of the federal poverty level. The reconciliation section of the statute also clearly intends for taxpayers not to be financially punished if an Exchange overestimates the taxpayer's household income for the taxable year. We therefore believe the special rule at 1.36B-2(6) is important to meet the intent of the law.

> **RECOMMENDATION:** Maintain the special rule for taxpayers with household income below 100 percent of the federal poverty level for the taxable year but who were projected by an Exchange to have higher income.

1.36(B)-2(c)(2)(iii)(B) Retroactive effect of eligibility determination

Under (c)(2)(iii)(B), individuals eligible for retroactive benefits, such as through Medicaid, are considered eligible for minimum essential coverage no sooner than the first full month following their approval. We strongly support this proposed rule and recommend that the final rule clarify that such individuals are considered eligible for minimum essential coverage, at the earliest, on the first full month following their approval, but also no sooner than the first full month it is possible for that individual to effectively terminate coverage through any qualified health plan in which they were previously enrolled. This is important to ensure that families are eligible to receive premium tax credits for all coverage months for which they are financially responsible for paying premiums, according to the termination terms of their qualified health plan.

> **RECOMMENDATION:** The final rule should clarify that individuals eligible for retroactive benefits are considered eligible (for the purposes of determining tax credit eligibility) for government sponsored minimum essential coverage no sooner than the first month following approval but also no sooner that the first full month an individual can effectively terminate their previous coverage, regardless of when government sponsored coverage actually becomes effective.

1.36(B)-2(c)(2)(iii) Additional comments

The preamble solicits comments on whether the proposed rules under (c)(2)(iii) should provide additional flexibility for individuals transitioning from a qualified health plan to coverage under a government-sponsored program, in the situation that operational challenges prevent a timely transition. Historically, government agencies have faced such challenges in the initial implementation of substantial health reform provisions, such as when Medicare Part D was first implemented. Operational challenges, like problems with data exchange, may occur in the initial implementation of Exchanges and Medicaid eligibility reform. Individuals should not face unfair gaps in coverage due to such setbacks. Thus, we recommend that in situations where operational challenges delay coverage transitions, individuals should remain eligible for premium tax credits up until the first full calendar month that they are actually able to receive benefits through government-sponsored coverage.

Beyond operational challenges, transitioning from a qualified health plan to government sponsored coverage could also be challenging for individuals in the midst of a single episode of care. If an individual transitions to Medicaid or other government-sponsored coverage while in the middle of receiving treatment from a provider through a qualified health plan, the individual may face problems continuing his or her course of treatment if that provider does not accept the government-sponsored coverage. This could present particularly serious health problems for someone in the midst of an acute care episode or someone requiring highly specialized care. To avoid disruptions in care, we recommend that the final rule allow individuals who are in the middle of an acute or highly specialized episode of care to remain eligible for premium tax credits through the duration of that episode of care. At minimum, state Exchanges should be given the flexibility to continue credits for such a person until that person can safely transition to a Medicaid provider.

> **RECOMMENDATION:** In situations where a coverage transition is delayed due to operational challenges, individuals should remain eligible for premium tax credits until the first full calendar month that they can actually receive benefits through a government-sponsored plan. In situations where transitioning coverage could disrupt the provision of care for an individual in the midst of an acute or specialized episode of care, that individual should remain eligible for premium tax credits through that episode of care.

1.36(B)-2(c)(3) Employer Sponsored Minimum Essential Coverage

1.36(B)-2(c)(3)(iv) Special rule for continuation coverage

We support the special rule for continuation coverage (COBRA) provided in section 1.36(B)-2(c)(3)(iv) that provides an individual is eligible for continuation coverage only if the individual enrolls in the coverage. Only enrollment in COBRA, not its offer, should make an individual ineligible for tax credits. This special rule properly uses the Department's regulatory authority to fulfill the intent of the law that all Americans have access to affordable health care. The special rule also fulfills the intent of the Consolidated Omnibus Budget Reconciliation Act, which is to increase access to coverage to people experiencing a transition that results in the loss of group health coverage.

RECOMMENDATION: Maintain the special rule for continuation of coverage that deems an individual eligible for continuation coverage only if the individual enrolls in the coverage.

1.36B-2(c)(3)(v) Employer-sponsored minimum essential coverage: affordable coverage

We oppose the proposed rule's stance on how affordability of employer-sponsored insurance would be tested for the purposes of determining eligibility for exchange subsidies. Not only is the proposal inconsistent with an appropriate reading of the Affordable Care Act, but it would leave many families essentially locked out of premium tax credits even though the only coverage available to them would be unaffordable.

The proposed regulations would use the cost of an employee's self-only coverage — but not the cost of family coverage — to determine whether the employee's family members can receive subsidies to help pay for coverage. If the final rule maintains this approach, millions of adults and children who are the dependents of workers with an offer of employer coverage would be barred from receiving subsidies in the insurance exchange. This would leave many people paying large portions of their household income for family coverage offered by an employer. Many others are likely to go without health insurance because of the high cost. This undermines the coverage goals of the Affordable Care Act, and it runs counter to the intent of the law. Our comments lay out the legal and policy analysis in support of a final rule that accounts for the employee's cost of covering family members when determining whether employer-sponsored coverage is affordable.

Under the Affordable Care Act, individuals eligible for "minimum essential coverage" are ineligible for premium and cost-sharing subsidies in the new health insurance exchanges, a provision often referred to as the "firewall." Minimum essential coverage includes "eligible employer-sponsored plans." However, employees will not be considered eligible for minimum essential coverage if the employee's contribution to the cost of the premium exceeds 9.5 percent of household income. (Employer-sponsored coverage must also meet a "minimum value" test to be considered minimum essential coverage. We expect to address this issue in comments on future rule-making.)

As background, we note three relevant provisions of the ACA:

- Section 36B(c)(2)(C) of the IRC states that the employee's required contribution is determined "within the meaning of section 5000A(e)(1)(B)," and that the firewall applies "to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee," such as a spouse or a child.

- Section 5000A(e)(1)(B) is part of the ACA provision on individual responsibility; it allows individuals who cannot afford coverage an exemption from the penalty for not having health coverage. The provision states that in calculating whether coverage is affordable, the required contribution for those eligible for an employer plan (which is then compared to household income) is based on the employee's contribution for self-only coverage.

- This provision is qualified by the following section, 5000(e)(1)(C), which states that "for purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an

employee, the determination under subparagraph (A) shall be made by reference to required contribution of the employee."

- Subparagraph A of section 5000A(e)(1) refers to the test for determining whether coverage is unaffordable for the purpose of the exemption from the penalty. The test is whether the individual must pay more than 8 percent of household income.

To summarize, when a family has an offer of employer coverage, the test of whether it is affordable depends on the employee's required contribution as a percentage of household income. The employee's required contribution is defined in the ACA provision on individual responsibility. In general, if available coverage costs more than 8 percent of household income, an individual does not have to pay a penalty for failing to have coverage. For an employee with an offer of employer coverage, the required contribution is defined as the amount the employee has to pay for self-only coverage. For dependents of the employee, the statute includes a "special rule" stating that the determination "shall be made by reference to the required contribution of the employee."

The Joint Committee on Taxation (JCT) reads the "special rule" to mean that the cost of *self-only* coverage is used to determine affordability for *family* coverage.[1] Because it reads the special rule this way, JCT also would use the cost of self-only coverage in determining whether the employee and dependents are exempt from the penalty. In effect, JCT reads the "special rule" for dependent coverage as requiring the same measure of affordability for families as for employees. However, the rule for employees specifies that the employee's contribution used to determine affordability is the cost of *self-only coverage*. Had Congress intended the special rule for dependents to use the same measure, it could have used similar language — or it could have omitted the special rule altogether. The special rule states that the determination of affordability should be made with reference to "the required contribution of the employee."

The better reading is that the measure of affordability should be "the required contribution of the employee" *for coverage of his or her dependents.* This reading would be a plain language reading when considered along with how employment based health benefits works. Employment based health benefits are most often paid jointly by the employer and a contribution by the employee. Individuals eligible for employment-based coverage due to a relationship to an employee do not pay for the coverage directly. These individuals are added to the coverage by the employee and any cost of coverage above the amount paid by the employer is paid for through a contribution by the employee. A plain language reading, when done in concert with an understanding of how employment based benefits are paid for, would suggest the statute requires affordability to be based on "the required contribution of the employee" *for coverage of his or her dependents*, rather than on the amount the covered individual pays for coverage.

Treasury's proposed rule on the health insurance premium tax credit appears to agree with this interpretation of the special rule – that it requires the use of the cost of family coverage in assessing whether coverage is affordable. But the proposed rule only applies this test to the individual responsibility requirement, not the firewall. The preamble states:

[1] Joint Committee on Taxation, "General Explanation of Tax Legislation Enacted in the 111th Congress," March 2011 at p. 281.

> Although the affordability test for related individuals for purposes of the premium tax credit is based on the cost of self-only coverage, future proposed regulations under section 5000A are expected to provide that the affordability test for purposes of applying the individual responsibility requirement to related individuals is based on the employee's contribution for employer-sponsored family coverage. *Section 5000A addresses affordability for employees in section 5000A(e)(1)(B) and, separately, for related individuals in section 5000A(e)(1)(C).* (emphasis added).

Treasury thus reads the special rule in 5000A(e)(1)(C) as using the cost of family coverage to determine affordability of coverage for the employee and dependents. However, in determining affordability for purposes of the firewall, Treasury would apply only 5000A(e)(1)(B) and ignore the special rule that qualifies the application of the affordability test to dependents in 5000(A)(e)(1)(C). The better reading is that, in requiring the use of the same test for the firewall as for the individual responsibility requirement, Congress intended that the entire rule be applied, including the special rule that qualifies the application of the affordability test for employees. It is unlikely that Congress intended affordability to be determined one way in determining whether a family is exempt from the application of the individual mandate and another way for the firewall. It is far more likely that in directing Treasury to use the test in 5000A(e)(1)(B), Congress intended that the special rule qualifying the treatment of dependents should also apply.

Under the approach in the proposed rule, many families would face similar difficulties. Failing to account for the affordability of employer-sponsored family coverage would render an estimated 3.9 million non-working dependents ineligible for subsidies, according to an analysis by the Kaiser Family Foundation. On average, these family members would have to pay 14 percent of their income to access the employer coverage.[2]
An analysis by the Urban Institute shows that basing the determination of affordability on self-only coverage would have a significant impact on coverage for children particularly if federal funding for CHIP is not extended beyond 2015, which is when the current authorization expires. The Urban Institute found that 6.3 million children are in families that have to pay more than 9.5 percent of their income for employer-based family coverage.[3] The vast majority of these children are currently income-eligible for CHIP (although not all are enrolled), but would lose this backup source of coverage if CHIP funding is not continued past 2015. Even if they are able to secure coverage for themselves, the lack of affordable coverage for their parents can be expected to introduce financial instability into their families. Moreover, there is a large body of research indicating that when parents lack coverage, their children fare worse.[4]

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[2] Larry Levitt and Gary Claxton, "Measuring the Affordability of Employer Health Coverage," Kaiser Family Foundation, August 24, 2011. The analysis relies on 2008 demographic and insurance data from the Medical Expenditure Panel Survey and employee premium contribution information from the Kaiser/HRET Employer Health Benefits Survey. It assumes no behavior changes by employers in response to the health reform law. See also, Peter Gosselin, "New Rule Could Narrow Aid for Health-Plan Buyers and Shrink Insurers' Sales," Bloomberg Government, September 27, 2011.

[3] Matthew Buettgens, Genevieve M. Kenney, "Update of Implications of Relying on a Single-Only Affordability Test for Families," The Urban Institute, May 27, 2011. (unpublished memorandum)

[4] J. M. Lambrew, "Health Insurance: A Family Affair: A National Profile and State-By-State Analysis of Uninsured Parents and their Children," Commonwealth Fund, May 2001; Dubay, L. and Kenney, G.

By failing to take the cost of family coverage into account in determining eligibility for premium credits and cost-sharing subsidies, the proposed Treasury rule fails to ensure that these family members have access to affordable coverage as the ACA intends. They could instead try to scrape together an outsized portion of their household income to buy coverage, but the high cost would likely cause many people to forgo coverage and remain uninsured.

The proposed rule creates incentives for employers to violate or find loopholes in the provisions of the Tax Code that outlaw discrimination in favor of highly compensated individuals, which were expanded to fully-insured plans in the Affordable Care Act.[5] This is because highly compensated employees may receive a greater benefit from an offer of coverage than lower wage employees. Lower wage employees will value family coverage offers less or not at all because such offers could exclude them from exchange subsidies and force them to pay for unaffordable employer-sponsored family coverage.

The proposed interpretation also goes against many federal policies that aim to strengthen families and actually discriminates against married couples and families. Some of the policies aimed at encouraging marriage are within the tax code, such as the size of the standard deduction for married couples compared to single filers and the income ranges of the 10 and 15 percent tax brackets for couples compared to the corresponding ranges for individuals.[6] However, the proposed affordability definition would undermine these provisions by encouraging couples to stay single if one individual is in need of health insurance. This could also increase adverse selection in the Exchange as healthier individuals are less likely to make the decision not to marry in order to maintain eligibility for premium tax credits.

> **RECOMMENDATION:** To ensure that the final rule is consistent with the statute and carries out the coverage goals of the ACA, we urge you to base the determination of whether employer-sponsored coverage is unaffordable on the employee's contribution for family coverage both for the purposes of the firewall and the exemption from the penalty for not having coverage.

1.36(B)-2(c)(3)(v)(2) Employee safe harbor

We want to express our strong support for the "employee safe harbor" in the proposed rule, which treats an employer-sponsored plan as unaffordable for the entire plan year once a determination of unaffordability is made. Without a safe harbor, individuals and families would be at risk of repaying large sums if the cost of employer coverage went below 9.5 percent of their household income for any months during the taxable year. For example, if an employee's spouse received an unexpected bonus the family's income for the taxable year could be greater than anticipated, and the cost of the employer-based coverage could end up being less than 9.5 percent of the household's income. Without the protection of a safe harbor, a retroactive determination of affordability at tax filing could result in a finding

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"Expanding Public Health Insurance to Parents: Effects on Children's Coverage under Medicaid,' Health Services Research, 38: 1283–1302. (2003).

[5] 42. U.S.C. 300gg-16; 26 U.S.C. 105(h)(2)

[6] Urban-Brookings Tax Policy Center, "The Tax Policy Briefing Book, A Citizens Guide for the 2008 Election and Beyond," available at http://www.taxpolicycenter.org/briefing-book/.

that the family was not eligible for premium credits in some or all months of the year. A family in this situation would have a large repayment obligation even though the exchange correctly determined that the family was eligible for premium credits at the time the family applied. The policy in the proposed rule will avoid this result, and it should be retained in the final rule.

> **RECOMMENDATION:** Maintain the "employee safe harbor" which treats an employer-sponsored plan as unaffordable for the entire plan year once a determination of unaffordability is made.

1.36(B)-2(c)(3)(vi) Minimum value

We agree with the proposed rules that the minimum value calculation is to be determined under regulations issued by the Secretary of Health and Human Services. However, because of the important role this calculation will have in determining access for the premium tax credits, we note that it is extremely important to establish a strong minimum value calculation. An employer plan offering the minimum value should offer benefits at least equal in coverage to a bronze plan on the Exchange. Under the ACA, employer-sponsored health benefit plans and plans offered in the large group market do not need to meet all the requirements of a qualified health plan offered on an Exchange and there are some requirements that will apply to plans in the small group market but not the large group market. We believe, however, that Congress selected a 60 percent standard for minimum value in employer coverage to achieve consistency with the bronze level of qualified health plans. Section 1302(d)(2)(C) of the ACA requires the Secretary of Health and Human Services to apply the same rules in determining the actuarial value of a qualified health plan offered on an Exchange and the total allowed costs of benefits provided under a group health plan or health insurance coverage. In order to meet the requirements of the statute, the calculation of whether an employment-based plan is providing minimum value must take into account the cost of coverage of the essential health benefits, even though such a plan is not required to cover the essential health benefits.

> **RECOMMENDATION:** The Department should urge the Secretary of Health and Human Services to include the costs of covering all essential health benefits in the calculation of whether an employment based plan provides minimum value. To the extent that employer coverage does not cover an essential health benefit, it should be judged to have zero percent actuarial value for that benefit rather than excluding that benefit as uncovered. The minimum value should be at least equal to a bronze plan offered in an Exchange.

1.36(B)-2(c)(3)(vii) Enrollment in an eligible employer-sponsored plan

Section 1511 of the Affordable Care Act requires employers with 200 or more full-time employees who offer health benefit plans to automatically enroll all eligible employees in a health benefit plans. This is an important provision of the law, however we are concerned that there may be some administrative difficulties when employers first implement it. For example, an employee may not receive notice of the opportunity to opt-out—either because the employer fails to follow proper procedure or the procedure itself has gaps that result in some employees not receiving notice. Employees with limited English proficiency may receive a notice in English and not understand the notice or the opportunity to opt-out until after the opt out period has passed. A family member may be reenrolled into a plan due to a relationship to an employee without the family member's knowledge if the notice to opt out is provided to the employee. There may also be administrative errors resulting in an

employer or plan mistakenly enrolling an employee or family member who has opted out of coverage or chosen a different coverage option. While we expect these instances to be few, they could have a significant impact on taxpayers and their family members who should not be prevented from accessing a premium tax credit because of an employer's or plan's mistake.

In addition, the relevant regulations have not yet been issued and it is possible that employees will be allowed to opt-out after they are enrolled in the benefits. In some instances, employers may need to automatically enroll employees and then retroactively disenroll the employees who opt out in order to ensure employees receive benefits as soon as they are eligible. An employee employed by such an employer should not be prevented from receiving a premium tax credit if the employee plans to opt-out and will be disenrolled.

> **RECOMMENDATION:** A special rule should allow a taxpayer or family member to be eligible for a premium tax credit if: (1) the taxpayer or family member never received notice of the opportunity to opt-out; (2) the taxpayer or family member was enrolled in an employer-sponsored plan even though the taxpayer or family member notified the employer or plan of the desire to opt-out of coverage; or (3) the taxpayer or family member will be opting out and retroactively disenrolled from coverage**.**

§1.36B-3 Computing the premium assistance amount

The proposed rules will leave many families facing a "double premium" or even a "triple premium" if they have one or more children eligible for CHIP or one parent eligible for employment-based coverage. The issue, sometimes known as "premium stacking" arises because each family is expected to contribute a specific percentage of household income for coverage through a qualified health plan. Under the proposed rules, a family would pay no less for a qualified health plan that covers two adults than the family would pay for covering two adults and children. If the children are enrolled in CHIP, this family would pay CHIP premiums in addition to percentage of income they are required to contribute for the qualified health plan.

The number of families subject to this type of "double premium" is likely to be significant. Estimates from the Urban Institute indicate that three out of four (75%) parents who are eligible for the Exchange will have one or more children who are eligible for CHIP or Medicaid. It is unknown how many of these families must pay premiums to enroll their children in public coverage, but 30 states charge a premium or annual enrollment fee to children in CHIP, so premium stacking will be widespread. While the fundamental issue arises from the statute, the proposed rules do not acknowledge the problem, nor do they provide states with any options or advice for addressing it.

We urge the Department to look into potential solutions to this problem to ensure the intent of the law—to provide affordable access to health coverage--is fulfilled. In doing so, we encourage the Department to recall that it has shown a willingness to rely on its regulatory authority to make practical, simplifying decisions surrounding implementation of the ACA in other context. Most notably, the Secretary of Treasury has exercised his regulatory authority to administer the premium credits to ensure effective implementation by proposing to create a safe harbor for employers when an employee's share of the cost of

self-only coverage is less than 9.5 percent of the employee's wages even if the employee's contribution is more than 9.5 percent of household income. We agree that the Treasury has the discretion to create the proposed safe harbor and believe that it should do so. We raise the example here because it demonstrates that Treasury has significant flexibility to decide how to interpret the ACA. When it comes to considering how to make the advance premium tax credit work for families, we encourage it to work just as hard to identify practical, workable solutions on behalf of families as it has for employers.

> **RECOMMENDATION:** Solutions to lessen the burden on families of multiple premium obligations should be explored in the final rules, such as counting CHIP premiums as part of the family contribution in tax credit calculations or using a benchmark plan for the entire family rather than for the family members enrolling in coverage. Additionally, the Department should work with HHS to modify CHIP rules to avoid adding unaffordable cost burdens for families with children in CHIP and adults in subsidized qualified health plans.

1.36B-3(f) Applicable benchmark plan, family coverage

Under 1.36B-3(f)(2), for Exchanges that offer multiple family categories, a family's benchmark plan is the category that best fits their family's composition. We understand that this proposed rule reflects the HHS's proposed policy in 156.255(c) of 45 CFR, which gives issuers the discretion to decide whether to offer coverage to each of four categories or to combine coverage categories. (The categories are individual, two adults, one adult with children, and family). For example, an issuer could choose to offer only two categories of coverage—single and family—rather than offering coverage to each of the four categories discretely. In addition, while they are required by the ACA, the proposed 156.255(c) does not contemplate the availability of child-only plans. We have strong concerns about the implications of this rule when calculating families' premium tax credits using the method the IRS proposes under 1.36B-3(f)(2). The best solution to these concerns is for HHS to make changes to the proposed 156.255(c) of 45 CFR.

Allowing issuers in an Exchange to choose different rating categories makes the calculation of the benchmark premium as proposed by the IRS impractical and unnecessarily complicated. As currently proposed, it would be possible for many carriers in an Exchange to offer only individual and family coverage while just a few carriers offer coverage in the one-adult with children or two adult rating categories. It would even be possible for only one qualified health plan in an Exchange to offer a certain category of coverage. If an Exchange only has one qualified health plan that offers a certain category of coverage, there would be no second lowest cost silver plan available in that category. The rules proposed by Treasury are unclear on how a taxpayer's premium tax credit would be calculated if the taxpayer's family enrolled in a category served by only one plan. In addition, it is unclear what category of coverage would be used to calculate the benchmark premium for a family that purchases a child- or children-only qualified health plan.

Further, in Exchanges with a limited market offering in certain coverage categories, the premiums for benchmark plans could vary among a number of dimensions unrelated to value, including market dynamics and risk selection. For example, if a limited number of carriers participated in the one adult with children market, premiums for such plans could be substantially more expensive than premiums for family coverage, without offering any added value through more robust benefits. Due to a lack of competition, benefits offered in

such a one adult with children plan could actually be somewhat less robust than those offered in the more competitive family coverage plan market.
To facilitate the identification of the benchmark plan (and assure meaningful competition among qualified health plans), each exchange must establish a set of rating categories that all participating issuers make use of.

> **RECOMMENDATION:** To avoid the aforementioned problems altogether, we strongly recommend that the IRS urge HHS to adopt in final rules at 45 CFR subsection 156.255(c) a requirement that qualified health plan issuers must cover all four rating categories (or another limited number of categories established by the Exchange, not by each issuer).

The preamble solicits comments on additional methods that should be used to determine a family's benchmark plan premium when multiple plans are needed to cover the entire coverage family. We support the proposed method in subsection (f)(3) which determines a family's benchmark premium based on the sum of premium costs for all of the benchmark plans needed to cover the entire coverage family. Adopting the other methods considered in the preamble would not provide adequate or equitable premium assistance to families unable to purchase a single plan that covers their entire family. As the premium cost of multiple plans will likely be substantially greater than the cost of a single-family plan premium, the alternative methods could result in families having to contribute a percentage of income greater than the statute deems affordable in order to secure coverage for the entire family.

> **RECOMMENDATION:** We recommend the proposed method in subsection (f)(3) which determines a family's benchmark premium based on the sum of premium costs for all of the benchmark plans needed to cover the entire coverage family.

1.36B-3(h) Plan covering more than one family.
We strongly support the proposed rule under (h) for calculating the premium tax credit amount in situations where a single qualified health plan covers more than one tax family.

> **RECOMMENDATION:** Retain the tax credit calculation at 1.36B-3(h).

§1.36B-4: Reconciling the premium tax credit with advance credit payments

The proposed rule on reconciling the premium tax credit with advance credit payments fails to appropriately take into account situations of families experiencing major changes in household income in the course of the year. We are very concerned that this omission will lower participation of healthier-than average people in the Exchanges, drive up premium costs in the Exchanges, and undermine support for the Affordable Care Act (ACA).

Over the course of the year, many families gain or lose a job. Many others get married or divorced, or have children who obtain a job and leave the household. In many cases, these changes will have a large effect on a household's income, measured as a percentage of the poverty line, and on the family's need for health coverage. For example:

Due to a mid-year job loss, a family could lose its employer-based coverage and see its income plummet, lowering the family's current income well below 400 percent of the poverty line and making the family unable to afford coverage unless it receives advance

premium credits that reflect its loss of income. But the family's income for the year as a whole might still be above 400 percent of the poverty line because of the income it received before the job loss.

Another family may have had low income for part of the year and have received advance premium credits to enable it to buy coverage, but then find a new job in the latter part of the year that lifts its income for the year as a whole modestly above 400 percent of poverty line.

The income of a family that is receiving advance premium credits could rise above 400 percent of poverty, making the family ineligible for a premium credit *without any change in its income,* because a child in the family gets a job and leaves the household. The smaller family size would raise the family's income as a percentage of the poverty line.

Two people who each have incomes below 400 percent of the poverty line and are receiving advance premium credits, but who then marry each other during the year, could see their combined income rise above 400 percent of the poverty line for a family of two, making them ineligible for the credits they have been receiving.

These situations demonstrate the need to take changes in circumstances into account. Every household in these situations would be at risk of being required to pay thousands of dollars back to the IRS if the household's change in circumstances is *not* taken into account in determining the amount of the premium credit for which it qualifies and hence the amount it may be required to repay. If, with no exceptions, the amount of the excess credit is based on a household's income for the entire year — including the part of a year when a household did *not* receive (or need) an advance premium credit — then substantial numbers of people who "played by the rules" and received a subsidy appropriate for their current circumstances for part of the year will be required to pay thousands of dollars back. Similar problems will arise for families with annual incomes below 400 percent of the poverty line. While their liability for excess advance payments is capped, they still can be required to pay back significant amounts relative to their incomes.

The health reform law is intended to fill gaps in health coverage that occur due to unemployment or other circumstances. If reconciliation requires repayment of the advance premium credits received during the periods when people's incomes are low and they lack other insurance, applicants for premium credits will need to be warned in advance, and many will decline to participate. Moreover, some people whose income drops during the year may not be considered eligible for a premium credit or they may be eligible for an insufficient credit because their projected income for the year is higher than their current income.

Moreover, if — as is likely — less healthy people are the ones most willing to purchase policies despite the risk of repayment, then adverse selection will result, and premiums in the health insurance Exchanges will increase. That will further decrease participation and threaten the viability of the Exchanges over time.

We believe that the ACA provides legal authority to implement reconciliation in a way that takes changes in circumstances into account and avoids these harmful effects. While reconciliation is under the authority of the Secretary of the Treasury and the IRS, responsibility for administering the premium tax credit is shared with the Secretary of HHS.

In general, the Secretary of HHS is charged with establishing standards and procedures for the eligibility determination process.

Section 36B of the Internal Revenue Code (IRC), as added by section 1401 of the ACA, sets out the eligibility criteria for the premium credits and the formula for determining the amount of the credit. Section 36B(f) defines the process for reconciliation and states that if advance payments exceed the credits allowed under 36B, the individual's tax liability should be increased by the amount of the excess payments, up to the cap applicable to the taxpayer's income.

Four ACA provisions outside the IRC—in addition to section 36B of the IRC, which establishes the rules for eligibility and how the credit amounts are calculated — together establish the process for determining eligibility for premium credits and the amount of the advance payments. These provisions show that Congress intended that the three agencies work together to establish a streamlined process to foster maximum participation in the premium credits, Medicaid, and CHIP:

i. **Section 1411: "Procedures for Determining Eligibility for Exchange Participation, Premium Tax Credits and Reduced Cost-sharing, and Individual Responsibility Exemptions."** This section requires the HHS Secretary to establish procedures for determining eligibility for the premium credits, stating in section 1411(a) that the program established by the HHS Secretary shall determine whether an individual claiming a premium credit "meets the income and coverage requirements" of section 36B. It sets out the information required from applicants and the procedures for establishing and verifying eligibility to participate in the exchange and for determining and verifying eligibility for the premium credits and cost-sharing assistance.

ii. **Section 1412: "Advance Determination and Payment of Premium Tax Credits and Cost-Sharing Reductions."** This section directs the HHS Secretary "in consultation with the Secretary of the Treasury" to establish a program for making advance determinations "under section 1411 with respect to the income eligibility of individuals" for premium tax credits and reduced cost-sharing.

iii. **Section 1413: "Streamlining of Procedures for Enrollment Through an Exchange and State Medicaid, CHIP, and Health Subsidy Programs."** This section requires the Secretary of HHS to establish a streamlined process through which individuals can apply for Medicaid, CHIP, Basic Health (if applicable), and premium credits, including the use of a joint application that can be filed on-line, in person, by mail or by telephone. States are required to develop data systems to allow a determination of eligibility for "all applicable State health subsidy programs," including premium tax credits and reduced cost-sharing, along with Medicaid, CHIP and Basic Health, based on a single joint application — and to enter into data-matching arrangements for determining eligibility for such programs.

iv. **Section 2201: "Enrollment Simplification and Coordination with State Health Insurance Exchanges."** This section amends the Medicaid statute (title XIX of the Social Security Act) to require states to ensure that individuals are screened for eligibility for the premium credits if they apply for and are determined *in*eligible for Medicaid. If they are determined to be eligible for premium credits, the state must ensure that these applicant individuals are enrolled in a plan offered in the exchange

> and receive the applicable premium credits and/or cost-sharing reductions for which they qualify.

Taking all relevant sections into consideration, the ACA can reasonably be read to allow the Secretary of Treasury to develop methods of reconciliation of advance credits that take mid-year changes in circumstances into account. Under the ACA, premium credits are provided on a sliding scale that matches the amount of the subsidy to the level of a family's income in order to ensure that health coverage is affordable. Many families experience changes in income or family circumstances over the course of the year that will affect their need for premium assistance or the amount of the assistance for which they qualify. If families experiencing such changes incur large repayment obligations despite "playing by the rules" and receiving appropriate subsidies during their period of need, it is likely that many families will be deterred from seeking premium credits to begin with and will remain uninsured, in contradiction to the purposes of the Act. One goal of the ACA is to ensure that if people lose their jobs and employer-based insurance, they will have access to affordable coverage through the use of premium credits to purchase insurance in the exchange.

In providing for payment of premium assistance through premium credits, Congress understood that people would need payments in advance and that the advance payments would have to be coordinated with the final credit determined under section 36B. This is clear from section 36B(g) of the Internal Revenue Code, which directs the Secretary of the Treasury to:

> Prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations which provide for —
>
> (1) the coordination of the credit allowed under this section with the program for advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act, and
>
> (2) the application of subsection (f) where the filing status of the taxpayer for a taxable year is different from such status used for determining the advance payment of the credit.

Moreover, subsection (3) of section 36B(f), which governs the process of reconciliation, lists the information that state exchanges should supply to the IRS and the taxpayer, including "any information provided to the Exchange, including any change of circumstances, necessary to determine eligibility for, and the amount of such credit."

As noted, section 1412 provides that the advance determination of the amount of the credit will be based on information from the most recent tax year for which complete information is available. This means that in general, individuals applying for a premium credit at the start of calendar year 2014 will use their 2012 tax returns to determine whether they are eligible for the credit and the amounts they will receive. But to accommodate changes in income and circumstances, the Secretary of HHS has flexibility under section 1412(b) of the ACA to establish procedures for making advance determinations of premium credit eligibility and amounts using other information "in cases where information included with an application form demonstrates substantial changes in income, changes in family size or other household circumstances, change in filing status, the filing of an application for unemployment benefits, or other significant changes affecting eligibility." It is presumably this information that the exchanges must provide to the IRS under the aforementioned

section 36B(f)(3), which requires exchanges to report "any information provided to the Exchange, including any change of circumstances, necessary to determine eligibility for, and the amount of" the credit.

Of course, changes in circumstances won't be reported only at the time that a family initially applies for a credit during the open enrollment period preceding the coverage year. Section 1412 (b)(1)(A) provides the Secretary of HHS with authority to provide for a determination of advance credits during *both* the regular open enrollment period *and* "such other enrollment period as may be specified by the Secretary." In addition, section 1311(c)(6) of the ACA, which sets out the rules for the Exchanges, directs the Secretary of HHS to require exchanges to have special enrollment periods for people who lose other coverage so that families losing employer-based coverage during the year will be able to report their changed income and coverage status and apply for an advance credit. Regulations defining these special enrollment periods were included in the July proposed rule issued by HHS.

Furthermore, individuals and families receiving credits likely will be required to report changes in income and family circumstances during the year, such as a change in the availability of affordable employer-based coverage that affects their eligibility for premium credits. In fact the proposed rule issued by HHS on August 17 would require individuals to report all changes to the Exchange within 30 days.[7] The information provided by taxpayers in such circumstances will then be reported by the Exchanges to the IRS.

The regulatory authority provided to the Secretary under section 36B(g) to administer the premium credits is broad. Paragraph (2) of 36B(g) anticipates changes in filing status that may occur during the coverage year, such as the marriage of a taxpayer receiving a premium credit in cases where combining the two spouses' incomes leads to ineligibility or eligibility for a lesser credit. Section 36B(g) specifically directs the Secretary to prescribe "regulations which provide for…the application of subsection (f) where the filing status for the taxable year is different from such status used for determining the advance payment of the credit." This implies that the Secretary has the regulatory flexibility to avoid requiring people like a newly married couple to pay back all of the subsidies the couple (or one member of the couple) received before getting married.

A reasonable reading of the statute also leads to the conclusion that the Secretary's regulatory authority is not limited to situations where a change in filing status (such as from a marriage or divorce) has occurred. Subsection (1) of 36B(g) is far more general than subsection (2). As noted, it directs the Secretary to issue such regulations as may be necessary for the coordination of the credit determined under section 36B with the advance payment of the credit. This implies a broad range of regulatory discretion, which is needed given that coordination will require consideration of many factors and circumstances. Congress recognized the need for flexibility in leaving to the implementing agencies the details of how coordination should be carried out.

The preamble to the proposed rule acknowledges the direction in the ACA to specify how advance credits will be reconciled when the taxpayer's filing status on his or her tax return

[7] Our comments on the exchange eligibility rule will address why we believe the requirement to report *all* changes to the Exchange is excessive and goes well beyond what is required in the ACA as well as what is necessary for effective administration of the premium credits.

is different from the filing status used to determine advance payments. As proposed, however, the rule does not adjust the process of reconciliation for taxpayers experiencing a change in filing status or any other change, although comments are requested on special rules for taxpayers who marry during the taxable year and for married taxpayers who face challenges in being able to file a joint return.[8]

In our comments on the HHS rule regarding eligibility determinations by exchanges, we discuss the need for an eligibility determination system that is based on income and family circumstances that are as up-to-date and accurate as possible as well as a system that makes it easy for individuals and families to report changes and have their premium credits adjusted during the course of the year. But, as our examples show, this will not be enough to eliminate the risks of reconciliation. Thus we make the following recommendations to alleviate potential harm to individuals and families and more generally to effective implementation of the ACA.

The best way to deal with a mid-year change in circumstances for families that receive advance payments of premium credits for part of the year would be to reconcile the advance payments based on income and family circumstances during the months the advance payments were received. We believe that such an approach is well within the Secretary's legal authority, but recognize that it would be very difficult to administer and is inconsistent with current IRS practice. Therefore we suggest a fallback approach of prorating the caps by the portion of the year that the family or individual received advance payments. For example, if a family with annual income of 375 percent of the poverty line received premium credits for six months of the year when its income was 200 percent of the poverty line, the maximum amount the family would have to pay would be $1,250, which is one-half of the $2,500 cap that would otherwise apply to this family based on its annual income. Prorating the caps should be relatively simple for the IRS to administer, requiring only a simple calculation based on readily available information. As discussed below, the IRS will receive information on the number of months that individuals and families receive premium credits over the course of the year as well as the amount of advance payments the taxpayer received.

> **RECOMMENDATION:** Consider dealing with a mid-year change in circumstances for families that receive advance payments of premium credits for part of the year by reconciling the advance payments based on income and family circumstances during the months the advance payments were received. As a fallback approach, consider prorating the caps by the portion of the year that the family or individual received advance payments.

> **RECOMMENDATION:** Families that appropriately and correctly received tax credits for one or more months, but then experienced a change in circumstances that brings their annualized income above 400 percent of the FPL should be provided with a safe harbor that treats them as if their annual income was at 400 percent of the poverty line and prorates the cap in the same way as described above.

[8] It also should be noted that the Secretary of Treasury has exercised his regulatory authority to administer the premium credits to ensure effective implementation by proposing to create a safe harbor for employers when an employee's share of the cost of self-only coverage is less than 9.5 percent of the employee's wages even if the employee's contribution is more than 9.5 percent of household income.

RECOMMENDATION: Treat couples that marry during the year based on their status during the coverage months. The proposed rule would reconcile advance payments made to two single people who marry during the year based on their filing status as a married couple and their annual income despite the direction in section 36B(g) to issue regulations addressing this situation. We recommend a change in the proposed rule to compute the contribution amount for the couple that allocates their annual income based on whether they were married or single during the coverage months. The following example shows how this would work (using the poverty line for 2011 and a benchmark premium of $5,200 for an individual and $10,000 for a couple):

Example 1: P's projected income is $21,780 (200 percent of the poverty line), and Q's projected income is $16,335 (150 percent of the poverty line).

P and Q marry in July, but from January to June, they received advance credit payments as single individuals. P's advance credit payments totaled $1,914. Q's credit payments totaled $2,274 during that period.

P and Q's projected combined annual income is $38,115 (259 percent of the poverty line), and from July through December, they receive advance payments totaling $3,416.

At reconciliation, their annual household income ends up being $40,000 (272 percent of the poverty line). The final credit would be computed as follows:

Assume P and Q each had annual income of $20,000 from January to June (188 percent of the poverty line). On this assumption, they each should have received $2,025 during this period. From July through December, assume their annual income was $40,000. They should have received $3,262 during that period.

The total amount of advance payments the couple received was $7,604. Under this alternative approach, the final credit amount would be $7,312, which reflects the slight increase in actual income over what they anticipated. However, if the Treasury approach is used, their final credit amount would be only $6,524 leaving them with an overpayment over $1,000. The difference of about $700 is solely because they were married during the year; it does not in any way reflect that they received excess payments.

If P or Q had dependents, a similar approach could be used that would allocate income on a proportional basis during the months prior to marriage.

Example 2: R's projected income is $16,335 (150 percent of the poverty line). From January to June, R receives advance payments of premium credits totaling $2,274. In July, R marries S and becomes eligible for employer-based coverage as S's dependent.

At reconciliation, the couple's annual income is $60,000 (408 percent of the poverty line). Under the proposed rule, the couple would have to repay the entire amount of premium credits R received before their marriage even though the amount was correct when received. Under the alternative approach, R's income would be assumed as $30,000 from January through June (275 percent of the poverty line). R

should have received $1,283 in credits, so the excess payments would be $991 rather than $2,274.

The preamble requests comment on relief for those married taxpayers who face challenges in being able to file a joint return. Under the ACA, married filing couples filing separately cannot claim premium credits. Relief is needed in some circumstances for married taxpayers who file their taxes separately. There are several legitimate reasons that it may be inadvisable or even impossible for married taxpayers to file jointly. One obvious reason is that victims of domestic violence may be keeping their whereabouts a secret. In these cases, it would be inappropriate to require a woman to file a joint return. In fact, domestic violence was a condition discussed extensively during the health care debate when it was discovered that women with a history of domestic violence were often considered uninsurable by health plans. As a result, section 2705 of the Public Health Services Act, as added by section 1201 of the ACA, expressly prohibits discrimination by insurers against conditions arising out of acts of domestic violence. It is appropriate that the IRS make a similar distinction for this class of individuals and allow an exception from the joint filing requirement for victims of domestic violence.

Abandoned spouses also warrant special protection. Such individuals have no choice but to file a separate return in cases when they cannot locate their spouse. Incarceration is another possible barrier to joint filing, particularly if a tax filer has not obtained power of attorney for the incarcerated spouse. In addition, there should be exceptions in the case of a spouse living out of the country.

Individuals in these situations should also be allowed to make such a certification when they apply for advance payments of premium credits at the Exchange. In other words, the exception should not just be applied to individuals who expect to file a joint return, receive advance payments on that basis, and then have to file their tax returns separately. As noted above, the Secretary's broad authority in administering the tax credits under section 36B(g) allows these situations to be addressed.

RECOMMENDATION: To facilitate the identification of cases that merit exceptions from the requirement to file a joint return, we recommend that taxpayers be able to certify on the schedule used to calculate the premium tax credit whether one of several conditions applies. The list of exceptions should capture general categories (domestic abuse, abandoned spouse, incarceration, spouse out-of-the-country). When such exceptional circumstances are identified, the individual should be permitted to file separately and receive a premium tax credit.