Employee Benefits Advisory

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Treasury Department and IRS Issue Final Regulations Implementing Affordable Care Act's Health Insurance Premium Tax Credit

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Commencing in 2014, the Patient Protection and Affordable Care Act (the Act) provides individuals and small businesses with the ability to purchase health insurance through state-based insurance exchanges or marketplaces. To help low-income individuals and families purchase coverage, the Act makes available refundable premium tax credits. The Act's premium tax credit provisions are set out in newly added Internal Revenue Code § 36B. The Treasury Department and IRS recently issued a final regulation implementing the Act's premium tax credits features.

Background

Beginning in 2014, the Act requires most U.S. citizens and green card holders to maintain health insurance that qualifies as "minimum essential coverage." Individuals who fail to maintain minimum essential coverage, and who are not otherwise exempt, are subject to a penalty for noncompliance. Minimum essential coverage includes eligible employer coverage, individual coverage, grandfathered plans, and federal programs such as Medicare and Medicaid, among others.

The Act enables and supports the creation by the states of "American Health Benefit Exchanges" (alternatively, "state-bases exchanges," or simply, "exchanges") the purpose of which is to provide eligible individuals and small businesses with access to quality, affordable health care coverage under Qualified Health Plans (QHPs). A QHP is an individual or small group health policy that provides minimum essential coverage, is issued by a state-licensed carrier, and satisfies certain other cost-sharing requirements. Carriers offering QHPs through state-based insurance exchanges must offer four levels of coverage (bronze, silver, gold, and platinum) based on the portion of costs paid by the plan. (For example, a silver plan will pay, on average, 70% of the costs, with the remaining 30% being paid by the covered individual in the form of co-pays, deductibles, co-insurance, and other cost-sharing.) To facilitate the purchase of affordable health insurance coverage, the Act makes available premium assistance tax credits to individuals with incomes up to 400% of the Federal Poverty Level (FPL). Individuals seeking premium assistance tax credits must submit an application to the state-based insurance exchange in the coverage area in which they reside. The exchange determines whether the individual meets the income and other requirements for advance credit payments and the amount of such payments. Premium tax credits may only be used to purchase QHP coverage through a state-based exchange. Premium assistance credits are advanceable and refundable. An advanceable credit is paid directly to the carrier immediately upon the purchase of coverage. A refundable credit is one that is available even if a taxpayer has no other tax liability. The recipient of the tax credit pays the balance. Thus, the recipient is not required to pay the premium tax credit out of pocket then await reimbursement when filing his or her annual income tax return or through some other mechanism.

Eligibility

To be eligible for a premium tax credit, an individual must be an "applicable taxpayer." Code § 38B defines the

term “applicable taxpayer” to mean a taxpayer —

i. With household income for the taxable year between 100% and 400% percent of the FPL for the taxpayer’s family size;

ii. Who may not be claimed as a dependent by another taxpayer, and

iii. Who files a joint return if married.

An individual who is not lawfully present in the US or who is incarcerated is not an applicable taxpayer, but he or she may be treated as such if a family member is eligible to enroll in a qualified health plan. A lawfully present alien whose household income is 100% FPL or less, and who is not eligible for Medicaid, is treated as an applicable taxpayer. An individual is lawfully present if he or she is and is reasonably expected to be present in the United States for the entire period of enrollment for which the premium tax credit is claimed. The final regulations clarify that the FPL means the most recently published HHS poverty guidelines as of “the first day of the regular enrollment period for coverage by a qualified health plan offered through an Exchange for a calendar year.”

A family’s “household income” is the sum of —

i. A taxpayer’s modified adjusted gross income;

ii. The aggregate modified adjusted gross income of all family members who are required to file an income tax return; and

iii. Social Security benefits not included in gross income. (Social Security benefits are included as a result of a change in the definition of modified adjusted gross income enacted as part of the 3% Withholding Repeal and Job Creation Act.)

Modified adjusted gross income means adjusted gross income (within the meaning of Code § 62) increased by foreign earned income and tax-exempt interest. Household income does not include the modified adjusted gross income of a family member who is required to file a tax return solely for reasons other than reporting income. Family size is equal to the number of individuals in the taxpayer’s family. The final regulation clarifies that “family” means the individuals for whom a taxpayer properly claims a deduction for a personal exemption the taxable year, and it includes individuals who are not subject to the requirement to maintain “minimum essential coverage” under the Act’s individual mandate. This would include, for example, an individual under the age of 18. The family size for computing the FPL percentage for a family with at least one unlawfully present individual is determined by excluding the unlawfully present individual.

If married taxpayers reside in separate states with different FPL guidelines, or if a taxpayer resides in states with different FPL guidelines during the year, the final regulation establishes a rule under which the applicable FPL is the higher of the two FPLs.

Minimum Essential Coverage

A taxpayer is allowed a premium assistance tax credit only for any month that one or more members of the applicable taxpayer’s family —

i. Is enrolled in one or more qualified health plans through an exchange; and

ii. Is not eligible for *minimum essential coverage* other than coverage in the individual market.

“Minimum essential coverage” means and includes —

- A government-sponsored program, including coverage under Medicare Part A, Medicaid, the Children’s Health Insurance Program, and TRICARE;
- An eligible employer-sponsored plan;
- A health plan offered in the individual market;
- A grandfathered group health plan; or
- Other health benefit coverage (such as a state health benefit risk pool) as determined by regulation.

An individual who timely completes the requirements necessary to receive benefits available under a government-sponsored program by the last day of the third full calendar month following the event that establishes eligibility is treated as eligible for the coverage no earlier than the first month that the individual may receive benefits. An individual who fails to complete the necessary requirements to receive government-sponsored benefits by the last day of the third full calendar month following the event that establishes eligibility, however, is treated as eligible for the coverage on the first day of the fourth calendar month. This latter three-month period is applied without regard to the time needed for a government agency to process an application. Individuals enrolling during the later months of their initial Medicare enrollment period will not be deemed eligible for Medicare before the expiration of the enrollment period.

An individual who may enroll in minimum essential coverage because of a relationship to another person, but for whom the other eligible person does not claim a personal exemption deduction, is treated as eligible for minimum essential coverage under the coverage *only* for months that the related individual is actually enrolled in the coverage. The related individual in this case is a member of a different family with different household income for purposes of the premium tax credit. A person who may not claim a related individual as a dependent is not responsible for any penalties for the related individual who does not receive coverage. Thus, coverage available through another person does not create an obstacle to a related individual claiming a premium tax credit.

COBRA coverage is treated as eligible for minimum essential coverage under an eligible employer-sponsored plan only for months in which an individual is actually enrolled in COBRA coverage.

Amount of the Premium Assistance Credit

A taxpayer's "premium assistance credit amount" is the sum of the premium assistance credit amounts for all coverage months in the taxable year for individuals in the taxpayer's family. The premium assistance credit amount also depends on whether the eligible individual elects "self-only coverage" (i.e., "means health insurance that covers one individual") or "family coverage" (i.e., "health insurance that covers more than one individual"). The premium assistance amount for a coverage month is the lesser of—

i. The premiums for the month for one or more qualified health plans that cover a taxpayer or family member, or

ii. The excess of the "adjusted monthly premium" for the second lowest cost silver plan available through the exchange in the individual's service area (the "benchmark plan")

over

1/12 of the product of the taxpayer's household income and the "applicable percentage" for the taxable year.

A "coverage month" is any month for which the taxpayer or any family member is covered by QHP enrolled in through an exchange and the premium is paid by the taxpayer or through an advance credit payment.

A taxpayer's "applicable percentage" increases as the taxpayer's household income as a percentage of the FPL for the taxpayer's family size increases, as follows:

Income Level	Applicable percentage
Up to 133% FPL	2%
133-150% FPL	3 – 4%
150-200% FPL	4 – 6.3%
200-250% FPL	6.3 – 8.05%
250-300% FPL	8.05 – 9.5%
300-400% FPL	9.5%

Taxpayers must pay the difference between the premium assistance amount and the premium for the plan they choose.

The "adjusted monthly premium" is the premium an insurer would charge for the plan adjusted only for the ages of the covered individuals determined without regard to any premium discount or rebate under a wellness discount demonstration project. Nor may the premium be adjusted for tobacco use.

Where an individual has elected family coverage, the benchmark plan is the plan that applies to the members of the taxpayer's family. If there is at least one silver level plan offered by the state-based exchange that does not cover all members of a taxpayer's coverage family under one policy and premium, the premium is the single premium or the combination of premiums that is the second lowest cost silver option for covering the entire family. (This might occur, for example, due to non-traditional relationships within the family.)

If an individual enrolls in both a QHP and a dental plan, the portion of the premium for the dental plan properly allocable to pediatric dental benefits that are essential health benefits is treated as premiums payable for a QHP plan for purposes of determining the monthly premium. The final regulation provides that the portion of the premium for a stand-alone dental plan properly allocable to pediatric dental benefits will be determined under guidance issued by the Department of Health and Human Services.

The monthly premium assistance amount is, therefore, the lesser of the premium for the qualified health plan in which a taxpayer or family member enrolls, or the excess of the premium for the benchmark plan over the applicable percentage of the taxpayer's household income. In general, this percentage of the taxpayer's household income represents the amount of the taxpayer's required out-of-pocket contribution to the premium cost if the taxpayer purchases the benchmark plan. The remainder of the premium for the benchmark plan is the premium assistance amount.

An individual must be enrolled in a qualified health plan as of the first day of the month for a month to be a coverage month. An individual is credited with a coverage month if, on at least one day of the month, he or she is not eligible for other minimum essential coverage. A month is not a coverage month, however, if the individual fails to timely pay his or her share of premiums. Payment is timely if made not later than the unextended due date for filing his or her income tax return for the tax year.

Employer-sponsored Plan Coverage — Affordability and Minimum Value

A coverage month for an individual does not include a month in which the individual is eligible for minimum essential coverage under an employer-sponsored group health plan, but only if the employee's share of the premiums is *affordable* and the coverage provides *minimum value.*

- Affordability. Under a proposed rule, coverage was deemed unaffordable if employee contributions for self-only coverage exceeded 9.5% of the employee's household income. The final regulation reserved on this issue. The matter will be determined in subsequent guidance.
- Minimum Value. A plan fails to provide minimum value if the plan's share of the total allowed costs of benefits is less than 60%. Minimum value standards have been/will be prescribed by the Department of Health and Human Services.

An individual is treated as eligible for employer-sponsored minimum essential coverage if the individual actually enrolls in an eligible employer-sponsored plan, even if the coverage does not meet the affordability and minimum value requirements. An employee or related individual is, however, treated as **not** enrolled in an eligible employer-sponsored plan if the employee or related individual is automatically enrolled in a plan if he or she terminates the coverage before the later of (1) the first day of the second full calendar month of the plan year, 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.

The final regulations clarify that an employee or related individual is treated as not eligible for coverage under the employer's plan during a waiting period.

Employer contributions to Health Savings Accounts (HSAs) do not affect the affordability of employer-sponsored coverage because HSA contributions may not (with some exceptions not here relevant) be used to pay for premiums for health insurance coverage. Similarly, amounts available under a Health Reimbursement Account (HRA) that may be used only to reimburse medical expenses other than the employee's required share of the cost

of employer-sponsored coverage do not affect the affordability of employer-sponsored coverage. The final regulation does not address how other HRAs are treated for purposes of determining the affordability of an employer-sponsored plan. This item will be addressed in subsequent guidance. Nor does the final regulation address the effect on affordability of wellness incentives that increase or decrease an employee's share of premiums.

The Affordability Safe Harbor

To establish that coverage is unaffordable, the employee must obtain an affordability waiver from a state health insurance exchange. To assist the exchange in making its determination in the matter, individuals applying for advance credit payments must provide the state-based exchange with information on whether they are eligible for employer-sponsored coverage. The final regulations refer to this determination as the "affordability safe harbor." The affordability safe harbor is not available to a taxpayer who misrepresents the availability of employer-sponsored coverage. Nor is the affordability safe harbor available if the employee, with reckless disregard for the facts, provides incorrect information to an exchange concerning an employee's portion of the annual premium for employer coverage. Moreover, the affordability safe harbor applies only until such time as the availability of employer-sponsored coverage changes.

Reconciliation

Taxpayers are required to reconcile the actual credit for the taxable year computed on the taxpayer's tax return with the amount of advance payments. A taxpayer need not reconcile payments for any month in which the issuer of the qualified health plan does not provide coverage. If a taxpayer's credit amount exceeds the amount of the taxpayer's advance payments for the taxable year, the taxpayer may receive the excess as an income tax refund. If a taxpayer's advance payments exceed the taxpayer's credit amount, the taxpayer owes the excess as an additional income tax liability. Any additional income tax liability is, however, limited based on a graduated set of caps for taxpayers with household income under 400% percent of the FPL. The repayment limitation amounts range from $600 to $2,500 (one half that amount for single taxpayers) depending on FPL and are adjusted to reflect changes in the cost of living beginning in 2015. In the case of taxpayers who marry during the taxable year, the credit for the "single" months is computed separately for each spouse as if each spouse's annual income was one-half of the actual household income for the year. The credit for the married months is computed using actual household income for the year. The premium tax credit is the sum of the credits computed for the single months and the married months.

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