October 31, 2011

VIA ELECTRONIC SUBMISSION

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

Re: Health Insurance Premium Tax Credit proposed regulations [IRS Reg-131491-10] RIN 1545-BJ82

Dear Sir/Madam:

Families USA is a national health care advocacy organization dedicated to expanding access to affordable and quality health care for all Americans, particularly low-income and underserved populations. In addition to drawing on our own experience, these comments reflect conversations with other advocacy and public policy organizations that work to protect consumer rights and advance policy changes that facilitate access to health coverage for millions of un- and underinsured Americans.

We appreciate the opportunity to comment on the proposed regulation for the Refundable Tax Credit Providing Premium Assistance for Coverage under a Qualified Health Plan, section 1401 of the Patient Protection and Affordable Care Act (Affordable Care Act), which establishes a refundable premium tax credit for households between 100 percent and 400 percent of the federal poverty level, to ensure health coverage is affordable for all families up to 400 percent of poverty. This premium tax credit will help individuals and families without another option of affordable coverage that meets the definition of minimum essential coverage by providing them advance credit payments to apply toward the cost of premiums for a qualified health plan in the Exchanges.

We are generally supportive of the proposed rule and believe that the recommendations below will serve to strengthen it. Our recommendations will ensure that premium assistance is made available to the full breadth of individuals and families intended by the statute and adequate and equitable assistance is provided to all eligible families. Five areas are of paramount concern to us. They are as follows:

1) **Affordability Test for Employer-Sponsored Coverage:** We are very concerned with the proposed rule's definition of affordable employer-sponsored coverage for the purposes of determining a household's eligibility for premium tax credits. Basing the affordability determination for an entire family on the cost of self-only coverage could result in millions of

American families without access to affordable health coverage. It is critical that the definition of affordable employer-sponsored coverage be based on the employee's premium cost for family coverage, not self-only coverage, to ensure the rule fulfills the coverage aims of the Affordable Care Act.

2) **Wellness Incentives:** It is critical that any wellness incentives attached to premium costs do not undercut the affordability tests established by the Affordable Care Act. The proposed rule does not address whether wellness incentives attached to premiums will be factored in when considering whether employer-sponsored coverage is affordable. In addition, it does not address whether wellness incentives will be included when calculating the benchmark premium for premium tax credit recipients. In order to reflect the intent of the statue, wellness incentives must explicitly be included in premium costs for the purpose of all affordability tests.

3) **Consumer Notification:** Individuals and families must be informed of their right to affordable health coverage and their options for accessing affordable coverage. The proposed rule issues no guidance on future rulemaking to ensure that employers provide adequate notice to workers explaining their health care rights. We believe it is essential that the Treasury call for future regulations be made by the Department of Labor to ensure that employees and those eligible for continuation coverage receive adequate notice of their insurance rights and options prior to making enrollment decisions.

4) **Transitions in Coverage:** The final rule must include protections for individuals as they transition from a qualified health plan to government-sponsored coverage. Adequate grace periods for completing enrollment requirements, as well as good faith exemptions from enrollment deadlines, are essential to ensuring that individuals do not have gaps in coverage or face financial penalties as they transition. Further, we stress that coverage transitions should be delayed if an individual is the midst of an episode of acute, highly-specialized care, to ensure the transition does not disrupt treatment and jeopardize such individual's health.

5) **Reconciliation:** We also have serious concerns with the proposed rule regarding the reconciliation of advance credit payments. Life changes that affect a family's eligibility for the premium tax credit, such as changes in employment and family size, are often unplanned and are difficult for a family to foresee over a year in advance. The reconciliation process should be responsive to changes in life situations, and families receiving premium tax credits should not face financial hardship or tax penalties at the time of reconciliation for changes in circumstances that they have properly reported.

Section 1.36B is critical to ensuring that the coverage and affordability aims of the Affordable Care Act are fulfilled. To this end, we strongly urge Treasury to adopt the recommendations below in its final rule.

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§1.36B-2 Eligibility for premium tax credit

Section §1.36B-2 establishes the eligibility requirements for receiving premium tax credits to use toward a qualified health plan. An inclusive and comprehensive eligibility definition is critical to ensuring that premium tax credits apply to the full breadth of individuals and families that the law intended to assist. To this end, the affordability of employer-sponsored coverage must be calculated based on the cost of family coverage. Consumers must be provided with adequate notice of their right to affordable coverage and their insurance options. In addition, adequate grace periods for completing enrollment requirements and maintaining premium tax credit eligibility are essential to protect individuals from experiencing gaps in coverage and/or unaffordable financial penalties when transitioning from a qualified health plan to government sponsored coverage. Therefore, we offer the following specific comments to strengthen section §1.36B-2.

§1.36B-2 (b)(2), Married taxpayers must file joint return

Under (b)(2) a married taxpayer is considered an applicable taxpayer only if the taxpayer and their spouse file a joint tax return at the end of the year. As we more thoroughly discuss in comments on section §1.36B-4(b)(3), certain circumstances, such as in cases of domestic violence, may prevent taxpayers from filing a joint tax return with their spouse. The final rule should ensure that, in cases where married taxpayers are unable to file a joint return, both taxpayers remain eligible for premium tax credits.

Recommendation: The final rule should include an exemption from this requirement, such that married taxpayers who demonstrate considerable barriers to filing a joint tax return are considered applicable taxpayers.

§1.36B-2(b)(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 the 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 line for the taxable year and advance credit payments are authorized and paid for one or more months during the tax year. The special rule uses the Treasury Department's regulatory powers to fill in a gap in the statute to ensure that the intent of the law is fulfilled in providing access to coverage to all eligible individuals with household income under 400 percent of the federal poverty line. We therefore believe the special rule 1.36B-2(b)(6) is important to meeting the intent of the law.

Recommendation: Maintain the special rule for taxpayers with household income below 100 percent of the federal poverty line for the taxable year.

§1.36B-2(b)(7), Computation of premium assistance amounts for taxpayers with household income below 100 percent of the federal poverty level.

In general, we support this provision, which computes the premium assistance amount on a taxpayer's actual household income if the taxpayer's household income is less than 100 percent of the federal poverty line. This provision meets the intent of the law that taxpayers not be financially punished if an Exchange overestimates their household income. However, as currently written, proposed rule's language is unclear as to whether a taxpayer's "actual household income" refers to a household's modified adjusted gross income.

Recommendation: Maintain the provision in 1.36B-2(b)(7) that provides for the computation of premium assistance amounts for taxpayers with household income below 100 percent of the federal poverty level on actual household income. The final rule should clarify that when calculating a low-income taxpayer's premium assistance amount, the household can adjust gross income to include deductions that apply, for example, for self-employed workers.

1.36(B)-2(c)(2) Government Sponsored Minimum Essential Coverage

§1.36(B)-2(c)(2)(iii)(A), Time of eligibility - In general

Under (c)(2)(iii)(A) individuals who qualify for minimum essential coverage under a government-sponsored program are treated as eligible for minimum essential coverage on the first day of the first full month of benefits. If an individual does not complete enrollment requirements with reasonable promptness, they are treated as eligible for minimum essential coverage on the first day of the second calendar month following the event that determined eligibility. However, the rule does not define "reasonable promptness" and does not allow for any good faith exemptions.

We support the general rule that an individual is considered eligible for minimum essential coverage on the first day of the first full month of benefits. However, as eligibility for minimum essential coverage disqualifies an individual from premium tax credit eligibility, we are concerned that this proposed rule could result in people having gaps in coverage as they transition into a government-sponsored plan, or unaffordable tax obligations at the time of reconciliation.

The final rule should mitigate a problem that Medicare late enrollees will otherwise face: For individuals transitioning from a qualified health plan into Medicare, late enrollment would result in particularly harsh financial penalties. Individuals transitioning into Medicare would face additional tax liability in the amount of the advance credit payments received during the last two months of their initial Medicare enrollment period, a period in which they technically were still eligible for premium tax credits. In addition, such individuals would have to pay a Medicare late enrollment premium fee and would either have to cover the full cost of private coverage until the next general enrollment period for Medicare or go without health coverage for that period. The final rule should prevent such a double penalty by allowing late Medicare enrollees to retain premium credit eligibility until the next Medicare open enrollment period.

We recommend that the final rule provide a standard definition for reasonable promptness to which states must adhere. Reasonable promptness should be defined as within 90 days from the event that determined eligibility. This would align the deadline for completing enrollment requirements with the length of Medicare eligibles' initial open enrollment period. This definition would also align with the deadline proposed in CMS-9974-P, 155.315(e)(2)(ii), which provides applicants a period of 90 days from date of notice to present satisfactory evidence to verify information required to determine eligibility for premium tax credits. The definition of reasonable promptness should also require good faith exemptions be made in situations where any delay is due to action or inaction by a government agency or official, such as a delay in the reissuing of an official copy of a birth certificate.

The proposed rule should be amended such that individuals who do not complete enrollment requirements with reasonable promptness remain eligible for premium tax credits for three full calendar months following the event that determined eligibility. This would allow individuals to maintain their premium tax credits through the 90 day period they have to complete enrollment requirements for government-sponsored coverage such as Medicare.

Recommendation: The final rule should define "reasonable promptness" as 90 days after the event that determined eligibility and should require good faith exemptions in situations where delay is due to action or inaction by a government agency or official. Individuals who fail to complete enrollment requirements for government sponsored coverage should remain eligible for the premium tax credits for three full months after the event that determined eligibility for government sponsored coverage.

§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 the qualified health plan in which they were previously enrolled. This will 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 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.

§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, states 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 during 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 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 their qualified health plan, the individual may face problems continuing their 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 address this problem, some states currently require plans to permit new enrollees to continue seeing their previous providers for up to 60 days if the enrollees have a life-threatening, degenerative, or disabling disease or condition, or an acute condition. To provide similar protections from 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.

Recommendations: 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 the 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

§1.36B-2 (c)(3)(iii), Eligibility for coverage months during a plan year

Proposed rule (c)(3)(iii) defines an individual as eligible for minimum essential coverage through employer sponsored coverage as long as such coverage is affordable and meets the definition for minimum value, regardless of whether or not that individual actually enrolls in the plan during their open enrollment period. To ensure that employees are properly informed of this rule when deciding whether to enroll in their employer's plan, we recommend that the final rule calls for additional regulations to be issued by the Department of Labor to require employers to provide written notice of this rule to their employees at the start of their plan's open enrollment period. This notice should include contact information for local consumer assistance programs that can assist workers in determining whether their employer's plan meets the definition of minimum essential coverage.

Recommendation: The final rule should call for additional regulations to be made by the Department of Labor to require that employers provide written notice to workers of their insurance rights and options at the start of their plan's open enrollment period and during any special open enrollment periods. This notice should include: (1) the definition of affordability and minimum value; (2) information on how workers can determine whether their offer of coverage is considered minimum essential coverage and contact information for local consumer assistance programs that can help families make this determination; (3) the timeline within workers have to decide whether to enroll in their employer's plan; and (4) and the premium tax credit eligibility consequences of that decision, including notice that workers will be ineligible for premium tax credits for the duration of that plan year if their offer of employer sponsored coverage meets the criteria for minimum essential coverage, even if they do not enroll in their employer's plan. The Department of Labor should provide model language for this notice in English and Spanish.

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

We support the special rule for continuation coverage provided in section 1.36(B)-2(c)(3)(iv) that an individual is considered eligible for minimum essential coverage only if the individual enrolls in the coverage. 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 was to increase access to coverage to people experiencing a transition that results in the loss of group health coverage.

We also read the proposed rule to apply if an individual terminates continuation coverage so that after termination of coverage, when the individual is no longer enrolled in continuation coverage, the individual is not deemed to be eligible for minimum essential coverage. It is important that this interpretation be clarified in the final rules.

There are multiple instances in which an individual may be enrolled in continuation coverage and should be allowed to terminate coverage and be eligible for a premium tax credit. One example is if P and Q are married. P loses his job and enrolls in continuation coverage. Three months later, Q also loses her job and the household can no longer afford the continuation coverage payments. P should be able to terminate continuation coverage and receive a premium tax credit if otherwise eligible. Another example is if R enrolls in continuation coverage. After 5 months, R receives notification that the premiums for the coverage will be increasing by 15% for the next plan year. Although R had determined when first enrolling that continuation coverage was the best form of coverage for her situation, given the premium increase, R now determines that she is better off purchasing coverage through an Exchange with a premium tax credit.

There may also be circumstances where an individual becomes eligible for and enrolls in continuation coverage before January 1, 2014. These individuals should not be prevented from receiving premium tax credits because the qualifying event resulting in eligibility for continuation coverage occurred prior to the existence of the Exchanges.

Finally, proposed regulations by HHS have the first day of coverage through a qualified health plan be either the first day of the following month or the first day of the second month if enrollment occurs after the 22nd of the month.[1] If an individual becomes eligible for continuation coverage after the 22nd of the month and these final HHS rules are not modified, there could be a gap of one month or more before coverage will begin through a qualified health plan through an Exchange. Individuals in the midst of health treatments may not be able to continue treatment without enrolling in continuation coverage during this gap. It is important that individuals requiring continuation coverage to provide coverage during this gap be allowed to receive premium tax credits once the qualified health plan coverage can begin or adverse selection into continuation coverage will be exacerbated with corresponding increases in costs of employer-sponsored coverage.

Additionally, consumers should be fully informed of this rule when deciding whether to enroll in continuation coverage. We recommend for the final rule to call for additional regulations to be issued by the Department of Labor that require employers to provide written notice of this rule to workers qualifying for continuation coverage. Such notice could be included in the Notice of a New Election Period.

Recommendation: Maintain the special rule for continuation coverage that deems an individual eligible for minimum essential coverage only if the individual enrolls in the coverage and clarify that the special rule applies if an individual terminates continuation coverage. The final rule should call for additional regulations to be issued by Department

[1] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. at 41,917.

of Labor that require employers to provide written notice of eligibility for premium tax credits to workers qualifying for continuation coverage. Such notice could be included in the Notice of New Election Period.

§1.36B-2(c)(3)(v), Employer-sponsored minimum essential coverage: Affordable Coverage

Like many other commenters, we strongly oppose the proposed rule's stance on how affordability of employer-sponsored insurance would be determined, because it would use the cost of an employee's self-only coverage — not the cost of family coverage — to determine whether the employee's family members can receive subsidies to help pay for coverage. As described below, this proposed rule could result in employers dropping their contribution to family coverage, would cause a continued strain on our health care system, and does not adequately address how wellness incentives should be applied to premiums for the purpose of determining affordability.

Although self-only coverage may be affordable for families, the cost of family coverage is substantially greater and is unaffordable for many low- and moderate-income families. 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 premium tax credits. This would leave many people paying large portions of their household income for job-based family coverage, and many others uninsured because of the high cost of coverage. 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 credits 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 Affordable Care Act:

- 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 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 statute's 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.[2] 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.*

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

This reading would be a plain language reading when considered along with how employer-sponsored health benefits operate. Employer-sponsored health benefits are most often paid jointly by the employer and a contribution by the employee. Individuals eligible for employer-sponsored 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 employer-sponsored 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:

> 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.

As written, the proposed rule would cause serious harm to families already having a hard time making ends meet. Take, for example, a family of four earning 250 percent of the federal poverty line, or $55,875 a year. One parent works and has an offer of employer coverage that costs $150 a month for the employee and $600 a month to cover the entire family. The family cannot afford

family coverage (a $600 monthly premium amounts to more than 12 percent of the household's income), so only the employed parent is covered by the employer plan. As the preamble to the proposed rule indicates, the rest of the family would be able to claim an exemption from the penalty for not having coverage, but they would remain uninsured.

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.[3]

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. Of these 6.3 million children, 1.7 million are currently uninsured and would likely remain uninsured even after premium credits become available in 2014. If CHIP is not extended, the number of uninsured children would be substantially higher.[4]

Further, under this proposed rule an employer could offer family coverage but make no contribution to the plan cost, and as long as their offer of self-only coverage met affordability criteria, a worker's family would be ineligible for premium tax credits. In 2011, the average annual premium for employer-based family coverage was $15,073.[5] For a family of three at 300% of poverty ($55,590), this is ***27% of their household income***. This is clearly out of reach for families with income between 133 and 400 percent of poverty ($24,645 to $74,120 for a family of three).

Moreover, as the employer safe harbor proposed in the preamble only penalizes employers if they do not offer family coverage and if they do not offer affordable self-only coverage, there could be a dangerous incentive for employers to offer family coverage but to contribute disproportionately more to self-only coverage than to family coverage, in order to avoid all

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[3] 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.

[4] 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)

[5] Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits Survey: 2011 Summary of Findings* (Washington: Kaiser Family Foundation, September 2011), available online at http://ehbs.kff.org/pdf/8226.pdf

penalties. The result would be that families would be banned from receiving premium tax credits and would be responsible for contributing an increasing proportion of the premium cost for family coverage.

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

More uninsured individuals mean a continued stress on our healthcare system. The uninsured will continue to need health care, but many will be unable to pay for that care. The result will be continued uncompensated care. State and local governments will continue to need to provide funding to hospitals and community health centers to help pay for the costs of the uninsured. Insurance rates will continue to be higher in order to cover costs of care to the uninsured that are never compensated elsewhere. As the uninsured become disabled due to lack of access to healthcare, there will be continued pressure on Medicaid and Medicare to pick up the cost of serious health conditions that could have been prevented if the individuals had access to health care.

The proposed rule will also create a disincentive for employers to continue offering coverage to low-income workers. Workers in firms with higher numbers of lower-wage workers contribute a greater percentage of the premium for family coverage than workers in firms with fewer numbers of lower-wage workers.[6] Many of the workers in these firms will realize they are in an economically better situation if their employer does not offer coverage and the family can receive premium tax credits for coverage in an Exchange. Over time, workers who have family members without other access to coverage will migrate to employers that do not offer coverage. Employers will recognize that an offer of coverage does not have the same recruitment and retention benefits of the past and many will stop offering coverage to low-income workers.

Similarly, the proposed rule creates an incentive for employers to violate or find loopholes in the provisions of the tax code, that were expanded to fully-insured plans in the Affordable Care Act, preventing discrimination in favor of highly compensated individuals.[7] This is because highly compensated employees may receive a greater benefit from an offer of coverage than lower wage employees.

The proposed interpretation also goes against many federal policies that aim to strengthen families and actually discriminates against marriage and families. Some of the policies aimed at

[6] Kaiser Family Foundation and Health Research & Education Trust, "Employer Health Benefits 2011 Annual Survey." September 2011.
[7] 42. U.S.C. 300gg-16; 26 U.S.C. 105(h)(2)

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.[8] 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 Exchanges as healthier individuals are less likely to make the decision to not marry and maintain eligibility for premium tax credits.

To ensure the final rule is consistent with the statue, achieves the coverage aims of the Affordable Care Act, and provides equitable access to affordable health insurance for all low and middle income families, affordability of employer sponsored coverage should be determined based on the employee's cost for family coverage.

In addition, the proposed rule's definition of affordability does not consider how wellness incentives will be factored in when determining whether employer-based coverage is affordable.. Under 1201(4) of the Affordable Care Act, Section 2705(j) of the Public Health Service Act is amended such that employer-sponsored plans that offer a wellness program may vary premiums up to 30% of the cost of coverage, based on standards related to health status factors. This could mean, on average, an additional $1,629or $4,522 in premium costs for individuals and families, respectively.[9]Further, there is no limit on how much an employer can vary workers' share of premiums based on participation in wellness programs. Clearly such rewards or penalties could result in an individual's share of premium costs far exceeding the definition of affordable employer-sponsored coverage, according to the statute. The Affordable Care Act does not explicitly reference wellness incentives under determining affordability, but the intent of the law is clear—employer sponsored coverage is only considered affordable if the employee's contribution to premium costs is no more than 9.5% of household income. ***Wellness incentives are a part of an employee's premium contribution and, as such, should be included in any calculation of affordability.***

If wellness rewards or penalties bundled to an employee's premium costs are not considered when determining affordability, employers could use wellness incentives as a vehicle to shift premium costs to their less healthy workers, while avoiding employer responsibility penalties. Less healthy workers would face unaffordable premiums and would be considered ineligible for premium tax credits. Thus, the workers who need health coverage the most would be without any affordable coverage option. ***To ensure wellness incentives do not undercut the statute's definition of affordable employer sponsored coverage, the final rule should clarify that employer sponsored coverage is only affordable if the employee's share of the premium, including the cost of any wellness incentive, is no more than 9.5 percent of household income.***

Recommendation: To ensure that the final rule is consistent with the statute and carries out the coverage goals of the Affordable Care Act, we urge the Department to base the

[8] 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/.

[9] Based on average annual premiums for 2011. Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits Survey: 2011 Summary of Findings* (Washington: Kaiser Family Foundation, September 2011), available online at http://ehbs.kff.org/pdf/8226.pdf

determination of affordability of employer-sponsored coverage 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. In addition, we strongly recommend that the final rule include that employer sponsored coverage is considered affordable only if the employee's premium cost, *including the cost of any wellness incentives,* is no more than 9.5 percent of their household income.

§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 tax 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 that the family was not eligible for premium credits after all. 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.

The safe harbor is also important because employees are unable to enroll in employer-sponsored plans mid-year without a qualifying event under the HIPAA special enrollment provisions.[10] Employees are not actually eligible to enroll in employer-sponsored coverage when there is a change in income in the middle of the plan year. The proposed rule will avoid situations where individuals and families are left without access to affordable coverage because they could not foresee an income increase.

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 want to note that it is extremely important that a strong minimum value calculation be put in

[10] Footnote for HIPAA special enrollment provisions

place and we are thus very concerned about two issues discussed in the preamble: that forthcoming rules many not require large employers to cover essential benefits; and that the agencies may offer transition relief to some employers. An employer plan offering the minimum value should offer benefits at least equal in coverage to a bronze plan in the Exchange. While we recognize that employer-sponsored plans and plans offered in the large group market do not need to meet all the requirements of a qualified health plan offered in an Exchange and there are some requirements which will apply to plans in the small group market but not in the large group market, we also believe the intent of Congress was to ensure consistency between the actuarial determination. Section 1302(d)(2)(C) of the Affordable Care Act requires the Secretary of Health and Human Services to apply the same rules in determining the actuarial value of a qualified health plan offered in 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 employer-sponsored plan is providing minimum value must be based on the cost of covering the essential benefits, whether or not the plan covers all the essential 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 employer-sponsored plan provides minimum value and 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 one or more health plan to automatically enroll all eligible employees in one of the health plans. This is an important provision of the law, however, we are concerned that there may be some administrative difficulties when employers first implement automatic enrollment that could result in people being incorrectly enrolled. 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. An individual may be re-enrolled into a plan due to a relationship to an employee without the individual's knowledge if the notice to opt-out of automatic re-enrollment 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 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 of such an employer should not be prevented from receiving a premium tax credit if the employee plans to opt-out and will be disenrolled.

Finally, as the employer responsibility penalty creates an incentive for employers to keep workers enrolled in their plan, it's critical that workers are fully informed of their insurance options and rights prior to deciding to enroll in or opt out of employer sponsored coverage.

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. The final rule should call for additional regulations to be made by the Department of Labor that require employers to provide written notice of insurance rights and options to their workers at the start of their plan's open enrollment period, as well during any special open enrollment period. This notice should include: (1) the definition of affordability and minimum value; (2) information on how workers can determine whether their offer of coverage is considered minimum essential coverage and contact information for local consumer assistance programs that can help families make this determination; (3) the timeline within workers have to decide whether to enroll in their employer's plan; (4) and the premium tax credit eligibility consequences of that decision.

Computing the premium assistance amount, §1.36B-3

Section §1.36B-3 defines the rules for calculating a family's premium assistance amount. It is essential that all families eligible for premium tax credits, regardless of income or family composition, receive adequate and equitable assistance with the cost of health coverage for their entire family. To this end, provisions must be put in place to protect families with children enrolled in CHIP from paying a greater percentage of their income than is required by statute to cover their entire family. In addition, wellness incentives tied to premiums should not result in a family paying a higher percentage of their income on premiums than is required by statute. Families must also have adequate assistance in calculating the amount of their advance credit payment. As such, we support these rules and offer the following recommendations to strengthen section §1.36B-3.

§1.36B-3(d), Premium assistance amount

The proposed rule does not consider how wellness incentives should be applied to premiums for the purpose of calculating a family's premium tax credit amount. There is no provision in the Affordable Care Act that precludes qualified health plan issuers in an Exchange from implementing wellness programs that vary enrollees' premiums based on either their participation in the program or standards related to health status factors. In fact, section 1201 of the Affordable Care Act amends the Public Health Service Act section 2705(l) such that the HHS will implement a 10-state demonstration project under which health insurance issuers will be able to apply amended Public Health Service Act rule 2705(j) to wellness programs offered in the individual insurance market. This would allow wellness programs offered in the individual insurance market to vary an enrollee's premium by up to 30% of the cost coverage, based on standards related to health status factors. The Affordable Care Act does not explicitly reference how wellness incentives should be factored in to affordability tests, but the intent of the law is clear: Individuals receiving premium tax credits should not be required to spend a greater share of their income on premiums than is defined for their income level under Section 1401 of the Affordable Care Act, including the costs of premium-based wellness incentives.

Recommendations: The final rule should state that premium tax credits are calculated based on an individual's applicable benchmark plan's premium, *including* the cost of any wellness incentive applied to that benchmark plan.

§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 rule 156.255(c) of 45 CFR, which requires qualified health plan issuers to offer coverage to four rating categories (individual; two adults; one adult with children; and family), but gives issuers the discretion to decide whether to offer coverage to each of the four family categories or to combine coverage categories. 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 discreetly. In addition, while required by the Affordable Care Act, the proposed 156.255(c) does not contemplate the availability of child-only plans. We have strong concerns about the implications of such a 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 carry 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 has only one qualified health plan within a certain category of coverage, there would be no second lowest cost silver plan available in that category. This proposed rule does not specify how a taxpayer's premium tax credit would be calculated if the taxpayer's family enrolled in a category that only one plan covered. In addition, the category of coverage that would be used to calculate the benchmark premium for a family that purchases a child- or children-only qualified health plan is unclear.

Further, in Exchanges with a limited market offering in certain coverage categories, the premiums for benchmark plans could vary in a way that does not coincide with value. For example, if a limited number of carriers participates 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, the 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 45 CFR, subsection 156.255(c) a requirement that: 1) qualified health plan issuers must cover all four rating categories (or another limited number of categories established by an Exchange, not by each issuer); and 2) a rating category be added for children, since qualified health plan issuers are explicitly required to offer child-only plans within Exchanges.

Only if HHS does not adopt the above recommendations do we strongly recommend that Treasury adopt the following additions to the final rule under 1.236B-3(f)(2) to mitigate the potential negative consequences of HHS rule 156.255(c) when calculating premium tax credits:

1) In Exchanges where there are two or fewer one adult with children plans, an applicable family's benchmark premium should be based on the second lowest cost family plan if its premium is higher than the combined premiums for the one adult with children plans; 2) In Exchanges where there are two or fewer plans offered discreetly to two-adult households, an applicable couple's benchmark premium should be based on the sum premium of two single benchmark plans if the sum is higher than the premiums for a plan in the two adult category; 3) In Exchanges where the premium for the second lowest cost silver plan in the one adult with children category is more than a set percent lower in cost than the benchmark plan premium for family coverage, the benchmark plan premium for families purchasing a plan for one adult and a child or children should be the benchmark plan premium for family coverage; 4) In Exchanges where the premium for the second lowest cost silver plan in the two adult household category is more than a set percent lower in cost than the sum of the benchmark plan premium for two individual plans, the benchmark premium for two-adult households should be the sum of the benchmark premium for two individual plans.

§1.36B-3(f)(3), Second lowest cost sliver plan not covering the taxpayer's family

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 premium cost of all the benchmark plans needed to cover the entire coverage family. The preamble considers calculating such a family's benchmark premium based on the applicable benchmark plan that would apply to the family's composition if one plan could cover all family members. It also considers basing a family's benchmark premium on the lesser of: the premium for a combination of plans that covers the entire family; or the premium for a single plan that covers the family's composition and is more expensive than the second lowest cost silver plan. Adopting such methods 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, such a method could result in families having to contribute a percentage of their income greater than required by statute in order to provide coverage to their entire family. Some families may be unable to afford this additional cost and would unable to provide coverage for their entire family as a result. Thus we do not recommend adopting either of these alternative methods for calculating such a family's benchmark premium.

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

§1.36B-3(g), Applicable percentage

Under section 1.36B-3(g) a family is required to contribute a defined percentage of their income to a benchmark plan, dependent on their level of poverty. Families seeking coverage for their entire household through an Exchange will not have to pay more than that defined percentage for the cost of coverage for their entire family. However, the children in families up to 200% of poverty will be eligible for coverage through CHIP while the parents will be eligible for premium tax credits to use towards purchasing coverage for themselves in the Exchange. CHIP premiums alone can cost a family up to 5 percent of their household income.

Under the proposed rules, families with CHIP-eligible children may actually have to spend a greater percentage of their household income than families at 400% of poverty in order to cover their entire family. For example, a family at 200% of poverty that contributes 5% of their income towards CHIP premiums would have to contribute an additional 6.5% of their income toward premiums for Exchange coverage. In total, this family would have to contribute 11.5% of their income toward the cost of health coverage for their family, while a family at 400% of poverty would only have to contribute 9.5% of their income. This is not equitable. Families with children enrolled in CHIP should not have to contribute a greater percentage of their household income toward premiums than is defined as affordable by statute because of the cost of CHIP premiums.

Unfortunately, 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 percent of) parents who are eligible for premium tax credits will have one or more children who are eligible for CHIP or Medicaid and must enroll in these programs. The number of these families that must pay premiums to enroll their children in public coverage is unknown, but 30 states charge a premium or annual enrollment fee to children in CHIP, so this is a serious concern.

Recommendation: We strongly recommend that the final rule include that premium tax credits for families with children enrolled in CHIP be calculated to ensure that their share of total premium costs, including CHIP premiums, does not exceed the income-related contribution defined in the Affordable Care Act. As such, the premium credit for a family at 200% of poverty that must contribute 5% of their household income towards CHIP premiums would be calculated assuming they should only spend 1.3 percent of their household income on premiums for coverage purchased in the Exchange. At a minimum, policies to lessen the burden on families that must pay premiums in more than one program should be explored in the final rule, such as counting CHIP premiums in the tax credit calculation or using a benchmark plan for the entire family rather than for the family members enrolling in coverage. Additionally, the Department should urge HHS to modify CHIP rules to ensure that families with children in CHIP are not penalized.

§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 family. Due to the complicated computations necessary to compute a family's premium tax credit under this rule, we strongly recommend that the final rule include tangible actions that the IRS must take to

provide direct consumer assistance and education to relevant consumer assistance and tax assistance agencies on premium tax credit calculations. The taxpayer assistance program within the IRS should be responsible for providing consumer assistance on premium tax credit calculations and questions. In addition, the IRS website should include links to the Exchange and navigator websites for each state and the Taxpayer Assistance line should have contact information for state Exchanges and navigators. We also recommend that IRS be responsible for providing training to consumer and taxpayer assistance programs on premium tax credit rules.

Recommendation: We recommend that IRS be required to (1) provide direct consumer assistance and education on the premium tax credit calculations; (2) disseminate contact information for Exchanges and navigators on their website and via the Taxpayer Assistance line; and (3) provide training to consumer and taxpayer assistance programs on the premium tax credit rules.

§1.36B-3(l), Families including individuals not lawfully present

Proposed rule § 1.36B-3(l)(2)(i) reiterates the Affordable Care Act's specific formula at § 1401(e)(1)(B)(i) for counting the income of a household that includes one or more members who are eligible for the Exchange, along with one or more members who are ineligible due to immigration status. The income-counting formula will be used when determining premium tax credits and cost-sharing reductions. In general, we support the formula's realistic assessment of the household's actual income and a determination of the number of family members who must be supported by that income to ensure that the health coverage they purchase is as affordable as it would be if all family members were eligible for coverage. Although the language of the formula may appear to require a new methodology for counting income of mixed status immigrant households, the ACA at § 1401(e)(1)(B)(ii) allows for the use of another methodology that would accomplish the same result. The NPRM acknowledges this Affordable Care Act provision by reserving for later rulemaking, §1.36B-3(l)(2)(B)(ii), "Comparable method."

We recommend use of the existing income-counting and family size determination procedures used by most states in the Medicaid program, as the comparable method that does accomplish this same result. The existing Medicaid formula provides that an entire household's income and size is taken into account to compute FPL and thus determine eligibility. It results in the same determination of FPL and could be easily adjusted to compute modified gross adjusted income (MAGI). State and federal agencies are already familiar with the Medicaid methodology of counting actual numbers of family members, and actual income supporting those family members when determining income eligibility. Applying consistent income counting rules for eligibility for Medicaid and for premium tax credits would reduce confusion and administrative costs and burdens. Thus, for efficiency and practicality of determining eligibility for a premium tax credit and for reconciling the credit with advance credit payments, final regulations

implementing § 1401(e)(1)(B) should incorporate commonly-practiced Medicaid income counting methodology for mixed-status households.

We are very concerned about the burden of implementing this provision in a way that requires family members who are not seeking coverage for themselves to declare their immigration status. Such a requirement would violate the standards of the HHS-USDA "Tri-Agency Guidance" issued in 2000[11] and now codified in new Medicaid rules at § 435.907(e)(1). Immigrant families have heightened concerns about the collection, use, and disclosure by government agents of personally identifiable information (PII). Breaches of confidentiality and privacy laws can lead to forcible separation of families. The Affordable Care Act provides strong protections in §§ 1411(g) (confidentiality) and 1557 (nondiscrimination), as does the Internal Revenue Code at 26 USC § 6103. Final rules should emphasize these authorities, and their protections should be implemented robustly by the Treasury regulations and in the development of any forms developed pursuant to the Affordable Care Act. Confidentiality concerns are another reason why final rules should reference and direct states to the commonly-practiced Medicaid income counting methods for mixed-status families.

Finally, it is unclear how the calculations made by applying the formula in § 1401(e)(1)(B) would be reconciled at the time of tax filing. If done incorrectly, it could create a situation where a family who receives the benefit of this reduction would then appear to have a premium tax credit that is disproportionate to their income and their family size, thus putting them at risk for an unwarranted tax penalty or create additional administrative burdens to establish eligibility for appropriately-sized credit.

Recommendations: We support the fairness of proposed rules in subsection (l)(1) and (l)(2)(i) as a formula for counting income and family size accurately for purposes of computing the premium tax credit of mixed-status immigrant households who have one or more members who are not eligible for the Exchange. We recommend the final rule amend (l)(2)(ii) by proposing and recommending that states use the Medicaid income counting currently in use by most states, as a comparable method that counts the actual income and actual family size when determining income eligibility based on comparing a household's income to FPL.

We recommend the final rule require states to implement this provision consistent with rules protecting collection, use, and disclosure of information in §§ 1411(g) (confidentiality) and 1557 (nondiscrimination), the confidentiality protections of the Medicaid program at § 1902(a)(7) of the Social Security Act, and the policies of the HHS-USDA "Tri-Agency

[11] Policy Guidance Regarding Inquiries into Citizenship, Immigration Status and Social Security Numbers in State Applications for Medicaid, State Children's Health Insurance Program (SCHIP), Temporary Assistance for Needy Families (TANF), and Food Stamp Benefits (2000), found at http://www.hhs.gov/ocr/civilrights/resources/specialtopics/tanf/triagencyletter.html

Guidance" issued in 2000 and now codified in new Medicaid rules at § 435.907(e)(1), as well as the protections of the Internal Revenue Code at 26 USC § 6103.

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

Section §1.36B-4 establishes rules for reconciling families' advance credit payments with the actual premium tax credit amount they are eligible for based on their MAGI for the tax year. Changes in employment status, family composition, or income within a year can significantly alter the premium tax credit amount a family is eligible for. However, such life changes are often unplanned and are difficult for a family to foresee over a year in advance. The reconciliation process should be responsive to changes in life situation and families receiving premium tax credits should not have to face hardship or tax penalties at reconciliation for changes in circumstances that they have properly reported. Therefore, we offer the following recommendations to strengthen Section §1.36B-4.

§1.36B-4 (a), Reconciliation

We are concerned about the hardship that many families will face due to reconciliation when their income or family composition changes during the course of the year. During a period of unemployment or reduced income, a family may apply for assistance with premiums through the Exchange and receive advance premium credits. If the family regains income during the course of the year, however, they may have to repay some or all of the assistance they received, even if they requested that their credits be adjusted accordingly and received the correct amount of assistance for each coverage month. After a period of unemployment, most families struggle to get out of debt and catch up on their expenses. It is not practical to expect them to pay a new back bill for premiums. Moreover, if this reconciliation amount is part of their general tax liability, families who cannot immediately repay at the end of a tax year may face interest and penalties. The Affordable Care Act is designed to help families afford premiums so that they will be able to obtain care. While paying monthly premiums will be new to some households, the coverage will help them avoid medical debt and is designed to be affordable given their household income. We urge you to keep these goals in mind as you work to ensure that families will receive appropriate assistance during periods of financial hardship.

Although the statute requires reconciliation of advance payments, 36B-g requires the Secretary to prescribe regulations "as may be necessary" including regulations which provide for "the coordination of the credit allowed under this section with the program for advance payment of the credit under section 1412." Subsection (2), specifically instructs the Secretary to issue regulations about the application where the filing status of a taxpayer changes, but the statute does not restrict the Secretary from issuing other regulations about coordination. Further, section 1411 charges the Secretary with establishing procedures for determining whether an individual is eligible for premium tax credits. We strongly urge the Secretary to use rulemaking authority to protect families who receive appropriate advance credits from financial hardship.

Four situations merit particular attention:

1) The household promptly reports changes in income and gets the appropriate advance credit for each month, but nevertheless receives an excess credit when calculated on an annual basis;
2) The household qualified for advance credits early in the year but later its income increased beyond 400 percent of poverty;
3) The family size decreases during the course of the year; and
4) The household experiences a small change in income that they are not required to report.

We discuss each of these below.

1) **Correct amount for the coverage month but excess on an annual basis:** When a person applies for advance credits, they will have an opportunity to update information from their previous tax returns to project their annual income. Their credits are calculated based on this income information. If their income changes substantially, they can also ask the Exchange to recalculate their credits during the course of a year. However, this is an imperfect solution: If the family's income has decreased, annual income does not readily reflect their current need for assistance; and if the family's income has increased, adjustments may not leave the family enough money to pay current premiums. As we understand the proposed regulations, when income increases, the family's alternatives would be to receive lower credit in a future month than their current income would dictate in order to adjust for a previous month's credit, or wait until the end of the year and face reconciliation. Neither alternative is feasible for a low- to moderate-income family. The former would require the family to pay more for premiums in a current month than the statute considers "affordable." The latter would require that the family face a lump-sum tax burden that they are unlikely to be able to afford.

   Under the proposed rules, families who rely on the premium credit exactly as intended – to help purchase insurance when they've experienced a change in circumstances like losing a job and the health coverage provided by that job – may end up with a tax liability at the end of the year. Premium credits are intended to help an individual or family pay their health insurance premiums each month. When a family or individual's needs change during the year, the amount of credit should change to reflect this. The law recognizes this by explicitly allowing an individual or family that experiences a sizeable drop in income (or other changes in circumstances) to apply for premium credits (or an adjustment of their premium credit amount) outside the annual enrollment period. However, even if the calculations are done 100 percent correctly and the family gets exactly the right amount on a monthly basis, the family could be required to repay assistance at the end of the year. This will create significant ill-will among many middle class families towards the Affordable Care Act. The fear of facing sizeable repayments

at the time of tax filing will create a powerful disincentive for individuals and families to take up the premium credits and enroll in Exchange coverage.

Recommendation: Reconciliation should only be required when a family has failed to report changes in income, and not when they have evidence from the Exchange that their credits were properly computed for the relevant coverage months. Create an additional "safe harbor" for families in this situation.

2) **Household income rises above 400 percent of poverty:**

This is a variation of the problem described above, but under the proposed rules, it makes the family ineligible for premium credits and subject to full repayment. A household head with income just below 400 percent of poverty may receive an unexpected year-end bonus that makes them ineligible for the premium credits they received throughout the year; or a person with income considerably below 400 percent of poverty at the start of the year could get a new job or a salary increase that puts their income above the threshold. The statute places no ceiling on the amount of premiums subject to repayment for households with annual income over 400 percent of poverty.

`Recommendations: Disregard de minimis changes in income near and slightly above the 400 percent threshold for reconciliation purposes. Reconciliation should only be required when a family has failed to report changes in income, and not when they have evidence from the Exchange that their credits were properly computed for the relevant coverage months.

3) **Family size decreases:**

1.36B-4 (2) requires reconciliation to be computed based on household income and family size at the end of a taxable year. While this may benefit some families who marry or have children before year end, it could cause hardship for families that lose a family member during the course of the year, depending on Treasury's interpretation of the rule, especially when such loss is unpredictable. For example, a family may need premium credits to afford coverage during a member's prolonged illness. If the ill family member dies in the 10th or 11th month of the year, how is this family's size computed? We assume that, as in the case of other tax filers, a couple that is married and filing jointly can include a deceased spouse for purposes of premium tax credits just as they can in other situations in the year of death, but please state this clearly in the regulation. Otherwise, the family could be liable for large premium repayments that it could not have reasonably predicted or avoided. Even in more predictable situations – for example, when a young person leaves dependency during the course of the year – the family's needs for premium assistance are not properly reflected by the household size at year end. For example, in

the case of one parent plus a child, the premiums and assistance needed to cover both may be considerably higher than the assistance the parent would need to cover herself only. If the child left in the latter part of the year, it would not be fair to require the parent to repay as if the child had never been part of her household for any portion of the year. Other parts of the tax code consider a child to be a dependent if he/she is home more than half of the year. Does this rule apply here and what happens with more distant relatives that may be considered as dependents for part of the year?

Recommendation: We strongly recommend that the computation be based on the largest family size of the household during the course of the year.

Section 1401(2) of the statute limits additional tax on reconciliation for low-income households, and this is discussed in 1.36B-4 (a) (3). If there is a change in income or family circumstances, the reconciliation limits should be calculated based on the number of months in which the income or circumstances were different than projected. For example, if the family was over the income limits for premium credits for four months of the year, or had excess credits due to family size for four months of the year, the applicable cap on excess advance payments should be one-third of the amounts listed in Section 1401(2) of the statute, not the full amount.

Recommendation: Calculate limits on repayment for households with incomes less than 400 percent of poverty on a pro-rated basis, based on the number of coverage months for which the person received incorrect premium payments.

4) **Small changes in income:** Reconciliation poses a dilemma for families and a potential administrative burden for Exchanges. If all changes in income could result in reconciliation payments, it would be unfair not to allow families to report changes in income and correct their advance credit amounts. However, frequently updating premium credit amounts could become a large task for Exchanges. Disregarding small changes in income will both minimize the burden on taxpayers to report throughout the year, and will minimize the administrative burden on Exchanges that would otherwise have to frequently recalculate advance payments and process changes in payments to plans. We strongly recommend that the regulations set a threshold for small changes in income, including amounts that are typical salary increases for two low- to moderate- wage-earners, that would not subject a family to reconciliation. Here are a few possible alternatives for setting such a threshold: (a) Use an amount that is familiar to tax filers, such as a standard deduction – e.g, if the income change is less than or equal to one standard deduction for the filing status, disregard it. (b) Disregard increases of income of less than 20 percent. Since section 1412(b)(2) of the statute defines this amount as a "substantial" income decrease, it could logically also count as an a threshold for an

income increase that would not require reconciliation. (However, elsewhere in our comments, we strongly recommend that on a voluntary basis, people be able to report decreases of less than 20 percent and accordingly adjust their premium credits.) (c) Disregard understatements of income of less than 10 percent. A ten percent threshold would be easy to remember, and would accommodate a typical cost of living increase plus a small promotion. However, we favor a larger disregard since this percentage may not adequately reflect typical salary movement for someone moving up a level from a minimum wage job.

Recommendation: The regulations for reconciliation should disregard unsubstantial or minimal changes in income.

Each of the reconciliation scenarios will create areas where taxpayers will need considerable help and counseling. The federal government should furnish tools to Exchanges and on the IRS website to easily calculate credit amounts, including for families that experience income changes during the course of the year that will enable families to adjust their credits and avoid reconciliation. The Taxpayer Advocate Service must be equipped to answer questions, and its availability must be widely publicized. Further, the rules should require training of Exchange staff and navigators in this area.

Finally, IRS should furnish households with all assistance possible to prevent reconciliation obligations from mounting and to exempt them from interest or penalty payments. One possible way of providing relief would be to develop a hardship waiver. Exchanges could certify that a household had carried out its obligations to report changes but nonetheless had an overpayment amount that would be difficult for the family to handle. Taxpayers filing this hardship waiver form with their tax returns could be exempt from reconciliation.

In addition, under current income tax code, taxpayers who substantially underreport their income tax must pay a penalty equal to 20% of the underpayment**.** An understatement is considered substantial if it is more than the greater of 10% of the correct tax or $5,000. Families who, over the course of the year, experience an increase in income that pushes them above the 400 percent of poverty threshold for qualifying for premium tax credits would be subject to this penalty. Families who experience a change in family size or an increase in income that makes them eligible for a smaller premium tax credit at the end of the year could also be subject to this penalty in some situations.

However, the tax code also states that the amount of the understatement may be reduced by the amount the understatement is due to an adequate disclosure and a reasonable basis. Excess advance credit payments that are paid despite a family fulfilling all obligations to report changes, should be considered due to adequate disclosure and reasonable basis and should not be subject to such penalty.

Recommendations: IRS should automatically offer payment plans for any reconciliation amounts and should not charge interest or penalties on these amounts. Families for whom repayment would pose hardship, as certified by an Exchange, should be exempt from reconciliation. IRS, in coordination with Exchanges, should furnish tools for calculating and adjusting premium credits when income changes; provide outreach and counseling, including through the Taxpayer Advocate Service; provide training to Exchanges and navigators; and require through regulation that each state Exchange have adequately trained staff to assist consumers in this area.

§1.36B-4(b)(1), Changes in Filing Status - Marriage

Changes in filing status occur when couples marry, divorce, or separate; when a spouse dies; or when new dependents are added or other dependents are removed from a tax return. Marital status is judged by the taxpayer's status on the last day of the year.

Taxpayers who marry during the year face special challenges in that their credits may have been appropriately calculated every month but the couple may still owe additional tax. This discriminates against couples that choose to get married and creates a substantial unanticipated expense for couples that have diligently reported changes in income and circumstance.

The following examples show 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.

This type of application would, in some respects, set this credit apart from other similar credits, such as the Earned Income Tax Credit (EITC). However, this distinction is merited. The credit will be predominantly advanceable, unlike the EITC, which has always been disproportionately calculated at the end of the tax year. Furthermore, this credit will be used to purchase a particular good – health insurance – which taxpayers will be required by law to obtain. Third, taxpayers are largely reliant on the calculations made by the Exchanges and will make complex decisions in choosing which level of coverage, cost sharing amount and plan to purchase. To have consumers make those decisions and faithfully report changes to income and circumstance, only to have the math change at the end of the year, would certainly cause a lack of consumer confidence in the Exchanges and in the tax system. The Exchanges (and taxfilers) will already be doing monthly calculations in the case of individuals who lose eligibility for the credit by gaining access to other minimum essential coverage.

Recommendation: The IRS should prorate the credit by adding the Exchange-calculated advance credit for the months prior to marriage and the Exchange-calculated advance credit for months of the year in which the filers were married. If this policy cannot be

adopted, the IRS should consider having a one-year waiver of reconciliation that applies to newly-married couples (a "marriage safe harbor").

§1.36B-4(b)(2), Taxpayers not married to each other at the end of the taxable year.

Permanent separation and divorce create particular complications in determining the premium tax credit. The proposed rule would require the advanced payments and benchmark plan premiums of the taxpayers to be allocated between the taxpayers for the months in which they were married. The regulation allows the divorced taxpayers to agree to an allocation or, failing agreement, requires each taxpayer to use an allocation of 50 percent.

Examples 3 shows that allocation of the credit and benchmark premium according to income appears to be more equitable, in that the advance payment is more closely aligned with the actual credit calculated at the end of the tax year. This is in contrast to Example 2, in which the higher-earning party owes more than $1,000 and the lower earner gets a substantial refund.

The IRS should consider requiring advance credits to be allocated by income. Women, who typically earn less than their spouses and disproportionately get primary physical custody of their children in a divorce, may be particularly disadvantaged if their former spouse rushes to file with a 50 percent allocation before an alternative allocation can be decided. In that case, a lower-income mother may owe additional tax based on the credits received prior to divorce. Even among well-intentioned tax filers, the additional complexity of figuring out the credit based on household income allocation, versus simply splitting credits in half, may deter filers from using the income-allocation method. On the whole, this is likely to discriminate against lower-income taxpayers.

Recommendation: Require income-based allocation. This could be facilitated if the Exchange assists in the allocation calculation based on plan and income information it has for both parties. If income-based allocation cannot be required, create a form and worksheet that offer examples of how allocation by income may prove more equitable and that helps taxpayers calculate the allocation.

§1.36B-4(b)(3), Married taxpayers filing separate tax returns

The tax code disadvantages the married filing separately tax status by disqualifying filers from the EITC, education credits and other benefits. However, premium tax credits will be different from those credits because they will be used directly to fulfill the required purchase of a product. Therefore, it is important for the IRS to carve out some common sense exceptions to the statutory requirement that married taxpayers must file jointly.

There are several legitimate reasons that it may be inadvisable or even impossible for married taxpayers to file jointly. One prominent reason is in cases of domestic violence, when a woman

may be living separately from her spouse and keeping her 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, 42 U.S.C. 300gg was amended by Section 1201 of the Affordable Care Act to prohibit 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.

Abandoned spouses may also warrant special protection, in cases where a person (with no dependents) cannot locate their spouse and is forced to file separately. In addition, a family could be financially crippled if an angry spouse uses the threat of filing separately as retaliation during divorce proceedings. 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.

Taxpayers could be asked to certify on the schedule used to calculate the premium tax credit whether one of these conditions applies. This could utilize "exception codes" in a manner similar to those used to identify exceptions to the early distribution tax on qualified retirement plans. The exception codes should capture general categories (domestic abuse, abandoned spouse, separation, incarceration, spouse out-of-the-country). If these exceptions prove to be too broad, a narrower exception might rely on verifiable information. For instance, in the case of domestic violence, an exception might be granted if the person currently has or during the tax year had an order of protection or sought criminal prosecution in a domestic abuse case. Incarceration is also easily verifiable.

When such exceptional circumstances are identified, the individual should be permitted to file separately and still receive a premium tax credit. In cases where both spouses, at some point in the year, were enrolled in the same insurance plan, the IRS could allocate the advance credit and the benchmark premium according to household income (with the absent spouse's income being determined by their tax filing). This would help protect the lower-income spouse. If the absent spouse did not file a tax return or if the filing spouse does not know their spouse's social security number, a reasonable allocation is 50 percent. In these cases, the repayment limits for single individuals should apply, according to income.

The preamble requests comment on whether the regulation should take into account whether a couple filed together in the previous year and whether they attested their expectation to file jointly in order to obtain tax credits. It is important that the regulation bear in mind the family changes that can occur during the year. For example, a couple may indicate that they intend to file together when applying for credits in November 2013 but face a completely different scenario in 17 or 18 months later when it's time to reconcile the premium tax credit on their tax return. It is reasonable, though, to expect that these exceptions would have limitations.

Restricting the exception for one year may be too restrictive. A complicated divorce involving custody or criminal charges may take a long time to resolve. Limiting the exception to three consecutive years would be helpful to accommodate these types of situations.

Future rules: Individual responsibility exemptions under Section 1411, and section 5000A of the Internal Revenue Code

This proposed rule has implications for individual responsibility penalties, for which rules have not yet been promulgated. Specifically, the statute provides that individuals will be exempt from the responsibility to purchase coverage if "there is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual." The preamble to these regulations explains that you intend to consider the cost of family coverage in making this determination. We strongly agree. No individual should be required to pay penalties if the cost of available coverage to them, in combination with their other family members, would exceed the applicable percentage of income. However, we reiterate that the affordability test for employer-based family coverage must be changed to enable dependents to purchase coverage in the Exchange and receive credits; otherwise, the Affordable Care Act will not achieve its goal of providing affordable care for all Americans.

Recommendation: In determining whether a household member is exempt from individual responsibility penalties, consider the cost of covering the family (or, if family coverage is not available, the combined cost of covering each family member under available plans) in relation to the household income.

Conclusion

In sum, we are generally supportive of the proposed rule and believe that the above recommendations will serve to strengthen it. Our recommendations will ensure that premium assistance is made available to the full breadth of individuals and families intended by the statute and adequate and equitable assistance is provided to all eligible families. If you have any questions about these comments, please contact Kim Bailey at (202) 628-3030 or kbailey@familiesusa.org or Lydia Mitts at (202) 628-3030 or lmitts@familiesusa.org. Thank you for your consideration of our recommendations.

Sincerely,

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