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

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Summary

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

ACA requires exchanges to be established in every state by January 1, 2014, either by the state itself or by the Secretary of Health and Human Services (HHS). Exchanges will not be insurers, but will provide eligible individuals and small businesses with access to private health insurance plans. Generally, the plans offered through the exchanges will provide comprehensive coverage and meet all ACA market reforms, as applicable.

The new premium credits established under ACA will be advanceable and refundable, meaning taxpayers need not wait until the end of the tax year in order to benefit from the credit, and may claim the full credit amount even if they have little or no federal income tax liability. Although the premium credits will not be available until 2014, the examples provided in this report estimate premium credit amounts by income levels and age, if the credits were available in 2013.

Under ACA, the amount received in premium credits is based on income tax returns. These amounts are reconciled in the next year and can result in overpayment of premium credits if income increases, which must be repaid to the federal government. ACA limited the amount of required repayments. Since the enactment of ACA, these limits have been amended twice, under P.L. 111-309 and P.L. 112-9.

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

Relative affordability of health insurance premiums that individuals and families might face within health insurance exchanges will likely vary from exchange to exchange based on a host of factors, including enrollees' age, the varying prices paid by plans for medical goods and services, the breadth of the provider network, the provisions regarding how out-of-network care is paid for (or not), and the use of tools by the plan to reduce health care utilization (e.g., prior authorization for certain tests). Examples provided in the **Appendix** of this report depict a range by which premiums might reasonably be expected to vary based on enrollees' age, and variation in medical costs across geographic areas, for purposes of illustration only. Actual premiums will likely vary among health insurance exchanges based on a wide range of factors other than those depicted in this report.

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This report describes who will be eligible for the premium tax credits and cost-sharing subsidies, and how the credit and subsidy amounts will be calculated. It also highlights selected issues addressed in the final regulation on premium credits.[3] The **Appendix** provides analysis of the concept of "affordability" as applicable to the premium credits.[4]

Background

ACA requires health insurance exchanges to be established in every state by January 1, 2014, either by the state itself or by the Secretary of Health and Human Services (HHS). The ACA exchanges are not insurance companies; rather, they will coordinate the offer of private health plans to qualified individuals and small businesses.[5] Generally, the plans offered through the exchanges will provide comprehensive coverage and meet all ACA market reforms, as applicable.[6] One of the requirements that most exchange plans must meet is to provide a certain level of coverage generosity based on actuarial value.[7] Each level of coverage generosity is designated according to a precious metal and corresponds to a specific actuarial value: Bronze (actuarial value of 60%), Silver (70%), Gold (80%), and Platinum (90%).

Given that exchanges are designed specifically to offer insurance options to individuals and small businesses, exchanges must be structured to assist these two different types of "customers." States, therefore, must establish an exchange to serve individuals and another to serve small businesses ("SHOP exchanges"). ACA gives states the option to merge both exchanges and operate it under one structure.

[1] §1401 of ACA; new §36B of the Internal Revenue Code of 1986 (IRC).

[2] For a comprehensive discussion about the exchanges established under ACA, see CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*.

[3] 77 *Federal Register* 30377, May 23, 2012, http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf.

[4] The affordability analysis was conducted during ACA enactment (March 2010), incorporating information available at the time, in order to estimate premiums for exchange plans and depict the "affordability" of such plans for exchange enrollees. Given the timing of this analysis, more recent cost data, as well as relevant regulations and guidance, are not reflected in the analysis. Furthermore, assumptions regarding eligibility for premium credits have not been updated to reflect the potential impact of the relevant Supreme Court decision. While the specific estimates do not incorporate more recent information, the discussion of the relative affordability of exchange plans for enrollees based on age, family size and composition, and geography is still relevant to understanding how these different factors interact and may potentially affect enrollee costs.

[5] Exchanges are designed to offer individual (nongroup) policies and small group plans. Before 2016, states will have the option to define "small employers" either as those with (1) 100 or fewer employees, or (2) 50 or fewer employees. Beginning in 2016, small employers will be defined as those with 100 or fewer employees. Beginning in 2017, large groups may participate in exchanges, at state option.

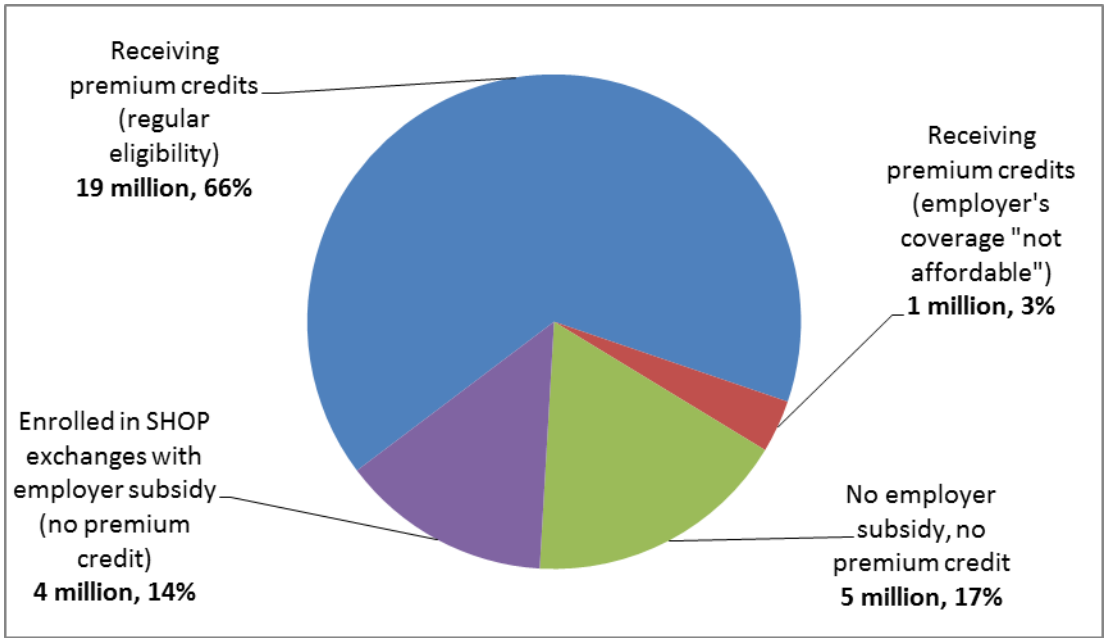
[6] See CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*.

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

Certain enrollees in the *individual* exchanges will be eligible for premium assistance in the form of federal tax credits. Since individuals who are eligible for employer-provided insurance are *not* eligible for the premium tax credits (with exceptions), such credits will not be provided through the SHOP exchanges. The premium credit will be an advanceable, refundable tax credit,[8] meaning taxpayers need not wait until the end of the tax year in order to benefit from the credit, and may claim the full credit amount even if they have little or no federal income tax liability.

The Congressional Budget Office estimates that 29 million individuals will be enrolled in exchange coverage in 2023. Of those exchange enrollees, 20 million are projected to receive premium credits (see **Figure 1**). CBO estimates that premium credits will increase federal outlays, from FY2014 through FY2023, by $796 billion.[9]

Figure 1. Total Estimated Exchange Enrollment, 2023



Source: U.S. Congressional Budget Office, *CBO's May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage,* May 2013, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf.

Notes: Beginning in 2014, an employer's coverage is not "affordable" when the employee's contribution toward the premium for the employer's lowest-cost, self-only plan would exceed 9.5% of household income. Employees with an employer offer of coverage may also be eligible for premium credits if the employer plan does not provide minimum value (i.e., covers less than 60% of total allowed costs). However, the CBO projection of individuals eligible for premium credits (besides meeting other eligibility criteria) because the employer plan would not provide minimum value was well under 1 million, and therefore not included in CBO published estimates or in this figure.

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

[9] U.S. Congressional Budget Office, "CBO's May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage," May 2013, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf.

As part of ACA's implementation process, the Treasury Department promulgated final regulation on the premium credits on May 23, 2012.[10] The final regulation confirmed certain eligibility and other requirements, as specified in the statute; such requirements are discussed in applicable sections of this report.

Individual Eligibility for Premium Credits

ACA specifies that premium credits will be available to "applicable taxpayers" in a "coverage month" beginning in 2014.[11]

An *applicable taxpayer* is an individual who

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

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

These eligibility criteria are discussed in greater detail below.

Part of a Tax-Filing Unit

Given that the premium assistance will be provided in the form of tax credits, they will be administered through individual tax returns (although advance payments will go directly to insurers).[12] The credits can only be obtained by qualifying individuals who file federal tax returns.

Couples married at the end of the taxable year will have to file joint returns to be eligible for the credit.[13] The final regulation includes special rules relating to the calculation and allocation of credit amounts in response to changes in filing status (e.g., taxpayers who marry or divorce during a tax year). The final regulation acknowledges that certain circumstances may make filing jointly a challenge (e.g., domestic abuse, abandonment, etc.); it states that the IRS will propose additional rules to address these kinds of circumstances.

[10] 77 *Federal Register* 30377, May 23, 2012.

[11] §1401(a) of ACA; new §36B(c)(1) of the IRC.

[12] §1412(a)(3) of ACA.

[13] On June 26, 2013, in United States v. Windsor, the U.S. Supreme Court struck down Section 3 of the Defense of Marriage Act (DOMA), finding that it violated the equal protection guarantees of the Fifth Amendment. Section 3 had required that, for purposes of federal enactments, marriage be defined as the union of one man and one woman. In Windsor, the plaintiff and her late spouse were New York residents who had been legally married in Canada and whose same-sex marriage was legally recognized in New York. Because of DOMA, the decedent's estate could not claim the unlimited marital deduction for purposes of the federal estate tax. The unlimited marital deduction is just one of many federal tax-related benefits available to opposite sex married couples that, through DOMA, were denied to same-sex couples whose marriages are legally recognized by the state in which the couple resides. Post-Windsor, these benefits would appear to be available to such couples. It is not clear, however, whether the same is true for a couple who was legally married in one state, but resides in a state that does not recognize the marriage. Given this uncertainty, it is not clear how the Court's decision will affect eligibility for and calculation of the premium tax credit. For additional information about these issues, see CRS Legal Sidebar, "DOMA, Taxes, and Uniformity."

Enrolled in an Individual Exchange

Premium credits will only be available to individuals enrolled in a plan offered through an individual exchange; premium credits are *not* available through the small business ("SHOP") exchanges. Individuals may enroll in a plan through their state's exchange if they are (1) residing in a state in which an exchange was established; (2) not incarcerated, except individuals in custody pending the disposition of charges; and (3) lawful residents.[14]

Only lawful residents may obtain exchange coverage. Undocumented immigrants will be prohibited from obtaining coverage through an exchange, even if they could pay the entire premium without any subsidy.[15] Because ACA prohibits undocumented immigrants from obtaining exchange coverage, they will not be eligible for premium credits.

The final regulation clarifies the potential credit eligibility for the family members of individuals who themselves may *not* be eligible to enroll in an exchange due to incarceration or legal status. For example, while the final regulation restates ACA's prohibition on incarcerated individuals enrolling in exchange plans, the rule confirms that family members (of incarcerated individuals) who are eligible to enroll in exchange plans may receive premium credits for that coverage.[16]

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

To be eligible for premium credits, individuals must have "household income" within statutorily defined guidelines based on the federal poverty level (FPL).[17] For purposes of premium credit eligibility, household income is measured according to the definition for "modified adjusted gross income" (MAGI).[18] An individual whose MAGI is at or above 100% FPL up to and including 400% FPL may be eligible to receive premium credits,[19] beginning in 2014.[20]

For illustrative purposes only, **Table 1** displays the income levels at 400% FPL, the amount *beyond* which individuals and families would *not* be eligible for premium credits, if the credits were available in 2013 (using 2013 HHS poverty guidelines).

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[14] §1401(a) of ACA; new §36B of the IRC.

[15] §1312(f)(3) of ACA. For more information about the treatment of noncitizens under ACA, see CRS Report R40889, *Noncitizen Eligibility and Verification Issues in the Health Care Reform Legislation*.

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

[17] The FPL used for public program eligibility varies by family size, and by whether the individual resides in the 48 contiguous states and the District of Columbia, Alaska, or Hawaii. See "Annual Update of the HHS Poverty Guidelines," 78 *Federal Register* 5182, January 24, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-01-24/pdf/2013-01422.pdf.

[18] In §2002(a) and §1401(a) of ACA, household income is defined to be MAGI, in compliance with the Internal Revenue Code (IRC). Under the IRC, gross income is total income minus certain exclusions (e.g., public assistance payments, employer contributions to health insurance payments). From gross income, adjusted gross income (AGI) is calculated to reflect a number of deductions, including trade and business deductions, losses from sale of property, and alimony payments. MAGI is defined as AGI plus certain foreign earned income and tax-exempt interest. However, for premium credit eligibility purposes, the definition of MAGI will also include nontaxable Social Security benefits (as amended by P.L. 112-56). For additional discussion about the use of MAGI with respect to ACA premium credits, see CRS Report R41997, *Definition of Income for Certain Medicaid Provisions and Premium Credits in ACA*.

[19] An exception is made for lawfully present aliens with income below 100% FPL, who are *not* eligible for Medicaid for the first five years that they are lawfully present. These taxpayers will be treated as though their income is exactly 100% FPL for purposes of premium credit eligibility.

[20] ACA includes provisions to expand Medicaid for individuals with income up to 133% FPL (with a 5% income disregard). If a state chooses to undertake the ACA Medicaid expansion, eligibility for premium credits would begin above that income level.

Table 1. Income Levels at 400% FPL, 2013

Number of Persons in Family	48 Contiguous States and DC	Alaska	Hawaii
1	$45,960	$57,400	$52,920
2	$62,040	$77,520	$71,400
3	$78,120	$97,640	$89,880
4	$94,200	$117,760	$108,360
5	$110,280	$137,880	$126,840
6	$126,360	$158,000	$145,320
7	$142,440	$178,120	$163,800
8	$158,520	$198,240	$182,280

Source: CRS computations based on "Annual Update of the HHS Poverty Guidelines," 78 *Federal Register* 5182, January 24, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-01-24/pdf/2013-01422.pdf.

Notes: Under ACA, premium credits for eligible exchange coverage will not be available until 2014; the data in this table are for illustrative purposes only. The data are the income levels beyond which individuals and families would *not* be eligible for premium credits, if such credits were available in 2013. The poverty guidelines are updated annually for inflation. "DC" is the District of Columbia.

Not Eligible for "Minimum Essential Coverage"

To receive a premium credit, an individual may *not* be *eligible* for "minimum essential coverage," with exceptions (described below). ACA broadly defines minimum essential coverage to include Medicare Part A, Medicaid, the State Children's Health Insurance Program (CHIP), Tricare, Tricare for Life, a health care program administered by the Department of Veterans Affairs (VA),[21] the Peace Corps program, any government plan (local, state, federal) including the Federal Employees Health Benefits Program (FEHBP), any plan established by an Indian tribal government, any plan offered in the individual health insurance market, any employer-sponsored plan, any grandfathered health plan,[22] and any other coverage (such as a state high risk pool) recognized by the HHS Secretary.[23]

Exceptions to Minimum Essential Coverage Eligibility

ACA provides certain exceptions regarding eligibility for minimum essential coverage and receipt of premium credits. An individual who is only eligible to obtain coverage through the individual (nongroup) health insurance market may be eligible to receive a premium credit. Also, an individual eligible for an employer-sponsored plan may still be eligible for premium credits if the

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

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

[23] The IRS final regulation on premium credits addresses various circumstances when individuals transition between exchange coverage and public coverage, such as Medicaid. For example, the regulation discusses the process and time period applicable to an individual who becomes eligible for "government-sponsored coverage," and therefore becomes ineligible for premium credits.

employer's coverage is either (1) not affordable; that is, the employee's premium contribution toward the employer's self-only plan would exceed 9.5% of household income;[24] or (2) does not provide minimum value; that is, the plan's payments cover less than 60% of total allowed costs on average.[25] As depicted in **Figure 1**, of the 29 million individuals estimated by CBO to enroll in exchanges in 2023, approximately 1 million are estimated to be enrolled because their employer's coverage is unaffordable.

Employer Contribution Toward Coverage in SHOP Exchanges

Certain small employers (and in later years, large employers at state option) may offer and contribute toward coverage through SHOP exchanges. If an individual is enrolled in an exchange through an employer who contributed toward that coverage, the individual will *not* be eligible for premium credits.[26]

Medicaid

Although Medicaid is generally beyond the scope of this report, ACA's Medicaid expansion provisions have the potential for affecting eligibility for premium credits if certain low to middle income individuals and families seek health insurance through the exchanges. Under ACA, states have the *option* to expand Medicaid eligibility to include all non-elderly, non-pregnant individuals (i.e., childless adults and certain parents, except for those ineligible based on certain noncitizenship status) with income up to 133% FPL.[27] (ACA does not change noncitizens' eligibility for Medicaid.[28]) States that choose to implement the ACA Medicaid expansion will receive substantial federal subsidies. If a person who applied for premium credits in an exchange is determined to be eligible for Medicaid, the exchange must have them enrolled in Medicaid.[29] Therefore, any state that expands Medicaid eligibility to include persons with income at or above 100% FPL (or any state that currently includes such individuals) would make such individuals ineligible for premium credits.

[24] The IRS final regulation on premium credits confirms that an employee safe harbor will be provided to an individual who is determined to be eligible for premium credits, but later determined that the worker was eligible for affordable employer coverage. Moreover, the employer would not be subject to a penalty because a full-time employee receives a premium credit under the safe harbor. For a discussion of ACA's employer requirements, see CRS Report R41159, *Potential Employer Penalties Under the Patient Protection and Affordable Care Act (ACA)*. For a discussion of the implementation delay related to the employer requirements and implications for the premium credits, see CRS Report R43150, *Delay in Implementation of Potential Employer Penalties Under ACA*.

[25] §1401(a) of ACA; new §36B(c)(2)(C) of the IRC.

[26] §1401(a) of ACA; new §36B(c)(2)(A)(ii) of the IRC.

[27] ACA specifies that an income disregard in the amount of 5% FPL will be used to determine Medicaid eligibility based on modified adjusted gross income; thus, the effective minimum income eligibility threshold for such individuals in this new Medicaid eligibility group will be 138% FPL.

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

[29] §§1311(d)(4) and 1413(a) of ACA. Nonetheless, nothing in ACA prohibits a Medicaid-eligible individual from enrolling in an exchange on his/her own. However, that individual will be responsible for the entire cost of exchange coverage, which will likely be prohibitive for a low-income individual.

Potential Premium Contributions and Premium Credit Calculations

The amount of the premium tax credit will vary from person to person: it depends on the household income of the taxfiler (and dependents), the premium for the exchange plan in which the taxfiler (and dependents) is (are) enrolled, and other factors. In certain instances, the credit amount may cover the entire premium and the taxfiler pays nothing towards the premium (see text box, scenario A). In other instances, the taxfiler may be required to pay part (or all) of the premium (see text box, scenario B).

Calculation of Premium Credit Amount

The premium credit amount will be the *lesser* of either:

(A) The cost of the exchange plan that the taxfiler (and dependents) is (are) enrolled in;

Or

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

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

Minus

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

Required Premium Contribution

If the premium credit amount (i.e., the lesser amount calculated above) is:

(A), the taxfiler (and dependents) pay(s) nothing towards the premium for exchange coverage.

Or

(B), the taxfiler (and dependents) pay(s) some (or all) of the premium for exchange coverage.

Choice of Plan Enrollment

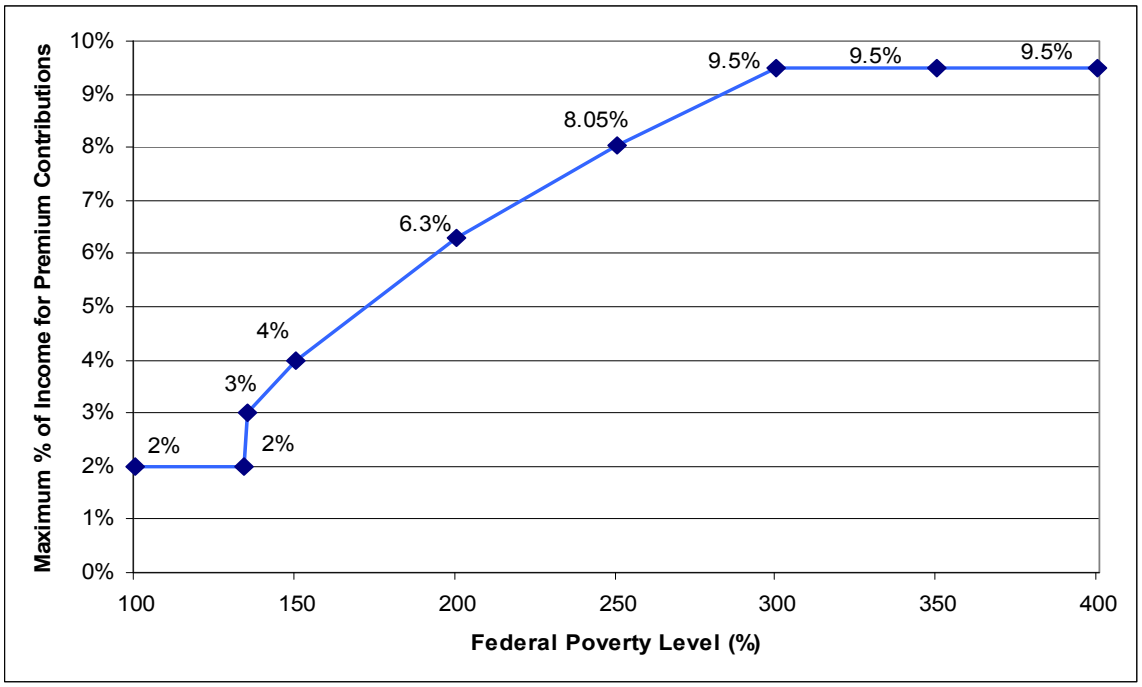
While the calculation in Scenario B is based on the second lowest cost silver plan in the taxfiler's area, the qualifying individual/family may enroll in any tiered plan in an exchange and still be eligible for a tax credit. However, if the individual/family enrolls in a plan with a premium that exceeds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

Under scenario B, the amount that a taxfiler who receives a premium credit would be required to contribute towards the premium is capped as a percent of household income; that is, the *required premium contribution* would be the product of the taxfiler's household income and the "applicable percentage," as specified in ACA. In general, the applicable percentage will be less

for those with lower incomes compared with those with higher incomes; where income is measured relative to the federal poverty level.[30]

Under scenario B, the amount that taxfilers with income between 100% FPL and 133% FPL will be required to contribute towards the premium will be capped at 2 percent of household income. For taxfilers with income 300%-400% FPL, their premium contribution will be capped at 9.5% of income. ACA further specifies the applicable percentages that taxfilers, whose incomes are between those two income bands, would be required to pay towards the cost of exchange coverage under scenario B (see **Figure 2**).

Figure 2. Maximum Percentage of Income, as Measured by FPL, to go towards Premium Contributions



Source: CRS analysis of ACA.

The line graph shows the applicable percentage (used to calculate the taxfiler's required premium contribution) at each income level, as measured relative to the federal poverty level. The ACA statute specifies the applicable percentage at certain incomes (income at 100% FPL, 133% FPL, 150% FPL, etc.). At each of those incomes, the line changes slope. Specifically, above 133% FPL up to and including 300% FPL, the applicable percentage increases *incrementally* as income increases. For example, a person with income at 150% FPL, under scenario B (see text box, "Calculation of Premium Credit Amount"), would be required to contribute 4% of household income toward exchange coverage (any remaining premium amount would be covered by the tax credit). A 1% increase in income (i.e., person has income at 151% FPL) would require a premium contribution equal to 4.05% of household income.

Calculation of the premium credit amount (under scenario B) would be the arithmetic difference (if any) after subtracting the taxfiler's required premium contribution from the premium for the

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

second lowest cost silver plan ("reference plan") available to the taxfiler. (While the credit amount under this scenario is based on the reference plan, the individual/family may enroll in any metal-tier plan.) It is theoretically possible that a taxfiler's required premium contribution could be equal to or exceed the premium for the reference plan, leaving that taxfiler with a premium credit amount of zero. Moreover, taxfilers who enroll in plans that are more expensive than the reference plan would have to pay the additional premium amount.

Illustrative Examples: If Premium Credits Were Available in 2013

For illustrative purposes only, if the premium credits were available in 2013, the annual income levels displayed in **Table 2** would be used in the calculation of premium credit amounts and required contributions, as discussed above.

Table 2. Annual Income by 2013 Federal Poverty Level and Family Size

For the 48 contiguous states and the District of Columbia

Federal Poverty Line (FPL)	Family Size			
	1	2	3	4
0%	$0	$0	$0	$0
50%	$5,745	$7,755	$9,765	$11,775
100%	$11,490	$15,510	$19,530	$23,550
133%	$15,282	$20,628	$25,975	$31,322
150%	$17,235	$23,265	$29,295	$35,325
200%	$22,980	$31,020	$39,060	$47,100
250%	$28,725	$38,775	$48,825	$58,875
300%	$34,470	$46,530	$58,590	$70,650
350%	$40,215	$54,285	$68,355	$82,425
400%	$45,960	$62,040	$78,120	$94,200

Source: CRS computations based on "Annual Update of the HHS Poverty Guidelines," 78 *Federal Register* 5182, January 24, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-01-24/pdf/2013-01422.pdf.

Notes: Under ACA, premium credits for eligible exchange coverage will not be available until 2014; the data in this table illustrate the income levels that would apply if premium credits were available in 2013. Different income levels, as measured against the FPL, apply separately to Alaska and Hawaii (see "Annual Update of the HHS Poverty Guidelines" referenced under Source). The poverty guidelines are updated annually for inflation.

For illustrative purposes, **Table 3** displays the *monthly* required premium contributions for individuals and families who receive premium credits (provided that they enrolled in the reference plan or a less expensive metal-tier plan).[31]

[31] It is possible that the calculation for a person's required premium contribution would be an amount that exceeds the actual premium for the plan he or she is enrolled in. In such cases, the person would pay only up to the premium amount. For an illustrative example, see footnote "c" in **Table 4** of this report.

Table 3. Monthly Required Premium Contributions, by Family Size, if Premium Credits were Available in 2013

For the 48 contiguous states and the District of Columbia

Federal Poverty Line (FPL)	Maximum Premium Contribution as a % of Income ("Applicable Percentages")	Monthly Required Premium Contribution (2013), by Family Size			
		1	2	3	4
100%	2.0%	$19	$26	$33	$39
133.00%	2.0%	$25	$34	$43	$52
133.01%	3.0%	$38	$52	$65	$78
150%	4.0%	$57	$78	$98	$118
200%	6.3%	$121	$163	$205	$247
250%	8.05%	$193	$260	$328	$395
300%	9.5%	$273	$368	$464	$559
350%	9.5%	$318	$430	$541	$653
400%	9.5%	$364	$491	$618	$746

Source: CRS computations based on "Annual Update of the HHS Poverty Guidelines," 78 *Federal Register* 5182, January 24, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-01-24/pdf/2013-01422.pdf.

Notes: Under ACA, premium credits for eligible exchange coverage will not be available until 2014; the data in this table are for illustrative purposes only. Different income levels, as measured against the FPL, apply separately to Alaska and Hawaii (see "Annual Update of the HHS Poverty Guidelines" referenced under Source). The poverty guidelines are updated annually for inflation. If individuals enroll in more expensive plans than the second lowest-cost silver plan in their respective areas, they would be responsible for the additional premium amounts. If the required premium contribution exceeds the actual premium amount, individuals would pay the entire premium for exchange coverage. The monthly premium contribution amounts are rounded to the nearest dollar.

Both **Figure 2** and **Table 3** illustrate the "cliff effect" that occurs at 133% FPL. For those individuals with income at or below 133% FPL, the credits will ensure that such individuals pay no more than 2% of their income (if any) for exchange coverage. Above 133% FPL, a formula is applied so that a family at 133.01% FPL could be required to contribute 3% of their income towards those premiums. For example, as shown in **Table 3**, a family of three with income at 133% FPL ($25,975 in annual income) may be required to pay $43 in monthly premiums, if the exchange and premium credit provisions were available in 2013. With two additional dollars of income ($25,977 in annual income), they would be required to pay $65 in monthly premiums. Thus, in this example, that additional $2 in income would lead to $22 more in required premium payments for the family per month (an additional $264 in premium contributions for the year). Some might observe that prior to implementation of the ACA premium credits in 2014, an even larger cliff exists for Medicaid beneficiaries when an incremental increase in income makes them ineligible for public coverage, at which point *no* premium credits were available.

Examples of Premium Credits for Self-Only and Family Coverage

For illustrative purposes only, assume that premium credits were available in 2013. The examples in **Table 4** were calculated using the formula specified in ACA.[32] The examples assume that the

[32] See scenario B in the text box "Calculation of Premium Credit Amount" in this report for the credit formula.

individual is (or family are) enrolled in an exchange plan with a premium that exceeds the amount of the credit they would receive, and therefore the credit would be based on the reference plan (second-lowest cost silver plan).

Individuals at the same income level will face different premium amounts based on age. This reflects the limited age rating allowed for individual health insurance policies, including those offered in the individual exchanges.[33] Moreover, the premium credit amounts are greater for those with lower incomes, compared with higher-income individuals of the same age, reflecting the income-based structure of the premium credits.

Table 4. Illustrative Examples of Required Premium Contributions and Monthly Credit Amounts, if Premium Credits were Available in 2013, by Coverage Tier

For the 48 contiguous states and the District of Columbia

Coverage Tier	Income Level (based on FPL)	Federal Poverty Level (FPL)	Maximum Premium Contribution as a % of Income	Age of youngest adult[a]	Monthly Premium[b]	Required Monthly Contribution from Enrollee(s)	Monthly Credit Amount
Self-Only	$17,235	150%	4.0%	20	$183	$57	$126
	$17,235	150%	4.0%	60	$782	$57	$725
	$40,215	350%	9.5%	20	$183	$183[c]	$0
	$40,215	350%	9.5%	60	$782	$318	$464
Family of Three[d]	$29,295	150%	4.0%	20	$549	$98	$451
	$29,295	150%	4.0%	60	$1,747	$98	$1,649
	$68,355	350%	9.5%	20	$549	$541	$8
	$68,355	350%	9.5%	60	$1,747	$541	$1,206

Source: CRS computations based on "Annual Update of the HHS Poverty Guidelines," 78 *Federal Register* 5182, January 24, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-01-24/pdf/2013-01422.pdf; and "National Health Care Calculator," U.C. Berkeley Labor Center, http://laborcenter.berkeley.edu/healthpolicy/calculator/.

Notes: Under ACA, premium credits will not be available until 2014; the data in this table are for illustrative purposes only. The monthly premium and contribution estimates reflect 2013 dollars. With respect to the poverty guidelines, different income levels apply in Alaska and Hawaii (see "Annual Update of the HHS Poverty Guidelines" referenced under Source). The poverty guidelines are updated annually for inflation.

a. Premiums for exchange plans will be age-adjusted to allow for a maximum 3:1 variation based on age for adults. Exchange premiums also will be allowed to vary based on tobacco use (1.5:1 variation), family size, and geography. For additional information about these rating restrictions, see CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*.

b. The actual premiums for exchange plans are not known at this time. The premium estimates are based on the Congressional Budget Office's national estimates for silver-tier plans, as incorporated in the National Health Care Calculator. Given these are national estimates, they do not reflect variation due to geographic cost differences; differences which are allowed to be incorporated into premiums for exchange plans.

c. The required premium contribution for an individual whose income is $40,215 in 2013 would be $318 per month, which is 9.5% of $40,215 divided by 12. However, the monthly premium for a 20-year-old is lower ($183), so that person would pay the lower amount for exchange coverage.

d. Premiums for exchange plans are allowed to vary based on family size. In this table, the hypothetical family comprises two adults and one child under age 21.

[33] For additional information about this issue, see the "Rating Restrictions" discussion in CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*.

Self-Only Coverage Examples

Assume that the premium credits are available in 2013 (see **Table 4**). Further assume the following monthly premiums for self-only coverage in the reference plan (second lowest-cost silver plan) are: $183 for a 20-year-old, and $782 for a 60-year-old.[34] An individual at age 20 with income at 150% FPL ($17,235 in 2013), would have a required monthly contribution of $57 (i.e., $17,235 annual income multiplied by 4.0%, then divided by 12). This individual would receive a monthly tax credit of $126 (i.e., $183 monthly premium minus $57 required monthly contribution).[35]

Assume the $782 monthly premium for an individual at age 60 with income at 150% FPL. Because this 60-year-old has the same income as the 20-year-old discussed in the previous example, they both are required to contribute the same amount towards the monthly premium: $57. However, since the older individual faces a higher premium, the 60-year-old receives a larger premium credit, compared to the 20-year-old. In this example, the older individual would receive a monthly tax credit of $725.

Family Coverage Examples

The examples discussed above for self-only coverage may be replicated for purposes of estimating contributions and credit amounts for family coverage. For example, assume the monthly premium for family coverage[36] in the reference plan is $549 for a family in which the youngest adult is 20-years-old. Such a family with income at 150% FPL ($29,295 in 2013), would have a required monthly contribution of $98 (i.e., $29,295 annual income multiplied by 4.0%, then divided by 12). This family would receive a monthly tax credit of $451 (i.e., $549 monthly premium minus $98 required monthly contribution).

Reconciliation of Premium Credits

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

Since the enactment of ACA, these limits have been amended twice: first under the Medicare and Medicaid Extenders Act of 2010 (P.L. 111-309), and then under the Comprehensive 1099

[34] These premium amounts are estimates based on CBO's national estimates for silver-tier plans, as incorporated in the National Health Care Calculator developed by the U.C. Berkeley Labor Center, http://laborcenter.berkeley.edu/healthpolicy/calculator/.

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

[36] The calculations for family coverage in **Table 4** assumes a family of three. In this table, the hypothetical family is comprised of two adults and one child under age 21.

Taxpayer Protection and Repayment of Exchange Subsidy Overpayment Act of 2011 (P.L. 112-9). The current repayment limits vary by income band (see **Table 5**). For example, a person who received overpayments for the tax credits he or she should have received in a given tax year would have to repay the excess when he or she files federal income taxes for that tax year. However, if such a person has income below 200% FPL, the IRS may only require him or to repay up to $600 (for tax credit overpayments during that tax year). While such a person may technically owe a larger amount, repayment is limited to a maximum of $600.

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

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

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

Cost-Sharing Subsidies

In addition to the premium credits, ACA establishes subsidies that are applicable to cost-sharing expenses. An individual who qualifies for the premium credit *and* is enrolled in a silver plan (actuarial value of 70%) through an exchange, will also be eligible for cost-sharing assistance.[37] The assistance will be provided in two forms, and both forms are based on income (see descriptions below). Individuals who receive cost-sharing subsidies may receive both types, as long as they meet the applicable eligibility requirements.

ACA requires each tier plan to limit the total amount an enrollee will be required to pay out of pocket for use of covered services (referred to as an annual cost-sharing limit in this report), and establishes separate limits for self-only coverage and family coverage.[38] Given that tiered plans will already be required to comply with annual cost-sharing limits, one form of cost-sharing assistance will reduce such limits, based on income (see **Table 6**). The cost-sharing assistance will reduce the limit by two-thirds for qualifying individuals with income between 100% and 200% FPL, by one-half for those with income between 201% and 300% FPL, and by one-third for those with income between 301% and 400% FPL. In other words, greater reductions are provided to those with lower incomes. In general, this cost-sharing assistance targets individuals and families who use a great deal of health care in a year and, therefore, would have high cost-sharing expenses. Enrollees who use very little health care would not generate enough cost-sharing expenses to reach the total limit, including lower-income enrollees who will have the lowest annual cost-sharing limit.

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

[38] The cost-sharing limits established under this provision in ACA uses existing limits applicable to high-deductible health plans (HDHPs) that qualify to be paired with health savings accounts (HSAs). For 2014, the cost-sharing limits for HSA-qualified HDHPs will be $6,350 for single coverage, and $12,700 for family coverage.

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

Household Income Tier, by Federal Poverty Level	Reduction of Annual Cost-Sharing Limit	New Annual Cost-Sharing Limits for 2014	
		Single Coverage	Family Coverage
Up to 200%	Reduce by two-thirds	$2,117	$4,233
201% - 300%	Reduce by one-half	$3,175	$6,350
301% - 400%	Reduce by one-third	$4,191	$8,510

Source: CRS analysis of ACA, as amended.

Note: The cost-sharing limits applicable to tiered plans established under ACA uses existing limits applicable to high-deductible health plans (HDHPs) that qualify to be paired with health savings accounts (HSAs). For 2014, the cost-sharing limits for HSA-qualified HDHPs will be $6,350 for single coverage, and $12,700 for family coverage. A two-thirds reduction in the 2014 cost-sharing limits would result in new annual limits of approximately $2,117 for single coverage and $4,233 for family coverage; a one-half reduction will result in new annual limits of approximately $3,175 and $6,350, respectively; and a one-third reduction will result in limits of approximately $4,191 and $8,510, respectively.

The second form of cost-sharing assistance targets individuals with income between 100% and 250% FPL. For eligible individuals, the cost-sharing requirements (in the plans they have enrolled) will be reduced to ensure that the plan covers a certain percentage of allowed health care expenses, on average. The practical effect of this cost-sharing assistance is to increase the actuarial value (AV)[39] of the exchange plan in which the person is enrolled (see **Table 7**). Given that this form of cost-sharing assistance will directly affect cost-sharing requirements, both enrollees who use minimal health care and those who use a great deal of services may potentially benefit from this assistance.

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

Household Income Tier, by Federal Poverty Level	New Actuarial Values for Cost-Sharing Subsidy Recipients
Up to 150%	94%
151-200%	87%
201-250%	73%

Source: CRS analysis of ACA, as amended.

Notes: Actuarial value (AV) is a summary measure of a plan's generosity, expressed as the percentage of medical expenses estimated to be paid by the insurer for a standard population and set of allowed charges. In other words, the higher the percentage, the lower the cost-sharing, on average. Given that in order to be eligible for cost-sharing subsidies, an individual must be enrolled in a silver plan, the coverage will already have to meet an AV of 70%. ACA did not specify how a plan would reduce cost-sharing requirements in order to increase the AV from 70% to one of these higher AVs. However, HHS published a bulletin in which it proposes for each insurance company offering a plan that is subject to these cost-sharing reductions to submit, for exchange approval, variations of its silver plan that comply with the higher levels of actuarial value (73%, 87%, and 94%). See "Actuarial Value and Cost-Sharing Reductions Bulletin," Centers for Medicare & Medicaid Services, February 24, 2012, http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf.

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

In order to be eligible for cost-sharing subsidies, an individual must be enrolled in a silver plan, so that coverage will already have an AV of 70%. For an individual who receives the subsidy referred to in **Table 7**, the health plan will impose a different set of lower cost-sharing requirements, so the "silver" plan will meet the new applicable AV. ACA did not specify how a plan would reduce cost-sharing requirements in order to increase the AV from 70% to one of these higher AVs. However, HHS published a bulletin in which it proposes for each insurance company offering a plan that is subject to these cost-sharing reductions to submit, for exchange approval, variations of its silver plan that comply with the higher levels of actuarial value (73%, 87%, and 94%).[40]

The HHS Secretary will provide full reimbursements to exchange plans that provide cost-sharing subsidies. CBO estimates that the cost-sharing subsidies will increase federal outlays, from FY2014 through FY2023, by $149 billion.[41]

[40] See "Actuarial Value and Cost-Sharing Reductions Bulletin," Centers for Medicare & Medicaid Services, Feb. 24, 2012, http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf.

[41] U.S. Congressional Budget Office, "CBO's May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage," May 2013, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf.

Appendix. Health Insurance "Affordability" in the Exchange

While there is no widely accepted definition of individual "affordability" when it comes to health insurance premiums, and other health-care related out-of-pocket costs,[42] ACA sets insurance premium credits for persons, and their covered dependents, such that individuals and families will be required to spend no more than a specified percentage of income on premiums for specified health insurance plans in an exchange. Insurance premium credits under ACA will extend to individuals and families with modified adjusted gross income (hereinafter referred to simply as "income" with respect to ACA) between 100% and 400% FPL. ACA will provide premium credit support scaled to individual and family income relative to poverty such that eligible families' and individuals' premium contributions will be limited from 2.0% to 9.5% of income. Individuals and families with income at or above 400% of poverty will be ineligible for premium credits.

In terms of the premiums, ACA implicitly sets a pre-tax "affordability cap" of 9.5% of income on base coverage plans in the exchange (i.e., plans with a beginning actuarial value of 70%, not including the impact of cost-sharing subsidies), for individuals and families with income up to 400% of poverty.

This section examines only the relative "affordability" of enrollee premiums in health insurance exchanges as a percentage of enrollee's income (adjusted gross income or AGI),[43] considering illustrative plan premiums, after subsidies and, if applicable, any federal tax deduction due to excess medical (i.e., qualifying health insurance and health care) expenses. (Note: this analysis was conducted during ACA enactment (March 2010), incorporating information available at the time, in order to estimate premiums for exchange plans and depict the "affordability" of such plans for exchange enrollees. Given the timing of this analysis, more recent cost data, as well as relevant regulations and guidance, are not reflected in the analysis. Furthermore, assumptions regarding eligibility for premium credits have not been updated to reflect the potential impact of the relevant Supreme Court decision.[44] While the specific estimates do not incorporate more recent information, the discussion of the relative affordability of exchange plans for enrollees based on age, family size and composition, and geography is still relevant to understanding how these different factors interact and may potentially affect enrollee costs.)

[42] ACA includes provisions to study affordability issues. It requires GAO to conduct a survey of the cost and affordability of health care insurance provided under the exchanges for owners and employees of small business concerns, including data on enrollees in exchanges and individuals purchasing health insurance coverage outside of exchanges. GAO is also required to conduct a study on the affordability of health insurance coverage (including the impact of credits for individuals and small businesses), the availability of affordable health benefits plans (including a study of whether the percentage of household income used for credit purposes is appropriate for determining whether employer-provided coverage is affordable and whether such level may be lowered without significantly increasing the costs to the federal government and reducing employer-provided coverage), and the ability of individuals to maintain essential health benefits coverage. ACA also requires the HHS Secretary to conduct a study examining the feasibility and implication of adjusting the FPL for premium and cost-sharing credits for different geographic areas so as to reflect the variations in cost-of-living among different areas. If the Secretary determines that an adjustment is feasible, the study should include a methodology to make such an adjustment.

[43] While the definition of income for the purposes of premium credit eligibility uses MAGI, for ease of analysis the illustrations discussed in this section uses AGI as the definition of income.

[44] For a brief discussion about the possible impact of the Supreme Court's decision regarding Medicaid expansion on premium credit eligibility, see the section titled "Interaction with Other ACA Provisions" in CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*.

The insurance premiums used in the examples are for purposes of illustration only. Ultimately, the premiums individuals would face in the health insurance exchanges will depend on a host of factors, including the varying prices paid by plans for medical goods and services, the breadth of the provider network, the provisions regarding how out-of-network care is paid for (or not), the use of tools by the plan to reduce health care utilization (e.g., prior authorization for certain tests), and other factors. The estimates shown here are based on illustrative premiums developed by the Kaiser Family Foundation (KFF) in 2009.[45] The illustrated plans are estimated to have a 70% actuarial value, meaning that the plans are expected to cover 70% of plan members' covered health care costs, with members' spending on cost-sharing (e.g., deductibles and copayments) covering the remaining 30%. In the exchanges, insurers will be allowed to age-rate premiums within prescribed bands—under ACA, the highest age-adjusted premium can be no more than three times the lowest age-adjusted premium. ACA also will allow premiums to vary by tobacco use (by no more than 1.5:1 ratio) and geographic area.

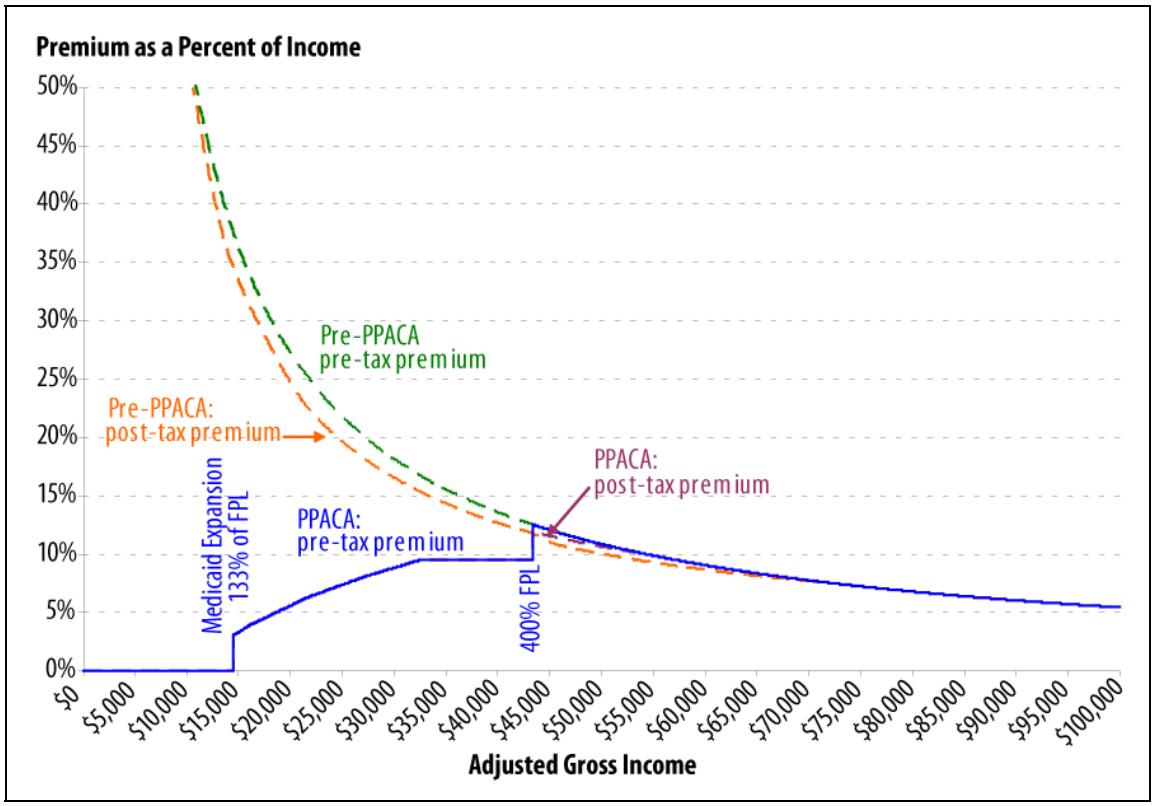
Figure A-1 depicts the relative "affordability" of health insurance premiums prior to the application of the credits and ACA as of 2014, depicting out-of-pocket premiums as a percentage of income. The figure is based on KFF's illustrated health insurance plan cost of $5,428 for a 50-year-old with single coverage living in a medium-cost area. Out-of-pocket premiums are shown based on pre-tax as well as post-tax premiums, using the excess medical expense threshold limit of 7.5% of adjusted gross income prior to ACA, and 10.0% after ACA.

The figure shows that at 100% of poverty, the illustrated insurance plan would cost individuals *half* of their pre-tax income prior to ACA—insurance premiums at this level, amounting to 50% of pre-tax income, would be considered unaffordable by many, and could crowd out spending on other basic needs such as food, shelter and utilities, and clothing. Prior to ACA, the 7.5% excess medical expense deduction was the only federal subsidy toward the cost of their medical insurance that these individuals were eligible to receive; at lower-income levels the deduction had little or no effect on net post-tax premiums. Under ACA, Medicaid will be expanded to 133% FPL, which will permit individuals to enroll with relatively limited or no premiums and cost-sharing. Under the depicted plan, health insurance premiums after reflecting ACA's subsidies would range from 3% of income at just above 133% of poverty, up to 9.5% of income at just under 400% FPL. At 400% FPL, individuals are shown bearing the full pre-tax cost of the illustrated plan ($5,428), which would amount to 12.5% of their pre-tax income; after applying the excess medical expense deduction under current law, the post-tax premium amounts to 11.7% of adjusted gross (pre-tax) income.

[45] http://healthreform.kff.org/SubsidyCalculator.aspx, accessed on March 23, 2010.

Figure A-1. ACA Compared to Pre-ACA Premiums: Pre- and Post-tax Out-of-Pocket Premiums as a Percentage of Adjusted Gross Income

Based on Illustrated Annual Insurance Plan Cost for a 50-Year-Old with Single Coverage in a Medium-Cost Area ($5,428)



Source: Prepared by CRS based on Kaiser Family Foundation (KFF) illustrative health insurance premiums, for plans with an estimated actuarial value of 70%, in 2009.

Notes: Estimates are for illustration only, based on illustrated KFF health insurance premiums. Actual premiums would likely vary among health insurance exchanges based on a wide range of factors. The figure shows that prior to ACA, no premium credits are provided to individuals under 400% FPL, with the only federal subsidy being the effect of the deduction of medical expenses in excess of the 7.5% AGI threshold (as illustrated by the post-tax premium). ACA provides premium credits up to 400% of FPL, but increases the excess medical expense deduction threshold to 10.0% of AGI.

Illustrated Potential Effects of Age-Banding and Area Cost Adjustments on "Affordability"

Table A-1 shows illustrative KFF plan premiums in the exchange based on 2009 plan costs.[46] The examples shown here reflect the possible effects of age-banding of premiums and geographic cost variation on health insurance premium affordability. In the examples shown, KFF illustrative premiums in higher-cost areas are set at 20% above those in medium-cost areas, and premiums in lower-cost areas are set 20% below. Under KFF's age-banding, premiums for 30-year-olds are

[46] Given that KFF developed their illustrative premiums in 2009, the original analysis compared such amounts to the federal poverty levels applicable for that year. Since FPLs are adjusted annually, the FPLs used in the analysis in the Appendix of the paper are different from the FPLs used elsewhere in the report.

only slightly above those of 20-year-olds. At age 40, premiums are one-third higher than at age 20; at age 50, just over twice; and at age 60, three times as high (consistent with the age-banding limits). KFF estimates single+1 premiums as simply twice those of single coverage. Premiums for a family of four follow a similar age progression, except at age 50, premiums are only 84% higher than for 20-year-olds, and for 60-year-olds, 1.6 times higher.[47] Further discussion will focus on single individuals and couples (married and unmarried) under single premium and single+1 premium plans.

Table A-1. ACA: Illustrative Health Insurance Premiums, by Enrollee Age, Geographic Cost, and Plan Type, 2009

	Single premium			Single+1 premium			Family of four premium		
Age	Lower-cost area	Medium-cost area	Higher-cost area	Lower-cost area	Medium-cost area	Higher-cost area	Lower-cost area	Medium-cost area	Higher-cost area
20	$2,110	$2,637	$3,165	$4,220	$5,274	$6,330	$5,687	$7,108	$8,530
30	$2,141	$2,676	$3,211	$4,282	$5,352	$6,422	$6,290	$7,862	$9,435
40	$2,800	$3,500	$4,200	$5,600	$7,000	$8,400	$7,548	$9,435	$11,321
50	$4,342	$5,428	$6,513	$8,684	$10,856	$13,026	$10,489	$13,112	$15,734
60	$6,329	$7,911	$9,494	$12,658	$15,822	$18,988	$14,960	$18,700	$22,440

Source: Prepared by CRS from Kaiser Family Foundation (KFF) illustrative health insurance premiums, for plans with an estimated actuarial value of 70%, in 2009. Available online at http://healthreform.kff.org/SubsidyCalculator.aspx, accessed on March 23, 2010.

Note: Estimates are for illustration only. Illustrated premiums reflect a 3:1 age-banding, with premiums of oldest enrollees being three times those of youngest enrollees. Illustrated premiums in lower-cost areas are 20% lower than in medium-cost areas, and in higher-cost areas, 20% higher. Actual premiums will likely vary among health insurance exchanges based on a wide range of factors.

Table A-2. ACA: Illustrative Health Insurance Premiums as a Percentage of Income at an Income Level of 400% of the Federal Poverty Level, by Enrollee Age, Geographic Cost, and Plan Type, 2009

	Single premium[a]			Single+1 premium[b]			Family of four premium[c]		
Age	Lower-cost area	Medium-cost area	Higher-cost area	Lower-cost area	Medium-cost area	Higher-cost area	Lower-cost area	Medium-cost area	Higher-cost area
20	4.9%	6.1%	7.3%	7.2%	9.0%	***10.9%***	6.4%	8.1%	9.7%
30	4.9%	6.2%	7.4%	7.3%	9.2%	***11.0%***	7.1%	8.9%	***10.7%***
40	6.5%	8.1%	***9.7%***	***9.6%***	***12.0%***	***14.4%***	8.6%	***10.7%***	***12.8%***
50	***10.0%***	***12.5%***	***15.0%***	***14.9%***	***18.6%***	***22.4%***	***11.9%***	***14.9%***	***17.8%***
60	***14.6%***	***18.3%***	***21.9%***	***21.7%***	***27.1%***	***32.6%***	***17.0%***	***21.2%***	***25.4%***

[47] Presumably the smaller difference for family coverage by age, compared to single coverage, is due to an assumption that by age 50, couples' children tend to be older than those of younger couples, and older children generally have lower health care utilization rates than younger children.

Source: Prepared by CRS based on Kaiser Family Foundation (KFF) illustrative health insurance premiums, for plans with an estimated actuarial value of 70%, in 2009. Available online at http://healthreform.kff.org/SubsidyCalculator.aspx, accessed on March 23, 2010.

Notes: Estimates are for illustration only, based on illustrated KFF health insurance premiums. Actual premiums will likely vary among health insurance exchanges based on a wide range of factors. Values in ***bold italic*** are above ACA's premium cap of 9.5% of income, extending up to 400% of FPL.

a. Premium as a percentage of income based on 400% of FPL for a single person ($43,320).

b. Premium as a percentage of income based on 400% of FPL for a 2-person family ($58,280).

c. Premium as a percentage of income based on 400% of FPL for a 4-person family ($88,200).

Table A-2 shows the illustrative KFF plan premiums as a percentage of income at 400% of the FPL, the point at which an individual or family no longer is eligible for premium subsidies under ACA. The table shows, for example, that 20- to 40-year-olds in the illustrated single plans have premiums ranging from 4.9% of income (for the youngest group in lower-cost areas), up to 8.1% for 40-year-olds in medium-cost areas—all below the ACA's implicit 9.5% affordability limit. For 40-year-olds in higher-cost areas, illustrated premiums (9.7% of income) are slightly above the law's affordability limit. For 50- and 60-year-olds, the illustrated premiums are above the 9.5% affordability limit in all markets, ranging from 10.0% to 15.0% of income for 50-year-olds, and 14.6% to 21.9% of income for 60-year-olds.[48]

Figure A-2 through **Figure A-4** depict pre- and post-tax premiums as a percentage of income under illustrated self-coverage plans, by enrollee age, in lower-cost, medium-cost, and higher-cost areas, respectively. **Figure A-2**, for example, shows that under the illustrated premiums for a lower-cost area all enrollees with incomes below 400% of poverty would have pre-tax premiums amounting to less than 9.5% income—ACA's affordability cap—due to the law's premium credits. However, the impact of age-rating premiums will differ for younger vs. older individuals, as their income increases. For example, for individuals age 30 and 40, the illustrated premiums as a percentage of income naturally decline before reaching the 400% FPL, because they face relatively low premiums (compared with older individuals) as their income increases. In contrast, individuals age 40 and 50 face higher exchange premiums and benefit from the 9.5% income affordability cap all the way up to the 400% income-eligibility limit. At 400% of poverty, illustrated premiums for the 50-year-olds increase slightly, to 10.0% of income, and for 60-year-olds, more substantially, to 14.6% of income.

In medium-cost areas, illustrated in **Figure A-3**, pre-tax premiums for 50-year-olds amount to 12.5% of income, and for 60-year-olds, 18.3% at 400% of the FPL. In higher-cost areas, illustrated in **Figure A-4**, pre-tax premiums at 400% of poverty amount to 15% of income for 50-year-olds, and 21.9% of income for 60-year-olds. For 60-year-olds, pre-tax premiums fall back to 9.5% of income once income reaches $99,937 or 923% FPL.

Figure A-5 through **Figure A-7** depict pre- and post-tax premiums as a percentage of income under illustrated plans, for a married couple with no children having "single+1" insurance coverage, by enrollee age, in three geographic cost areas. The illustrated premiums for "single+1" coverage are twice those for single coverage. **Table A-2** shows that for a married couple with a single+1 policy, at 400% of poverty, illustrated premiums in lower-cost areas for 50- and 60-year-olds are well above the 9.5% "affordability threshold" with illustrated premiums at 14.9% of income for 50-year-olds, and 21.7% for 60-year-olds. In medium-cost areas, illustrated premiums at 400% of poverty for a 40-year-old (12.0% of income) are above the 9.5% "affordability

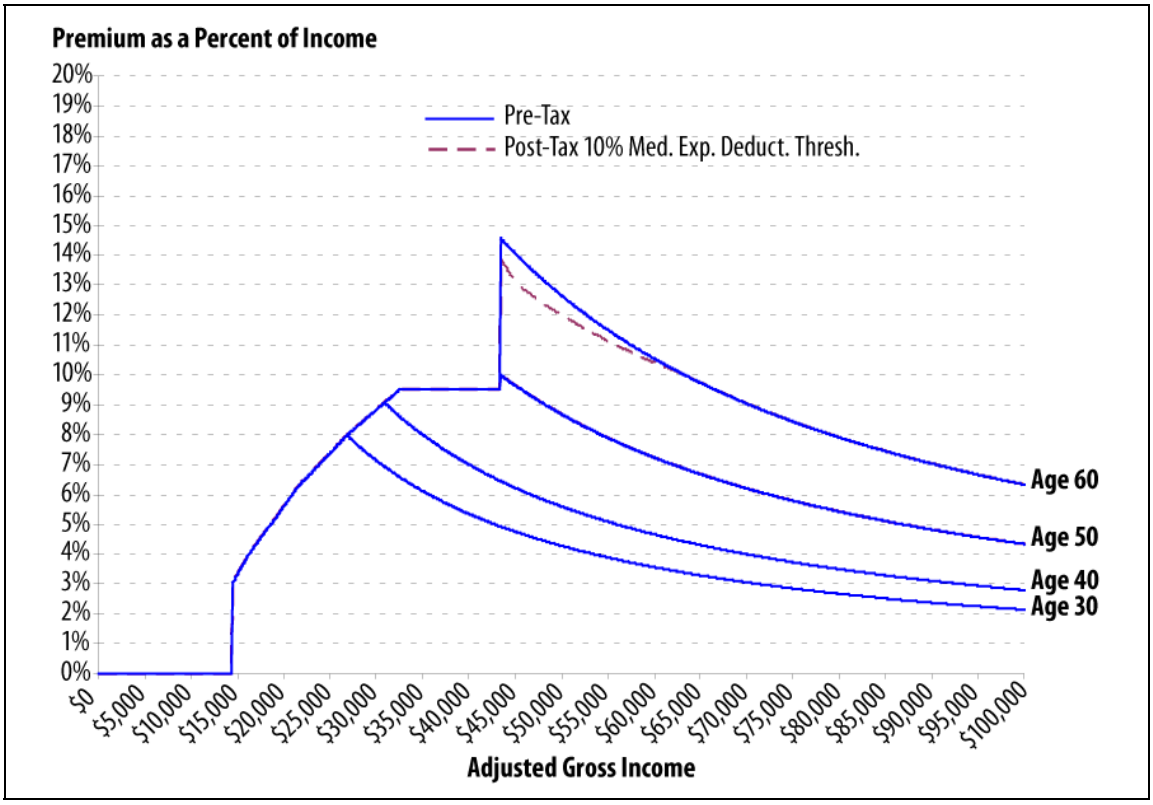
[48] One study found that annual premiums in the nongroup market for 60- to 64-year-olds averaged $5,755 in 2009, which would be 13.3% of income for an individual at 400% FPL. See Table 2, "Individual Health Insurance," AHIP Center for Policy and Research, October 2009.

threshold," and range up to 27.1% of income for 60-year-olds. For married-couples in higher-cost areas, illustrated premiums at 400% of poverty are higher than the 9.5% "affordability threshold" at all ages, ranging from 10.9% of income for a 20-year-old, up to 32.6% for 60-year-old enrollees.

It should be noted that the figures that follow reflect estimates under ACA only, unlike **Figure A-1**, which illustrates pre- and post-tax premiums both before and after ACA.

Figure A-2. ACA: Pre- and Post-Tax Out-of-Pocket Premiums as a Percentage of Adjusted Gross Income, by Age—Single Policy in a Lower-Cost Area

Based on Illustrated Annual Insurance Plan Costs—
Age 30: $2,141, Age 40: $2,800, Age 50: $4,342, Age 60: $6,329



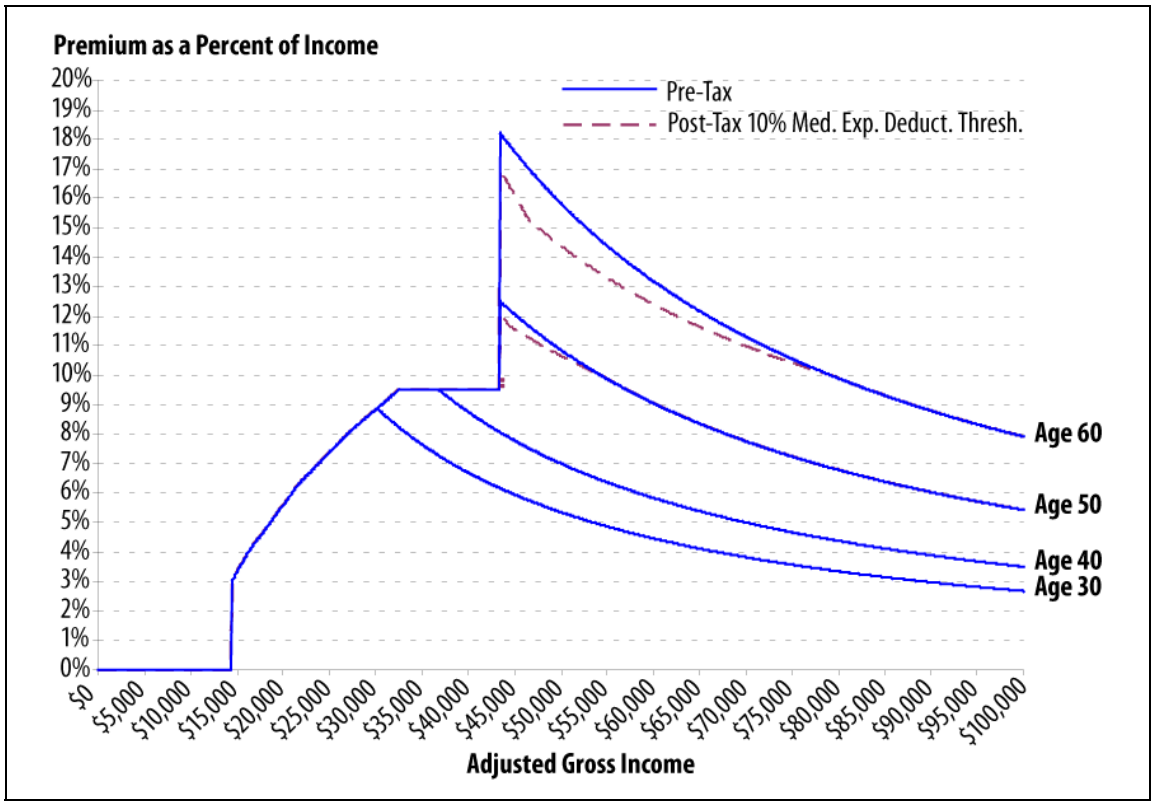
Source: Prepared by CRS based on Kaiser Family Foundation (KFF) illustrative health insurance premiums, for plans with an estimated actuarial value of 70%, in 2009.

Notes: Estimates are for illustration only, based on illustrated KFF health insurance premiums. Actual premiums would likely vary among health insurance exchanges based on a wide range of factors. Persons and families with incomes of 400% of poverty and above would be ineligible for premium subsidy support, and their pre-tax premiums would be the same they faced prior to ACA (absent other effects the law might have on reducing the price of health insurance). Net post-tax premiums are based ACA's excess medical expense deduction threshold of 10.0%.

Figure A-3. ACA: Pre- and Post-Tax Out-of-Pocket Premiums as a Percentage of Adjusted Gross Income, by Age—Single Policy in a Medium-Cost Area

Based on Illustrated Annual Insurance Plan Costs—

Age 30: $2,676, Age 40: $3,500, Age 50: $5,428, Age 60: $7,911

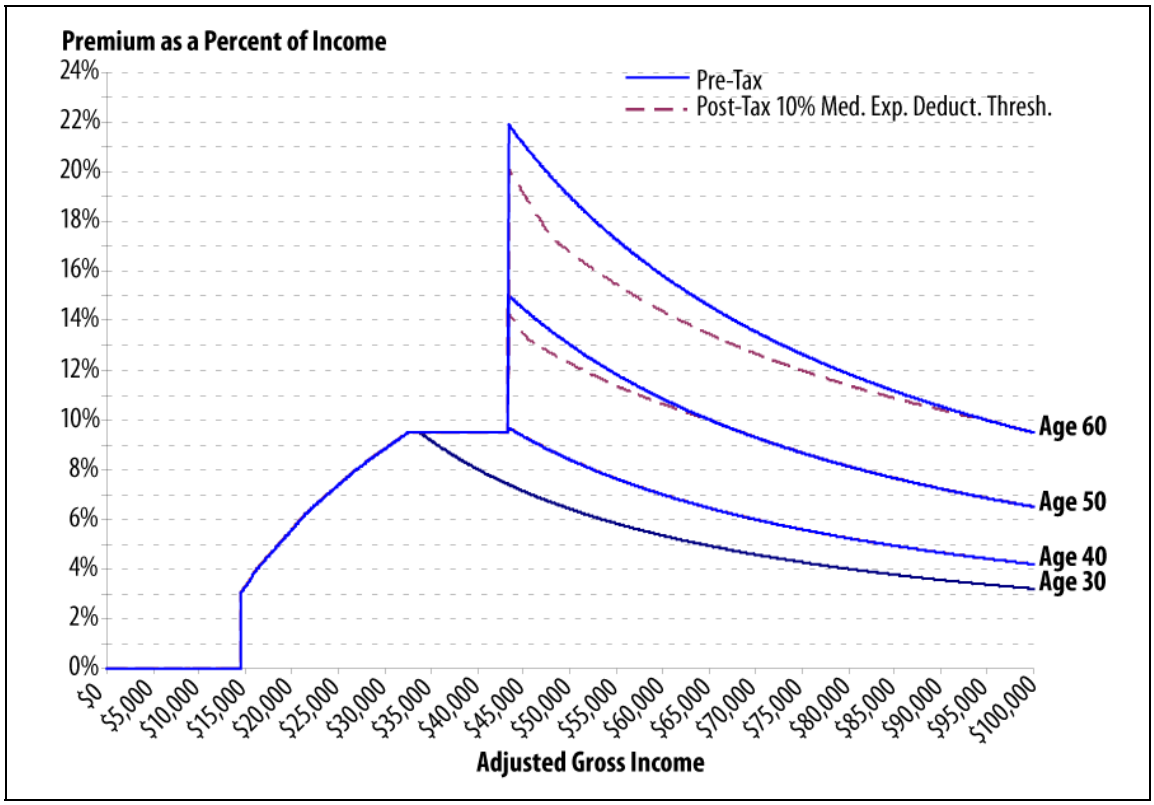


Source: Prepared by CRS based on Kaiser Family Foundation (KFF) illustrative health insurance premiums, for plans with an estimated actuarial value of 70%, in 2009.

Notes: Estimates are for illustration only, based on illustrated KFF health insurance premiums. Actual premiums would likely vary among health insurance exchanges based on a wide range of factors. Persons and families with incomes of 400% of poverty and above would be ineligible for premium subsidy support, and their pre-tax premiums would be the same they faced prior to ACA (absent other effects the law might have on reducing the price of health insurance). Net post-tax premiums are based ACA's excess medical expense deduction threshold of 10.0%.

Figure A-4. ACA: Pre- and Post-Tax Out-of-Pocket Premiums as a Percentage of Adjusted Gross Income, by Age—Single Policy in a Higher-Cost Area

Based on Illustrative Annual Insurance Plan Costs—
Age 30: $3,211, Age 40: $4,200, Age 50: $6,513, Age 60: $9,494

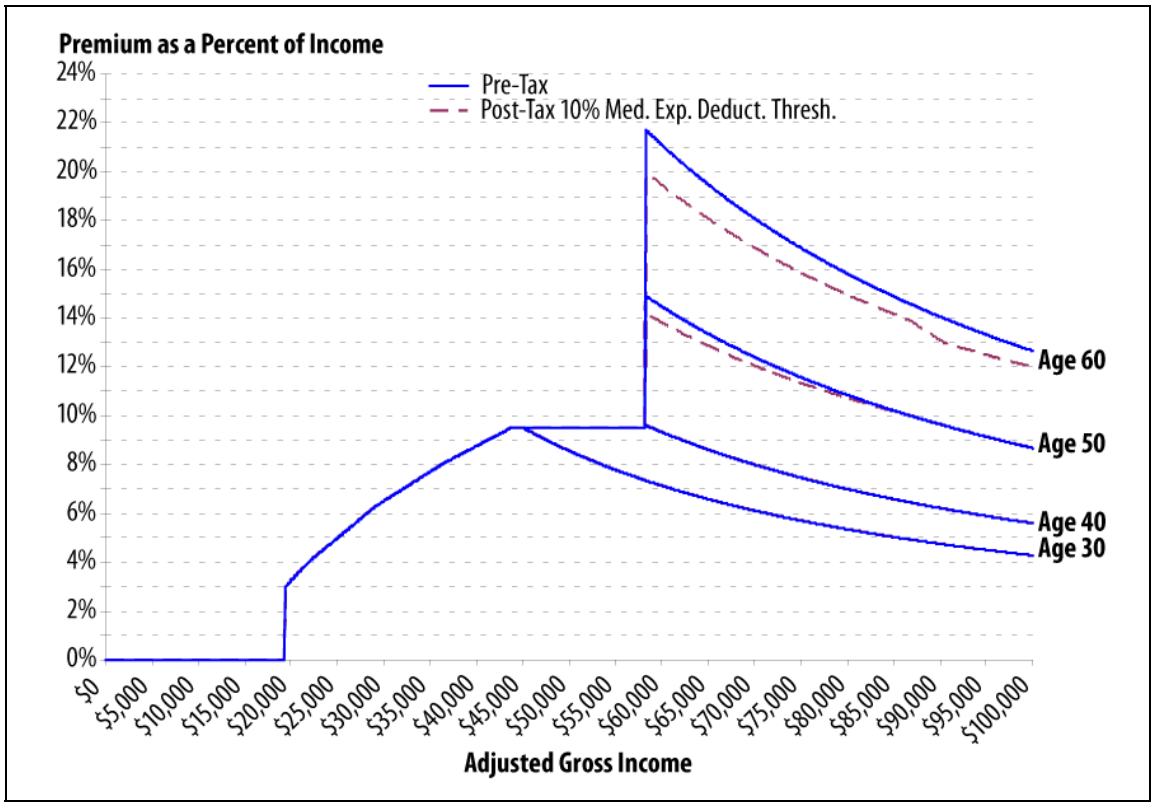


Source: Prepared by CRS based on Kaiser Family Foundation (KFF) illustrative health insurance premiums, for plans with an estimated actuarial value of 70%, in 2009.

Notes: Estimates are for illustration only, based on illustrated KFF health insurance premiums. Actual premiums would likely vary among health insurance exchanges based on a wide range of factors. Persons and families with incomes of 400% of poverty and above would be ineligible for premium subsidy support, and their pre-tax premiums would be the same they faced prior to ACA (absent other effects the law might have on reducing the price of health insurance). Net post-tax premiums are based ACA's excess medical expense deduction threshold of 10.0%.

Figure A-5. ACA: Pre- and Post-Tax Out-of-Pocket Premiums as a Percentage of Adjusted Gross Income, by Age—
Married Couple with no Children, Single+1 Policy in a Lower-Cost Area

Based on Illustrated Annual Insurance Plan Costs—
Age 30: $4,282, Age 40: $5,600, Age 50: $8,684, Age 60: $12,658

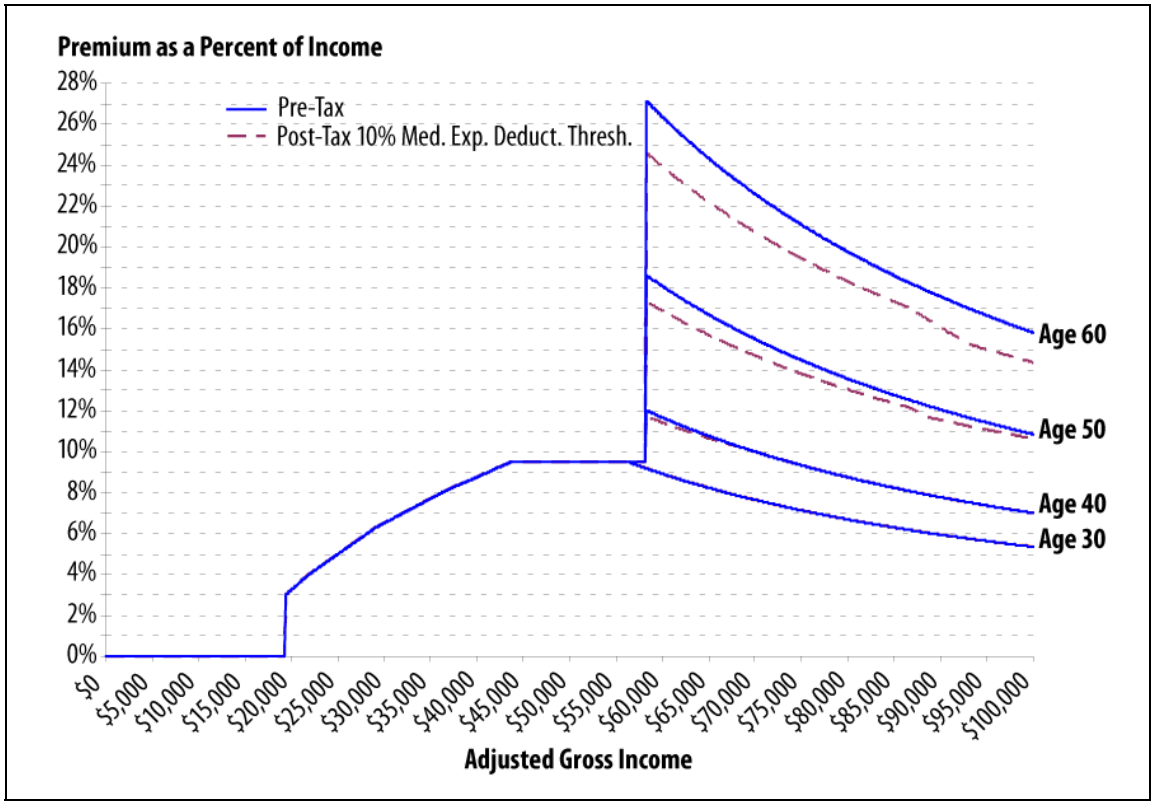


Source: Prepared by CRS based on Kaiser Family Foundation (KFF) illustrative health insurance premiums, for plans with an estimated actuarial value of 70%, in 2009.

Notes: Estimates are for illustration only, based on illustrated KFF health insurance premiums. Actual premiums would likely vary among health insurance exchanges based on a wide range of factors. Persons and families with incomes of 400% of poverty and above would be ineligible for premium subsidy support, and their pre-tax premiums would be the same they faced prior to ACA (absent other effects the law might have on reducing the price of health insurance). Net post-tax premiums are based ACA's excess medical expense deduction threshold of 10.0%.

Figure A-6. ACA: Pre- and Post-Tax Out-of-Pocket Premiums as a Percentage of Adjusted Gross Income, by Age—
Married Couple with no Children, Single+1 Policy in a Medium-Cost Area

Based on Illustrated Annual Insurance Plan Costs—
Age 30: $5,352, Age 40: $7,000, Age 50: $10,856, Age 60: $15,822

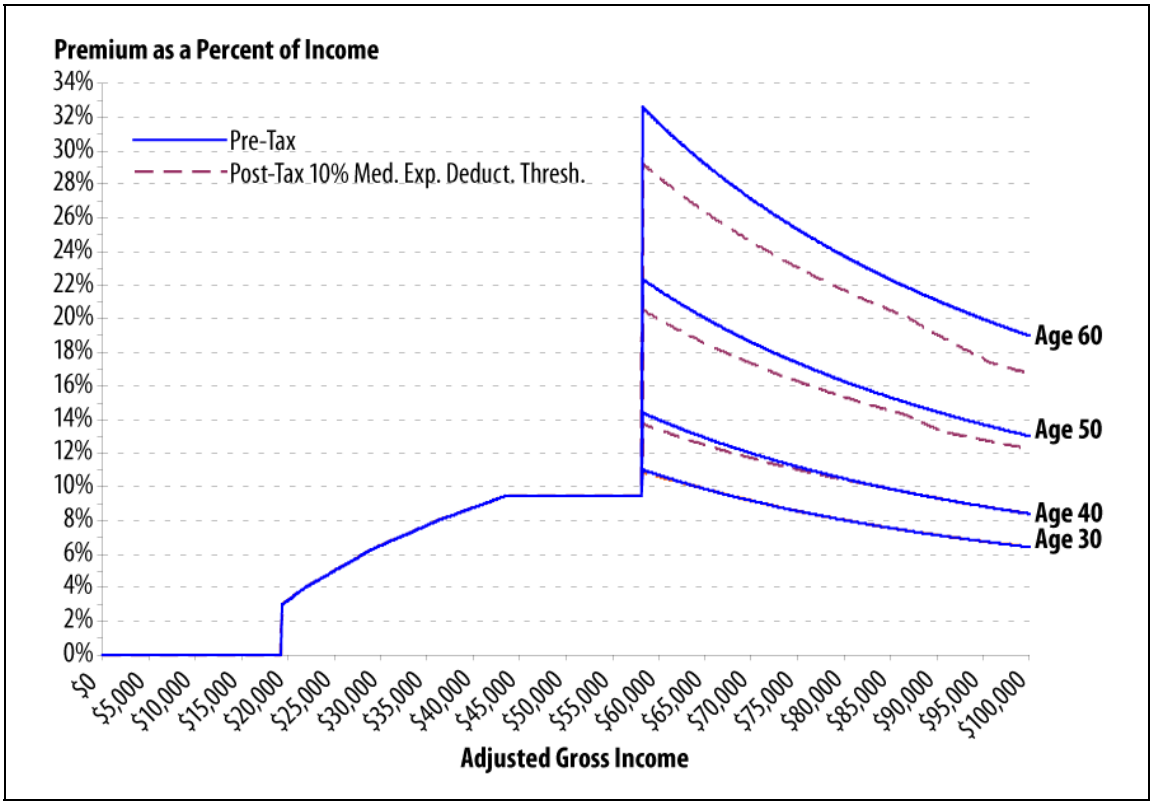


Source: Prepared by CRS based on Kaiser Family Foundation (KFF) illustrative health insurance premiums, for plans with an estimated actuarial value of 70%, in 2009.

Notes: Estimates are for illustration only, based on illustrated KFF health insurance premiums. Actual premiums would likely vary among health insurance exchanges based on a wide range of factors. Persons and families with incomes of 400% of poverty and above would be ineligible for premium subsidy support, and their pre-tax premiums would be the same they faced prior to ACA (absent other effects the law might have on reducing the price of health insurance). Net post-tax premiums are based ACA's excess medical expense deduction threshold of 10.0%.

Figure A-7. ACA: Pre- and Post-Tax Out-of-Pocket Premiums as a Percentage of Adjusted Gross Income, by Age—
Married Couple with no Children, Single+1 Policy in a Higher-Cost Area

Based on Illustrated Annual Insurance Plan Costs—
Age 30: $6,422, Age 40: $8,400, Age 50: $13,026, Age 60: $18,988



Source: Prepared by CRS based on Kaiser Family Foundation (KFF) illustrative health insurance premiums, for plans with an estimated actuarial value of 70%, in 2009.

Notes: Estimates are for illustration only, based on illustrated KFF health insurance premiums. Actual premiums would likely vary among health insurance exchanges based on a wide range of factors. Persons and families with incomes of 400% of poverty and above would be ineligible for premium subsidy support, and their pre-tax premiums would be the same they faced prior to ACA (absent other effects the law might have on reducing the price of health insurance). Net post-tax premiums are based ACA's excess medical expense deduction threshold of 10.0%.

Relative "Affordability" of Premiums for Married and Unmarried Couples

Some have described the structure of the premium support provided under ACA's health insurance exchanges, with respect to the phase out of premium support relative to enrollees' income, as resulting in a "marriage penalty."[49] Under ACA's health insurance exchanges, a couple may receive a lesser subsidy, and consequently incur higher out-of-pocket insurance premiums, if they are married, as opposed to unmarried, all other things being equal, thus resulting in a

[49] Martin Vaughan, "Married Couples Pay More than Unmarried Under Health Bill," *Wall Street Journal*, January 6, 2010, online edition. Available online at http://online.wsj.com/article/SB126281943134818675.html.

"marriage penalty."[50] ACA phases out premium support on the basis of income relative to the Federal Poverty Level. Premium support in the exchanges for a married couple would be based on their combined income relative to the FPL for two persons ($14,570), and if unmarried, based on their individual incomes relative to the FPL for one person ($10,830). Because the FPL for the married couple is not twice that of a single person, but only 35% higher (i.e., $14,570/$10,830), premium support phases out at a faster rate for the married couple than for the unmarried couple, with equal incomes and combined (pre-subsidy) insurance plan costs. If married, the couple would be ineligible for premium support in the exchange once their income reaches $58,280 (i.e., 400% of the FPL), but if unmarried, premium support could potentially be retained until each individual's income reaches 400% for a single person ($43,320), or potentially until their combined income reaches $86,640 (which would be 595% FPL for a married couple).[51]

The FPL, as originally constructed, recognized that while two persons cannot live as cheaply as one, they can live more cheaply living together, than living apart. In other words, there are economic gains that result from "economies of scale" from living jointly, rather than apart. "Marriage penalties" can result to the extent that FPLs assign lower cost to each additional family member, regardless of whether that family member is a spouse, children, etc.[52] In addition, "marriage penalties" may result more directly from the definition of the economic unit to which the FPL, or other income criteria, is applied.[53] Following are two examples of other federal programs that illustrate how the definition of the economic unit can affect couples' eligibility.

Many federal programs use the FPL as the basis for determining eligibility, setting benefit levels, and phasing out benefits. For example, the Supplemental Nutrition Assistance Program (SNAP) (formerly named the Food Stamp program) counts *household* income for purposes of determining household income eligibility. *Households* with gross income above 100% of poverty are ineligible for the program, as are *households* with net income (after certain disregards) above 130% of poverty. With respect to SNAP, a married couple is treated the same as an unmarried couple, if living together in the same *household*. So, in this context, there is no inherent "marriage penalty" in SNAP, even though it uses the FPL. However, there is a potential "penalty" for two persons living apart, where one or both are receiving SNAP benefits, if they choose to live together, as their combined household income might make them ineligible for SNAP benefits. However, by living together, rather than separately, two individuals, whether married or unmarried, could benefit from implied economies of scale.

In contrast, the Earned Income Tax Credit (EITC) may be said to have a "marriage penalty," even though it does not use the FPL to scale benefits. This is because two unrelated unmarried individuals are treated as individuals under the tax code (single filers), whereas if married their incomes are combined and they are treated as married joint filers. With respect to the EITC, one or both individuals could be eligible for the EITC based on their individual earnings, if

[50] The Treasury Department, in the NPRM on premium credits, requested comments on providing relief to individuals who would receive less premium support after they marry during the tax year. The comment period ended on October 31, 2011. *Federal Register*, Vol. 76, No. 159, August 17, 2011.

[51] This assumes that the two members of the unmarried couple have individual incomes that are equal. For the married couple, it makes no difference how their income is split.

[52] The 2009 federal poverty levels were $10,830 for an individual, and $3,740 for each additional person.

[53] Because premium credit amounts under the exchanges will be scaled based on income relative to poverty, other types of individuals might find differences in their premiums depending on their living arrangements, other than just whether they're married or not. For example, the total premiums for a single parent with two older children (e.g., age 18 to 25) might differ depending on whether the children enroll separately, based on their individual income, or under the umbrella of a family policy, based on the parent's and children's combined income.

unmarried, but become ineligible, or receive a lesser benefit, if they were married, as the EITC would then be based on their combined earnings.

Figure A-8 and **Figure A-9** compare premiums under ACA as a percentage of income for a married couple relative to an unmarried couple, in a medium-cost area, at age 30 and age 50, respectively. The figures show that premiums as a percentage of income would be higher for a married couple than if the couple were unmarried, even though their incomes and insurance premiums are the same.[54]

In the illustrated example at age 30 (**Figure A-8**), the difference in premiums between married and unmarried couples, and as a percentage of income, is much greater, as the married couple's premium subsidy phases out at a faster rate based on its income than it does for the unmarried couple based on their combined income. In the illustration, the married couple no longer receives premium support once their income exceeds $56,337. At that point their premium as a percentage of income naturally falls below ACA's 9.5% "affordability cap," and they are deemed to no longer need premium subsidy support. For the unmarried couple at the same combined income level, assuming their income is equally split, they are individually eligible for premium support of $326 each, based on their individual income ($28,168), and thereby would receive combined premium support of $652. In the example, the unmarried couple's combined premiums amount to 8.3% of their combined income, compared to 9.5% for their married counterpart.

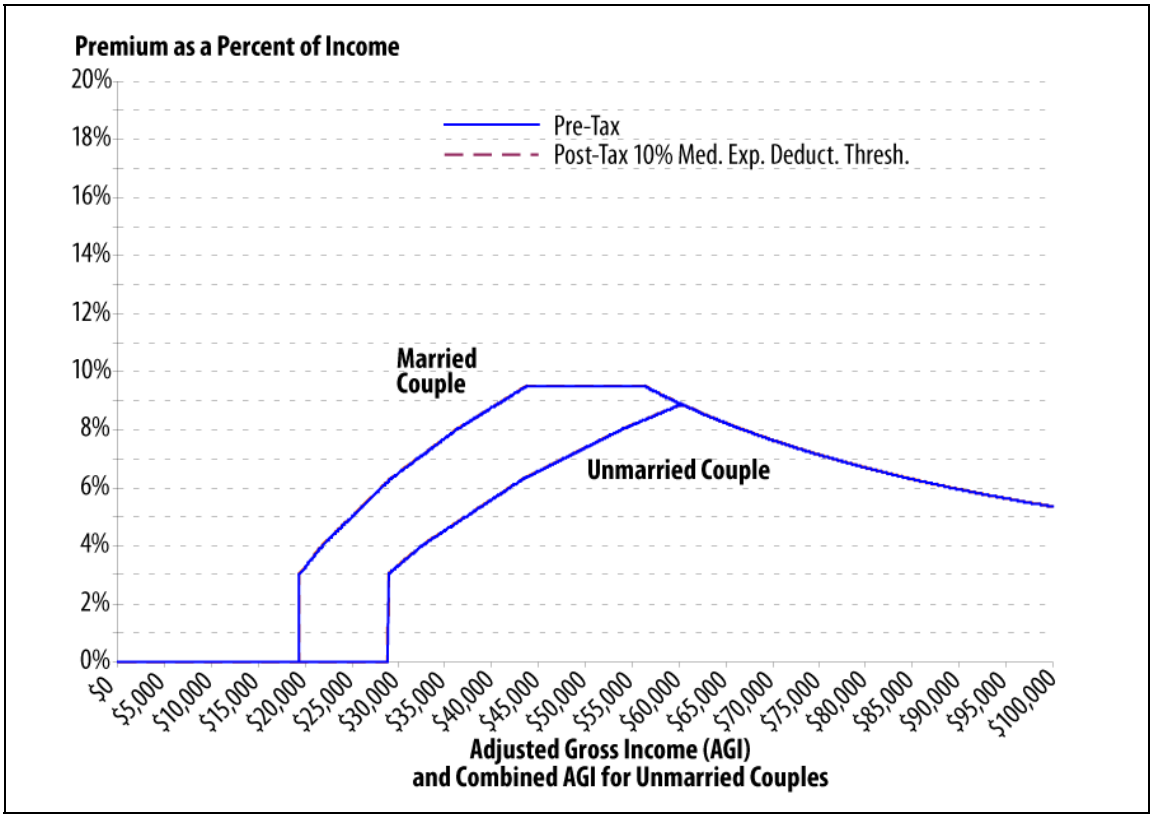
The "marriage penalty" effect increases to the extent premiums exceed the 9.5% "affordability cap" at the point at which a married couple no longer qualifies for premium support (i.e., 400% of poverty, or $58,280). For example, for the 50-year-old couple depicted in **Figure A-9**, at an income level just below $58,280 (i.e., 400% of poverty for the married couple) their premium as a percentage of income is at the 9.5% cap if they are married and 8.6% if they are unmarried. However, the married couple loses premium subsidy support once their income reaches $58,280, and their premium nearly doubles, amounting to 18.6% of their income. In contrast, the unmarried couple continues to be eligible for premium support, at the same combined income level and plan cost as their married counterpart; their combined premiums amount to 8.6% of their combined income—less than half that of the married couple. In the example, both members of the unmarried couple would continue to receive premium support until their individual income reaches $43,320 (400% of the FPL for a single individual), which amounts to a combined income of $86,640. At that, and higher, combined income levels, the unmarried and married couples' premiums are identical, since neither would then qualify for premium credits.

[54] For the 30-year-old couple, if they're married, $5,352 for a single+1 policy, and if they're unmarried, each with a $2,676 single policy, amounting to $5,352 combined. For the 50-year-old couple, if they're married, $10,586 for a single+1 policy, and if they're unmarried, each with a $5,428 single policy, amounting to $10,586 combined. The figures assume the two members of the unmarried couple have equal income. Results would differ if their income were split unequally. For the married couple, it makes no difference as to how their income is split.

Figure A-8. ACA: Pre- and Post-Tax Out-of-Pocket Premiums as a Percentage of Adjusted Gross Income, Comparison of Two Couples Age 30 (Married and Unmarried) in a Medium-Cost Area

Based on Illustrative Annual Insurance Plan Costs—

Married Single+1: $5,352, Unmarried Couple: $5,352 ($2,676 Each)



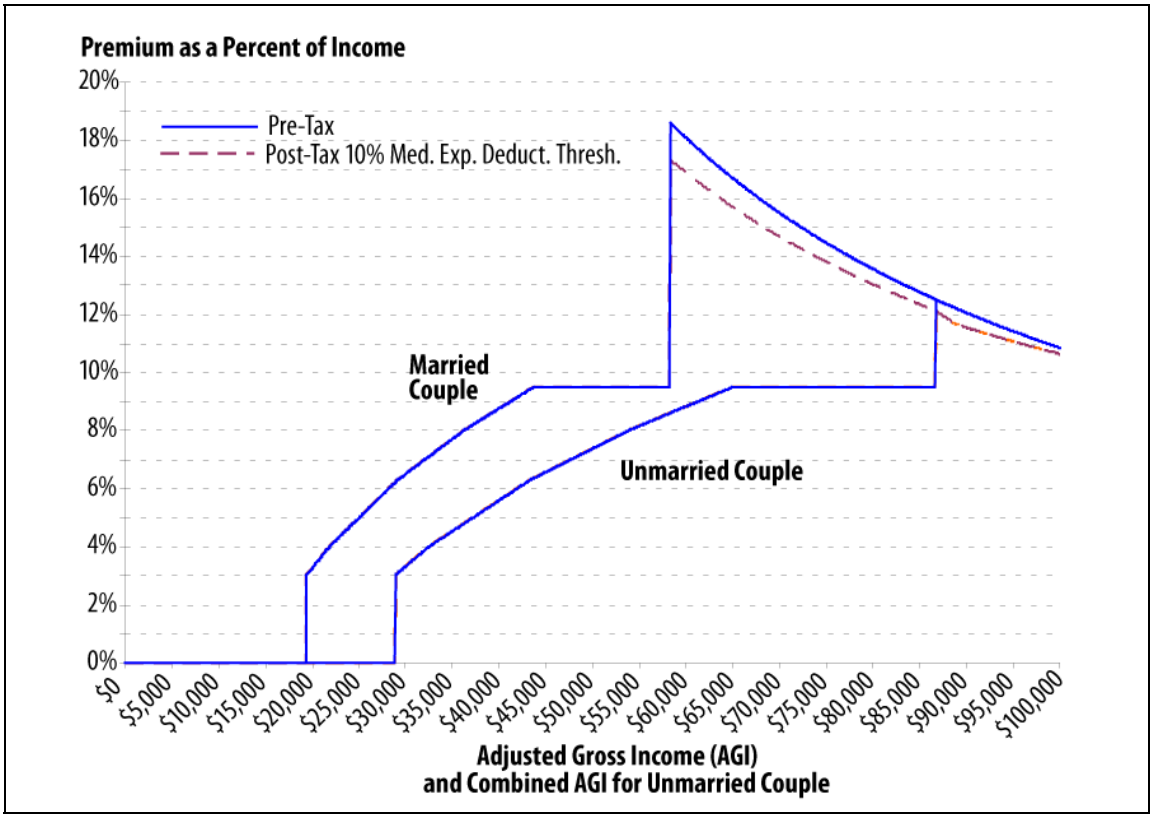
Source: Prepared by CRS based on Kaiser Family Foundation (KFF) illustrative health insurance premiums, for plans with an estimated actuarial value of 70%, in 2009.

Notes: Estimates are for illustration only, based on illustrated KFF health insurance premiums. Actual premiums would likely vary among health insurance exchanges based on a wide range of factors. Persons and families with incomes of 400% of poverty and above would be ineligible for premium subsidy support, and their pre-tax premiums would be the same they faced prior to ACA (absent other effects the law might have on reducing the price of health insurance). Net post-tax premiums are based ACA's excess medical expense deduction threshold of 10.0%. Under this example, gross premiums are below the 10% excess medical expense deduction threshold at all income levels.

Figure A-9. ACA: Pre- and Post-Tax Out-of-Pocket Premiums as a Percentage of Adjusted Gross Income, Comparison of Two Couples Age 50 (Married and Unmarried) in a Medium-Cost Area

Based on Illustrative Annual Insurance Plan Costs—

Married Single+1: $10,856, Unmarried Couple: $10,856 ($5,428 Each)



Source: Prepared CRS based on Kaiser Family Foundation (KFF) illustrative health insurance premiums, for plans with an estimated actuarial value of 70%, in 2009.

Notes: Estimates are for illustration only, based on illustrated KFF health insurance premiums. Actual premiums would likely vary among health insurance exchanges based on a wide range of factors. Persons and families with incomes of 400% of poverty and above would be ineligible for premium subsidy support, and their pre-tax premiums would be the same they faced prior to ACA (absent other effects the law might have on reducing the price of health insurance). Net post-tax premiums are based ACA's excess medical expense deduction threshold of 10.0%.

Conclusion

Relative affordability of health insurance premiums individuals and families might face within health insurance exchanges will likely vary from exchange to exchange based on a host of factors. The examples shown in this report are for illustration only, depicting a range by which premiums might reasonably be expected to vary.

ACA will directly improve health insurance affordability for individuals and families with income up to 400% of poverty, by ensuring that no individual or family would pay more than 9.5% of their income for a health insurance plan with an actuarial value of 70% (not including the impact of cost-sharing subsidies). Additionally, ACA will extend Medicaid coverage to 133% of poverty for many individuals, which will permit them to enroll with relatively little or no premiums and cost-sharing. Persons and families with incomes of 400% of poverty and above will be ineligible

for premium subsidy support, and their premiums will be the same they would have faced before ACA (absent other effects the law might have on reducing the price of health insurance). Individuals and families who are younger and/or who live in lower-cost areas, as opposed to higher-cost areas, may be able to find plans offered in the exchange costing 9.5% or less of income at some income ranges below 400% of poverty. Others might face exchange premiums that well exceed 9.5% of income, but due to ACA's premium subsidy support their premiums will be capped until their income reaches 400% of poverty. At that point, enrollees might incur abrupt, and in some cases substantial, increases in their health insurance premiums. Additionally, ACA raises the excess medical expense deduction threshold from 7.5% to 10.0% of AGI. Consequently, some individuals and families may find their post-tax insurance premiums to be higher after ACA than before, all other things being equal.

ACA phases out premium support subsidies based on individuals' or families' income relative to poverty. Because the FPL for the married couple is not twice that of a single person, but only 35% higher (i.e., $14,570/$10,830), premium support under ACA phases out at a faster rate relative to *income* for a married couple than it does for a single person, even though the phase-out rate relative to the *FPL* is the same. The structure of the phase-out results in what some might describe as a "marriage penalty." One or both individuals in a couple who are unmarried might be eligible for premium support subsidies based on their individual incomes, but if they married they might not, based on their combined income; if found eligible, the premium subsidy they might receive as a married couple could be less than the combined premium subsidies they might receive as an unmarried couple.

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