Chapter 4: Covered California

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4. Covered California

Covered California is the trade name for the California Health Benefit Exchange – California's state-based health insurance exchange established under the Affordable Care Act.[1] Californians can buy a health plan that offers comprehensive health benefits through Covered California, and some are eligible for financial assistance in the form of tax credits or cheaper out-of-pocket costs. Health plans sold by Covered California have strict requirements as to what medical services they cover and what enrolleess must pay for those services. Once individuals are found eligible to purchase a plan or get financial assistance, they must pick their plan and make the first premium payment before they are actually enrolled in coverage (see Chapter 5, Section C.2). Enrollees who choose to receive their premium tax credits in advance – sent directly to their health plan to help pay their monthly premium – must file a form with their federal income tax return to reconcile the amount of premium tax credits received for the year with their actual income for that year.

Legal Authority for Covered California: Covered California manages the federal tax credit established by the Affordable Care Act for Californians. While the federal Department of Health and Human Services regulates many of the actions of Covered California itself, several of the finer points regarding eligibility rules are codified in federal tax regulations at 26 C.F.R. § 1.36b-1, *et seq.* Fortunately the California regulations on eligibility, enrollment, and appeals, found in Title 10, Chapter 12 of the California Code of Regulations, do a good job of referencing the relevant federal authority at the end of each section. It is often easier to start with the California regulations, as they are better known to Covered California staff, and then look to the federal authorizing regulations and statutes when further research is needed. As the California regulations have been promulgated on an emergency basis with short timeframes, to be sure you are using the most recent set of regulations, we recommend going to www.healthexchange.ca.gov and clicking on "Regulations" in the Resources tab.

1. *See* Gov't Code §§ 100500-100521 establishing the Exchange. 10 CCR § 6410 states that the California Health Benefit Exchange may be referred to and do business as "Covered California." *See also* 42 U.S.C. § 18031 (providing for the establishment of state-based exchanges). After the passage of the Affordable Care Act, CMS started using the term "marketplace" instead of "exchange," but the term "marketplace" is not broadly used in California.

A. Qualified Health Plans

Before discussing how individuals become eligible to enroll in Covered California plans and get financial assistance, some explanation of what individuals are purchasing is helpful. Individuals enrolling through Covered California are buying a "Qualified Health Plan." A Qualified Health Plan is a health plan that meets Covered California's requirements and contracts with Covered California to be sold on the state health care exchange.

1. Essential Health Benefits

Qualified Health Plans, like all plans now sold on the individual market in California, must provide the following essential health benefits, as defined by the Affordable Care Act and California statute and regulation:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services (including behavioral health treatment);
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services, preventive and wellness services and chronic disease management; and
- Pediatric services (including oral and vision care).[2]

State law also requires Qualified Health Plans offered through Covered California to include additional benefits, including, in certain cases, acupuncture, nonemergency ambulance transportation, and durable medical equipment.[3] Thus, advocates

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2. 42 U.S.C. § 18022; 45 C.F.R. §§ 156.100 and 156.115.
3. Health & Safety Code § 1367.005(a)(2)(A)(v); 28 CCR § 1300.67.005(c), (d). Essential Health Benefits are codified in California's Insurance Code § 10112.27 and Health and Safety Code § 1367.005. The most detailed list incorporating all of these is in 28 CCR § 1300.67.005.

looking to get a specific service covered for a client should look not only to the health plan's Evidence of Coverage documents, but to the California statutes and regulations specifying the types of services that are mandatory.

2. Standard Benefit Design

In addition to the essential health benefits, the plans also must meet federal actuarial standards so that each plan offers a pre-defined percentage actuarial value.[4] As provided by the Affordable Care Act, plans are divided into metal tiers, with each tier offering a different value[5]:

Metal Tier Level	Actuarial Value (average percentage the plan pays toward the total cost of services)
Platinum	90%
Gold	80%
Silver	70%
Bronze	60%

The premium price is heavily affected by the actuarial value of the plan. In other words, in a Bronze plan, where the *enrollee* is expected to pay, on average, 40% of the cost of care, premiums are significantly cheaper than in a Platinum plan, where the enrollee pays, on average, only 10% of the cost of care.

Another way to evaluate how much a plan will cost an enrollee is to look at what is known as the "total cost of care." The total cost of care considers not only the

4. 42 U.S.C. § 18022(d). The actuarial value is what enrollees who buy the plan pay on average in out-of-pocket expenses and may vary for any individual. Nonetheless, the percentage should help guide how much enrollees can expect their health insurance to pay. Alternatively, it may be easier to look at the maximum out-of-pocket cost of a plan to determine what enrollees can expect to pay during the plan year if they end up needing to use their insurance for any significant medical issues. For example, in 2016 the maximum out-of-pocket cost for a Bronze plan through Covered California was $6,500 for an individual.
5. 42 U.S.C. § 18022(d); 45 C.F.R. § 156.140; Health & Safety Code § 1367.008(a); Ins. Code § 10112.295(a).

premium, but the deductible (how much enrollees must pay before many services are covered), copayments and coinsurance for each visit, copayments or coinsurance for prescription medications, and the maximum out-of-pocket cost (the most a enrollee would have to pay in a plan year if all services are provided in the plan's network).

For example, in 2016 the deductible for a Bronze plan was $6,000 and the maximum out-of-pocket cost was $6,500. This means that enrollees have to pay up front $6,000 toward their care before the plan will pay for most medical services.[6] Once the enrollee reaches the maximum out-of-pocket cost by paying $6,500 for care received in the plan's network, the plan must pay for all other in-network care that year. A Platinum plan on the other hand, has no deductible, so the plan will pay a significant portion of all medical care received. The maximum out-of-pocket for a Platinum plan is $4,000 for any care received in network.[7]

Each individual's specific health care needs will impact which type of plan will cost the most. An individual who uses three to four brand name medications per month and visits a doctor just as often may find a Platinum plan to be the most affordable option; while the premium may be higher in Platinum, the out-of-pocket costs likely would be lower. An individual who does not use many health care services and is buying a plan for "just in case," may find that a Bronze plan, with its lower premium, is the best option.[8] For lower-income individuals, the Silver plans with additional cost-sharing reductions are almost always the cheapest plans as they are higher value plans without the large deductibles, as discussed in Section F at the end of this chapter.

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6. A limited number of doctor visits and preventive services are covered prior to meeting the deductible. Note that currently only Silver and Bronze plans have deductibles, and Silver plans cover more services before the deductible is paid.
7. *See* 10 CCR § 6460 for further detail on what costs enrollees must pay for specific services.
8. Anyone choosing Bronze, however, should be prepared for the high deductible if services are needed.

Advocacy Tip: Covered California went one step further than required under federal law and standardized not only the actuarial values of the plans themselves, but also the benefits in the Qualified Health Plans, so that one Bronze HMO plan will have the same covered services and the same co-payments and deductibles as any other Bronze HMO plan. The Covered California Board approves the standard plan benefit design by regulation the year prior to the plan year. When helping clients deal with unexpected bills, reviewing the charts in the regulation can help determine how the charges were assessed and if they are accurate.

The standard plan design for 2016 is found at 10 CCR § 6460, but due to the nature of the charts that are attached to the regulation describing the design, the regulations are better viewed directly on Covered California's website than in a search engine like Westlaw.[9]

Premium rates are also set based on geographic region and age of the individual. California has 19 regions[10] and the choice of plans available in each region varies, with rates in the southern or metropolitan areas being cheaper on average than those in northern or rural areas. The Affordable Care Act limits how much older individuals can be charged for care, so that charges are no more than three times that of what younger individuals are charged.[11] Note that age, region, and whether the plan covers an individual or family are the only factors that insurers can now use to set premiums – no longer can they consider gender, tobacco use, or preexisting medical conditions.[12]

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9. Rather than the Covered California consumer website for enrolling in Covered California, go to the agency website at www.healthexchange.ca.gov and click on Resources and then Regulations from the pull down menu to get a copy of the Standard Benefit Design Regulations for the year in question.
10. Ins. Code §§ 10753.14(a)(2), 10965.9(a)(2); Health & Safety Code §§ 1357.512(a)(2), 1399.855(a)(2).
11. 42 U.S.C. § 300gg(a)(1)(A)(iii); 45 C.F.R. § 147.102(a)(1)(iii); Ins. Code §§ 10753.14(a)(1), 10965.9(a)(1); Health & Safety Code §§ 1357.512(a)(1), 1399.855(a)(1).
12. Ins. Code §§ 10753.14(a), 10965.9(a); Health & Safety Code §§ 1357.512(a), 1399.855(a). 45 C.F.R. § 147.102(a)(1)(iv) allows for discriminating rates for tobacco users but California's legislation enacting the Affordable Care Act's rate setting protections excluded the consideration of tobacco use. *See* ABX1-2 (Pan), statutes of 2013, preamble.

B. Eligibility to Purchase Coverage Through Covered California

Individuals who would like to purchase a Qualified Health Plan through Covered California must be 1) U.S. citizens, nationals, or lawfully present immigrants, 2) not incarcerated, and 3) residents of California. If individuals do not meet one of these criteria, specifically if they are not U.S. citizens or lawfully present, they may be able to purchase the same plans outside of Covered California in the off-Exchange individual market.[13] Since financial assistance is only available through Covered California plans, individuals buying individual market products outside of the Exchange pay full price – a tough option for low-income Californians.

1. Citizenship and Immigration Status

Unlike Medi-Cal, where immigration status only affects the *scope* of benefits, in Covered California, immigration status affects *who* gets benefits. Under federal law, only California residents who are U.S. citizens,[14] nationals, or who are "lawfully present" as defined in the Affordable Care Act are eligible to enroll in Covered California plans.[15]

Lawfully present immigrants include:[16]

- Lawful Permanent Resident (LPR/Green Card holder);
- Asylee;
- Refugee;
- Cuban/Haitian Entrant;
- Paroled into the U.S.;[17]

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13. All health plans selling on the Exchange must offer the same product in the off-Exchange individual market. 42 U.S.C. § 18021(a)(1)(C)(iii).
14. Citizens include persons born in the United States and those who later naturalize or derive citizenship.
15. 10 CCR § 6472(c); 45 C.F.R. § 155.305(a)(1). California regulations follow the federal definition of "lawfully present." *See* 10 CCR § 6410 (referencing 45 C.F.R. § 152.2).
16. 45 C.F.R. § 152.2. For additional details, see "Lawfully Present under the Affordable Care Act," National Immigration Law Center, September 2012, available at www.nilc.org/lawfullypresent.html.
17. Except when paroled for prosecution, for deferred inspection or pending removal proceedings.

- Conditional Entrant Granted before 1980;
- Battered Spouse, Child and Parent;
- Victim of Trafficking and his/her Spouse, Child, Sibling or Parent;
- Granted Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture;
- Individual with Non-immigrant Status/Lawful Temporary Residents;[18]
- Temporary Protected Status;
- Deferred Enforced Departure;
- Deferred Action Status (Exception: Deferred Action for Childhood Arrivals (DACA) is not an eligible immigration status for applying for health insurance);[19]
- Administrative order staying removal issued by the Department of Homeland Security;
- Member of a federally-recognized Indian tribe or American Indian Born in Canada; or
- Resident of American Samoa.

Applicants for the following statuses are also eligible:

- Temporary Protected Status with Employment Authorization;
- Special Immigrant Juvenile Status;
- Victim of Trafficking Visa;
- Adjustment to LPR Status;
- Asylum;[20] or
- Withholding of Deportation, or Withholding of Removal, under the immigration

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18. Includes temporary worker visas (such as H1, H-2A, H-2B), student visas, U-visa, T-visa, and other visas, and citizens of Micronesia, the Marshall Islands, and Palau.
19. *See* 45 C.F.R. § 152.2(8). Although individuals with Deferred Action for Childhood Arrivals are considered lawfully present under immigration law, the Obama administration specifically excluded this group from the definition of "lawfully present" for purposes of the Affordable Care Act. *See also* Q.1 USCIS' FAQ on DACA available at www.uscis.gov/humanitarian/consideration-deferred-action-childhood-arrivals-process/frequently-asked-questions. This rationale will likely be applied to Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA), should that program ever be implemented. DAPA is currently enjoined from implementation by court order.
20. Must have been either granted employment authorization or are under the age of 14 and have had an application pending for at least 180 days.

laws or under the Convention against Torture (CAT).[21]

Persons with the following immigration status who also have an employment authorization document are also eligible:

- Registry Applicants;
- Order of Supervision;
- Applicant for Cancellation of Removal or Suspension of Deportation;
- Applicant for Legalization under Immigration Reform and Control Act (IRCA); or
- Legalization under the LIFE Act.

The categories of immigrants who are considered lawfully present for purposes of enrollment in a Covered California plan are similar to the eligibility categories for full-scope Medi-Cal, but are narrower in some cases. For example, individuals with Deferred Action for Childhood Arrivals (DACA) status are not considered "lawfully present" for purposes of Covered California and premium tax credit eligibility, but are "lawfully present" for purposes of full-scope Medi-Cal.[22] See Chapter 1 for more information about lawfully present under Medi-Cal.

21. Must have been either granted employment authorization or are under the age of 14 and have had an application pending for at least 180 days.
22. MEDIL 14-45 (Aug. 6, 2014), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDILI14-45.pdf.

Note on Newly Qualified Immigrants: California supplements its Medi-Cal program to avoid the "five year bar," a federal provision that precludes new immigrants from receiving federal benefits.[23] Currently immigrants who are age 21-64, without children, and are subject to the five-year bar may enroll in Medi-Cal if they otherwise meet Medi-Cal eligibility requirements. Starting in 2017, these immigrants will be dually enrolled in Covered California and Medi-Cal. Covered California will be the primary insurance, and Medi-Cal will cover benefits not included in Covered California, such as adult dental.[24] DHCS will pay the premiums and out-of-pocket costs of these individuals. Those who do not enroll in Covered California will have their benefits limited to restricted scope Medi-Cal. All other immigrants who have been in the United States less than five years, such as parents and children, will continue to receive full scope Medi-Cal services.

2. Incarceration

Individuals cannot enroll in a Covered California health plan if they are incarcerated, unless they are incarcerated pending the disposition of charges, *i.e.*, if they are awaiting trial or sentencing.[25] Advocates may wonder why anyone would apply for health insurance while incarcerated, since they could not use the services to access care outside of the prison health system and prisons are required to cover the health care needs of inmates. Nonetheless, this eligibility condition may affect some individuals seeking coverage; for example, individuals can face barriers if an electronic verification of incarceration status says they are in prison when they actually are not. *See* Chapter 5, Section B on verification procedures. Persons who are released from prison are entitled to buy coverage through Covered California during a 60-day special enrollment period that begins from the time they are released.[26]

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23. 8 U.S.C. § 1613.
24. Welf. & Inst. Code § 14102.
25. 42 U.S.C. § 18032(f)(1)(B); 45 C.F.R. § 155.305(a)(2); 10 CCR § 6472(d).
26. 45 C.F.R. § 155.420(c)(1); Health & Safety Code § 1399.849(d)(1)(D); 10 CCR § 6504(a)(8) and (f). *See* Chapter 5, Section C.2.b, subsection b, "Covered California Special Enrollment.".

3. Residency

Only residents of California can purchase insurance through Covered California.[27] To meet the residency requirement, a person age 21 or over must live in California and either have an intent to reside in the state, have a job commitment, or be seeking employment in California.[28] Children under age 21 may use where they reside or the residency of the parent or caretaker with whom they live to determine residency.[29] A homeless individual can have California residency; a fixed address is not required.[30] Persons who move to California are entitled to enroll in Covered California during a 60-day special enrollment period.[31]

Covered California also requires that people live in the service area or region in which they are receiving services – in other words, if someone lives in Alameda County (Region 6), they have to enroll in a Region 6 plan, even though the person works in and would prefer to access health services in San Francisco County (Region 4).[32] There are special rules for individuals under age 21 that allow them to pick either the service area connected to the residency of their parent or caretaker or the region where they actually reside, as in the case of a student living away from home.[33] Similar rules apply for households where not all members live in the same service area – they may in enroll in any of the service areas that one of the tax filers lives in.[34] Finally, for persons who are institutionalized out of state or do not otherwise fit the other scenarios, the Medicaid residency rules apply.[35]

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27. 45 C.F.R. § 155.305(a)(3).
28. 45 C.F.R. § 155.305(a)(3)(i).
29. 45 C.F.R. § 155.305(a)(3)(ii).
30. 45 C.F.R. § 155.305(a)(3)(i)(A); 10 CCR § 6472(e)(1)(A).
31. 45 C.F.R. § 155.420(c), (d)(7); 10 CCR § 6504(a)(8) and (f). See Chapter 5, Section C.2.b.
32. 45 C.F.R. § 155.305(a)(3)(i); 10 CCR § 6472(e)(1).
33. 45 C.F.R. § 155.305(a)(3)(ii); 10 CCR § 6472(e)(2).
34. 45 C.F.R. § 155.305(a)(3)(iv); 10 CCR § 6472(e)(4). An example would be persons under age 26 who can enroll in their parents plan, yet they need not live with their parents to do so. *See* 45 C.F.R. § 147.120.
35. 45 C.F.R. § 155.305(a)(3)(iii); 10 CCR §6472(e)(3). The Medicaid residency regulations are at 42 C.F.R. § 435.403.

4. Age

Individuals of any age can purchase a plan through Covered California, though practically speaking, eligibility for Medicare precludes most people over age 65 from enrolling.[36]

Catastrophic plans (high deductible plans with little or no coverage until the deductible is paid) sold by Covered California have additional requirements – applicants must be under age 30 or have received an exemption due to the affordability of available plans.[37] Advocates helping individuals understand the different available products should point out that there is minimal difference both in pricing and in product between catastrophic plans and Bronze plans, so individuals who are seeking financial exemptions to purchase a cheaper catastrophic plan might be wasting their time. Individuals also cannot get financial assistance to purchase a catastrophic plan.

C. Eligibility for Financial Assistance

The previously discussed rules are only to *purchase* a Covered California plan. In order to be eligible for financial assistance – premium tax credits[38] and cost-sharing reductions[39] – individuals must also lack minimum essential coverage, be income eligible, and agree to certain tax filing requirements.[40]

Individuals who qualify for financial assistance get a tax credit to offset the cost

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36. *See* question A.1 of the Aug. 1, 2014 Medicare and the Marketplace FAQ (available at http://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Overview1.html): "Consistent with the longstanding prohibitions on the sale and issuance of duplicate coverage to Medicare beneficiaries (section 1882(d) of the Social Security Act), it is illegal to knowingly sell or issue an Individual Marketplace Qualified Health Plan (or an individual market policy outside the Marketplace) to a Medicare beneficiary. This prohibition does not apply in the SHOP market, or to employer coverage outside of the SHOP market." The FAQ itself is updated from time to time. *See also* the discussion on Minimum Essential Coverage in section C.1 below.
37. 42 U.S.C. § 18022(e)(2); 45 C.F.R. § 155.305(h); 10 CCR § 6472(f).
38. Premium tax credits are also known as "advanced premium tax credits (APTCs)" when taken in advance or simply "premium assistance" on Covered California materials.
39. Cost sharing reductions are also known by the abbreviation "CSRs" or "help with out-of-pocket costs" on Covered California materials.
40. 26 U.S.C. § 36B(c); 26 C.F.R. § 1.36b-2(a), (b); 10 CCR § 6474.

of their health insurance premiums. The Affordable Care Act allows enrollees to take the tax credit in advance – called advanced premium tax credits – or wait until filing taxes the following year. When they take the tax credit in advance, the federal government pays a part of the full tax credit directly to the health plan each month, reducing the amount of money the enrollee has to pay in premiums each month. Because it is a tax credit taken in advance based on an estimate of the tax household's modified adjusted gross income, the advanced premium tax credits must be reconciled when filing taxes the next year.

Advocacy Tip: Enrollees who are uncertain about their income estimate may be well served by taking a smaller amount of premium tax credits each month in advance so they are not at risk of owing money come tax time. The Covered California website includes a sliding bar that allows enrollees to choose how much of the tax credit to take ahead of time.

1. Lack of Minimum Essential Coverage

Individuals must show that they do not have other minimum essential coverage in order to qualify for financial assistance through Covered California.[41] Minimum essential coverage includes:[42]

- Medicare Part A and Medicare Advantage plans;
- Full-scope Medi-Cal programs, including the Targeted Low-Income Children's Program (former Healthy Families program),[43] Medi-Cal Access Program (MCAP – former AIM program), and Refugee Medical Assistance programs

41. 26 U.S.C. § 36B(c)(2)(B); 26 C.F.R. § 1.36B-2(a)(2); 10 CCR § 6474(c)(1)(B)(2).
42. 26 U.S.C. § 5000A(f); 26 C.F.R. § 1.5000A-2.
43. Starting sometime in 2015, the Department of Health Care Services began referring to TLICP as "Medi-Cal for Families."

administered by Medi-Cal;[44]

- TRICARE;
- Comprehensive health care offered by the Veterans Administration;[45]
- Coverage provided to Peace Corps volunteers;
- Coverage under the Nonappropriated Fund Health Benefit Program from the Department of Defense;
- Self-funded health coverage offered to students by universities for plan or policy years that began on or before Dec. 31, 2014 (for later plan or policy years, sponsors of these programs may apply to HHS to be recognized as minimum essential coverage);[46]
- State high risk pool coverage established on or before November 26, 2014 in any state;[47]
- Most employer-sponsored health plans, including COBRA and retiree coverage;
- Plans purchased on the individual market;
- Grandfathered health plans; and

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44. Medicaid coverage is typically treated as minimum essential coverage. 26 C.F.R. § 1.5000A-2(b)(1)(ii). However, if the Medicaid coverage consists solely of "excepted benefits" than it is not considered minimum essential coverage. 26 C.F.R. § 1.5000A-2(g). Coverage that only provides certain types of benefits, such as dental policies, long-term care coverage, or coverage limited to minor consent services, are "excepted benefits" and therefore are not minimum essential coverage. 42 U.S.C. § 300gg-91(c)(2). In addition, coverage for medically needy individuals is considered minimum essential coverage only if the individual has no share of cost. 26 C.F.R. § 1.5000A-2(b)(2)(v); MEDIL 14-02 (Jan. 9, 2014), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDILI14-02.pdf; CMS, State Medicaid Director Letter #14-002, "Minimum Essential Coverage" (Nov. 7, 2014), http://www.medicaid.gov/federal-policy-guidance/downloads/sho-14-002.pdf (the regulations have been slightly reordered since this guidance was published). Persons in these programs, such as Medi-Cal share of cost, should be permitted to enroll in Covered California. Medi-Cal programs for pregnant women that were previously considered "limited scope" (as opposed to restricted scope programs for undocumented women) are now considered minimum essential coverage as they provide all medically necessary services. Note that the Medi-Cal Access Program (formerly AIM, Access for Infants and Mothers) is not technically a Medicaid program, but is a CHIP program administered by Medi-Cal. Nonetheless it is minimum essential coverage.
45. *See* 26 C.F.R. § 1.5000A-2(b)(1)(v) for specific programs.
46. CMS, "Minimum Essential Coverage," available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/minimum-essential-coverage.html.
47. *Id*.

- Other plans as designated by HHS.[48]

As discussed below, for most forms of government program coverage and employer sponsored coverage, simply being eligible for the program is enough to make an individual *ineligible* for financial assistance through Covered California.[49] For other types of minimum essential coverage, such as plans purchased on the individual market, an individual has the option of deciding whether to keep the other coverage or enroll in a Covered California plan with financial assistance, provided the individual has not already entered into a health insurance contract or is able to end such a contract.

Note that because certain Medi-Cal programs are *not* minimum essential coverage, (namely Medi-Cal Share of Cost[50] programs and programs with limited scope of services such as Minor Consent), individuals enrolled in these programs can simultaneously enroll in a Covered California plan with advanced premium tax credits so long as they meet Covered California's eligibility criteria. Medi-Cal only covers what Covered California does not, such as In-Home Supportive Services, adult dental, or long-term care, so individuals should check provider networks before picking a Covered California plan for most regular health services.

a. Months of Partial Coverage

Individuals have minimum essential coverage for purposes of determining eligibility for premium tax credits only in months that they have the other coverage for the entire month.[51] In other words, if someone is enrolled in a Qualified Health Plan as of the first day of the month but becomes eligible for Medi-Cal or coverage through a

48. 26 U.S.C. § 5000A(f).
49. 26 C.F.R. § 1.36B-2(c)(2)-(3).
50. Persons who meet their Share of Cost for the month have minimum essential coverage and thus cannot continue to receive premium tax credits or be enrolled in a plan with cost-sharing reductions. 26 C.F.R. § 1.5000A-2(b)(2)(v); MEDIL 14-02 (Jan. 9, 2014), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDILI14-02.pdf; CMS, State Health Official Letter #14-002, "Minimum Essential Coverage" (Nov. 7, 2014), http://www.medicaid.gov/federal-policy-guidance/downloads/sho-14-002.pdf. Note that such dually enrolled individuals will be using Covered California before Medi-Cal given Medi-Cal program rules. How such programs should work together for persons needing services such as IHSS has not yet been fully explained in guidance or regulation.
51. 26 U.S.C. § 36B(c)(2)(A); 26 C.F.R. § 1.36B-3(c).

job part way through the month, they are still eligible for premium tax credits for the rest of that month. This prevents people from having to cancel their coverage early or needing to repay advanced premium tax credits for partial months.

b. Eligible but Not Enrolled

For most government programs such as Medi-Cal and Medicare, individuals are required to enroll in the government program if they are eligible. Even if not actually enrolled, they are treated as enrolled and denied Covered California financial assistance.[52] There is an obligation to complete an application for the government program by the end of the third full calendar month that they would be eligible.[53] If they are denied coverage, even if wrongfully, or coverage is delayed, they may be enrolled in a Covered California plan and receive advanced premium tax credits until the month after the eligibility determination is made for the government program.[54]

The federal regulations found at 26 C.F.R. § 1.36B-2(c)(2) have numerous examples as to how this plays out and are worth looking at when questions of the timing for enrollment in public programs come up. The regulations and examples make clear that enrollees in Covered California plans who later become Medi-Cal eligible are able to keep taking advanced premium tax credits until the month after they receive their notice of Medi-Cal eligibility. In this scenario, enrollees don't have to pay back premium assistance for the month during which they applied for Medi-Cal or any period during which they are retroactively determined to have been Medi-Cal eligible.

Reminder: Medi-Cal eligibility only makes individuals ineligible for premium tax credits; they may still enroll in Covered California plans without the credits. While few Medi-Cal-eligible individuals can afford the full price of a Covered California plan, there is no legal reason why they cannot purchase one.

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52. *See* 26 U.S.C. § 5000A(a); 26 C.F.R. § 1.36B-2(c)(2).
53. 26 C.F.R. § 1.36B-2(c)(2)(ii).
54. 26 C.F.R. § 1.36B-2(c)(2)(iv) and (v).

Veterans programs are treated differently. The individual is only considered to have minimum essential coverage if actually enrolled in a comprehensive health program – not if the veteran is just using VA services for a particular service-related injury.[55]

c. Special Rules Regarding Employer Coverage

Advocates should be aware that there are several special rules regarding employer coverage that determine both whether an employee or family member can enroll in Covered California and whether the employee has minimum essential coverage. Just as with most government benefits, if an employee has the opportunity to enroll in a plan that would be minimum essential coverage, the employee cannot enroll in a Covered California plan with financial assistance.

i. Affordability and Value of Other Coverage

Employer-sponsored coverage is considered minimum essential coverage if it is affordable and offers "minimum value."

An employer plan is considered *affordable* if the amount that the employee must pay for self-only coverage is no more than the maximum required contribution percentage of the total tax household's taxable income, which is currently set at 9.66%.[56] In other words, premiums that are less than roughly ten percent of an employee's income are considered affordable. See Section D.2 for more information on calculating required contribution percentages. Employees who do not have an offer of affordable coverage from an employer can instead enroll in a Covered California plan with financial assistance.

Even if the employer plan meets the affordability test, advocates should check to

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55. 26 C.F.R. § 1.36B-2(c)(2)(iii). 26 U.S.C. § 5000A(f)(1)(A)(v) gives the Secretaries of Veterans Affairs and Health & Humans Services the authority to determine which veterans programs meet the minimum essential coverage standard. Currently the Veterans Affairs website identifies the following three programs as meeting minimum essential coverage: the Veteran's health care program, the Civilian Health and Medical program (CHAMPVA), and the spina bifida health care program. http://www.va.gov/health/aca/EnrolledVeterans.asp.
56. 26 U.S.C. § 36B(c)(2)(C)(i); 26 C.F.R. § 1.36B-2(c)(3)(v)(A)(1).

be sure that the plan also offers *minimum value*.[57] In order to be of minimum value, the plan must cover at least 60% of the expected total allowed costs for service (as measured actuarially, rather than on an individual basis).[58] Employees who are offered employer plans that do not meet the minimum value test can instead enroll in a Covered California plan with financial assistance.

If the employer plan meets the affordability test and is of minimal value, the employee can still enroll in a Covered California plan, but not with financial assistance.

ii. Family Glitch

An employer's offer of minimum essential coverage to a spouse or dependents can make those individuals ineligible for financial assistance through Covered California. When an employer offers spouse or dependent coverage, the affordability is determined by the cost of the employee's self-only coverage.[59] In other words, if the premium for the employee's self-only coverage is affordable, but dependent coverage is offered to the employee at a significantly higher rate that the employee cannot afford, the dependent coverage is still considered affordable. In this case, the employee may still purchase insurance for a spouse or dependents on Covered California if that is the better deal, but the family members will not get financial assistance.

iii. The Enrolled Employee Exception

Employees *actually enrolled* in employer plans are considered to have minimum essential coverage for the full months they are enrolled, even if those plans are not affordable or do not have minimum value.[60] Employees must drop their employer's health plan to change to a Covered California plan and can do so only during open

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57. 26 U.S.C. § 36B(c)(2)(C)(ii); 26 C.F.R. § 1.36B-2(c)(3)(vi); 10 CCR § 6410.
58. *Id.* Advocates will need to check a plan's Evidence of Coverage or other documents to know the actuarial value.
59. 26 U.S.C. § 36B(c)(2)(C)(i); 26 C.F.R. § 1.36B-2(c)(3)(v)(A)(1)-(2); 26 C.F.R. §1.36B-2T(c)(3)(v)(C) as updated by IRS Rev. Proc. 2014-62.
60. 26 C.F.R. § 1.36B-2(c)(3)(vii).

enrollment or when the contract ends via special enrollment.[61]

iv. COBRA

While COBRA coverage is not evaluated on affordability and minimum value like employer coverage, enrolling in COBRA does preclude enrollment in Covered California with financial assistance. Nonetheless, given the gap in coverage that can occur while waiting for coverage in a Covered California plan, an individual can enroll in both a Covered California plan with financial assistance and COBRA, provided the individual cancels COBRA once they start receiving financial assistance through Covered California.[62] This can help avoid a 1-2 month gap in coverage. For more information on Covered California enrollment when losing coverage, see Chapter 5, Section C.2.b on Special Enrollment.

2. Income Threshold for Financial Assistance

Individuals with household income between 100% FPL and up to and including 400% FPL are income eligible for financial assistance through Covered California.[63] Most adults with household incomes up to 138% FPL in California are eligible for Medi-Cal (for children, the income standard is set at 266% FPL), and as described above, eligibility for Medi-Cal precludes eligibility for Covered California. In the vast majority of cases, an individual must have household income above 138% FPL to qualify for premium tax credits – and most children must be in families with incomes above 266% FPL in order to obtain premium tax credits.[64]

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61. *See* 26 C.F.R. § 1.36B-2(c)(3)(vii), including the examples in (C), and 26 C.F.R. § 1.36B-2(c)(3)(iii)(C), Example (ii).
62. The notes to the final federal rules and guidance from the Department of Labor make it clear that individuals can elect both COBRA coverage and Exchange-based coverage, provided they cancel their COBRA coverage as soon as the Exchange-based coverage goes into effect. *See* 79 FR 30297 (May 27, 2014) or Q4 of the Dept of Labor Guidance at http://www.dol.gov/ebsa/faqs/faq-consumer-cobra.html.
63. 26 U.S.C. § 36B(c)(1)(A); 26 C.F.R. § 1.36B–2(b); 10 CCR § 6474(c)(1)(A).
64. Certain lawfully present immigrants who are not eligible for full-scope Medi-Cal due to their immigrant status and are below 100% FPL will be treated as at 100% FPL and eligible for Covered California. 26 U.S.C. § 36B(c)(1)(B)(ii); 26 C.F.R. § 1.36B-2(b)(5); 45 C.F.R. § 155.305(f)(2); 10 CCR § 6474(c)(2).

a. Exceptions to the Lower Limit of Eligibility: Individuals Below 100% FPL

Persons below 100% FPL can be eligible for Covered California tax credits in two scenarios:

- Lawfully present immigrants who are ineligible for Medi-Cal may obtain tax credits.[65]
- A person may receive a tax credit if (1) the person enrolls in a plan through Covered California; (2) Covered California estimates that the person's household income will be between 100-400% FPL; (3) the person receives premium tax credits; and (4) the person is otherwise eligible for Covered California.[66]

Enrollees in the second scenario do not have to pay back their tax credits because their income was lower than expected, though they should report changes in income within 30 days of the change, which in many cases will move them to the Medi-Cal program.[67] Even in these situations, Medi-Cal still would have been the better deal because the premium tax credit does not fully pay for the individual's Covered California premium. Unlike Medi-Cal, which is free, an individual in Covered California still has a required contribution toward the premium payment and cost sharing when services are received.

b. Income Counting: Modified Adjusted Gross Income (MAGI) Methodology

The first step in determining if the amount of income qualifies an individual for financial assistance is to determine when to start counting the income. For persons applying for financial help through Covered California, the income that matters is the income for the entire calendar year. In other words, if someone applies in 2015 for coverage starting January 2016, it is the full 2016-year income that will be reported

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65. 26 U.S.C. § 36B(c)(1)(B)(ii); 26 C.F.R. § 1.36B-2(b)(5); 45 C.F.R. § 155.305(f)(2); 10 CCR § 6474(c)(2).
66. 26 C.F.R. § 1.36B-2(b)(6)-(7).
67. 45 C.F.R. § 155.330(b); 10 CCR § 6496(b).

on the 2016 personal income federal tax return in early 2017 that counts toward Covered California eligibility. [68]

This requires families to project at the time they apply what they think their income will be for the entire calendar year. Families with fluctuating income must project what their income will be for the calendar year, but if a change is not expected, then income can be calculated by multiplying the current monthly income by 12.

In the simplest of cases, determination of household income under the MAGI rules starts with the household federal income tax form, the 1040EZ,[69] the 1040A, or the 1040, and looking to the line labeled "Adjusted Gross Income" (the "AGI" in MAGI - lines 4, 21, and 37 respectively on the 2015 forms).[70] The Adjusted Gross Income of all household members *required* to file a tax return must be included.[71]

The MAGI rules also add a few additional sources of income that must be included that are normally excluded from taxes: excluded foreign income, tax-exempt interest, and non-taxable Social Security income.[72] The excluded foreign income refers specifically to income excluded for American citizens and residents living abroad that is filed on IRS form 2555[73] – someone applying for benefits would only have this type of income during the year that person moves to or from the United States.

If a family has not filed taxes, advocates should still look at the IRS Form 1040 and write in what is known about the family's income to determine the Adjusted Gross Income. And for families that have filed, advocates should ask to look at their IRS Form 1040 from the previous year and ask whether the income is the same. As mentioned above, Covered California program rules look to the projected income for the calendar year.

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68. 45 C.F.R. § 155.305(f).
69. While the 1040EZ may be used to estimate income for the next year, once enrolled in Covered California, households can no longer use the 1040EZ form as premium tax credits require the filing of supplemental tax forms as discussed below.
70. 42 U.S.C. § 1396(e)(14)(G); 26 U.S.C. § 36B.
71. 26 U.S.C. § 36B(d)(2)(A); 26 C.F.R. § 1.36B-1(e)(1). Thus for children, their income is only included if they earn enough to have to file.
72. 26 U.S.C. § 36B(d)(2)(B); 26 C.F.R. § 1.36B-1(e)(2).
73. 26 U.S.C. § 36B(d)(2)(B)(i) and 26 C.F.R. § 1.36B-1(e)(2)(i) reference 26 U.S.C. § 911. This income exclusion is obtained by filing IRS Form 2555 or 2555EZ as part of a tax return.

i. Household Size and Members

For Covered California, the household or family size can affect whether an individual is eligible for premium tax credits and cost-sharing reductions, and if so, the amount of those tax credits and reductions. Determining the household size affects both how much income is included and the family's income relative to the federal poverty level (FPL). A taxpayer's household size equals the number of individuals for whom the taxpayer may claim a deduction under federal tax law.[74] The taxpayer may claim deductions for him or herself, a spouse, and dependents who are not claimed as dependents by other taxpayers. Dependents can include the taxpayer's qualifying children and qualifying relatives.[75]

ii. Children

A qualifying child dependent for tax filing is a child residing in the United States, Canada, or Mexico under 19 (or under 24 if a full-time student) at the end of the calendar year who is the taxpayer's child (whether natural, adopted, step, or foster); brother; sister; stepbrother; stepsister; half-brother; half-sister; or one of their descendants, and

- lives with the taxpayer for more than one-half of the taxable year;
- has not provided over one-half of their own support for the taxable year; and
- has not filed a joint tax return with a spouse in that taxable year.[76]

The age requirement is waived for adult children who are permanently disabled.[77] The requirement to live with the taxpayer is waived for full-time students, so long as they are not part of another tax household.[78] When two parents can claim the child but do not file a joint tax return, the child is considered the qualifying child of the

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74. 26 U.S.C. § 36B(d)(1).
75. 26 U.S.C. § 152(a). *See also* 26 U.S.C. § 36B(d)(1); 26 C.F.R. §§ 1.36B-1(d), (f), and 1.36B-2(b)(3).
76. 26 U.S.C. § 152(b), (c); 26 C.F.R. §§ 1.152-1, 1.152-2(a). Whether a child is a tax dependent is not the same rule as whether a child can enroll on their parents' health insurance policy. A child need not be a tax dependent (or even live with a parent) to enroll in their parents' health plan if under age 26. 42 U.S.C. § 300gg-14; 45 C.F.R. § 147.120.
77. 26 U.S.C. § 152(c)(3)(B).
78. 26 C.F.R. §§ 1.152-1(c), 1.152-3(b).

parent with whom the child lives with more during the tax year. If the child lives with both parents equally, the child is considered the qualifying child of the parent with the highest adjusted gross income.[79] The parent claiming the child is known as the custodial parent. The custodial parent can choose to not claim the qualifying child as a dependent by signing IRS Form 8332. The non-custodial parent must attach this form to the return for that taxable year and may include the child in the household when claiming for premium tax credits.[80]

iii. Special Consideration for Pregnancy and Newborns

For purposes of Covered California, a baby is not considered to be part of the household until birth, but then the baby counts as part of the household for the entire year. In other words, a single woman with no other children who gives birth in December cannot report her child as part of her household until the child is actually born. From the time she gets pregnant until the baby's birth, her eligibility for premium tax credits will be based on a family of one. But, once her child is born, the child becomes part of her household for tax purposes, including premium tax credits, for the entire year, making her a family of two for the full year. This means that the baby's birth will increase the amount of premium tax credits she is eligible for. Although she would not have been able to apply as a two-person family until after the birth of her child, when she files taxes and reconciles her premium tax credits, she may be eligible for more tax credits than she got in advance, based on her new household of two. She will likely be due tax credits unless her income was significantly more than estimated when she applied.

iv. Qualifying Relative Dependents

A taxpayer's qualifying relative dependent is an individual residing in the United States, Canada, or Mexico, for whom the taxpayer has provided over half of the relative's support, who has not filed jointly with a spouse, and who does not meet the definition of a qualifying child. The relative dependent must also have earned less than the exemption amount – the threshold amount for determining whether

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79. 26 U.S.C. § 152(c)(4)(B); 26 C.F.R. § 1.152-4(a).
80. 26 U.S.C. § 152(e); 26 C.F.R. § 1.152-4(b).

someone must file a federal tax return at all.[81] The qualifying relative must be related to the taxpayer as a:

- child or a descendant of a child;
- brother, sister, stepbrother, or stepsister;
- father or mother, or an ancestor of either;
- stepfather or stepmother;
- son or daughter of a brother or sister of the taxpayer;
- brother or sister of the father or mother of the taxpayer;
- son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law; or
- anyone, other than the taxpayer's spouse, who lives with the taxpayer during the entire taxable year and is a member of the taxpayer's household.[82]

Note that domestic partners are not dependents for purposes of premium tax credits unless one partner is claiming the other as a qualifying relative dependent under this definition.[83]

v. Spouses

A spouse is part of the taxpayer's household. If a taxpayer has a spouse, they must file a joint tax return for persons in the household to qualify for premium tax credits unless an exception applies.[84] Similar to other IRS household rules (for example, the birth of a child), whether someone is married or not depends on their status at the end of the entire calendar year, unless their spouse died during the year.[85]

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81. *See* IRS Pubs. 17 or 501 for the current exemption amounts for dependents. These publications are updated every year with a table "Filing Requirements for Dependents." Exemption amounts depend on marital status, age (under or over 65) and whether or not the dependent is blind. There are also additional exemptions for a dependent's SSI (never taxed), or if the dependent's only income is social security or railroad retirement income. If the dependent has Social Security income and other income, the rules are found in IRS Pub. 915.
82. 26 U.S.C. § 152(b), (d); 26 C.F.R. §§ 1.152-1, 1.152-2(a).
83. 10 CCR § 6410.
84. 26 U.S.C. § 36B(c)(1)(C); 26 C.F.R. §§ 1.36B-4T(b)(3), 1.36B-2T(a)(2); 10 CCR § 6476(d)(2)(B).
85. 26 U.S.C. § 7703(a)(1). In other words, widows or widowers are considered married for the year their spouse died. Everyone else is considered married only if they were married by December 31 of that year.

Individuals who are separated from their spouses are still considered married unless they legally separate under a decree of divorce or separate maintenance.[86] For example, a couple who is separated for all of 2015, but whose divorce is not finalized until January of 2016, must still jointly file their tax return for 2015 in order to claim premium tax credits for 2015, unless they have a decree of separate maintenance. For exceptions to this rule see Section C.4 below.

vi. Family Members who are Not Lawfully Present

A household includes individuals who are not lawfully present in the United States,[87] but members of the family who are not lawfully present are excluded from the family in calculating household size. Their income, however, is included in counting income.[88]

3. Assets

Because Covered California uses the MAGI methodology, just like MAGI Medi-Cal, there is no assets test. Covered California does not ask for information about money in savings or retirement accounts or property owned to determine eligibility for financial assistance.

4. Tax Filing Status

a. Must File Taxes for the Year that Premium Tax Credits are Received

Individuals who have never filed taxes can sign up for a Covered California plan with advanced premium tax credits, but they must file a federal income tax return

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86. 26 U.S.C. § 7703(a)(2).
87. 26 U.S.C. § 36B(e)(1)(B)(i)(I); 26 C.F.R. §§ 1.36B-1(d), 1.36B-3(l)(1). In other words, if someone has an exemption from the individual mandate, they can still be part of the household unless the exemption is based on unlawful presence.
88. 26 U.S.C. § 36B(e)(1)(B)(i)(II); 26 C.F.R. 1.36B-3(l)(2). Note that qualifying dependents living in Canada or Mexico are not unlawfully present in the United States. They should not be excluded.

for each calendar year that they received advanced premium tax credits.[89] Initially, some individuals were wrongly turned away from enrolling in Covered California plans because they had not previously filed, but the income tax requirement only exists to ensure that enrollees who take advanced premium tax credits receive the correct amount of those tax credits. This tax-filing requirement applies even to those enrollees who do not have taxable income for the year.

In subsequent years, individuals must attest to having met their tax-filing obligation in order to continue receiving advanced premium tax credits.[90] The IRS forwards information to Covered California on who filed taxes, though this information does not contain persons who may have filed taxes with an Individual Taxpayer Identification Number (ITIN) rather than a Social Security number. Covered California is currently allowing individuals to attest that they have filed their taxes to avoid losing access to advanced premium tax credits. Because the tax-filing requirement is only a condition of eligibility for premium tax credits, individuals that do not meet the tax-filing requirement may continue enrollment in a qualified health plan without premium tax credits. They may be subject to IRS fines or penalties, however.

b. Married Couples Must File a Joint Income Tax Return

If at least one of the married partners signs up for a Covered California plan with advanced premium tax credits, the couple must file a joint income tax return.[91] There are three exceptions to this rule: spouses who can claim head of household, spouses who are victims of domestic violence, and spouses who have been abandoned.[92] Currently, these are the only exceptions – others who took premium tax credits and do not file jointly must repay all of their advanced premium credits at tax time.

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89. 26 C.F.R. § 1.6011-8; 10 CCR § 6476(d)(2)(A).
90. 10 CCR § 6470(d)(5).
91. 26 U.S.C. § 36B(c)(1)(C); 26 C.F.R. § 1.36B-2(b)(2) (referencing temporary regulation at 26 C.F.R. § 1.36B-2T); 45 C.F.R. § 155.310(d)(2)(ii)(B); 10 CCR § 6476(d)(2)(B).
92. Current regulations regarding domestic violence and spousal abandonment are found at 26 C.F.R. § 1.36B-2T(b)(2) and require that the spouse claiming abuse or abandonment certify meeting the criteria, *e.g.*, the spouse cannot file due to abuse or being unable to locate the other spouse. 26 U.S.C. § 7703 and 26 C.F.R. § 1.7703-1(b) consider an individual not living with their spouse, but raising their child (living with person claiming more than 50% of the year and providing more than 50% of the cost of care) to be not married for purposes of the tax code. This person can file without the spouse, under the status "head of household."

i. Head of Household Exception

The first exception is for married individuals who are eligible to file as a head of household. Such individuals:

- Maintain the principal place of residence for more than one half of the year for a dependent child or relative;
- Contribute over half of the cost of maintaining the household; and
- During the last six months of the taxable year, the individual's spouse was not a member of the individual's household.

Individuals meeting the above criteria can file taxes separately from their spouse as "Head of Household."[93] Typically only one spouse can be considered "head of household," unless the absent spouse also has a different qualifying dependent. Without another qualifying dependent, the absent spouse will be ineligible for premium tax credits altogether because the absent spouse is not filing jointly and cannot claim head of household status.

ii. Domestic Violence and Spousal Abandonment Exception

Starting January 1, 2014 through July 24, 2017, a married taxpayer can still get premium tax credits if they are unable to file a joint return due to domestic abuse or spousal abandonment. The spouses must be living apart at the time the return is filed.[94] Domestic abuse includes physical, psychological, sexual, or emotional abuse, including efforts to control, isolate, humiliate, and intimidate, or to undermine the victim's ability to reason independently. Depending on the facts and circumstances, abuse of the victim's child or another family member living in the household may constitute abuse of the victim.[95] A taxpayer is a victim of spousal abandonment if the taxpayer is unable to locate their spouse after reasonable diligence.[96] Either of these

93. 26 U.S.C. §§ 2(b)(1), (c), 7703; 26 C.F.R. §§ 1.2-2(b)-(e), 1.7703-1(b).
94. 26 C.F.R. § 1.36B-2T(b)(2)(ii). Note that these are temporary regulations.
95. 26 C.F.R. § 1.36B-2T(b)(2)(iii).
96. 26 C.F.R. § 1.36B-2T(b)(2)(iv).

exceptions may only be claimed for three consecutive years.[97]

c. Individuals who are Dependents Cannot Take Premium Tax Credits

While individuals who are dependents can be part of a tax household and the primary filer in the household can get premium tax credits on their behalf, the dependent individuals themselves cannot independently take premium tax credits.[98] This is most likely to be an issue for young adults – if the young adult is not a legal dependent, the young person can take premium tax credits by filing their own taxes. If the young adult is a legal dependent, it is the parents (or other primary tax filer claiming the person) who take the tax credit. As discussed above, the young adult does not have to be a dependent to be included in the parents' policy – in that case, the credits are calculated separately.

5. Enrollment in a Covered California Plan

Individuals must enroll in a Qualified Health Plan through Covered California to be eligible for premium tax credits.[99] But advocates should note that the inverse of this is also true: individuals who enroll in a plan through Covered California without premium tax credits and realize later that they were eligible can claim those premium tax credits when they file at tax time. This is important to remember when an individual is not currently eligible for a Covered California plan, but might be in the future. For example, if the plan offered by a individual's employer is barely affordable, the individual might decide to enroll in a Covered California unsubsidized plan instead. At the end of the year if the individual's income turns out to be less than estimated – so much so that the employer's plan is no longer affordable – the individual can then take the tax credits when filing their federal income tax return.

Similarly, individuals who are not sure whether their final adjusted gross income for the year will be less than 400% FPL can enroll in a Covered California plan without

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97. 26 C.F.R. § 1.36B-2T(b)(2)(v).
98. 26 U.S.C. § 36B(c)(1)(D); 26 C.F.R. § 1.36B-2(b)(3). *See also* discussion in Section D.1 on calculating the second lowest cost silver premiums for households that share a plan.
99. 42 U.S.C. § 18071(b)(1); 45 C.F.R. § 155.305(f)(3); 10 CCR § 6470(b).

taking any tax credits. They can then take the premium tax credits, if they qualify, at tax time. These strategies may not be realistic for many individuals because the individual would be required to pay the entire cost of the unsubsidized premium during the year.

D. Calculating Premium Tax Credits

Premium tax credits (which become *advanced* premium tax credits when taken before filing taxes) are calculated based on the premium cost of the *second lowest cost silver plan* available to that person and the *required contribution percentage* the person can be charged based on the individual's household income.[100] If the premium assistance amount is higher than the amount the individual actually must pay in premiums, the individual is entitled only to the amount actually paid.[101]

1. Second Lowest Cost Silver Plan – The Benchmark Premium

The second lowest cost silver plan premium, or the *benchmark premium*, is the cost of the second lowest cost silver premium that is actually available to the individual or family applying when age and region are factored in.[102] If the whole family enrolls, but enrolls in separate plans, the applicable benchmark premium is the second lowest cost silver plan that would cover the whole family, even if that is not the plan they actually choose.[103]

If more than one household enrolls under a single policy, the second lowest cost silver plan premium must be determined separately for each household. For example, if a couple includes on their health plan their 25-year old child who is no longer a dependent, two separate households would be considered to have enrolled under the policy: one household consisting of the parents, and the other household consisting of the child. The couple would determine the second lowest cost silver plan premium based on a policy available to the two of them (as a household of two in their region) and the 25-year old adult child would determine his second

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100. 26 U.S.C. § 36B(b)(2); 26 C.F.R. §1.36B-3(d); 10 CCR § 6474(c)(4).
101. 26 U.S.C. § 36B(b)(2); 26 C.F.R. §1.36B-3(d); 10 CCR § 6474(c)(4).
102. 26 U.S.C. § 36B(b)(3)(B); 26 C.F.R. § 1.36B-3(f).
103. 26 C.F.R. § 1.36B-3(f)(7), Example 6.

lowest cost premium based on a policy available to him (as a household of one in his region). If both households are eligible for premium tax credits, they could use the advanced premium tax credit amount available to each for a single policy.[104]

At the time of enrollment, both the lowest cost and second lowest cost plan must be open for enrollment to the individual in order to count as the second lowest cost silver premium; but if the plan stops accepting new enrollees or ceases altogether, that plan cannot be used to calculate the premium tax credits for incoming applicants.[105]

2. Required Contribution Percentage

The required contribution percentage (or the *expected contribution* or *applicable percentage*) is based on a person's household income as a percentage of the federal poverty level (FPL). The FPL table that applies is the one in effect during open enrollment for the plan year, which is the previous year's FPL table. For example, for 2016 plans the FPL table in effect was the 2015 FPL table. Once the household income is known, a sliding scale is applied to determine the specific applicable percentage for the individual. The chart below provides the range of applicable percentages as they correspond to the federal poverty level. Persons earning under 400% of the federal poverty level are expected to pay an amount of their income indexed annually by the IRS on their health care premiums.[106]

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104. 26 C.F.R. § 1.36B-3(h)(2). While the law allows this it may take special assistance to actually enroll with the correct amount.
105. 26 C.F.R. § 1.36B-3(f)(6); *see also* 26 C.F.R. § 1.36(f)(7), Examples 13, 14, and 15.
106. 26 U.S.C. § 36B(b)(3)(A); 26 C.F.R. § 1.36B-3(g). 2015 numbers are found in IRS Rev. Proc. 2014-37, 2016 in IRS Rev. Proc. 2014-62. For a breakdown of all the percentages within the tier, either divide the range by the number of percentage points, *i.e.,* for the tier 150-200% FPL in 2014, divide 2.3 (6.3-4) by 50 (200-150) and add that number (.046) to each percentage point (150 = 4%, 151 = 4.046%, 152 = 4.092%, etc.) Alternatively, use an online premium tax calculator or check the tax table for the applicable figure found in the instructions to IRS Form 8962. The IRS rounds to the nearest hundredth of a percent as provided in 26 C.F.R. § 1.36B-3(g)(3), Example 1.

Income	Required Contribution Percentage	2015%	2016 %
Up to 133% FPL	2% of income	2.01%	2.03%
133 up to 150% FPL	3–4% of income	3.02-4.02%	3.05-4.07%
150 up to 200% FPL	4–6.3% of income	4.02%-6.34%	4.07-6.41%
200 up to 250% FPL	6.3-8.05% of income	6.34-8.10%	6.41-8.18%
250 up to 300% FPL	8.05-9.5% of income	8.10%-9.56%	8.18%-9.66%
300 up to 400% FPL	9.5% of income	9.56%	9.66%

Applying the two rules together is how the premium tax credit is established. If the benchmark premium costs more than the required contribution of the individual's monthly household income, then a premium tax credit is available.[107]

For example, an individual earning $23,340 in 2015 (200% of the applicable 2014 federal poverty level) would have a required contribution percentage of 6.34% (using the applicable 2015 table): $1479.76 a year or $123.31 a month. If the second lowest cost monthly premium available to that person in their area were $250 a month, they would have a monthly premium tax credit of $126.69 that they could use to help pay for the premium of any Covered California plan available sold in their region.[108]

Remember: For purposes of determining household size, immigrants who are not lawfully present are excluded from the family size when figuring out the premium tax credits, but any income earned by them is included.[109]

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107. 26 U.S.C. § 36B(b)(2).
108. Although the second lowest cost silver premium is used to calculate the premium tax credit, there is no requirement that someone purchase a silver plan to use it.
109. 26 U.S.C. § 36B(e); 26 C.F.R. § 1.36B-3(l); 10 CCR § 6482(a).

E. Premium Tax Credit Reconciliation

Because advanced premium tax credits are based on an estimation of a household's adjusted gross income that is only finalized the following year during tax time, reconciliation is needed to re-account for any amounts over or underpaid. In general, if a family earned less than anticipated, they would be due additional tax credits for the difference. If they earned more, they likely would have to pay additional taxes.[110] However, there are limits on the amount that must be repaid if the advanced credits they received exceeded the credits to which they were entitled. For tax year 2014, the limit on repayment was based on the following chart, which will be adjusted according to a cost-of-living adjustment and published by the IRS every year: [111]

2014 Maximum Tax Repayment Amounts

% of FPL	Single	Married, Filing Jointly
<200%	$300	$600
200<300%	$750	$1,500
300<400%	$1,250	$2,500
>400%	Full Reconciliation	

In other words, a married couple earning less than 200% of the federal poverty level would be required to repay up to $600 of advanced premium tax credits that were taken in excess. A single mother of two earning over 400% of the federal poverty level would be required to repay *all* advanced premium tax credits received that were in excess of the amount the mother was entitled to.

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110. 26 U.S.C. § 36B(f); 26 C.F.R. § 1.36B-4(a); 10 CCR § 6410.
111. 26 U.S.C. § 36B(f)(2)(B); 26 C.F.R. § 1.36B-4(a)(3)(ii). The amounts were not indexed for 2015 and remain the same.

Practically speaking, enrollees reconcile after Covered California sends in IRS Form 1095-A in January after the plan year ends. Form 1095-A shows how much the second lowest cost silver plan was, the amount of advanced premium tax credits taken, the months enrolled in the plan, and the cost of the premium. Enrollees use the information on form 1095-A to fill out IRS Form 8962 that compares the household's modified adjusted gross income to the advanced premium tax credits taken to find the amount owed or to be returned. IRS Form 8962 is filed with the household 1040 or 1040A income tax return. Enrollees who take advanced premium tax credits or who want premium tax credits cannot use IRS Form 1040EZ because there is no way to attach IRS Form 8962 to the 1040EZ form.

The instructions on IRS Form 8962 walk through the reconciliation process, including some of the special rules for couples that marry or divorce during the plan year. Those instructions also address special scenarios, such as where a dependent is claimed by a different household than anticipated or reflected on the 1095-A form, or households that share a 1095-A form with people who are not part of the tax household.[112] IRS Form 8962 has both annual and monthly reconciliation methods – households who maintained the same coverage for all 12 months use the monthly method, and households with any change in coverage or coverage for less than a full year reconcile each month to appropriately pro rate the premium tax credit.

Enrollees with complicated reconciliation issues should be advised to seek a tax professional such as at a VITA clinic. Health advocates should have a general understanding of how reconciliation works and may want to look at IRS Form 8962 to better understand it, but in general may want to avoid giving specific tax advice.[113]

On the other hand, health advocates can advise individuals who are not certain about their income estimation that they do not have to take the full amount of advanced premium tax credits for which they are found eligible. By taking less during the year, if their income does turn out to be higher than estimated, they will have less to repay. Similarly, households earning close to 400% FPL should be warned that if their income is above 400% FPL at tax time, they will have to repay all premium tax credits received – no matter how large.

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112. See the full reconciliation regulations at 26 C.F.R. §1.36B-4 and §1.36B-4T.
113. The form is available from the IRS website: http://www.irs.gov/pub/irs-pdf/f8962.pdf.

F. Cost-sharing Reductions

In addition to premium tax credits, another form of financial assistance is available to lower income enrollees in the form of *cost-sharing reductions*, such as lower deductibles, co-pays, and co-insurance. Eligibility for cost-sharing reductions is determined in the same way as for premium tax credits, but individuals face two additional requirements in order to qualify for a cost-sharing reduction. First, Covered California must determine that the individual is in a household that is expected to earn less than 250% of the federal poverty level during the year.[114] Second, unlike premium tax credits, individuals *must* enroll in a Silver plan to get cost-sharing reductions, unless they are an American Indian or Alaskan Native.[115]

The cost-sharing reductions raise the actuarial value of the Silver plans available to the individual. For example, when an eligible individual purchases a Silver 94 plan (a silver plan which, on average, covers 94% of costs), the individual gets a plan with benefits that are more generous than a platinum plan, but pays for a plan that costs the same as a silver plan.

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114. 45 C.F.R. § 155.305(g)(1)(i)(C); 10 CCR § 6474(d)(1)(C).
115. 45 C.F.R. § 155.305(g)(1)(ii); 10 CCR § 6474(d)(2). See note 118 below for information on the American Indian/Alaskan native exception that allows for cost-sharing regardless of the plan chosen.

The following chart shows the eligibility range for the cost-sharing reduction plans, *i.e., enhanced Silver plans*):[116]

Income	**Actuarial Value (AV) with Cost-sharing Reduction**
100–150% FPL [117]	Plan covers 94% AV
150–200% FPL	Plan covers 87% AV
200–250% FPL	Plan covers 73% AV
American Indians/Alaskan Natives up to 300% FPL or receiving services from an Indian Health provider. [118]	Plan covers 100% AV

Advocacy Tip: In some regions, individuals who are eligible for cost-sharing reductions will not get premium tax credits because the premiums in their area are lower than their expected contribution to those premiums. This does not mean they are not eligible for cost-sharing reductions because they still meet the criteria for premium tax credits.[119]

Policies that cover individuals with different household incomes, for example a parent and adult child who is not a dependent, will only be eligible for cost-sharing

116. 42 U.S.C. § 18071(c)(1)(B).
117. Lawful immigrants earning less than 100% FPL who are eligible for Covered California solely because they are ineligible for Medi-Cal are also eligible for Silver 94 plans. 26 U.S.C. § 36B(c)(1)(B); 45 C.F.R. § 155.305(f)(2); 10 CCR § 6474(c)(2).
118 42 U.S.C. § 18071(d); 45 C.F.R. § 155.350(b); 10 CCR § 6494. American Indians and Alaskan Natives must be members of federally-recognized tribes to enroll in 100% cost sharing plans, but others may be eligible for care through Indian Service providers. See http://www.ihs.gov/aca/faq/#q5 for further explanation of the special rules for American Indians and Alaskan Natives.
119. 45 C.F.R. § 155.305(g)(1)(B), and 10 CCR § 6474(d)(1)(A) only require that applicants meet the premium tax credit eligibility criteria and make no reference to the computation of available credits.

reductions at the level of the household with the higher income.[120] In other words, one family member cannot bootstrap another into a more beneficial policy.

Unlike premium tax credits, there is no reconciliation process for cost-sharing reductions. Therefore, if an enrollee who benefitted from cost-sharing reductions sees an increase in income that makes the enrollee ineligible for cost-sharing reductions, the enrollee will not have to pay back the value of the reductions when they file their taxes.

120. 45 C.F.R. § 155.305(g)(3); 10 CCR § 6474(d)(4). "Household income" is defined at 26 U.S.C § 36B(d)(2) and 26 C.F.R. § 1.36B-1(e).