Department of Health & Human Services

Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: December 16, 2016

Subject: Second Lowest Cost Silver Plan Technical FAQs

The Second Lowest Cost Silver Plan (SLCSP) is used along with income and family size to calculate a household's premium tax credit, which is available to eligible individuals and families who enroll in Marketplace coverage. At the time of enrollment, the Marketplace determines the SLCSP and calculates a premium tax credit that enrollees can use in advance to lower monthly premiums. This SLCSP amount is included on the 1095-A form all Marketplace enrollees receive at the end of the year. If enrollees did not request financial assistance at the time of enrollment or did not report a life change to the Marketplace during the year, they will need to use the Marketplace tax tool to find the correct SLCSP (https://www.healthcare.gov/tax-form-1095/).

While consumers do not need to determine the SLCSP independent from the Marketplace, questions about the calculation of the SLCSP are common. This document covers some of the frequent questions and, in the process, explains why the SLCSP returned by the Marketplace may not match what estimator tools return in certain scenarios.

Note that these FAQs do not incorporate any of the proposed changes described in the Premium Tax Credit proposed rule released on July 8, 2016. The answers below apply to plan year 2017, before any of the proposed changes to the SLCSP determination would take effect. Also, additional guidance about the premium tax credit can be found at https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit.

1. How do a QHPs' rules about which family members may be covered together under a policy affect the SLCSP determination?

Per 26 CFR 1.36B-3(f)(3), the SLCSP may be a plan that supports the entire family on a single policy, or it may be a plan that requires the family to purchase multiple policies.

For all states using the Federal platform for eligibility and enrollment (meaning Federally-facilitated Marketplaces, State Partnership Marketplaces, and State-based Marketplaces using the Federal Platform), the sum of rates from multiple policies generally equals the rate of a single policy, except for families with more than three covered children under age 21.

Federal regulations at 45 CFR 147.102(c)(1) require that the rates for no more than three children under age 21 be taken into account in determining a total family premium in a single policy.

Different plans have different business rules regarding the types of dependent relationships that can be placed on a single policy. For those plans that have relationship business rules that restrict the number of additional children under age 21 who can be placed on a single policy, the total family premium calculated will include the rates for covering all children on multiple policies. Note that almost all family plans allow children to enroll with their parents on a policy, although many do not allow siblings to enroll together without a parent.

For example, consider a family which consists of four siblings age 0 to 20 seeking Marketplace coverage, and assume the following three silver plans are available in their zip code and county:

- Plan A: does not allow sibling dependents, age 0 to 20 rate = $25, total family premium = $100
- Plan B: allows sibling dependents, age 0 to 20 rate = $30, total family premium = $90
- Plan C: allows sibling dependents, age 0 to 20 rate = $40, total family premium = $120

All four siblings would each need to be placed on their own policy if they enrolled in plan A, but all four would be able to enroll in a single policy for plans B and C that reflects the cost of covering only three siblings (when age 0 to 20 siblings are placed on a single policy, no more than three of the siblings are rated). In the example above, the SLCSP is plan A, with a $100 premium.

2. For states using the Federal platform for eligibility and enrollment, who is the subscriber for purposes of finding the SLCSP?

The subscriber for purposes of finding the SLCSP is the household contact (i.e., the person who fills out the application) if he or she is eligible for an advance payment of premium tax credit (APTC) and seeking coverage. Otherwise, the subscriber is the oldest APTC eligible applicant if at least one APTC eligible family member is over age 20, or the youngest APTC eligible applicant if all APTC eligible applicants are age 0 to 20.

The subscriber for purposes of determining the SLCSP may differ from the subscriber identified when a family selects a plan for enrollment. In determining the subscriber during enrollment, HealthCare.gov uses this same hierarchy but does not consider APTC eligibility. For example, consider a household with a taxpayer who is APTC ineligible because she can get affordable employer-sponsored coverage that provides minimum value, and dependents who are APTC eligible because they do not have access to the employer-sponsored plan. If the taxpayer applies for QHP coverage for herself and her dependents, she will be the subscriber when selecting plans for enrollment, but one of the dependents will be the subscriber when determining the SLCSP.

When determining whether all relevant family members can enroll on a single policy, the Marketplace looks at each plan's applicable business rules, which define which relationships are allowed on a single policy. All relationships are relative to the subscriber. Therefore, if a parent and four children are enrolling together and the parent is the household contact, the relevant relationship is "child", and Marketplace plans allow a child of the subscriber to be placed on the same policy. However, if the parent is not seeking coverage, or is not APTC-eligible for purposes of SLCSP determination, one of the children will be the subscriber and the relevant

relationship is “sibling”, and many Marketplace plans do not allow siblings of the subscriber to be placed on the same policy.

3. How are child-only and adult-only plans incorporated into the SLCSP determination?

Enrollment groups consist of all individuals enrolling in a single policy. Child-only plans are available to enrollment groups where all members are under age 21 and no dependent has a spouse, child, domestic partner, or parent relationship to the subscriber. Adult-only plans are available to enrollment groups where subscriber member is age 21 or over or enrollment groups where the subscriber is under age 21 and at least one dependent has a spouse, child, domestic partner, or parent relationship to the subscriber. Therefore, every enrollment group is eligible for either child-only plans or adult-only plans, but not both.

Child-only and adult-only plans could be excluded in the SLCSP determination, depending on the family makeup. Child-only plans will be excluded when the family includes individuals age 21 or older. Adult-only plans will be excluded if the family includes only individuals under age 21 with no spouse, child, domestic partner, or parent relationships. Adult-only plans will also be excluded if the family includes a dependent under age 21 who has a relationship to the subscriber that the adult-only plan does not allow.

4. At what geographic level is SLCSP determined?

Only plans that are available for sale in the subscriber’s zip code and county are included in the SLCSP determination. Rating areas, defined in 45 CFR 147.102(b), are collections of zip codes, counties, or metropolitan statistical areas and non-metropolitan statistical areas, as defined by the Office of Management and Budget, in which each plan must have an identical premium for a given individual or family. Rating areas do not have to align with a plan’s service area, which defines where a plan is available for sale. If a plan’s service area does not cover an entire rating area, the plan is only included in the SLCSP determination for families that reside in its service area. Once a plan is included in the SLCSP determination, its premium is calculated using the rating area associated with the subscriber’s zip code and county. The rating areas for each state can be found at https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/state-gra.html.

5. If consumers meet the income, tax filing, and other coverage requirements for the premium tax credit, will they receive a premium tax credit (or advance payments)?

Generally, yes. However, if a taxpayer’s monthly cost of the SLCSP is equal to or less than the taxpayer’s expected contribution amount, the taxpayer’s premium tax credit (or advance payments) for the month is equal to $0. This is true even if the taxpayer’s household income for the year is less than 400% of the Federal poverty level. The taxpayer’s expected contribution amount is the amount the taxpayer would have to pay toward the premium if the APTC-eligible members of the taxpayer’s household enrolled in the SLCSP; it is equal to the product of the applicable percentage and 1/12 of the taxpayer’s household income for the year. The applicable percentage is the percent of household income a taxpayer’s household is required to contribute towards the cost of the SLCSP. The applicable percentage is higher for taxpayers with higher

household incomes. The 2017 applicable percentages can be found at https://www.irs.gov/irb/2016-18_IRB/ar08.html.

6. How is essential health benefits (EHB) percent of premium used when determining SLCSP?

Only the portion of the premium allocable to EHBs (the EHB premium) is considered when finding the SLCSP and its premium. Silver plans are compared in terms of EHB premiums to determine which plan is the second lowest cost silver plan, and the premium tax credit is no greater than the difference between EHB premium of the SLCSP and the taxpayer's contribution amount. Some plans' premiums may exceed its EHB premiums, for example, because it provides services in addition to EHB, such as routine adult dental coverage. As a result, some families may have to pay more than the expected contribution amount to purchase the SLCSP.

7. At what point in time is the SLCSP determined?

The SLCSP is determined at the time of enrollment, and only plans that are available to the tax household are considered in the SLCSP determination. As an example, a plan under an enrollment freeze, or in a "suppressed" status, is only included in the SLCSP determination for families to whom the plan is available, such as because they are renewing coverage in that plan. If the lowest cost silver plan or SLCSP for a tax household becomes decertified or closed to new enrollment after a family enrolls, the SLCSP for that tax household is not re-determined unless the tax household completes a new enrollment, such as during a Special Enrollment Period.

Note that the eligibility determination notices generated upon application submission on HealthCare.gov include an amount of advance payments of the premium tax credit that is based on the plans available at the time of the application submission. The final determination of advance payments of the premium tax credit takes place when applicants confirm their plan selections and may differ slightly from the amount displayed on the eligibility determination notice if the plan availability changes between when the application is submitted and when a plan selection is confirmed.

The premium of the SLCSP determined at the time of enrollment is included on the 1095-A form consumers receive at the end of the year. If a consumer does not report a mid-year life change – such as marriage, birth of a child, or a move – to the Marketplace, the SLCSP on the 1095-A may be incorrect, and the consumer will need to use the Marketplace tax tool to determine the SLCSP premium.

8. Can I use the QHP landscape to determine SLCSP?

You can use the landscape to find an estimate of the SLCSP and the Marketplace Public Use Files (PUF) to find a more precise estimate of the SLCSP premium for an individual or family. The QHP landscape is a summary of the plan data and has a number of limitations, including that:

- It does not include service area information at the zip code level. While most plans cover whole counties, a small number of plans cover only certain zip codes within a county.

- It gives only one rate for each county. For states that define rating areas by three digit zip codes, a plan may have more than one rate for a county, depending on the zip code. Of the states using the Federal platform for eligibility and enrollment, Alaska and Nebraska are the only states that rate by three digit zip codes. Rating area definitions are available at https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/state-gra.html.
- It does not include the rate for every age. While all plans should be following a state-specific or Federal age curve, the actual rates for a given age may vary slightly depending on the issuer's rounding methodology.
- It does not include the business rules used for eligibility (e.g., allowed relationships) and rating (e.g., the number of children age 0 to 20 rated for various family types).

The QHP landscape is available at https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/, and the Marketplace PUF at https://www.cms.gov/cciio/resources/data-resources/marketplace-puf.html.