



Summary of Coverage Provisions in the Affordable Care Act

On March 23, 2010, President Obama signed comprehensive health reform, the Affordable Care Act (ACA), into law. The following summary explains key health coverage provisions of the law including:

- The Medicaid expansion to 138% of the federal poverty level (\$15,415 for an individual and \$31,809 for a family of four in 2012) for individuals under age 65;
- The creation of health insurance exchanges through which individuals who do not have access to public coverage or affordable employer coverage will be able to purchase insurance with premium and cost-sharing credits available to some people to make coverage more affordable;
- New regulations on all health plans that will prevent health insurers from denying coverage to people for any reason, including health status, and from charging higher premiums based on health status and gender;
- The requirement that most individuals have health insurance beginning in 2014; and
- The penalties to employers that do not offer affordable coverage to their employees, with exceptions for small employers.

Expansion of Public Programs

The ACA provides for the expansion of Medicaid to individuals with incomes up to 138% of the federal poverty level based on modified adjusted gross income. This expansion creates a new minimum Medicaid eligibility level for adults and eliminates a limitation of the program that prohibits most adults without dependent children from enrolling in the program (though as under current law, undocumented immigrants are not eligible for Medicaid). Eligibility for Medicaid and the Children's Health Insurance Program (CHIP) for children with family incomes above 138% of the poverty level will continue at their current eligibility levels until 2019.

- The federal government will provide 100% federal funding for the costs of those who become newly eligible for Medicaid for years 2014 through 2016, 95% federal funding for 2017, 94% federal funding for 2018, 93% federal funding for 2019, and 90% federal funding for 2020 and subsequent years. States that have already expanded adult eligibility to 100% of the federal poverty level will receive a phased-in increase in the FMAP for non-pregnant childless adults.
- The recent Supreme Court ruling on the ACA limits the ability of the Department of Health and Human Services to enforce the Medicaid expansion. This change in enforcement authority may affect state decisions to implement the expansion.

American Health Benefit Exchanges

States will create the American Health Benefits Exchanges where individuals can purchase insurance and separate exchanges for small employers to purchase insurance. These new marketplaces will provide consumers with information to enable them to choose among plans. Premium and cost-sharing subsidies will be available to make coverage more affordable.

- Access to Exchanges will be limited to U.S. citizens and legal immigrants. Small businesses with up to 100 employees can also purchase coverage through the Exchange.
- Plans in the Exchanges will be required to offer benefits that meet a minimum set of standards. Insurers will offer four levels of coverage that vary based on premiums, out-of-pocket costs, and benefits beyond the minimum required plus a catastrophic coverage plan.
- Premium subsidies will be provided to families without access to other coverage and with incomes 100-400% of the poverty level (\$23,050 to \$92,200 for a family of four in 2012) to help them purchase insurance through the Exchanges. These subsidies will be offered on a sliding scale basis and will limit the cost of the premium to between 2% of income for those up to 133% of the poverty level and 9.5 % of income for those between 300-400% of the poverty level.
- Cost-sharing subsidies will also be available to people with incomes between 100-250% of the poverty level to limit out-of-pocket spending.

Changes to Private Insurance

New insurance market regulations will prevent health insurers from denying coverage to people for any reason, including their health status, and from charging people more based on their health status and gender. These new rules will also require that health plans provide comprehensive coverage that includes at least a minimum set of services and caps annual out-of-pocket spending.

- Health plan premiums will be allowed to vary only based on age (by a 3 to 1 ratio), geographic area, tobacco use (by a 1.5 to 1 ratio), and the number of family members.
- Young adults will be allowed to remain on their parent's health insurance up to age 26.
- Health insurers will be prohibited from imposing lifetime limits on coverage and will be prohibited from rescinding coverage, except in cases of fraud.
- New health plans will be required to cover certain preventive services with no cost-sharing.
- Increases in health plan premiums will be subject to review.
- Insurers will be required to spend at least 80% of premiums on medical costs or pay rebates back to consumers.

Individual Mandate

All individuals will be required to have health insurance, with some exceptions, beginning in 2014. Those who do not have coverage will be required to pay a yearly financial penalty of the greater of \$695 per person (up to a maximum of \$2,085 per family), or 2.5% of household income, which will be phased-in from 2014-2016. Exceptions will be given for financial hardship and religious objections; and to American Indians; people who have been uninsured for less than three months; those for whom the lowest cost health plan exceeds 8% of income; and if the individual has income below the tax filing threshold (\$9,500 for an individual in 2011).

Employer Requirements

There is no employer mandate but employers with more than 50 employees will be assessed a fee of \$2,000 per full-time employee (in excess of 30 employees) if they do not offer coverage and if they have at least one employee who receives a premium credit through an Exchange. Employers with 50 or more employees that offer coverage but have at least one employee who receives a premium credit through an Exchange are required to pay the lesser of \$3,000 for each employee who receives a premium credit or \$2,000 for each full-time employee (in excess of 30 employees).

- Large employers that offer coverage will be required to automatically enroll employees into the employer's lowest cost premium plan if the employee does not sign up for employer coverage or does not opt out of coverage.

For more information about the Affordable Care Act, see the summary of the law at <http://www.kff.org/healthreform/8061.cfm>.

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