March 2017

Summary of the Affordable Care Act

This summary describes key provisions of the Affordable Care Act (ACA) related to private health insurance, Medicaid, and Medicare. A more detailed summary of the law is available at http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/

	Patient Protection and Affordable Care Act (P.L. 111-148) and Health Care and Education Reconciliation Act (P.L. 111-152)
Overall approach	• **Require most U.S. citizens and legal residents to have health insurance.** • **Create state-based health insurance exchanges** through which individuals and small businesses can compare plans, apply for financial assistance, purchase coverage. • **Provide refundable premium tax credits**, based on income and cost of coverage, for individuals/families with income between 100-400% of the federal poverty level. • **Impose new insurance market regulations**, including requiring guaranteed issue of all non-group health plans during annual open enrollment and special enrollment periods; limiting rating variation to 4 factors: age (3 to 1 ratio), geographic rating area, family composition, and tobacco use (1.5 to 1 ratio); prohibiting pre-existing condition exclusion periods; prohibiting lifetime and annual limits on coverage; and extending dependent coverage to age 26. • **Require ten essential health benefits be covered** by all individual and small group health insurance • **Require plans to provide no-cost preventive benefits** and limit annual cost-sharing. • **Expand Medicaid** to 138% of the federal poverty level at state option and require a single, streamlined application for tax credits, Medicaid, and CHIP. • **Extend CHIP funding to 2015** and increase the match rate by 23 percentage points up to 100%. • **Close the Medicare Part D doughnut** hole and enhance coverage of preventive benefits in Medicare. • **Reduce Medicare spending** by reducing payments for Medicare Advantage plans, hospitals, and other providers. • **Establish the Independent Payment Advisory Board** and the Center for Medicare and Medicaid Innovation (CMMI).
Individual mandate	• Require U.S. citizens and legal residents to have qualifying health coverage. Individuals without coverage pay a tax penalty of the greater of $695 per year, indexed by inflation, or 2.5% of household income. Exemptions granted for affordability, financial hardship, religious objections, other reasons.
Premium subsidies to individuals	• Provide refundable, advanceable premium tax credits to eligible individuals with incomes between 100-400% FPL to purchase insurance through the exchanges. Credits computed on sliding scale so people pay no more than a required percentage of income for the second lowest cost silver plan for their age in their area. Credit amount decreases as income increases; amount increases as cost (including age-rated premium) of benchmark plan increases. Annually index individual required contribution by premium growth over income growth through 2018. Examples of national average tax credit amount by age and income in 2017 include:

	100% FPL	200% FPL	401% FPL
Age 34	$ 6,019	$ 4,734	$ 0
Age 49	$ 7,686	$ 6,400	$ 0
Age 64	$12,068	$10,782	$ 0

U.S. citizens and legal immigrants who meet income limits and who are not eligible for affordable coverage through an employer or public program are eligible for tax credit.

- Premium tax credit can be applied to any individual health insurance policy, other than catastrophic policies, sold through the exchange
- Individuals who are eligible for public programs, including Medicare, Medicaid, CHIP, or for employer sponsored coverage that meets affordability and minimum value standards are not eligible for tax credit.

Cost sharing subsidies to individuals

- Provide cost-sharing subsidies to eligible individuals with household income between 100%-250% FPL. Subsidies reduce deductibles, copays and OOP limit that otherwise apply under silver plans by increasing actuarial value of plan on sliding scale. National average deductible and OOP limit under silver exchange plans in 2016 were:

	Annual Deductible	Annual OOP Limit
100-150% FPL	$221	$874
150-200% FPL	$709	$1,795
200-250% FPL	$2,491	$4,850
>250% FPL	$3,064	$6,160

Individual health insurance market rules

- Require guaranteed issue of all non-group health plans during annual open enrollment (3 months for 2017 plan year). Insurers also must offer 60-day special enrollment periods (SEP) for individuals after qualifying events. Small group health insurance plans must be guaranteed issue year round.
- Require insurers to set prices to reflect expected costs for single risk pool. Rating variation permitted for just 4 factors: age (limited to 3 to 1 ratio), geographic rating area, family composition, and tobacco use (limited to 1.5 to 1 ratio).
- Prohibit pre-existing condition exclusions.

Benefit design

- Require all plans offered in the individual and small group markets to cover ten categories of essential health benefits: ambulatory care, emergency care, hospitalization, maternity and newborn care, mental health and substance use care, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive care, chronic disease management, and pediatric dental and vision care.
- Prohibit lifetime and annual dollar limits on coverage under individual and group health plans
- Limit annual cost-sharing to $7,150/individual and $14,300/family in 2017, indexed to inflation. Exchange plans must be offered at 4 cost sharing levels based on actuarial value (AV) categories: Bronze (60% AV); Silver (70% AV), Gold (80% AV) and Platinum (90% AV). Catastrophic plans with lower AV also offered to young adults.
- Prohibit cost sharing for preventive health benefits in individual and group plans
- Require in-network level of cost sharing for out-of-network emergency services
- Prohibit abortion coverage from being required. Federal premium and cost-sharing subsidies cannot pay for abortion beyond saving the life of the woman or in cases of rape or incest (Hyde amendment). If a subsidy-eligible individual enrolls in a plan that chooses to cover abortion services federal subsidy funds must be segregated from private premium payments or state funds. Prohibit plans from discriminating against any provider because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.

Women's health	• Require all plans offered in the individual and small group markets to cover ten categories of essential health benefits including maternity care and preventive care, such as contraception and cancer screenings. • Prohibit preexisting conditions exclusions which historically have included pregnancy, prior C-section, and history of domestic violence. • Prohibit discriminatory premium pricing based on gender (gender rating). • Prohibit abortion coverage from being required. Federal premium and cost-sharing subsidies cannot pay for abortion beyond saving the life of the woman or in cases of rape or incest (Hyde amendment). If a subsidy-eligible individual enrolls in a plan that chooses to cover abortion services federal subsidy funds must be segregated from private premium payments or state funds. • Prohibit plans from discriminating against any provider because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.
Health Savings Accounts (HSAs)	• Leave in place HSA rules as authorized by the Medicare Modernization Act of 2003, including: – Individuals must be enrolled in qualified high deductible health plan (HDHP) in order to make tax deductible contributions to an HSA – Eligible individuals may contribute up to $3,350 annually (2016-2017) tax free, amount indexed annually to CPI. Additional catch up contribution of up to $1,000 may be made by persons over age 55. Contribution limits doubled for enrollment in family coverage – Amounts withdrawn for qualified medical expenses are not subject to income tax. Qualified medical expenses include amounts paid out-of-pocket for services subject to deductible or other cost sharing, and for other uncovered services, such as eyeglasses, dental care, or long term care. Nutritional supplements and health club fees are not qualified medical expenses. ACA also excluded over-the-counter drugs as a qualified expense. Tax free HSA withdrawals cannot be used to pay for insurance premiums, with exception for COBRA premiums, health insurance premiums paid while receiving unemployment benefits, and long term care insurance premiums up to certain limits. Amounts withdrawn for any non-qualified expense are subject to income tax; in addition, before age 65 a 20% tax penalty applies for non-qualified distributions. – Upon death of account holder, HSA can rollover tax free to an HSA of surviving spouse; for any non-spousal beneficiary, the account ceases to be a HSA and account balance becomes taxable to the beneficiary.
High-risk pools	• Create a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions 2010-2013.
Selling insurance across state lines	• Permit states with similar rules to enter into interstate compacts to share enforcement and allow insurers to sell policies in any compacting state. Insurers selling policies through a compact would only be subject to the laws and regulations of the state where the policy is written or issued, except for rules pertaining to market conduct, unfair trade practices, network adequacy, and consumer protections. Compacts may only be approved if it is determined that the compact will provide coverage that is at least as comprehensive and affordable as coverage provided through the exchanges.
Exchanges/ Insurance through associations	• Create state-based health insurance exchanges and Small Business Health Options Program (SHOP) exchanges through which individuals and small businesses with up to 100 employees can purchase qualified coverage. Exchanges must display all qualified health plans and facilitate comparison by consumers and small businesses. Exchanges must offer call center and navigator services to help consumers and small businesses apply for coverage and financial assistance and compare plans. Require the federal government to establish an exchange in states that choose not to establish their own. • Apply single risk pool rating requirement to plans offered both on and off the exchange. Plans offered both on and off the exchange that are otherwise the same must be offered at same price. • Apply individual insurance market rating and other rules to coverage provided to associations, but not related to employment, and sold to individuals. Generally,

	where association coverage is offered to employer members to provide coverage to their employees, the size of each employer determines whether rules of the small group or large group market apply.
Dependent coverage to age 26	• Provide dependent coverage for children up to age 26 for all individual and group policies.
Other private insurance standards	• Set minimum medical loss ratio standards for all health plans. Insurers must provide rebates to policyholders for the amount of the premium revenue spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. Establish a process for reviewing increases in health plan premiums and require plans to justify increases. • Require all health plans to offer independent external review to resolve claims disputes. • Require all plans to report transparency data on enrollment, disenrollment, claims payment practices and denials, out of network claims, and other performance measures required by the Secretary. Require all plans to provide standard, easy-to-read summary of benefits and coverage.
Employer requirements and provisions	• Impose a tax penalty on employers with 50 or more full-time employees that do not offer coverage that meets standards for affordability and minimum value. In general, large employers subject to the mandate cannot reimburse employees for the purchase of individual health insurance. • Apply a "Cadillac tax" on high-cost health plans beginning in 2020: an excise tax on insurers of employer-sponsored health plans whose value exceeds $10,200 for individuals, $27,500 for families (higher thresholds for plans with retirees, higher cost due to age, gender, or high-risk work of employees). Plan value includes employer contributions to health savings accounts (HSAs) and health reimbursement accounts (HRAs). Excise tax is 40% of plan value in excess of threshold. • Require employers with more than 200 employees to auto enroll employees into the group health plan; employees may opt out of coverage • Permit employers to adopt wellness incentives, up to 30% of cost of group health plan (50% if wellness incentives include tobacco cessation incentives) for group health plan participants to meet wellness targets • Provide tax credits for 2 years for low-wage small employers (up to 25 employees). Credit amount up to 50% of the employer's premium contribution
Medicaid	*Expansion* ▪ Expand Medicaid eligibility to all non-elderly adults with incomes up to 138% FPL based on modified adjusted gross income at state option. As under current law undocumented immigrants are not eligible for Medicaid. Provide newly eligible adults with a benefit package that meets the essential health benefits. To finance the eligibility expansion, states will receive 100% federal funding for 2014 through 2016, 95% federal financing in 2017, 94% federal financing in 2018, 93% federal financing in 2019, and 90% federal financing for 2020 and subsequent years. *Children's Health Insurance Program (CHIP)* ▪ Require states to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019 and extend funding for CHIP through 2015. Beginning in 2015, increase CHIP match rate by 23 percentage points up to a cap of 100%. *Other program changes* ▪ Increase the Medicaid drug rebate percentage for brand name and non-innovator, multiple source drugs and extend the drug rebate to Medicaid managed care plans. ▪ Reduce aggregate Medicaid DSH allotments. Require the Secretary to develop a methodology to distribute the DSH reductions based on uninsured rates.

	▪ Create demonstration projects to test health home models and new payment methodologies. ▪ Provide states with new options for offering home and community-based services.
Medicare	*Coverage enhancements* ▪ Gradually close the Medicare Part D coverage gap ("donut hole") by 2020 ▪ Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under traditional Medicare. ▪ Eliminate cost-sharing for Medicare covered preventive services that are recommended (rated A or B) by the U.S. Preventive Services Task Force and waive the Medicare deductible for colorectal cancer screening tests. *Changes to provider payments* ▪ Reduce payments for Medicare Advantage (MA) plans; phase-in adjustments to plan payments for coding practices and provide the Secretary the authority to further adjust plan payments for coding intensity. ▪ Reduce payment updates for hospitals and other Medicare providers. ▪ Reduce Medicare Disproportionate Share Hospital (DSH) payments. *Other program changes* ▪ Increase Medicare premiums (Parts B and D) for higher income beneficiaries (those with incomes above $85,000/individual and $170,000/couple). ▪ Establish an Independent Payment Advisory Board to recommend strategies to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. ▪ Establish various quality, payment and delivery system changes, including a new Center for Medicare and Medicaid Innovation to test, evaluate, and expand methods to control costs and promote quality of care.
State role	• Establish a state based health insurance exchange and provide oversight of health plans with regard to the new insurance market regulations, consumer protections, rate reviews, solvency, reserve fund requirements, premium taxes, and to define rating areas. • Establish an office of health insurance consumer assistance or an ombudsman program to serve as an advocate for residents who are uninsured or covered under any private coverage and to help consumers appeal denied claims • Permit states to create a Basic Health Plan for uninsured individuals with incomes between 138% and 200% FPL in lieu of these individuals receiving premium subsidies to purchase coverage in the exchanges. • Permit states to obtain a five-year waiver of certain new health insurance requirements if the state can demonstrate that it provides health coverage to all residents that is at least as comprehensive as the coverage required under an Exchange plan and that the state plan does not increase the federal budget deficit.
Financing	• Key sources of new tax revenue include: • Tax penalties associated with individual and large employer mandate; Cadillac tax on high-cost employer-sponsored group health plans • Increase the Medicare payroll tax (HI) rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly and impose a 3.8% tax on unearned income for higher-income taxpayers (thresholds are not indexed). • New taxes on health insurers: $8 billion in 2014; $11.3 billion in 2015-2016; $13.9 billion in 2017; $14.3 billion in 2018, indexed in later years by the rate of premium growth. Lower rates or exemptions for non-profit insurers.

	• New taxes on pharmaceutical manufacturers: $2.8 billion in 2012-2013; $3.0 billion in 2014-2016; $4.0 billion in 2017; $4.1 billion in 2018; and $2.8 billion in 2019 and later. • New excise tax of 2.3% on the sale medical devices (delayed until 2018). • Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through a tax preferred health savings account (HSA) • Increase the tax on HSA distributions that are not used for qualified medical expenses from 10% to 20%.
Sources of information	https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf and https://www.gpo.gov/fdsys/pkg/PLAW-111publ152/pdf/PLAW-111publ152.pdf