THE AFFORDABLE CARE ACT AND HEALTH INSURANCE EXCHANGES

FREQUENTLY ASKED QUESTIONS

Adapted from the Henry J. Kaiser Family Foundation

A central goal of the Affordable Care Act (ACA) is to significantly reduce the number of uninsured by providing a continuum of affordable coverage options through Medicaid and new Health Insurance Exchanges.

The following provides some answers to commonly asked questions about the ACA and exchanges.

INSURANCE

Q: Will everyone have to buy health insurance? What happens if they don't? How will people prove they have health insurance?

Starting in 2014, most people will be required to have health insurance or pay a penalty if they don't. Coverage may include employer-provided insurance, coverage someone buys on their own, or Medicaid.

Several groups are exempt from the requirement to obtain coverage or pay the penalty, including: people who would have to pay more than 8% of their income for health insurance, people with incomes below the threshold required for filing taxes (in 2012, $9,750 for a single person and $26,000 for a married couple with two children), those who qualify for religious exemptions, undocumented immigrants, people who are incarcerated, and members of Indian tribes.

The penalty for people who forego insurance is the greatest of two amounts: a specified percentage of income or a specified dollar amount. The percentages of income are phased in over time at 1% in 2014, 2% in 2015, and 2.5% starting in 2016. (Income is defined as total income in excess of tax filing thresholds.) The dollar amounts are also phased in at $95 in 2014, $325 in 2015, and $695 beginning in 2016 (with annual increases after that). The Congressional Budget Office projects that 3.9 million people will pay the penalty in 2016. The total penalty for the taxable year will not exceed the national average of the annual premiums of a bronze level health insurance plan offered through the health insurance Exchanges.

Health insurance plans will provide documents to people they insure that will be used to prove that they have the minimum coverage required by law.

Q: What is a health insurance exchange?

Exchanges are new organizations that will be set up to create a more organized and competitive market for buying health insurance. They will offer a choice of different health plans, certifying plans that participate and providing information to help consumers better understand their options.

Beginning in 2014, Exchanges will serve primarily individuals buying insurance on their own and small businesses with up to 50 employees, though states can choose to include larger employers in the future. States are expected to establish Exchanges—which can be a government agency or a non-profit organization—with the federal government stepping in if a state does not set them up. States can create multiple Exchanges, so long as only one serves each geographic area, and can work together to form regional Exchanges. The federal government will offer technical assistance to help states set up Exchanges.

Q: How will the new provision allowing young adults to remain on a parent's insurance work?

The health reform law contains a provision that requires private insurers to continue dependent coverage of children until age 26. Department of Health and Human Services regulations specify that a young adult can qualify for this coverage even if he or she is no longer living with a parent, is not a dependent on a parent's tax return, or is no longer a student. Both married and unmarried young adults can qualify for the dependent coverage extension, although that coverage does not extend to a young adult's spouse or children. For employer plans that were in place prior to March 23, 2010, young adults can only qualify for dependent if they are not eligible for another employer-sponsored insurance plan. Insurers that do not offer coverage to dependent children will not be required to offer this coverage to young adults.

The extension of dependent coverage to age 26 took effect on September 23, 2010, but plans were not required to comply with the regulations until the first plan year beginning on or after that date.

Regulations also state that young adults who gain dependent coverage under the health reform law cannot be charged more for coverage than similar individuals who did not lose coverage due to the end of their dependent status. Young adults newly qualifying as dependents under the health reform law must also be offered the same benefits package as similar individuals who were already covered as dependents.

Currently, some states require that private insurance extend coverage to young adults in their twenties. In New York, health plans are required to extend the availability of health insurance coverage to young adults through the age of 29. These state requirements do not extend to self-funded insurance plans, but the new federal health reform law is designed to apply to these self-funded plans, and the requirement for coverage of children up to age 26 will apply to those plans.

Q: What protections are there in the new health reform law for people with preexisting conditions?

Starting in 2014, all health insurers will have to sell coverage to everyone who applies, regardless of their medical history or health status. At that time, insurers will not be allowed to charge more to individuals with preexisting conditions, nor will they be to able exclude coverage of those conditions from the insurance plans they sell. It is worth noting that since 1993 New York law already required health plans to sell coverage to anyone who applies for it—this is

known as guaranteed issue—and prohibited plans from charging higher prices based on health status, age or gender—a practice called community rating.

The law provides new protections for children with preexisting conditions, which took effect on September 23, 2010. Insurers are not permitted to deny coverage to children due to their health status, or exclude coverage for preexisting conditions.

Q: What preventive services will be covered?

Since July 2010, any new plans offered by employers or insurers have to provide coverage for a range of preventive services, including: services recommended with a rating of "A" or "B" from the U.S. Preventive Services Task Force, immunizations recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices, and additional services for women contained in guidelines issued by the Health Resources and Services Administration (including routine mammograms for women over age 40). In addition, plans are required to cover these preventive services without any cost-sharing for patients.

EMPLOYERS

Q: How are small businesses affected by health reform?

The health reform law includes a number of provisions that reform the insurance market and encourage small businesses to offer health insurance. Coverage offered in the small group market and in the exchanges established for small business to purchase insurance, must meet minimum benefit standards; be subject to reviews of premium increases; and comply with other consumer protections.

The provisions to encourage small firms to offer coverage apply only to firms under a certain size.

Fewer than 25 Employees:
Beginning in 2010, business with fewer than 25 full time equivalents and average annual wages of less than $50,000 that pay at least half of the cost of health insurance for their employees are eligible for a tax credit. The full credit is available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as firm size and average wage increases. The credit is capped based on the average health insurance premium in the area where the small business is located.

Fewer than 50 Employees:
Businesses with fewer than 50 employees are exempt from penalties faced by larger employers that do not offer coverage. The penalties for larger employers (50 or more employees) go into effect in 2014.

Small businesses with fewer than 50 employees will be able to purchase coverage through Small Business Health Options Program (SHOP) Exchanges beginning in 2014. These state-based exchanges are intended to allow employers to shop for qualified coverage and more easily compare prices and benefits. In 2017, states will have the option to allow businesses with more than 100 employees to purchase coverage through the SHOP Exchanges.

Q: Will employers that don't provide health benefits have to pay a penalty?

The health reform law does not require employers to provide health benefits. However, it does impose penalties in some cases on larger employers (those with 50 or more workers) that do not provide insurance to their workers or that provide coverage that is unaffordable.

Larger employers that do not provide coverage will be assessed a penalty beginning in 2014 if any one of their workers receives a tax credit when buying insurance on their own in a health insurance Exchange. Workers with income up to 400% of the poverty level are eligible for tax credits. The employer penalty is equal to $2,000 multiplied by the number of workers in the business in excess of 30 workers (with the penalty amount increasing over time).

In some instances, larger employers that offer coverage could be subject to penalties as well. If the coverage does not have an actuarial value of at least 60%—meaning that on average it covers at least 60% of the cost of covered services for a typical population—or the premium for the coverage would exceed 9.5% of a worker's income, then the worker can obtain coverage in an Exchange and be eligible for a tax credit. For each worker receiving a tax credit, the employer will pay a penalty of $3,000 up to a maximum of $2,000 times the number of workers in excess of 30 workers.

Q: How does the new law apply to companies with self-funded plans?

Self-funded plans—those where the employer accepts the risk for the health benefits it provides, rather than buying coverage from an insurance company—are generally exempt from state insurance regulations and are instead regulated by the Employee Retirement Income Security Act (ERISA). The new health reform law contains many provisions that apply nationally to both self-funded plans and fully insured plans. Some of these provisions include the extension of dependent coverage until age 26, no cost sharing for preventive services, the limit on waiting periods to no more than 90 days, maximum patient out-of-pocket costs, and no lifetime or annual limits on coverage. However, self-funded plans will not be subject to meeting the minimum essential health benefit requirements. "Grandfathered" plans (i.e., those that were in place on March 23, 2010) are not subject to all the above requirements.

Q: How will the health reform law help people with their out-of-pocket expenses?

The new law has several provisions that are aimed at making private health insurance more affordable that will take effect in 2014. First, premium tax credits and cost-sharing subsidies will be available for U.S. citizens and legal immigrants purchasing coverage on their own in the new health insurance exchanges. The premium tax credits will be available to those with incomes up to 400% of the poverty level (estimated at about $47,000 for an individual or $96,000 for a

family of four in 2014) and will limit what a person has to pay toward the premium to a specified percentage of income. The amount people will have to pay will range from 2% of income for those with income up to 133% of the poverty level to 9.5% of income for those with income between 300 and 400% of the poverty level. In addition to premium tax credits, people with incomes up to 250% of the poverty level (estimated at about $29,000 for an individual or $60,000 for a family of four in 2014) will be eligible for cost-sharing subsidies that will reduce what they will have to pay out-of-pocket for covered health services.

Second, the law establishes limits on what people buying insurance in the exchanges and some others will pay out-of-pocket for services covered by health plans. These limits are set initially at $6,400 for an individual and $12,800 for a family, and grow over time. For people purchasing coverage in the exchanges who have incomes at or below 250% of the poverty level, the out-of-pocket limits will be reduced.

MEDICAID AND CHIP

Q: Who will be eligible for Medicaid?

As enacted, the ACA expands state Medicaid programs beginning in 2014 to cover nearly all individuals under age 65 with incomes up to 138% of the federal poverty level ($15,856 for an individual or $26,951 for a family of three in 2013). The ACA establishes a uniform minimum Medicaid eligibility level and income definition across all states and eliminates a prohibition that prevented states from providing Medicaid coverage to adults without dependent children except under a waiver of federal rules. However, while the Supreme Court upheld the ACA, it limited the federal government's ability to enforce the Medicaid expansion to low-income adults, effectively making implementation of the Medicaid expansion a state choice. This means eligibility for Medicaid for this population will vary depending on whether a state implements the expansion. If all states implemented the expansion, an additional 21.3 million people could be added to Medicaid. Undocumented immigrants are not eligible for Medicaid regardless of their income, and legal immigrants who have resided in the U.S. for less than five years are also not eligible, though states have the option of extending Medicaid coverage to legal immigrant children and pregnant women who are in the 5-year waiting period.

AFFORDABILITY AND SUBSIDIES

Q: Who will be eligible for subsidies to make health insurance more affordable?

Beginning in 2014, tax credits will be available to U.S. citizens and legal immigrants who purchase coverage in the new health insurance exchanges and who have income up to 400% of the federal poverty level ($43,320 for an individual or $88,200 for a family of four in 2009). To be eligible for the premium tax credits, individuals must not be eligible for public coverage—including Medicaid, the Children's Health Insurance Program, Medicare, or military coverage—

and must not have access to health insurance through an employer. (There is an exception in cases when the employer plan does not cover at least 60% of covered benefits on average or the employee share of the premium exceeds 9.5% of the employee's income.)

The premium tax credits will be advanceable and refundable, meaning they will be available when an individual purchases coverage and will be available regardless of whether or not an individual owes any taxes. The premium tax credits will vary with income and are structured so that the premium an individual or family will have to pay will not exceed a specified percentage of income, ranging from 2% for those with incomes up to 133% of the poverty level (about $14,400 for an individual) to 9.5% for those with incomes between 300 and 400% of the poverty level ($32,490 to $43,320 for an individual).

FINANCING AND TAXES

Q: Will employees be taxed for the portion of the health insurance premium that is paid by the employer?

Starting for the 2012 tax year, W-2 forms provided by employers (in the beginning of 2013) show employees how much their health insurance costs. However, the reporting is for informational purposes only; employees will not be taxed on this amount.

A separate provision of the health reform law creates a new tax on so-called "Cadillac" insurance plans provided by employers. Beginning in 2018, plans valued at $10,200 for individual coverage or $27,500 for family policies will be subject to an excise tax of 40% on the value of the plan that exceeds these thresholds. The tax will be levied on insurers and self-insured employers, not directly on employees.

The threshold amounts will be increased for inflation beginning in 2020, and may be adjusted upwards if health care costs rise more than expected prior to implementation of the tax in 2018. The thresholds are also adjusted upwards for retired individuals age 55 and older who are not eligible for Medicare, for employees engaged in high-risk professions, and for firms that may have higher health care costs because of the age or gender of their workers.