



Summary of Coverage Provisions in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act passed by the Senate on December 24, 2009 and by the House of Representatives on March 21, 2010. The following summary explains key health coverage provisions in the new law and incorporates modifications to the law included in the Health Care and Education Reconciliation Act of 2010, signed by President Obama on March 30, 2010.

The legislation will do the following:

- Most individuals will be required to have health insurance beginning in 2014.
- Individuals who do not have access to affordable employer coverage will be able to purchase coverage through a health Insurance Exchange with premium and cost-sharing credits available to some people to make coverage more affordable. Small businesses will be able to purchase coverage through a separate Exchange.
- Employers will be required to pay penalties for employees who receive tax credits for health insurance through the Exchange, with exceptions for small employers.
- New regulations will be imposed 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.
- Medicaid will be expanded to 133% of the federal poverty level (\$14,404 for an individual and \$29,327 for a family of four in 2009) for all individuals under age 65.

The Congressional Budget Office estimates that the legislation will reduce the number of uninsured by 32 million in 2019 at a net cost of \$938 billion over ten years, while reducing the deficit by \$124 billion during this time period.

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 (\$9,350 for an individual and \$18,700 for a married couple in 2009).

Expansion of Public Programs

Medicaid will be expanded to all individuals under age 65 with incomes up to 133% of the federal poverty level (\$14,404 for an individual and \$29,327 for a family of four in 2009) based on modified adjusted gross income. This expansion will create a uniform minimum Medicaid eligibility threshold across states and will eliminate a limitation of the program that prohibits most adults without dependent children from enrolling in the program today (though as under current law, undocumented immigrants will not be eligible for Medicaid). Eligibility for Medicaid and the Children's Health Insurance Program (CHIP) for children will continue at their current eligibility levels until 2019. People with incomes above 133% of the poverty level who do not have access to employer-sponsored insurance will obtain coverage through the newly created state health insurance Exchanges.

- 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 poverty level will receive a phased-in increase in the FMAP for non-pregnant childless adults.
- Medicaid payments to primary care doctors for primary care services will be increased to 100% of Medicare payment rates in 2013 and 2014 with 100% federal financing.

American Health Benefit Exchanges

States will create American Health Benefit 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 purchase coverage through the Exchange.
- Although there will not be a public plan option in the Exchanges, the Office of Personnel Management, which administers the Federal Employees Health Benefit Program, will contract with private insurers to offer at least two multi-state plans in each Exchange, including at least one offered by a non-profit entity. In addition, funds will be made available to establish non-profit, member-run health insurance CO-OPs in each state.
- 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 with incomes between 133-400% of the poverty level (\$29,327 to \$88,200 for a family of four in 2009) 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 133-400% 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 all new health plans provide comprehensive coverage that includes at least a minimum set of services, caps annual out-of-pocket spending, does not impose cost-sharing for preventive services, and does not impose annual or lifetime limits on coverage.

- Health plan premiums will be allowed to vary 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.
- Health insurers will be prohibited from imposing lifetime limits on coverage and will be prohibited from rescinding coverage, except in cases of fraud.
- Increases in health plan premiums will be subject to review.
- Young adults will be allowed to remain on their parent's health insurance up to age 26.
- States will be allowed to form health care choice compacts that enable insurers to sell policies in any state that participates in the compact.
- Waiting periods for coverage will be limited to 90 days.
- Existing individual and employer-sponsored insurance plans will be allowed to remain essentially the same, except that they will be required to extend dependent coverage to age 26, eliminate annual and lifetime limits on coverage, prohibit rescissions of coverage, and eliminate waiting periods for coverage of greater than 90 days.

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 that do 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.

- Employers that offer coverage will be required to provide a voucher to employees with incomes below 400% of the poverty level if their share of the premium cost is between 8-9.8% of income to enable them to enroll in a plan in an Exchange. Employers that offer a free choice voucher will not be subject to the above penalty.
- 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.

Coverage and Cost Estimates

The Congressional Budget Office (CBO) estimates that the legislation will reduce the number of uninsured by 32 million in 2019 at a net cost of \$938 billion over ten years. According to CBO, by 2019, the legislation will result in 24 million people obtaining coverage in the newly created state health insurance Exchanges, including some who previously purchased coverage on their own in the individual market. In addition, 16 million more people would enroll in Medicaid and the Children's Health Insurance Program. The cost of the legislation will be financed through a combination of savings from Medicaid and Medicare and new taxes and fees, including an excise tax on high-cost insurance. The Congressional Budget Office estimates the health care components of the legislation will reduce the deficit by \$124 billion over ten years (the total reduction in the deficit including the health care and education components is estimated to be \$143 billion over ten years).

For more information about the **Summary of Coverage Provisions in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010** see the side-by-side comparison of the health reform proposals at <http://www.kff.org/healthreform/sidebyside.cfm>.

Last modified: April 5, 2010



This publication (#8023-R) is available on the Kaiser Family Foundation's website at www.kff.org.

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