UC BERKELEY LABOR CENTER

Summary of Affordable Care Act Provisions Affecting Children, Non-Elderly Adults and Employers

This summary is based on the Patient Protection and Affordable Care Act (HR 3590) and the Reconciliation Act of 2010 (HR 4872), signed into law in March 2010, and federal regulations implementing the law.

Medicaid/CHIP Eligibility

- Medicaid expanded to 133% FPL or less for non-elderly (children, parents and childless adults) in 2014[1]
- Requires states to maintain current Medicaid and CHIP eligibility standards for children until 2019, extends CHIP funding through 2015 and increases federal CHIP match rate by 23 percentage points (not to exceed 100%) in 2015-2019[2]
- CHIP-eligible children who can't get coverage due to waiting lists can get subsidized coverage in exchange[2]
- Maintenance of Medicaid eligibility standards required until the exchange is fully operational, except that standards for children must be maintained until 2019. State does not have to maintain standards between 2011 and 2013 for optional non-pregnant non-disabled adult populations above 133% FPL if budget issues are certified.[3]
- Medicaid income eligibility based on modified adjusted gross income (MAGI[a]) with a 5 percentage point income disregard for non-elderly Medicaid eligibility categories[4]
- CHIP income eligibility rules changed to modified adjusted gross income[4]
- States required to offer premium assistance to Medicaid beneficiaries who are offered employer sponsored insurance (ESI) if cost-effective for the state[5]
- Federal government covers 100% of the cost of Medicaid expansion in all states in 2014–2016, 95% in 2017, 94% in 2018, 93% in 2019 and 90% in 2020 and subsequent years[6]
- Federal government covers additional percentage of the cost of covering adults below 100% FPL in states that have already expanded coverage; federal government will pay 50% of the difference between the state's match rate and the Medicaid expansion match rate in 2014, 60% in 2015, 70% in 2016, 80% in 2017, 90% in 2018 and 100% in 2019 and subsequent years[6]

Exchange Eligibility

- Option to purchase subsidized coverage through exchange if not offered ESI or if the employee premium cost for ESI exceeds 9.5% of income or has actuarial value of less than 60% and not eligible for other minimum essential coverage, including Medicare, Medicaid and CHIP[7]
- Beginning in 2015, the 9.5% affordability standard is adjusted by the excess of premium growth over income growth[7]
- Undocumented immigrants not eligible for coverage or subsidies in exchange, but documented immigrants subject to the five-year wait period can get subsidies in exchange[8] and documented children with undocumented parents can access exchange[9]
- Small employers of up to 100 employees can participate when exchanges open by 2014; state option to define small employers as 50 employees or less through 2015[10]
- States can expand exchange to all businesses beginning in 2017[11]
- Exchange plans must offer child-only plan[12]

[a] MAGI equals gross income including interest income minus deductions for business expenses, losses from the sale of property or expenses related to property held for the production of rents or royalties, alimony payments and above the line deductions such as those related to Health Savings Accounts, certain moving expenses, one-half of self-employment tax, alimony payments, contributions to Individual Retirement Accounts and student loan interest (this list is not comprehensive). Gross income is determined without regard to income earned while living abroad or in an American possession such as Guam or the Virgin Islands.

Premium Subsidies

- Premium subsidies for families with income up to 400% FPL, based on MAGI[13]
- Premiums capped at
  - 2.0% of income up to 133% FPL, but only applicable for legal residents who are not eligible for Medicaid
  - 3.0–4.0% for 133–150% FPL
  - 4.0–6.3% for 150–200% FPL
  - 6.3–8.05% for 200–250% FPL
  - 8.05–9.5% for 250–300% FPL
  - 9.5% for 300–400% FPL[14]
- Premium credit amount will be tied to the lesser of the actual premium paid by the individual or the second lowest-cost Silver plan in the area adjusted only for the enrollee's age[15]
- Premium subsidies can be applied to any plan in the exchange,[16] but only individuals enrolled in the Silver plan are eligible for cost sharing subsidies[17]
- In 2015-2018, premium percentages are indexed by the excess of premium growth over income growth; beginning in 2019, if total premium credits and cost-sharing reductions exceed 0.504% of GDP, premium percentages are indexed by the excess of premium growth over CPI[18]
- Married couples must file joint returns to be eligible for subsidies[15]
- Undocumented immigrants are not included in family size for purposes of calculating FPL, but their income is taken into account[15]

Cost Sharing

- Plans must reduce cost sharing for credit-eligible individuals to reach the actuarial values specified:
  - 133–150% FPL: 94%
  - 150–200% FPL: 87%
  - 200–250% FPL: 73%
  - 250–400% FPL: 70%[19]
- Cost sharing subsidies only apply to eligible individuals who enroll in the Silver plan[20]
- OOP maximums are based on a percentage of HSA limits as follows (2010 dollars):
  - 100–200% FPL: $1,983/$3,967
  - 200–300% FPL: $2,975/$5,950
  - 300–400% FPL: $3,967/$7,933
  - 400%+ FPL: $5,950/$11,900[20]
- The Secretary makes payments to health plans equal to the value of the reductions, such payments may be capitated[20]

Actuarial Values (Exchange Plans)

- Plans offered in exchange—Bronze (60% actuarial value), Silver (70%), Gold (80%) and Platinum (90%) and "young invincibles" policy[21]
- Minimum actuarial values for subsidized individuals and families:
  - 133–150% FPL: 94%
  - 150–200% FPL: 87%
  - 200–250% FPL: 73%
  - 250–400% FPL: 70%[22]

Health Plan Standards

- Existing employer plans are grandfathered for current employees, their family members and new employees; certain changes to plan design will nullify a plan's grandfathered status, such as elimination of benefits for certain conditions; any increase in coinsurance percentage; an increase in deductible or out-of-pocket limit by more than 15 percent plus medical inflation; an increase in co-payment by more than $5 adjusted for medical inflation or 15 percent plus medical inflation, whichever is greater; an increase in employee share of premium by more than 5 percentage points; or certain increases in a plan's annual benefits limit. Changes to premiums, changes made to comply with federal or state laws, or a change of third party administrator will not cause a plan to lose its grandfathered status.[23]
- Fully-insured plans pursuant to a collective bargaining agreement (CBA) are grandfathered until the last expiration date of a CBA related to that coverage. Grandfathered status may be maintained upon the CBA expiration date if no changes were made since March 23, 2010 that would have otherwise caused the plan to lose its grandfathered status. A change in carrier during the terms of a CBA will not invalidate grandfathered status after the CBA expires.[23]
- Effective the first day of the next plan year beginning on or after September 23, 2010, all plans including grandfathered plans:
  - ✧ are prohibited from rescinding coverage[24]
  - ✧ are prohibited from having lifetime limits and annual limits are restricted to no less than $750,000 beginning September 23, 2010, $1.25 million September 23, 2011 and $2 million September 23, 2012, and are banned completely beginning January 1, 2014[23]
  - ✧ must allow adult children under age 26 to enroll in a parent's plan; through 2013, adult children may only enroll in a parent's grandfathered plan if they are ineligible for another employer-sponsored plan[25]
- Effective the first day of the next plan year beginning on or after September 23, 2010, all plans excluding grandfathered plans:
  - ✧ must offer first dollar coverage (no co-payment or deductible) for certain preventive services[26]
  - ✧ are prohibited from requiring a referral to see an obstetrician or gynecologist and from requiring prior authorization or higher cost sharing for out-of-network emergency services[27]
- Beginning in 2011, fully-insured plans including grandfathered plans must provide rebates to consumers if their medical loss ratios are below 85% for large group plans or 80% for small group and individual plans (or higher standard set by state, if applicable) [28]
- Beginning in 2014:
  - ✧ all individual and fully-insured group plans excluding grandfathered plans must have out-of-pocket maximums of $5,950/$11,900 (2010 dollars) or less[29]
  - ✧ small group fully-insured plans excluding grandfathered plans must also limit deductibles to $2,000 for single coverage and $4,000 for family[30]
- Additional requirements for individual and small group plans in and out of exchange and large group plans in the exchange (excludes grandfathered plans) beginning in 2014: medical underwriting and pre-existing condition exclusions prohibited,[31] rating variation allowed: age (3:1), tobacco (1.5:1.0), family composition and geography;[32] and minimum services covered: preventive and primary care, emergency, hospital, physician, outpatient, maternity and newborn care, pediatric (including dental and vision), medical/ surgical care, drugs, lab, and mental health and substance abuse; the Secretary must certify that scope of benefits is equal to that of the "typical" employer plan[33]
- Self-insured plans and Multi-Employer Welfare Arrangements (MEWAs) are exempt from many of the plan requirements, however if a self-insured plan requires employee contributions that are more than 9.5% of income or has an actuarial value of less than 60%, the plan is considered unaffordable and the individual is eligible for the exchange[34]
- Proposal does not eliminate individual market outside of the exchange[35]

Employer Responsibilities

- Beginning in 2014, large employers not offering coverage with at least one employee receiving subsidies in the exchange pay $2,000 multiplied by the number of full-time employees (not including the first 30 workers), where full-time is defined as an average of 30 hours or more with respect to any month[36]
- Large employers offering coverage with at least one employee receiving subsidies in the exchange pay the lesser of $3,000 multiplied by the number of full-time employees receiving subsidies and $2,000 multiplied by the total number of full-time employees (not including the first 30 workers)[36]
- Waiting periods of more than 90 days are banned[37]
- Applicable large employers are those with more than 50 full-time equivalents regardless of industry[36]
- Fees are indexed like premiums after 2014[38]

- Employers with more than 200 full-time employees must automatically enroll employees into a plan unless they opt out of coverage[39]
- Employers offering coverage must offer a free choice voucher to employees below 400% FPL if employee contribution is 8.0-9.8% of income. The voucher allows the employee to use the amount the employer would have contributed towards purchasing unsubsidized coverage in the exchange. Employer penalties shall not apply for employees using the voucher.[40]

Individual Mandate

- Penalty for not enrolling in qualifying coverage is the lesser of (a) the national average bronze plan premium for the applicable family size or (b) the greater of a flat dollar amount or a percentage of income:
  - 1.0% of taxable income or $95 per adult plus half that amount per child in 2014
  - 2.0% of taxable income or $325 per adult plus half that amount per child in 2015
  - 2.5% of taxable income or $695 per adult plus half that amount per child in 2016 and beyond[41]
  - Families pay a maximum of three times the adult flat dollar amount, unless the percentage of income amount is greater[42]
- Qualifying coverage includes plans meeting exchange standards, Medicare, Medicaid, CHIP, TRICARE or VA coverage, a plan in the individual market, "young invincible" plan, a grandfathered plan, any employer plan or other coverage recognized by the Secretary[42]
- Hardship exemption given if the lowest cost option available (less employer contributions and subsidies) is more than 8% of modified adjusted gross income or if income is below tax filing threshold ($9,350 for singles and $18,700 for couples in 2009)[41]
- Undocumented immigrants not subject to individual mandate[42]

Small Business Tax Credit

- Tax credits for small businesses with 25 FTEs or fewer and average wages of no more than $50,000 in 2010-2013, in subsequent years the amount is $25,000 plus $25,000 multiplied by a cost of living adjustment[43]
- To be eligible, businesses must contribute at least 50% towards premiums[43]
- Credit pays up to 50% of employer contributions (up to 35% in the case of tax-exempt small businesses) beginning in 2014; in 2010–2013 the maximum credit is 35% (up to 25% in the case of tax-exempt businesses)[43]
- The credit varies based on employer size and average wage—full credit if 10 FTEs or fewer and average wages of $25,000 or less, but phases out as firm size and average wage increases according to the following formula:

  *Credit = 0.5 – 0.5 * [(Total FTEs – 10)/15 + (Average annual wages - $25,000)/$50,000]*

  (Note: The formula for tax-exempt small businesses replaces 0.5 with 0.35) [43]
- Credit can only offset tax liability and is not refundable[43]
- Credit only available for employers that purchase coverage through exchange beginning in 2014[43]
- An employer can only receive the credit through the exchange for 2 consecutive years[43]

Taxes on Insurers and Individuals

- Tax insurers at 40% of aggregate value of plans above $10,200 for individual coverage and $27,500 for family coverage beginning in 2018. The thresholds would be:
  - Adjusted upwards initially to the degree that Federal Employee Health Benefits Program Blue Cross/ Blue Shield standard premiums rise more than 55% between 2010 and 2018
  - Indexed by CPI in 2020 and subsequent years (CPI plus 1% in 2019)
  - Adjusted for firm-specific age and gender
  - Adjusted upwards by $1,650/$3,450 for retirees age 55+, individuals in high-risk jobs and electrical and telecommunications installation/repair workers; high risk jobs include longshore workers, emergency responders, firefighters, and those working in law enforcement, construction, mining, agriculture, forestry and fishing
  - Calculated excluding dental and vision benefits[44]

- Fee on insurers excluding self-insured plans, government-run plans and certain non-profits and plans that serve critical purposes for the community; totals $8 billion in 2014, $11.3 billion in 2015-2016, $13.9 billion in 2017 and $14.3 billion in 2018 and inflated thereafter; fee calculated based on insurer's market share of premiums; only 50% of premiums counted for non-profits[45]
- Annual fee on all insurers (including self-insured plans) of $2 per covered life in each policy year 2013–2019; fee is $1 during policy years ending during 2013[46]
- Medicare payroll tax increased to 3.8% in 2013 for taxpayers with income greater than $200,000 for individuals and $250,000 for couples; includes income from interest, dividends, annuities, royalties and rents[47]

Retiree Coverage

- $5 billion appropriated to temporarily reimburse employers or insurers for retiree coverage for those aged 55–64, reimburses 80% of claims between $15,000 and $90,000 effective 90 days after enactment; program ends when the funds are expended or at the end of 2013, whichever is sooner[48]

Risk Adjustment

- Beginning in 2014, each state shall assess charges to individual and small group plans with low actuarial risk and make payments to plans with high actuarial risk to minimize adverse selection; excludes self-insured and grandfathered plans[49]
- Insurers in individual and group markets (including self-insured plans but excluding grandfathered plans) are required to purchase reinsurance beginning in 2014 and the reinsurance entity will make payments to plans covering high-risk individuals (to be defined by each state); aggregate national reinsurance payments should total $25 billion in 2014-2016[50]
- The Secretary will establish a risk corridor program modeled after the Medicare Part D risk corridors. Individual and small group health plans in the exchange must participate in 2014–2016. Plans will receive from or make payments to the government depending on their allowable costs:
    - ✧ If allowable costs (reduced by any risk adjustment or reinsurance payments) are 103–108% of the "target amount" (total premiums minus administrative costs), the government and the plan will split the excess equally
    - ✧ If more than 108%, the government will pay the plan 2.5% of target amount plus 80% of allowable costs above 108%
    - ✧ If 92–97%, the government and the plan will split the difference evenly
    - ✧ If less than 92%, the plan will pay the government 2.5% of expected costs plus 80% of allowable costs under 92%[51]

---

[1] Affordable Care Act, Sec. 2001
[2] Affordable Care Act, Sec. 2101
[3] Affordable Care Act, Sec. 2001
[4] Affordable Care Act, Sec. 1004
[5] Affordable Care Act, Sec. 2003
[6] Affordable Care Act, Sec. 1201
[7] Affordable Care Act, Sec. 1001
[8] Affordable Care Act, Sections 1312 and 1401
[9] Affordable Care Act, Sections 1312 and 2707
[10] Affordable Care Act, Sections 1304 and 1311
[11] Affordable Care Act, Sec. 1312
[12] Affordable Care Act, Sec. 2707
[13] Affordable Care Act, Sec. 1001 and 1004
[14] Affordable Care Act, Sec. 1001
[15] Affordable Care Act, Sec. 1401
[16] Enrollment in a particular plan is not listed as a qualification for "applicable taxpayers" in Section 1401
[17] Affordable Care Act, Sec. 1402
[18] Affordable Care Act, Sec. 1001
[19] Affordable Care Act, Sec. 1001
[20] Affordable Care Act, Sec. 1402
[21] Affordable Care Act, Sec. 1302
[22] Affordable Care Act, Sec. 1001

[23] Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act
[24] Affordable Care Act, Sec. 2712
[25] Affordable Care Act, Sec. 2301
[26] Affordable Care Act, Sec. 1001
[27] Interim Final Rules: Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections
[28] Affordable Care Act, Sec. 1001
[29] Affordable Care Act, Sec. 1302
[30] Affordable Care Act, Sec.1302
[31] Affordable Care Act, Sec. 1302
[32] Affordable Care Act, Sec. 2701
[33] Affordable Care Act, Sec. 1302
[34] Affordable Care Act, Sec. 1301
[35] Affordable Care Act, Sec. 1312
[36] Affordable Care Act, Sec. 1003
[37] Affordable Care Act, Sec. 1201
[38] Affordable Care Act, Sec. 1513
[39] Affordable Care Act, Sec. 1511
[40] Affordable Care Act, Sec. 10108
[41] Affordable Care Act, Sec. 1002
[42] Affordable Care Act, Sec. 5000A
[43] Affordable Care Act, Sec. 1421
[44] Affordable Care Act, Sec. 1401
[45] Affordable Care Act, Sec. 1406
[46] Affordable Care Act, Sections 4375-4377
[47] Affordable Care Act, Sec. 1411
[48] Affordable Care Act, Sec. 1102
[49] Affordable Care Act, Sec. 1343
[50] Affordable Care Act, Sec. 1341
[51] Affordable Care Act, Sec. 1342