# The Affordable Care Act in Action

**How Health Insurance Reform Could Affect You**

The Impact of the
**Individual Mandate**

Health Insurance Marketplace
**Exchanges**

**Provisions**
Affecting Individuals and Businesses

**Higher Taxes**
on High-Income Earners

# Foreword

The Patient Protection and Affordable Care Act (generally called the Affordable Care Act, or ACA) entered full implementation in 2014. By mid 2015, almost 10 million consumers were covered through the ACA Health Insurance Marketplace.

The ACA offers many health insurance safeguards and options, and also imposes penalties on those who do not comply with the law's individual mandate. To help offset the program's costs, there are taxes on high-income earners, businesses, and the medical and insurance industries.

If you have health insurance through your employer, your coverage has probably not been affected, but you may benefit from ACA provisions such as the elimination of annual out-of-pocket caps. With Medicare, there is no change in the way beneficiaries obtain coverage or choose a supplemental policy. If you don't have health insurance, you may find it easier to obtain comprehensive coverage on a health insurance exchange, and you cannot be denied because of pre-existing medical conditions.

Understanding the ACA is the first step in determining how it could affect your health-care options and your financial situation. As you read, jot down any questions you may have for your financial professional, who may be able to tell you more specifically how you could be affected.

The information in this booklet comes from the Department of Health and Human Services and the Internal Revenue Service, unless otherwise indicated.

# The Individual Mandate

The Affordable Care Act generally requires all American citizens and residents to have "minimum essential" health coverage or pay an annual penalty. This requirement is often called the *individual mandate*. Health insurance provided by an employer, individual policies that meet minimum standards, and government programs such as Medicare, Medicaid, and veterans' plans typically satisfy the mandate. You may have seen changes to your own health coverage resulting from other ACA provisions.

## Penalty



The penalty for not having health insurance is the *greater* of a flat dollar amount or a percentage of income.* This penalty is being phased in over a three-year period. After 2016, it will be indexed annually for inflation.

| Tax year | Flat dollar penalty per adult | Maximum household penalty | Percentage of income* |
|---|---|---|---|
| 2014 | $95 | $285 | 1% |
| 2015 | $325 | $975 | 2% |
| 2016 | $695 | $2,085 | 2.5% |

* Income is defined as total household income in excess of the threshold for filing a federal income tax return: $10,300 for an individual or $20,600 for a couple filing jointly in 2015 ($10,350 and $20,700, respectively, in 2016).

The dollar penalty is assessed for each adult in a household. Minors under age 18 are subject to 50% of the penalty. There is also a family maximum for the flat dollar amount (equal to three times the individual amount). The penalty cannot be higher than the national average premium for a bronze-level plan under the health insurance exchanges. *(See next page for more on exchanges.)*

However, if an individual has to pay more than 8% of income for coverage (after taking into account any tax credits or employer contributions), there is no penalty for not having health insurance. There are several other exceptions.

# Health Insurance Marketplace

State-based health insurance exchanges help consumers compare policies online, sign up for coverage, and claim a subsidy (if qualified). In 2016, 12 states and the District of Columbia were operating exchanges directly, 11 state exchanges were utilizing federal support or partnership, and 27 state exchanges were operated by the federal government.[1] Taken together, the exchanges are called the Health Insurance Marketplace.

All marketplace plans are offered by private companies and must cover a set of 10 essential benefits, such as hospitalization, doctors' visits, prescription drugs, maternity care, and mental health care. Plans are grouped by tier, based on the percentage of expected health-care costs (*actuarial value*) the plan is designed to pay: bronze (60% of the actuarial value of expenses), silver (70%), gold (80%), and platinum (90%). Premiums vary within each tier, as do the deductibles, copays, and coinsurance rates.



## Enrollment guidelines

Open enrollment for 2016 coverage ended on January 31, 2016. For 2017 coverage, open enrollment is expected to run from October 1, 2016, to December 15, 2016. During open enrollment, qualifying individuals can choose from the plans available in their state insurance exchanges and see whether they are eligible for a subsidy. Individuals may be able to enroll at other times due to a qualifying event such as the loss of job-based coverage, a move to another state, or a change in family status.

To learn about your options, go to the federal government's official website, **HealthCare.gov**. The site will link you to the appropriate state insurance exchange.

## Comparison shopping

For 2016 coverage, consumers could choose from an average of five issuers on federally facilitated exchanges. In 2015, about 86% of enrollees were able to find a lower premium plan by shopping for coverage.

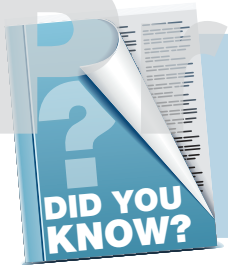
1) Kaiser Family Foundation, 2015

## Premium subsidies

In 2015, about 84% of exchange enrollees were eligible for the premium tax credit to help pay their health insurance premiums. Although these subsidies are aimed at low- and middle-income consumers, the income limits are relatively high. People with household incomes of 100% to 400% of the federal poverty level may be eligible as long as they do not have coverage available through work or other goverment programs.

Advance credit payments are based on estimated income and may require adjustment when filing your annual income tax return. If you underestimated your income, you may have to pay back some or all of the tax credit.






**The average monthly subsidy for ACA enrollees who received subsidies in 2015 was $270.**

Centers for Medicare & Medicaid Services, 2015

## Who might benefit from the exchanges?

Anyone who needs individual insurance might benefit from the health insurance exchanges. Here are a few examples.

- Self-employed people who have had difficulty finding cost-effective insurance.
- Part-time workers who do not qualify for employer coverage.
- Workers who retire before age 65, when Medicare eligibility kicks in. Previously, many people have continued working in order to receive health insurance benefits.
- Older individuals who were charged high premiums for individual coverage and who are more likely to have health issues.
- Women who have paid higher premiums than men.
- People with a pre-existing medical condition that has prevented them from obtaining insurance or from leaving an employer out of fear of losing insurance coverage.

# New Benefits Under the Affordable Care Act

ACA reforms apply not only to marketplace plans but also to most employer-sponsored group medical plans and privately purchased health plans. There are some exceptions for "grandfathered" plans *(see page 7).*

**Pre-existing conditions.** Insurers can no longer refuse or rescind coverage for anyone because of health status, nor will they be able to charge higher premiums because of risk factors. This provision has been in effect for children since 2010 and to adults since 2014.

**Doctor choice and ER access.** Plan participants may choose any doctor in their plan's network and may receive OB-GYN care without a referral from a primary physician. Plans cannot charge more for emergency care from an out-of-network hospital.



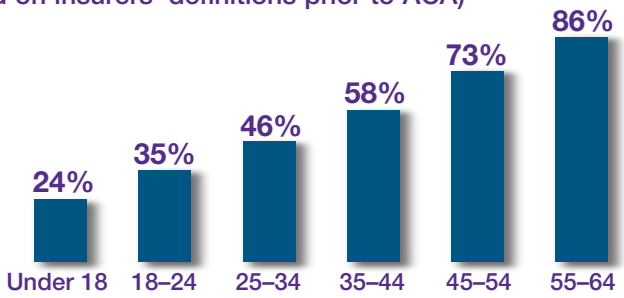
**Free preventive care.** Plans are required to provide various types of preventive screening, counseling, and immunizations without charge.

**Lifetime and annual benefit limits.** Since 2010, the law has prevented insurance companies from imposing *lifetime* benefit limits. Since 2014, insurers have been barred from imposing *annual* benefit limits on covered services.

**Coverage for adult children**. An adult child up to age 26 is eligible for dependent coverage under a parent's health plan. (Some plans may cover a child up to age 26 regardless of other available coverage.)

## Americans with Pre-Existing Conditions, by Age

(based on insurers' definitions prior to ACA)




Source: Department of Health and Human Services, 2012 (data from 2008)

# Medicare Enhancements

The ACA includes a number of changes aimed at improving the Medicare system. These are some of the most significant.

**Preventive coverage.** Certain preventive services, such as mammograms and colonoscopies, are covered without the Medicare Part B coinsurance or deductible. Beneficiaries are also eligible for an annual wellness exam without charge.


**Medicare covers about 60% of expenses associated with retiree health-care services.**

Employee Benefit Research Institute, 2015



**Prescription drug coverage.** The law gradually closes the Medicare Part D coverage gap, often called the *donut hole*. Prior to enactment of the ACA, participants paid 100% of costs while in the coverage gap. In 2016, beneficiaries pay 45% of the cost for brand-name drugs and 58% of the cost for generic drugs. By 2020, both of these shares will be reduced to 25%. In 2016, the coverage gap starts when the participant and the plan have collectively paid $3,310 for covered drugs and ends when the participant has paid $4,850 out of pocket for covered medications since the start of the year.

**Care coordination.** New programs encourage health-care providers to coordinate services in order to reduce costs and provide higher-quality care.

**Potential cost savings.** Various ACA provisions are intended to help reduce costs, waste, fraud, and abuse under the Medicare system. Although the outcome of these efforts remains to be seen, the federal government believes they could help extend the life of the Medicare trust fund.

Source: Centers for Medicare & Medicaid Services, 2015

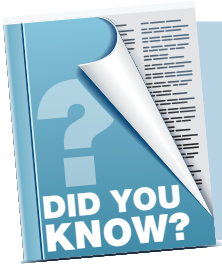
# Requirements Affecting Insurance Companies

To help protect consumers and control premium costs, the Affordable Care Act requires some changes in the way that insurance companies conduct business. There are some exceptions for grandfathered plans.

**Limits on individual premiums.** Individual premiums within a given health plan can vary based on only four characteristics: age, family size, geographical area, and tobacco use. Premiums based on gender are no longer allowed. Older consumers (ages 50–64) may be charged no more than three times the average premium paid by a 21-year-old. Smokers could be charged up to 50% more than nonsmokers.

**Rate review.** Before raising premiums, insurance companies must publicly justify any rate increase of 10% or more.






**About 6.8 million consumers saved a total of $4.1 billion in health insurance premiums in 2013 due to the rate review provision of the Affordable Care Act.**

U.S. Department of Health and Human Services, 2014

**80/20 rule.** Insurance companies must spend at least 80% of the premiums they receive on health care and quality improvement. Companies insuring large groups (generally more than 50 employees) must spend at least 85% on these items. If a company does not meet the appropriate standard, it must issue a rebate to the policyholder or employer, depending on the situation.

**No frivolous cancellations.** Insurance companies cannot cancel coverage because the applicant made a mistake or left out irrelevant information in completing the application for insurance.

**Right to appeal.** The ACA guarantees the right of a policyholder to appeal private health plan decisions, with the right to external review if the initial appeal is denied. The insurance company must

inform the participant why it has denied a claim and specify the participant's right to dispute the decision.

**Clear summary of benefits and coverage.** Insurance companies and group plans must provide two standardized forms to make it easier to understand and compare plans: (1) a short, plain-English Summary of Benefits and Coverage and (2) a Uniform Glossary of terms used in health coverage and medical care.

## Grandfathered health insurance plans

Some plans in existence on March 23, 2010, that have stayed basically the same may be considered "grandfathered" under the Affordable Care Act. Grandfathered plans may be exempt from the following ACA provisions:

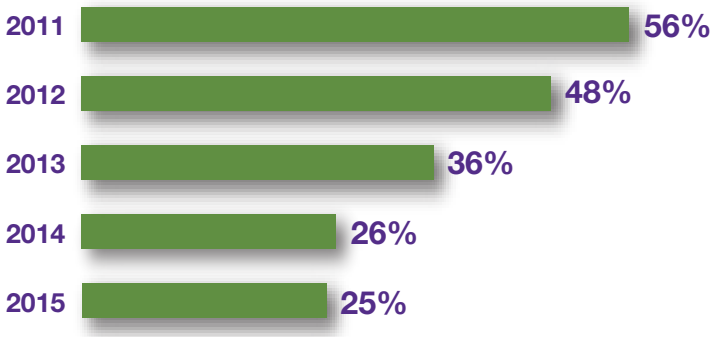
- Free preventive care
- Protecting choice of physicians and access to emergency care
- Rate review
- Guaranteed right to appeal



Grandfathered *individual* plans (but not employer-sponsored plans) may also be exempt from covering pre-existing health conditions and ending annual coverage limits.

Some grandfathered plans may provide benefits they are not required to provide. If you have questions regarding the grandfathered status of your plan, check the plan materials or contact your plan administrator.

### Percentage of Covered Workers in a Grandfathered Health Plan




Source: Kaiser Family Foundation, 2015

# Tax Provisions Affecting Individuals

To help fund the law's provisions and strengthen Medicare, the ACA implemented several taxes and changes to tax deductions.

## Medicare taxes on high-income individuals

Since 2013, high-income individuals have been subject to:

- An additional 0.9% Medicare hospital insurance payroll tax on *earned income* (wages and salaries) exceeding $200,000 ($250,000 for married couples filing jointly).
- A 3.8% *unearned income* tax on net investment income if modified adjusted gross income (AGI) exceeds $200,000 ($250,000 for joint filers). Unearned income includes capital gains, dividends, interest, royalties, rents, and passive income.



These income thresholds are not indexed for inflation.

## Changes to medical deductions, FSAs, and HSAs

**Itemized medical deduction.** Taxpayers can only deduct unreimbursed, qualified medical expenses that exceed 10% of AGI (prior to 2013, the threshold was 7.5%). However, individuals older than 65 can continue to claim qualified medical expenses that exceed 7.5% of AGI through 2016.

**Health flexible spending arrangements (FSAs).** Pre-tax contributions to FSAs were limited to $2,500, indexed annually for inflation, from 2013 through 2014. The limit rose to $2,550 for 2015 and 2016. Under prior law, there was no federal limit, although employers were free to set their own contribution limits. *Note: Since 2011, over-the-counter medicines are not considered reimbursable FSA or HSA expenses unless they were prescribed by a physician.*

**Health savings accounts (HSAs).** Individuals under the age of 65 who withdraw funds from an HSA for purposes other than qualified medical expenses are subject to a 20% income tax penalty on the amount withdrawn, in addition to ordinary income taxes. Prior to 2011, the tax penalty on nonqualified withdrawals was 10%.

# Taxes and Fees Affecting the Health-Care and Insurance Industries

Funding for the Affordable Care Act also comes from taxes and fees on the insurance and medical industries.

- **10% excise tax on indoor tanning services (2010 implementation).**
- **Annual fee on drug makers (2011 implementation).** Manufacturers and importers that sell more than $5 million annually in brand-name drugs through certain government programs are subject to an annual fee, allocated by share of sales to the programs.
- **Medical device excise tax (2013 implementation; now delayed until 2018 as a result of the PATH Act).** Medical device manufacturers and importers are subject to a 2.3% excise tax on sales in excess of $5 million of devices such as surgical instruments, x-ray machines, and pacemakers. The tax does not apply to devices commonly sold at the retail level, such as hearing aids, eyeglasses, and contact lenses.
- **Nondeductibility of health insurance executive pay (2013 implementation).** Most health insurance companies and affiliates, whether privately owned or publicly traded, cannot deduct amounts in excess of $500,000 paid to each high-level executive. This compares with a $1,000,000 limit for all publicly traded companies, with certain exceptions.
- **Annual fee on health insurance providers (2014 implementation; suspended for 2017).** The fee is apportioned among providers based on their share of the private health insurance market. Smaller companies and nonprofit providers are exempt.
- **Excise tax on high-value group health insurance plans (delayed until 2020).** Providers or administrators of "Cadillac" group insurance plans will be subject to a 40% excise tax on the amount of the annual premium that exceeds $10,200 for an individual or $27,500 for a family, indexed for inflation.

## Employer shared responsibility payment

Large employers face an annual nondeductible penalty if they do not provide coverage to at least 95% of employees in 2016 (70% in 2015), or if at least one employee qualifies to save money on monthly premiums in the Health Insurance Marketplace. This provision applied to companies with 100 or more full-time–equivalent (FTE) employees beginning in 2015 and was extended to companies with 50 to 99 FTEs in 2016. ("Full time" is considered 30 or more hours per week; hours worked by part-time employees are included in monthly FTE calculations.)



In order to avoid this penalty, the employer must offer coverage that is affordable and meets minimum value, defined as follows:

- Coverage is generally considered **affordable** if the employee's share of premium costs for employee-only coverage is no more than 9.5% of annual household income (typically based on wages reported on the employee's W-2 Form).
- A health plan meets **minimum value** if the plan's share of the total costs of covered services is at least 60% (equivalent to a bronze plan on the state exchanges).

If an employer does not offer health insurance, the penalty is $2,000 per full-time employee, excluding the first 30 employees.

*Example: Acme Parachutes employs 50 full-time workers but does not offer health insurance. If one employee obtains insurance through the Health Insurance Marketplace, Acme could be liable for an annual penalty of up to $40,000 ($2,000 for each employee in excess of the 30-employee exemption).*

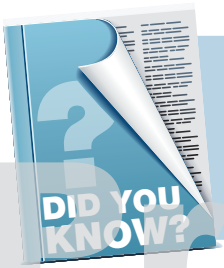
If an employer offers health insurance that does not meet the minimum requirements, the annual penalty would be $3,000 per full-time employee who qualifies for a premium savings in the marketplace.

*Example: Acme offers insurance that does not meet minimum value and/or is not affordable. If three employees obtain insurance at a lower premium in the Health Insurance Marketplace, the company could be subject to an annual fine of $9,000.*

## New reporting requirements

- The value of health insurance provided by the employer must be reported on each employee's W-2 Form. The reporting is informational only, and the amount is typically not taxable for the employee.
- Since 2015, large employers (including those that self-insure) must follow certain reporting guidelines on the coverage they offer.




**In 2015, 89% of companies with 50 to 99 workers and 97% of businesses with 100 or more workers offered health benefits. Only 54% of businesses with less than 50 workers offered benefits.** Kaiser Family Foundation, 2015



## Small Business Health Options Program (SHOP)

The SHOP Marketplace is designed to simplify the process of obtaining health insurance for small businesses. SHOP has been open to employers with 50 or fewer full-time employees since 2014. Starting in 2016, in some states it will be open to employers with up to 100 FTEs. Unlike the individual exchanges, there is no specific enrollment period for SHOP.

- SHOP is composed of state-based exchanges, similar to the individual exchanges. Employers must have an office or worksite in a state to use that state's SHOP.
- In order to use SHOP, a business must offer coverage to all full-time employees (generally those working an average of 30 or more hours per week).
- In many states, at least 70% of full-time employees must enroll in a business's SHOP plan.
- A business may qualify for a small-business health-care tax credit of up to 50% of premium costs. Premium costs not covered by the tax credit are generally tax deductible.

**Self-employed individuals** with no employees can obtain coverage through the individual Health Insurance Marketplace but not through SHOP.

# Looking Toward the Future

The Affordable Care Act is the law of the land, affirmed by the U.S. Supreme Court but subject to continuing legal and political challenges. Some provisions have already been changed or delayed as lawmakers, insurance companies, and consumers continue to experience the ACA in action.

The period from 2014 to 2016 has been a transitional period. The Congressional Budget Office projects that enrollment in the exchanges will increase to about 21 million by the end of 2016 and then level off at between 22 and 24 million between 2017 and 2025.



## Private exchanges

Rather than providing insurance directly, some large employers have given employees subsidies to purchase insurance through *private exchanges*. The options offered by these private exchanges are similar to those offered by government-sponsored exchanges in the Health Insurance Marketplace. The dollar value of subsidies may be similar to the current employer share of premiums, but employees could have more choice in the type of coverage they can obtain for their own share of premiums.[1]

## Rising medical costs

The rising cost of medical care will affect consumers regardless of how they obtain insurance. The federal government maintains that the Affordable Care Act will hold down costs by increasing the pool of insured individuals, offering consumers a wider range of choices while limiting insurance company profits and taxing medical manufacturers. The actual impact remains to be seen.

Clearly, the next few years will be a testing period as the ACA shifts into full implementation. Be sure to take all steps you are required to take and keep an eye out for future changes.

1) Society for Human Resources Management, 2015

## The Importance of Health Insurance

The reason to have insurance coverage — whether medical insurance, homeowners insurance, disability income insurance, or life insurance — is to help protect your family from financial disaster. Therefore, it is important to understand not only the costs but also the benefits of the coverage you plan to purchase.

Different health insurance plans have different premiums, deductibles, and limitations. A bronze-level plan on an exchange would most likely offer the lowest premium, but it would have the highest out-of-pocket costs compared with silver, gold, and platinum plans.



Most plans have a deductible before the insurance company will start to pick up a percentage of the costs. You still pay a percentage of medical costs out of pocket (about 40% for a bronze-level plan, 30% for a silver-level plan, 20% for a gold-level plan, or 10% for a platinum-level plan) until you reach the annual out-of-pocket limit.

In addition to comparing premiums and potential out-of-pocket costs, look at the plan's network of doctors, specialists, and health-care facilities. Ideally, you want the physicians and facilities you use consistently to be "in-network." Remember that there is no limit on charges you could incur from using out-of-network facilities and physicians. Prescription costs could also vary because specific brand-name medications may not be covered.

If you want to check your options in the Health Insurance Marketplace, visit the government's official website, **HealthCare.gov**. By doing a little research, you should be able to find a medical plan that meets your family's needs.

# Preview



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