

HEALTH CARE REFORM

INTRODUCTION:

On March 23, 2010, the Patient Protection and Affordable Care Act (Public Law 111-148) was signed into law, making some significant changes to the health care system in the United States. One week later, The Patient Protection and Affordable Care Act was modified by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152). These two bills together are commonly referred to as the Affordable Care Act or the ACA. Changes mandated by this law will occur gradually from 2010 to 2020, with the biggest changes to be implemented in 2014.

As with all legislation, some details of these changes will remain undetermined until: 1) federal agencies, such as the U.S. Department of Health and Human Services (HHS) released federal regulations (e.g., official rules); 2) states pass laws to implement certain provisions; and 3) insurance companies and employers re-write their policies to comply with the ACA. Furthermore, some states¹¹⁹ have filed lawsuits in federal court, charging that Congress was overstepping its right to regulate commerce under Article 1 of the U.S. Constitution and that the ACA is a violation of the Tenth Amendment. The U.S. Supreme Court will hear oral arguments in March to determine whether or not provisions in the ACA are constitutional. The outcome of that litigation, any changes in the membership of Congress or the presidency, and the actions of insurance companies, employers, and government agencies may change how the ACA is implemented over the next few weeks, months, and years.

I. WHICH POLICIES MUST COMPLY WITH THE ACA

A. **How to figure out if the ACA applies:** Different types of policies will have to comply with certain provisions of the ACA at different times. In order to figure out which reforms apply to a particular health insurance plan, we must first look at when the plan was issued, and second, we must determine if the employer-sponsored health plan is self-insured (aka self-funded) or insured (aka fully funded).

1) Date the policy was issued:

(i) **Policies issued prior to March 23, 2010:** These policies are considered “grandfathered plans,” meaning that they do not have to comply with many of the reforms discussed below. Plans may keep their grandfathered status indefinitely, as long as they do not make substantial changes to the plan.

- Plans will lose grandfathered status if they:
 - ⇒ Significantly cut or reduce benefits;
 - ⇒ Raise co-insurance or co-payment changes;
 - ⇒ Significantly raise deductibles;
 - ⇒ Lower employer contributions;
 - ⇒ Add or tighten annual limits; or
 - ⇒ Change insurance companies.

(ii) **Policies issued on or after September 23, 2010:** These policies must immediately comply with many of the reforms discussed below.

¹¹⁹ The following states are involved in litigation: Alabama, Alaska, Arizona, Colorado, Florida, Georgia, Idaho, Indiana, Louisiana, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Pennsylvania, South Carolina, South Dakota, Texas, Utah, and Washington.

- 2) **Self-Insured vs. Insured Health Plans:** Employer-sponsored health plans are plans where employees and their dependents enroll in a health plan through work, and the employer generally pays a portion of all of the cost of coverage. Compare this to an individually purchased plan, which is health insurance that is purchased directly from an insurance company and the individual purchasing the policy pays the entire premium.
- (i) There are two types of employer-sponsored health plans:
- Self-Insured Plan: Employers provide health care coverage by directly paying for employee's health care.
 - Insured Plan: Employers contract with insurance companies to provide employees with health care coverage.
- (ii) It is sometimes difficult for employees to know whether their employer-sponsored plan is insured or self-insured because employers often contract with third parties to administer their self-funded plan. Those third parties are often insurance companies. Sometimes these third parties are called Administrative Service Organizations (ASO). Because some of the reforms in the ACA do not apply to self-insured plans, it is important to find out what type of plan a person holds. To find out whether their employer-sponsored plan is self-insured or not, employees should ask the person who administers the employee benefits at work (e.g., an HR representative).

II. THE PORTAL

- A. **Statute:** The ACA required HHS to create a website portal to provide consumers with information about the ACA and health insurance options at the federal and state level. By answering a few basic questions, individuals can obtain information on the health insurance options available to them based on their specific situations. The Portal went live on July 1, 2010, and is available in both English (www.healthcare.gov) and Spanish (www.CuidadoDeSalud.gov).

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Employers

GETTING YOUR MONEY'S WORTH ON HEALTH INSURANCE
Starting in January, insurance companies will have to spend most of your premium dollars on health care—not on overhead, expenses or executive salaries. If they don't, you'll get a refund starting in 2012. Learn more.

B. **Available Information:** Although the Portal will continue to evolve over time, it now includes detailed information about the provisions in the ACA, pricing information on insurance options available to individuals and small businesses, and state-specific information on:

- 1) Individual health coverage offered by insurance companies;
- 2) Medicaid coverage;
- 3) Children’s Health Insurance Program (CHIP) coverage;
- 4) State high risk pool coverage;
- 5) Federal Pre-Existing Condition Insurance Plan options; and
- 6) Coverage options for small businesses and their employees.

III. HEALTH INSURANCE REFORMS

A. **Lifetime and Annual Limits:** Previously, insurance companies had the ability to establish lifetime and annual caps that limit the total dollars in benefits paid out per year or over the lifetime of an enrollee. The annual limits could be as low as \$50,000. People whose claims exceeded health plan limits were forced to find other ways to pay for their medical costs. The ACA will eventually eliminate lifetime and annual limits on all insurance plans.

- 1) **Lifetime Limits:** As of September 23, 2010, insurance companies may no longer impose lifetime limits on “essential health benefits.”
 - (i) HHS has decided to allow states to determine what would be included in an essential health benefits package for their residents, by selecting an existing health plan as the “benchmark.” States may choose a benchmark plan from:
 - One of the three largest small group plans in the state;
 - One of the three largest state employee health plans;
 - One of the three largest federal employee health plan options; or
 - The largest HMO plan offered in the state’s commercial market.

Although states would have the option to change the benefits package from the one they selected, they cannot reduce the value of benefits.¹²⁰

- (ii) Applies To:
 - Grandfathered Plans: Yes
 - Self-Insured Plans: Yes

2) **Annual Limits:** As of September 23, 2010, insurance companies may only impose annual limits on essential health benefits. If insurance companies do impose these annual limits, they must comply with the minimum limits for all employer-sponsored plans and all new individual market plans.

- (i) Minimum Annual Limits:
 - September 23, 2010: \$750,000
 - September 23, 2011: \$1.25 million
 - September 23, 2012: \$2 million¹²¹

¹²⁰ HHS Essential Health Benefits Bulletin
http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf

¹²¹ HealthReform.gov. “Fact Sheet: The Affordable Care Act’s New Patient’s Bill of Rights.”
www.healthreform.gov/newsroom/new_patients_bill_of_rights.html.

- (ii) Exceptions: Restrictions on annual limits do not apply to Flexible Spending Accounts (FSA), Medical Savings Accounts (MSA), or Health Savings Accounts (HAS).
- (iii) Elimination of Annual Limits: On January 1, 2014, insurance companies will no longer be permitted to impose annual limits on the total dollars in benefits paid out to a beneficiary per year for essential health benefits.
- (iv) Applies to:
 - Grandfathered Plans:
 - ⇒ Group: Yes
 - ⇒ Individual: No
 - Self-Insured Plans: Yes

B. Rescissions: Previously, some insurance companies would review an individual's original insurance application to look for any mistakes or omissions, intentional or not, and then retroactively cancel (rescind) the individual's policy if the individual became ill, leaving the individual uninsured.

- 1) As of September 23, 2010, an insurer may not rescind an individual's policy as long as the premiums are being paid, unless the individual:
 - (i) Commits fraud; or
 - (ii) Makes an intentional misrepresentation of a material fact (i.e., lied) on the application.¹²²
- 2) Applies to:
 - (i) Grandfathered Plans: Yes
 - (ii) Self-Insured Plans: Yes

C. Preventative Care: For insurance policies issued on or after September 23, 2010, health insurance plans must cover preventative services.¹²³

- 1) A complete list of preventative services can be found at:

www.healthcare.gov/law/about/provisions/services/lists.html

 - (i) Examples:
 - Covered Preventative Services for Adults
 - ⇒ Colorectal Cancer screening for adults over 50;
 - ⇒ BRCA counseling about genetic testing for women at higher risk
 - ⇒ Breast Cancer Mammography screenings every 1-2 years for women over 40
 - ⇒ Breast Cancer Chemoprevention counseling for women at higher risk
 - ⇒ Cervical Cancer screening for sexually active women
- 2) Deductibles and Co-Payments: If the individual uses an in-network provider to receive preventative services, those services will be exempt from deductibles and co-payments.
- 3) Applies to:
 - (i) Grandfathered Plans: No
 - (ii) Self-Insured Plans: Yes

¹²¹ HealthReform.gov. "Fact Sheet: The Affordable Care Act's New Patient's Bill of Rights."

www.healthreform.gov/newsroom/new_patients_bill_of_rights.html.

¹²² ACA § 2712, Amending 42 U.S.C. §300gg-12

¹²³ ACA § 1001, Amending PHSA §2712

D. Pre-Existing Conditions:

- 1) **Children:** As of September 23, 2010, children under 19 cannot be denied health insurance coverage based on a pre-existing condition.
- 2) **Adults:** As of January 1, 2014, adults cannot be denied health insurance coverage based on a pre-existing condition.
 - (i) After 2014, when considering whether to provide health insurance coverage, insurers cannot consider:
 - Pre-existing condition (physical or mental);
 - Health status;
 - Medical history;
 - Genetic information;
 - Gender; or
 - Age.
 - (ii) After 2014, in establishing premium rates, insurers may only consider:
 - If the insured is purchasing an individual or family policy;
 - Age of the insured;
 - The insured's rating area;¹²⁴ and
 - The insured's use of tobacco.
- 3) Applies to:
 - (i) Grandfathered Plans
 - Group: Yes
 - Individual: No
 - (ii) Self-Insured Plans: Yes

E. Cancer Clinical Trials: As of January 1, 2014, all group health plans or group or individual health insurance policies:

- 1) May not deny an individual's participation in a clinical trial;
- 2) May require the individual to use a participating provider in the network, if the provider will accept the individual;
- 3) Allow an individual to participate in a clinical trial out of state, unless there is a doctor in his or her network participating in the clinical trial in state and that doctor will accept the individual; and
- 4) May not deny, limit, or impose additional conditions on "the coverage of routine patient costs for items and services furnished in connection with participation in the trials."
 - (i) Routine patient costs do not include:
 - Investigational item device or services
 - Items and services provided solely to satisfy data collection and analysis needs and are not used in direct clinical management of the patient
- 5) May not discriminate against the individual for participating in the clinical trial.

¹²⁴ Rating area is a geographic area used for determining premium rates, usually by ZIP code. The premium is based on the average health care costs and the physician/hospital discounts in that area. Therefore, costs may be higher if the insured lives in a metropolitan city, as opposed to a small town. These rating areas must be approved by the HHS Secretary.

IV. **INSURANCE APPEALS**

A. **External Medical Review** (Independent Medical Review): For more information on External Medical Reviews, please refer to the Health Insurance & Health Care Options chapter.

- 1) As of September 23, 2010, all plans must have an “effective” internal appeals process and provide beneficiaries an external medical review process.
- 2) Internal appeals process: According to the National Association of Insurance Commissioners (NAIC), an effective internal appeals process is one that:
 - (i) Allows consumers to appeal when a health plan denies a claim for a covered service or rescinds coverage;
 - (ii) Gives consumers detailed information about the reason a claim was denied;
 - (iii) Gives consumers information about their right to appeal and how to start the appeals process;
 - (iv) Ensures a full and fair review of denial; and
 - (v) Provides for an expedited appeals process in urgent cases.
- 3) External Medical Review Process: States will also be required to enact external review policies that either, comply with the NAIC Model Act, or the HHS standards.
 - (i) NAIC Model Act recommends:¹²⁵
 - External review of denial decisions based on medical necessity, health care setting, appropriateness, level of care, or effectiveness of a covered benefit
 - Clear information be given to consumers about their rights to internal and external review
 - Expedited access to external review in emergency situations or in cases where the health plan did not follow internal review process
 - Health plans pay for the cost of the external appeal and that states may not require consumers to pay more than a nominal fee
 - Review organization be an independent body, randomly assigned by the state
 - Insurance companies abide by final decision of the independent organization¹²⁶
 - (ii) NAIC Model Act – Process for Filing an Appeal
 - Patients can file a request with the Commissioner for External Medical Review within four months of receiving a notice of a denial
 - The Commissioner notifies insurer of the request and insurer does a preliminary review to determine if patient is eligible for Independent Medical Review
 - The Commissioner randomly assigns an independent review organization
 - Independent review organization has 45 days to provide written notice of its decision to uphold or reverse the denial
- 4) Applies to:
 - (i) Grandfathered Plans: No
 - (ii) Self-Insured Plans: Yes

¹²⁵ It is important to note that these standards are just the minimum with which states and insurance companies must comply. The federal law does not preempt more protective state laws.

¹²⁶ <http://www.healthcare.gov/law/provisions/appealing/appealinghealthplandecisions.html>

V. CHANGES TO MEDICARE

A. For more information on Medicare, please refer to the Health Insurance & Health Care Options Chapter.

B. The ACA made several changes to the way that Medicare will operate.

- 1) **Part B:** Starting in 2007, Medicare Part B premiums were tied to an individual's income level, so that higher income Medicare beneficiaries have been paying a higher amount for their Part B premium. Each year, those income levels were decreasing so that more people were paying a higher Part B premium. The ACA froze the income threshold for Part B premiums to 2010 levels, through 2019, at \$85,000 for those who are single, and \$170,000 for those who are married. However, Part B premium amounts may still increase each year.
- 2) **Part C (Medicare Advantage Plans):** There are no significant changes in the ACA for enrollees in Medicare Advantage Plans. However, some Advantage Plan providers were receiving a reimbursement of approximately \$1,000 more per patient than Medicare fee-for-service providers. Under the ACA, those reimbursement rate gaps for Medicare fee-for-service providers and Advantage Plan providers will be closed.
- 3) **Part D and the Prescription Drug “Donut Hole”:** For more information on Medicare Part D, please refer to page 45 in the Health Insurance & Health Care Options chapter.
 - (i) Starting in 2010: A \$250 rebate was available for any Part D enrollee who entered the donut hole in 2010. Rebate checks were sent automatically. If you believe you should have received a rebate check, contact Medicare at (800) 633-4227.
 - (ii) Starting on July 1, 2010: In order for a drug to be covered by Medicare Part D, the drug company must enter into an agreement with the HHS Secretary to provide a significant discount (up to 50%) on name brand drugs to Part D enrollees who enter the donut hole.¹²⁷
 - (iii) Between 2011 and 2020: The prescription drug donut hole will progressively decrease, eventually requiring enrollees to only pay 25% of the cost of their brand name and generic drugs.¹²⁸

Year	You will pay this percentage for brand name drugs when you are in the coverage gap	You will pay for this percentage for brand name drugs when you are in the coverage gap
2012	50%	93%
2013	50%	86%
2014	47.5%	72%
2015	45%	65%
2016	45%	58%
2017	40%	51%
2018	35%	44%
2019	30%	37%
2020	25%	25%

¹²⁷ Closing the Coverage Gap—Medicare Prescription Drugs Are Becoming More Affordable. Centers for Medicare and Medicaid Services (2010). www.medicare.gov/Publications/Pubs/pdf/11493.pdf.

¹²⁸ *Id.*

VI. HEALTH INSURANCE COVERAGE OPTIONS

Please refer to the chapter on Health Insurance & Health Care Options for more information about current options.

A. **Expansion of Coverage for Children and Young Adults:**¹²⁹ Most people who attend college graduate by the age of 23. This typically means that they lose their full time student status and are no longer eligible for health insurance coverage through their parent's health insurance plan. Finding a job after graduation that offers health insurance can be very difficult. Under the ACA, young adults have access to health insurance coverage through their parent's health insurance policy longer than they would have previously.

1) **As of September 23, 2010:** Children may remain covered under their parent's plan until they reach the age of 26 years old.

(i) **Requirements:** Children cannot be eligible for employer-sponsored health insurance offered through their own jobs.

(ii) **Note:** The "child" does not need to be claimed as a dependent under IRS standards. Also, the child can be married; however, the plan's coverage will not extend to the child's children or spouse.

2) **Implementation Timeline:** Although this provision went into effect on September 23, 2010, the implementation time was up to the employer.

(i) Private employers had the option to implement this provision:

- Immediately after March 23, 2010 (early implementation)
- Immediately after September 23, 2010 (when the provision went into effect)
- At the beginning of the next plan year after September 23, 2010 (e.g., when the parent's plan is renewed). Therefore, the latest possible implementation date is September 22, 2011. At the time of publishing this manual, all plans will have had a new plan year, and therefore, all plans must offer dependent coverage for children up to the age of 26 under this provision.

(ii) This provision will go into effect for federal employees on January 1, 2011.

(iii) Plans were required to give written notice of the option to enroll children on the employee's plan by the first day of the plan year, and coverage for the dependent must start the first day of the plan year.

(iv) If parents are not enrolled through their employers, they were be given a one-time option to enroll (or change plans) for both themselves and their dependents.

3) Applies to:

- (i) Grandfathered Plans: Yes
- (ii) Self-Insured Plans: Yes

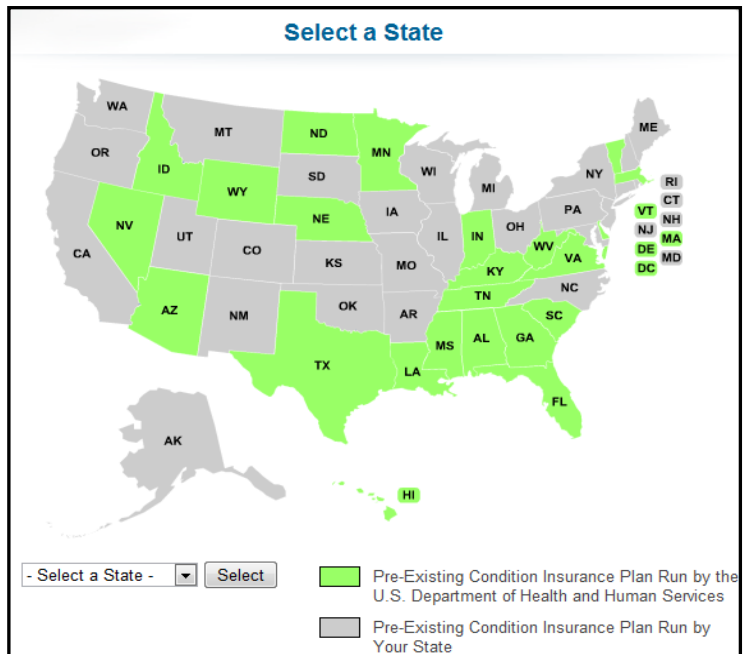
¹²⁹ §1201 of P.L. 111-148 (new PHSA §2704), as amended by §2301 of P.L. 111-152.

B. Pre-Existing Condition Insurance Plans¹³⁰

- 1) For background information on high risk insurance pools see the Health Insurance & Health Care Options chapter.
- 2) If an individual currently has a pre-existing medical condition, and is over the age of 19, then he or she may not be able to purchase individual health insurance. Until the ACA protections for adults with pre-existing conditions are fully implemented in 2014, the federal government has provided high risk insurance plans to individuals with pre-existing conditions, which will remain in existence until 2014, when new options will be available.
 - (i) The ACA requires all states to have a Pre-Existing Condition Insurance Plan (PCIP). Some states opted to run their own plans, funded by the federal government, and some states chose to have federal government administer their state’s plan.
 - (ii) States began collecting applications for the PCIP plans on July 1, 2010. As of January 2012, all states are still accepting applications..

(iii) Eligibility:

- U.S. citizens or persons who are lawfully present;
- Who have a pre-existing illness or condition; and
- Who have had no creditable coverage for 6 months or more



(iv) Maximum Out-of-Pocket Costs (excluding premiums):

- Individuals: \$5,950
- Families: \$11,900

(v) Premiums: Monthly premiums for the PCIP plans will vary from state to state. For example, in 2011:

Age	0-34	35-44	44-54	55+
Illinois (State run)	\$149	\$192-\$269	\$280-\$393	\$408-\$562
Indiana (HHS run)	\$310	\$372	\$476	\$662

(vi) For more information on PCIP plans available in each state, go to www.healthcare.gov or www.pcip.gov/StatePlans.html, or contact the CLRC.

¹³⁰ ACA §1101 (pg. 23)

C. **Health Insurance Exchanges:** The PCIP plans established by the ACA will only last until July 1, 2014. After this date, individuals will have the option to purchase health insurance through the health insurance exchanges. The actual details of health insurance exchanges will vary state to state, but generally, they are supposed to provide an easier way for people to research options and obtain health insurance. States are required to have a baseline plan for their exchange by January 1, 2013. Some states, such as California, have already passed legislation to implement their state health insurance exchange.

- 1) Generally, the exchanges will provide:
 - (i) A standardized format for presenting plan options;
 - (ii) An internet portal for search, selection, purchase, and enrollment;
 - (iii) A toll-free telephone hotline to call for assistance;
 - (iv) A calculator to determine the actual cost of coverage for each plan option.
- 2) Five Plan Options in the Health Insurance Exchanges
 - (i) Bronze
 - Represents the minimum creditable coverage for most Americans
 - Provides the essential health benefits
 - Covers 60% of the benefit costs of the plan
 - (ii) Silver
 - Provides the essential health benefits
 - Covers 70% of the benefit costs of the plan
 - (iii) Gold
 - Provides the essential health benefits
 - Covers 80% of the benefit costs of the plan
 - (iv) Platinum
 - Provides essential health benefits
 - Covers 90% of the benefit costs of the plan
 - (v) Catastrophic Plan (limited eligibility)
 - Provides catastrophic coverage to people up to age 30; or
 - Those who are exempt from the individual mandate (e.g., religious objections)
 - This plan will only be available in the individual market
- 3) Implementation Timeline:
 - (i) 2014: Exchanges will be open to individuals and small businesses (50 and fewer employees).
 - (ii) 2017: States may allow employers with up to 100 employees to participate in exchange.

D. **Individual Mandates:** As of January 1, 2014, the ACA requires all US citizens and legal residents to have health insurance or pay a penalty.¹³¹

- 1) Exceptions:
 - (i) A break in coverage of less than 3 months;
 - (ii) Religious objections; and
 - (iii) Financial hardship (i.e., the required contribution to pay premiums would exceed 8% of household income).

¹³¹ ACA §§ 1501, 1502, and 10106 adding §§ 5000A and 6055 to the Internal Revenue Code (IRC); § 1002 of Reconciliation Bill.

- 2) Penalties for Non-Compliance: Those who choose not to buy health insurance will have to pay a penalty on their taxes. The amount of the penalty increases each year:
 - (i) 2014: ~\$95
 - (ii) 2015: ~\$325
 - (iii) 2016: ~\$695
 - (iv) 2017: The penalty will be adjusted for inflation, but can never cost more than the national average cost of a bronze plan¹³²

E. **Early Retiree Reinsurance Program:** The ACA gives employers a way to recoup some expenses for providing insurance to certain retirees. These are individuals who retire before the age of 65 and are not yet eligible for Medicare.

- 1) This program allows approved companies to use federal funds to lower premiums for employees and other health care cost relief to their retirees and workers and their families, to offset increases in their own health care premiums or costs, or for combination of these purposes. This plan will reimburse employers or insurers for 80% of retiree claims between \$15,000 and \$90,000. This program will run until January 1, 2014, when the health insurance exchanges begin.
- 2) For more information, visit www.errp.gov.

VII. **MEDICAID ELIGIBILITY**

A. For more information on Medicaid, please refer to the Health Insurance & Health Care Options chapter.

B. As of January 1, 2014, states are required to expand Medicaid coverage to include:

- 1) “Newly-Eligible” Adults: Adults at the income level of 133% of the federal poverty level (FPL). In 2011, 133% FPL for an individual was \$14,484 per year or \$1,207 per month. For a family of four, 133% of the FPL was \$29,726 per year or \$2,477.16 per month
- 2) Children ages 6 to 19 at 133% of FPL.

C. **Notes:** States have the option to expand Medicaid eligibility beginning in 2010, but most states will not, because they cannot afford it due to budget crises. In 2014, when it becomes mandatory for states to expand their Medicaid programs the federal government will pay for the costs associated with the expansion of eligibility. However, some states, such as California, have applied for state waivers to pilot early implementation programs. For more information about state programs, contact the state’s Medicaid agency. (See the STATE APPENDICES)

VIII. **TAX IMPLICATIONS**

A. **Employer-Sponsored Health Insurance Included in W-2**

- 1) Beginning with the 2011 tax year, in order to help the government determine who has health insurance coverage through their employer, employers are able to include the “aggregate cost” of insurance on their employees’ W-2 forms. This will become required for the tax year 2012. Employers are required to report this amount, but it is not for the purpose of taxing the employee or the employer.¹³³

¹³² IRC § 5000A(c)(3).

¹³³ ACA §9002, amending ACA §6051(a) of the Internal Revenue Code of 1986; IRS website: www.irs.ustreas.gov/newsroom/article/0,,id=220809,00.html.

B. **Small Business Tax Credits**¹³⁴: Beginning in 2010, the ACA established tax credits for small businesses that are designed to encourage small employers to offer health insurance coverage for the first time or maintain coverage they already have for employees.

- 1) Eligibility: Small businesses with fewer than 25 full-time equivalent (FTE) employees making \$50,000/year or less per employee. However, because the formula is based on FTEs, not the number of employees, a business could be eligible even if it has more than 25 individual workers.
- 2) Amount of Credit: The credit amount will vary depending on the size of the employer. The following maximum credits are for smaller employers (10 or fewer FTEs making \$25,000/year or less).
 - (i) 2010 maximum credit: 35% of the premiums an employer pays for its employees.
 - (ii) 2014 maximum credit: 50% of the premiums an employer pays for its employees.
- 3) Applying for Credit: The IRS will be automatically notifying businesses that may qualify for the credit. If you have questions about this credit, contact the IRS at www.irs.gov or call 800-829-4933.

C. **Premium Tax Credit**: Beginning on January 1, 2014, the ACA provides subsidies for individuals with incomes between 133% and 400% of the FPL, in order for them to purchase health insurance in the exchanges. Those with incomes between 100% and 133% of FPL may also be eligible for reduced cost sharing (e.g., copayments, coinsurance, & deductibles).¹³⁵

- 1) Eligibility: This credit is not available to most people who have:
 - (i) Employer-sponsored health insurance;
 - Unless the employer coverage is below 60% actuarial value or if premiums exceed 9.5% of their income
 - (ii) Medicare or Medicaid;
 - (iii) CHIP; or
 - (iv) TRICARE or coverage through Veterans Affairs.
- 2) Process: A person will enroll in a plan offered through an exchange and report her income to the exchange. Based on that information the person will get a premium assistance credit. The federal government will then pay the credit directly to the person's insurance plan. The person is then only responsible for paying the difference between the premium tax credit and the total monthly premium.
 - (i) The credit will be either:
 - The total monthly premium for the taxpayer and any covered dependents; or
 - The amount over a percentage of the household income that it costs to purchase the lowest "Silver" plan purchased through the Exchange. The percent of the household income is on a sliding scale based on FPL ranging from 2% to 9.5% of income.

¹³⁴ Information from IRS: www.irs.gov/newsroom/article/0,,id=220848,00.html. At the time of publishing this edition, the IRS was still working with HHS to obtain the average premium figures for the Small Employer Health Care Tax Credit for the 2011 tax year.

¹³⁵ ACA § 1401, adding § 36B to the Internal Revenue Code of 1986; ACA § 10105, amending § 36B to the Internal Revenue Code of 1986.

⇒ Example: Jane has an income that is 250% of the federal poverty level (FPL) (~\$29,000 in 2014). The cost of the second lowest cost silver plan in the exchange in Jane’s area is estimated to be approximately \$5,000 per year. Under the ACA, because Jane’s income puts her at 250% FPL, she would not be required to pay more than 8.05% of income for her health insurance coverage, or \$2,334.50, to enroll in the second lowest cost silver plan. The tax credit available to Jane would be \$2,665.50 (\$5,000 premium minus the \$2,334.50 limit on what Jane must pay).¹³⁶

D. **High-Cost Excise Tax:** The ACA imposes an excise tax on “Cadillac plans,” which are high-cost health insurance policies, usually with low deductibles and very good benefits.¹³⁷

- 1) Beginning in 2018, insurance companies will be taxed on the amount of premiums above the established thresholds of \$10,200 for an individual plan, and \$27,500 for a family plan. These are not taxes to be paid by employees or employers.

IX. RESOURCES

<p>For information about the ACA: www.HealthCare.gov</p>	<p>For more information on the federal Pre-Existing Condition Plan options available in each state: www.PCIP.gov</p>
<p>Kaiser Family Foundation Video, “Healthcare Reform Hits Main Street:” healthreform.kff.org/the-animation.aspx</p>	
<p>For information about implementation and oversight of the ACA provisions related to private health insurance: The Center for Consumer Information and Insurance Oversight (CCIIO): http://cciio.cms.gov/</p>	

¹³⁶ Note: This is only an example based on estimate figures for 2014.

¹³⁷ www.kaiserhealthnews.org/Stories/2010/March/18Cadillac-Tax-Explainer-Update.aspx; ACA § 9001, adding § 4980I to the Internal Revenue Code of 1986.