WHAT IS THE AFFORDABLE CARE ACT?

President Obama signed the Patient Protection and Affordable Care Act (known as the Affordable Care Act or ACA) into law on March 23, 2010. While this complex legislation affects all healthcare stakeholders, its primary focus is on insurance market reform.

AFFORDABLE CARE ACT TIMELINE AND PROVISIONS

On the following pages are some of the major ACA provisions, presented by the year they became or will become effective, with a particular focus on the big changes in 2014. For a more complete list of provisions, please visit the websites noted below.

2010

- **Extended coverage.** Parents and guardians can keep their adult children on their health insurance coverage to age 26.

- **Insurer requirements.** Health insurance plans are prohibited from dropping policyholders who get sick, placing lifetime limits on the dollar value of coverage, denying children coverage based on pre-existing conditions, and other actions. Insurers are required to cover certain preventive services without charging copay, coinsurance, or deductibles. New, robust claims and appeals procedures take effect. Other requirements include increased transparency.

- **Premium tax credit.** Small employers (< 25 full-time equivalents)—with average annual wages less than $50K per employee and who pay at least half of the premium cost of their employee health plans—are eligible for a premium tax credit of up to 35%.

- **Community Health Needs Assessments.** Nonprofit hospitals are required to conduct “community needs assessments” and develop a financial assistance policy.

- **The Patient-Centered Outcomes Research Institute** is established (nonprofit and independent of the government) to conduct research into best practices and the comparative effectiveness of treatments. Task forces on Preventive Services are also funded.
2011

- **Extended Medical Loss Ratio.** Insurers are required to annually report their “medical loss ratios”—the percentage of health insurance premium spent on medical care and quality-improvement activities (versus administrative costs/overhead and profits)—and provide premium rebates to insureds on a pro-rata basis for each of the insurer’s plans for which its medical loss ratio is less than:
  - 80% in the individual and small employer markets; and
  - 85% in the large employer market.
- **Rate Review.** Insurers must inform the public and justify any proposed premium increases for individual and small employer plans of 10% or more.
- **Innovation Center.** CMS develops the Center for Medicare and Medicaid Innovation to test innovative payment and delivery models.

2012

- **ACOs.** CMS certifies the first Medicare Accountable Care Organizations. (Intermountain does not pursue certification but is actively developing its Shared Accountability strategy.)
- **Readmissions Reduction Program.** CMS begins its Readmissions Reduction Program, which reduces payments to hospitals with high readmission rates.
- **A new Summary of Benefits and Coverage (SBC) must be provided** by employers and insurers to applicants and enrollees before enrollment or re-enrollment. The SBC must accurately describe, in a prescribed format, the benefits and coverage offered through the applicable plan(s).

2013

- **Health Flexible Spending Account (FSA) elections** are capped at $2,500.
- **Health Insurance Marketplaces.** Open enrollment in state-based health insurance marketplaces (previously called health insurance exchanges) begins October 1.

2014

On January 1, 2014:

- **Guaranteed Issue/Renewability.** Insurers in the individual and group markets must accept every applicant for health coverage, regardless of health status. Insurers must renew coverage at the option of the employer or individual, regardless of claims experience.
- **No Pre-existing Condition Exclusions.** Insurers in the individual and small employer markets are prohibited from imposing pre-existing condition exclusions.
- **Community Rating.** Insurers in the small employer and individual markets must determine premiums for coverage using adjusted community rating rules. The only permissible factors are: self versus family coverage; geography, as determined by the state; age (by no more than a 3:1 ratio for adults; and tobacco (by no more than a 1.5:1 ratio).
• **Individual Mandate.** Most Americans are required to either maintain minimum essential health coverage for themselves and their dependents, qualify for an exemption, or be subject to a shared responsibility payment (penalty). The limited exemptions include those for: religious conscience, Indian tribes, the incarcerated, and those not lawfully present in the country. The penalties start modestly, for 2014 at the greater of 1% of taxable income or $95 times the number of uncovered individuals in the family (not to exceed 300% of $95); and rise after that, in 2016 reaching the greater of 2.5% of taxable income or $695 times the number of uncovered individuals in the family (not to exceed 300% of $695); subject to a ceiling of the average annual premium the individual would have to pay for qualifying private health insurance.

• **Individual Subsidies.** Two kinds of subsidies are available for low-income individuals:
  
  **Premium tax credits.** Citizens and legal residents in families with incomes between 100% and 400% of federal poverty level (FPL) who purchase coverage through a Marketplace are eligible for a (sliding scale) tax credit to help reduce the cost of coverage.

  **Reduced cost-sharing.** Families with incomes at or below 250% of FPL are also eligible for reduced cost-sharing, i.e., receiving higher actuarial value. In addition, people with incomes at or below 400% of FPL have their out-of-pocket liability capped at lower levels. Subsidies are not available for those who are eligible for public coverage (including Medicaid, CHIP and Medicare) or qualifying employer-sponsored coverage.

• **Health Insurance Marketplaces.** Each state has a new online marketplace for both individuals and small employers, where purchasers can comparison shop between new, standardized health plans called “Qualified Health Plans” or QHPs, which must offer a core set of “Essential Health Benefits” and meet other standards regarding quality, marketing, network adequacy, etc. States have the option of creating and administering these marketplaces themselves (a state-based marketplace), having the federal government do it for them (a federally facilitated marketplace), or entering into a hybrid (partnership) model. Utah has chosen a federally facilitated marketplace in the individual market, and a state-based marketplace in the small group market. The federal government agreed with Utah’s request to allow Avenue H, the Utah exchange that existed before the Affordable Care Act, to serve as an ACA-compliant small-employer marketplace.

• **Medicaid Expansion.** In participating states—to all individuals with income up to 133% of the poverty line.

• **DSH Payments.** Federal payments to “disproportionate share hospitals” that treat high proportions of patients unable to pay begin to be reduced and adjusted.

**2015**

• **Large Employer “Shared Responsibility” (Play or Pay).** Large employers (>50 full-time equivalents) are penalized for not offering “minimum essential coverage” to their full-time employees. There are actually two different kinds of penalties:
Failure to offer minimum essential coverage to substantially all full-time employees and their dependents. The penalty is $2,000 annually times the total number of full-time employees minus 30; and

Failure to provide affordable coverage (no more than 9.5% of household income) or minimum value (60% actuarial value) to full-time employees. The penalty is $3,000 annually for each full-time employee receiving a premium tax credit or cost-sharing reduction in a Marketplace.

In both cases, the penalty is assessed if/when a full-time employee receives an individual subsidy through a Marketplace.

- Medicare payments to physicians incentivize the provision of high-value care.
- CHIP. The federal match for the Children’s Health Insurance Program (CHIP) is significantly increased.

2016

- “Compacts.” States may form healthcare compacts that allow health insurance plans to be sold across state lines.

2018

- High-cost health insurance plans (so-called “Cadillac” plans) are subject to a 40% excise tax.

2020

- The prescription drug “donut hole” for Medicare-eligible people—the Medicare Part D coverage gap—is completely phased out. (The term “donut hole” refers to the difference between the initial coverage limit and the catastrophic coverage threshold. In 2013, the gap occurs between $2,970 and $4,750 of prescription drug expenses. That is, Medicare enrollees must pay prescription expenses beyond $2,970 until they reach the threshold of $4,750.)

WEBSITES WITH COMPREHENSIVE HEALTHCARE REFORM INFORMATION


(Also see SelectHealth At-A-Glance reform updates)