



Affordable Health Care for America Act (H.R. 3962): Summary of Coverage Provisions Passed by U.S. House of Representatives

The Affordable Health Care for America Act was introduced in the House of Representatives on October 29, 2009 and was passed on November 7, 2009. The following summary explains key health coverage provisions in the legislation.

Individual Mandate

All individuals will be required to have health insurance, with some exceptions, beginning in 2013. Those who do not have coverage will be required to pay a financial penalty of 2.5% of adjusted gross income that is capped at the average cost of qualified coverage. Exceptions will be given to people with incomes below the tax filing threshold (\$9,350 for individuals and \$18,700 for couples), for religious objections, and for financial hardship.

Expansion of Public Programs

Medicaid will be expanded to all individuals under age 65 with incomes up to 150% of the federal poverty level (\$16,245 for an individual and \$33,075 for a family of four in 2009). This expansion will create a uniform minimum Medicaid eligibility threshold across states and will eliminate a current limitation of the program that prohibits most adults without dependent children from enrolling in the program today. States will be required to maintain Medicaid eligibility levels above 150% of the poverty level into the future. The Children's Health Insurance Program (CHIP) will end in 2014; children with family incomes below 150% of the poverty level will move into Medicaid, while those with incomes above that level will obtain subsidized coverage through the newly created National Health Insurance Exchange.

- Medicaid coverage will be provided to all uninsured newborns until they can be enrolled in other coverage. In addition, states will be given the option to provide Medicaid coverage to low-income HIV-infected individuals and for family planning services to certain low-income women.
- The costs of the Medicaid expansion will be financed jointly between the federal government and the states. The federal government will provide 100% federal funding for the costs of those who become newly eligible for the program for two years (2013-2014). Beginning in 2015, federal financing for these costs will drop to 91%.

National Health Insurance Exchange

A National Health Insurance Exchange will be created where individuals and employers can purchase insurance. This new marketplace 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.

- People can only purchase coverage through the Exchange if they do not have other qualified health coverage, or if their share of the premium for coverage offered by an employer exceeds 12% of their family income. Access to plans in the Exchange will be phased-in for employers, starting with the smallest employers.
- Individuals will be able to choose among private plan options and a public plan. The public plan must meet the same requirements as private plans regarding the minimum benefits, provider networks, consumer protections, and cost-sharing.
- Plans in the Exchange 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.

- Premium subsidies will be provided to families with incomes up to 400% of the poverty level (\$88,200 for a family of four in 2009) to help them purchase insurance through the Exchange. These premium subsidies will be offered on a sliding scale basis and will limit the cost of the premium to between 3% of income for those at 150% of the poverty level to 12% of income for those at 400% of the poverty level. Cost-sharing subsidies will also be available 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, gender, or occupation. These new rules will also require that all 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 (employer plans must comply with these coverage requirements by 2018).

- Health plan premiums will be allowed to vary based on age (by a 2 to 1 ratio), geographic area, and the number of family members.
- Health insurers will be required to spend at least 85% of their revenue on health coverage, rather than on administrative costs and profits, and they will be prohibited from rescinding coverage, except in cases of fraud.
- Increases in health plan premiums will be subject to review before they can be implemented.
- Young adults will be allowed to remain on their parent's health insurance up to age 27.

Employer Requirements

Employers will be required to offer coverage to their employees and to contribute a specified share of the premium cost or pay a penalty of 8% of payroll. Small employers with total payroll of less than \$500,000 will be exempt from the requirement and those with payroll between \$500,000 and \$750,000 that do not offer coverage will pay a reduced penalty.

- Small employers that employ lower-wage workers will be eligible to receive a tax credit to help them afford coverage for their employees.
- 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 bill will reduce the number of uninsured by 36 million in 2019 at a net cost of \$894 billion over ten years. According to the CBO, by 2019, the bill would result in 21 million people obtaining coverage in the newly created National Health Insurance Exchange, including some who previously purchased insurance on their own in the individual market. In addition, 15 million more people would enroll in Medicaid and an additional six million would obtain coverage through an employer. The cost of the bill is financed through a combination of savings from Medicare and Medicaid and new taxes and fees. The Congressional Budget Office estimates the proposal will reduce the deficit by \$109 billion over ten years.

For more information about the Affordable Health Care for America Act, see the side-by-side comparison of the health reform proposals at <http://www.kff.org/healthreform/sidebyside.cfm> and the legislation text at <http://thomas.loc.gov/cgi-bin/query/z?c111:H.R.3962:>

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