FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

Patient Protection and Affordable Care Act: Summary of Coverage Provisions For U.S. Senate Consideration

The Patient Protection an Affordable Care Act was released on November 18, 2009; debate on the bill began on November 30, 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 2014. Those who do not have coverage will be required to pay a yearly financial penalty of $750 per person, up to a maximum of $2,250 per family, which is phased-in from 2014-2016. Exceptions will be given for financial hardship and religious objections; and to American Indians; people who have been uninsured for less than three months; if the lowest cost health plan exceeds 8% of income; and if the individual has income below the poverty level ($10,830 for an individual and $22,050 for a family of four in 2009).

Expansion of Public Programs

Medicaid will be expanded to all individuals under age 65 with incomes up to 133% of the federal poverty level ($14,404 for an individual and $29,327 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. Eligibility for Medicaid and the Children's Health Insurance Program (CHIP) for children will continue at their current eligibility levels until 2019. People with incomes above 133% of the poverty level will obtain coverage through the newly created state health insurance Exchanges.

- The federal government will provide 100% federal funding for the costs of those who become newly eligible for the program for three years (2014-2016). In 2017 and 2018, states will receive an increase in the federal medical assistance percentage (FMAP) based on current state eligibility levels for adults, and then beginning in 2019, all states will receive the same FMAP increase.

American Health Benefit Exchanges

States will create the American Health Benefits Exchanges where individuals can purchase insurance and separate exchanges for small employers to purchase insurance. These new marketplaces 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.

- Access to Exchanges will be limited to U.S. citizens and legal immigrants. Individuals who are incarcerated are excluded. Small businesses with up to 100 employees can purchase coverage through the Exchange.
- Individuals will be able to choose among private plan options and a public community health plan option, though states will have the option of not offering the public plan in their Exchange. If it is offered, the community health plan must meet the same requirements as private plans regarding the minimum benefits, provider networks, consumer protections, and cost-sharing.
- Plans in the Exchanges will be required to offer benefits that meet a minimum set of standards. Insurers will offer four levels of coverage and catastrophic 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 between 100-400% of the poverty level ($88,200 for a family of four in 2009) to help them purchase insurance through the Exchanges. These subsidies will be offered on a sliding scale basis and will limit the cost of the premium to between 2% of income for those between 100-133% of the poverty level to 9.8% of income for those between 300- 400% of the poverty level.
- Cost-sharing subsidies will also be available to people with incomes between 100-200% of the poverty level 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 and gender. These new rules will also require that all new 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 (existing individual and employer-sponsored plans do not have to meet the new benefit standards).

- Health plan premiums will be allowed to vary based on age (by a 3 to 1 ratio), geographic area, tobacco use (by a 1.5 to 1 ratio), and the number of family members.
- Health insurers will be prohibited from imposing lifetime limits on coverage and 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 26.
- States are allowed to form health care choice compacts that enable insurers to sell policies in any state that participates in the compact. Insurers are also allowed to offer a national health plan with specified benefit levels in any state in which they are licensed, and the plan would be exempt from state benefit requirements.
- Health plans cannot impose a waiting period for coverage of more than 90 days.

Employer Requirements

There is no employer mandate but employers with more than 50 employees will be assessed a fee of $750 per full-time employee if they do not offer coverage and if they have at least one employee who receives a premium credit through an Exchange. Employers who do offer coverage but have at least one employee who receives a premium credit through an Exchange are required to pay the lesser of $3,000 for each employee that receives a premium credit or $750 for each full-time employee.

- Large 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 31 million in 2019 at a net cost of $848 billion over ten years. According to the CBO, by 2019, the bill would result in 25 million people obtaining coverage in the newly created state health insurance Exchanges, including some who previously purchased insurance on their own in the individual market. In addition, 15 million more people would enroll in Medicaid. CBO estimates that the number of people with employer coverage and individual coverage would each decrease by five million enrollees. 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 $130 billion over ten years.

For more information about the Patient Protection and Affordable Care 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://www.democrats.senate.gov/.

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