



# Provisions of the Affordable Care Act and Washington's Health Insurance Exchange

WASHINGTON STATE UNIVERSITY EXTENSION FACT SHEET • FS121E

The Affordable Care Act (ACA) was signed into national law on March 23, 2010. The United States Supreme Court upheld the constitutionality of most of its provisions on June 28, 2012, with the notable exception of Medicaid expansion. Although most of the provisions are expected to take effect on January 1, 2014, a number of provisions have been implemented already.

Given the vastness of the ACA, this factsheet will focus on explaining some popular provisions related to employers, private insurance, and Medicare, Medicaid, and dual-eligible beneficiaries, along with their implementation timelines. In the final section, the factsheet will explain the concept of state-based health insurance exchanges and related activity in the state of Washington.

The information provided here has been primarily compiled from [HealthCare.gov](http://www.healthcare.gov) and Kaiser Family Foundation ([www.kff.org](http://www.kff.org)). Specific links and resources are presented in the reference list, below. This factsheet is intended to provide the most up-to-date information (current as of August 13, 2013) on the provisions of the ACA, and will not analyze implications of any of the provisions or estimate the impact of the ACA on access, costs, and health outcomes. These issues will be discussed separately in future policy briefs and factsheets.

## Private Insurance

### In effect (as of 2013)

**Access and coverage.** In an effort to expand coverage and access, the ACA extends coverage of young adults up to age 26 years through their parents' insurance policies (inclusive of all individual and group policies), and prohibits coverage exclusions for children with pre-existing conditions. Protections for children with pre-existing conditions took effect on September 23, 2010. Similar prohibition for adults will take effect in 2014. In the meantime, the federal government is offering a temporary Pre-existing Condition Insurance Plan (PCIP) in 23 states and the District of Columbia (while the remaining states, including Washington, are running their own programs) to provide health coverage to high-risk adults with pre-existing medical conditions who have been uninsured for at least six



### Home page for HealthCare.gov.

months. Washington's PCIP started coverage for enrollees on September 1, 2010.

The ACA also prohibits insurance companies from rescinding coverage except in cases of fraud; prohibits individual and group health plans from placing lifetime limits on the dollar value of essential benefits (such as hospital stays); and provides consumers with a way to appeal coverage decisions or claims to their insurance company while insurance companies are required to establish an external review process for new plans. All new plans are to cover certain preventive services (such as mammograms and colonoscopies) without charging a deductible, co-payment, or coinsurance.

**Information.** The ACA requires the Department of Health and Human Services to develop a website to help consumers compare health coverage options and identify preferred coverage. The website is located at <http://www.healthcare.gov/>. The ACA also requires private individual and group health plans to provide a uniform summary of benefits and coverage to all applicants and enrollees that is easy to read and understand.

**Rebates.** Medical loss ratio (MLR) is the share of insurance premium dollars spent on reimbursement for clinical services and activities to improve health care quality, as opposed to administrative costs and profits (including executive salaries, overhead, and marketing). Beginning

in 2011, insurance companies are required to spend 80% of premium dollars for plans in the individual and small group markets and 85% for plans in large group market on medical care and quality improvement activities, meeting a MLR standard. Companies not meeting the MLR standard are required to provide rebates to their enrollees beginning in 2012. For those enrolled in group policies the final rule, published by the Department of Health and Human Services in May 2012, directs issuers to provide rebates to the group policyholder (usually the employer) through lower premiums or in other ways that are not taxable.

## To be implemented (2014 onwards)

The two most discussed features of the ACA are individual requirement to have insurance and establishment of health insurance exchanges (discussed in detail in the final section, below).

**Basic Individual Insurance.** Starting in 2014, all U.S. citizens and legal residents must be enrolled in a health insurance plan that provides basic benefits. There will be a penalty for being without insurance, with exceptions for low-income individuals (below the threshold for filing a tax return), those who cannot afford coverage, those incarcerated, members of Indian tribes, and conflicts with religious beliefs. The affordability exemptions are slightly different under the individual mandate and the employer mandate and explained here using information from Internal Revenue Service regulations.

Note that the individual mandate requires most individuals to maintain minimum essential health coverage or pay a penalty. A lower-income individual receives a refundable premium tax credit if he/she is not eligible for affordable coverage from another source and purchases individual health insurance. The employer mandate imposes an excise tax on large employers that fail to offer affordable, minimum value coverage to their full-time employees.

An employee's own coverage under an employer group health plan is "affordable" if his/her required contribution for the lowest-cost, self-only coverage (whether paid through salary reduction or otherwise) is not more than 8% of his/her household income. Employer group health coverage is "affordable" if an employee's required contribution is no more than 9.5% of the employee's annual household income for the lowest-cost, self-only coverage that provides "minimum value." The coverage provides "minimum value" if it covers at least 60% of the total allowed costs of benefits provided under a typical large employer plan. See <http://www.insidecompensation.com/2013/02/25/irs-clarifies-family-health-coverage-mandates/> for a complete discussion of the family health coverage mandates.

The penalty for noncompliance is assessed at the greater of either \$95 per adult (\$47.50 per child and up to \$285 for a family) in 2014 or 1% of family income; at the greater of either \$325 per adult (\$162.50 per child and up to \$975 for a family) in 2015 or 2% of family income; and, at the greater of either \$695 per adult (\$347.50 per child and up to \$2,085 for a family) in 2016 and thereafter or 2.5% of family income.

**Annual coverage limits.** Starting in 2014, the ACA prohibits annual limits on the dollar value of coverage in all individual and group plans.

**Grandfathered plans.** Grandfathered health plans are not required to comply with some of the consumer protections of the ACA that apply to the other plans. A plan may be considered a grandfathered plan if it existed on March 23, 2010, and if it covered at least one person continuously from that day forward.

Grandfathered plans are not required to: 1) provide certain preventive services at no additional charge to enrollees; 2) offer new protections when an enrollee appeals claims and coverage denials; and 3) protect the choice of health care providers and access to emergency care. In addition, grandfathered individual plans are not required to phase out annual dollar limits on key benefits or to eliminate pre-existing condition exclusions for children under 19 years old.

**Essential health benefits.** The ACA ensures that health plans offered in the individual and small group markets offer a core package of items and services, known as essential health benefits (EHB), which must include items and services within at least the following ten categories:

- ambulatory patient services,
- emergency services,
- hospitalization,
- maternity and newborn care,
- mental health and substance use disorder services, including behavioral health treatment,
- prescription drugs,
- rehabilitative and habilitative services and devices,
- laboratory services,
- preventive and wellness services and chronic disease management, and
- pediatric services including oral and vision care.

Each state can select a benchmark plan from among several options including the three largest small-group plans, the three largest state employee health plans, the three larg-



*Prescription drug coverage is one of the core package items that is included in individual and group health plans.*

est federal employee health plans, and the largest Health Maintenance Organization (HMO) insurance offered in the state's commercial market. In the state of Washington, the EHB will be based on the largest health plan in the small employer market (Regence's Innova Plan) and will include all current state mandated benefits. The Children's Health Insurance Program (CHIP) will serve as the pediatric dental supplement, and the Federal Employee Vision Plan as the pediatric vision supplement in the state.

## Medicare, Medicaid, and Dual-Eligibles

### In effect (as of 2013)

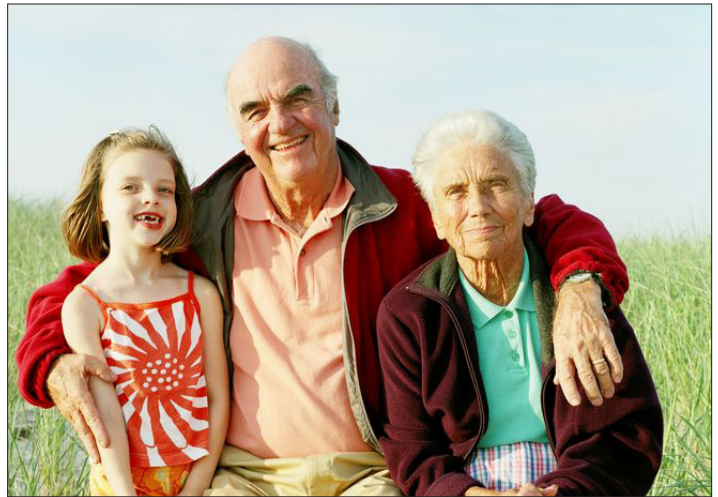
**Payments.** Beginning 2013, the ACA has established a national Medicare pilot program to develop care coordination and evaluate bundled payments for acute, inpatient hospital services, physician services, outpatient services, outpatient hospital services, and post-acute care services for an episode of care. In other words, under "bundling," hospitals, doctors, and providers are paid a flat rate for an episode of care instead of the current system of billing each service separately. The design is expected to improve the efficiency of care delivery and the overall quality of care while aligning incentives to providers as savings are shared between providers and the Medicare program.

Through the Bundled Payments for Care Improvement initiative, the ACA has also created new demonstration projects in Medicaid in a small number of states (starting January 1, 2012 and ending December 31, 2016) to pay bundled payments for episodes of care that include hospitalizations. Currently, no health care organization from Washington is participating in the BPCI initiative.

In order to reduce the discrepancy between spending per person for those in traditional Medicare and those enrolled in Medicare Advantage plans, the ACA reduces rebates paid to Medicare Advantage plans and provides bonus payments to high-quality plans. Effective January 2014, the ACA requires Medicare Advantage plans to have MLR no lower than 85%.

**Drug rebates.** Medicare beneficiaries who reached the gap in Medicare prescription drug coverage in 2010, commonly known as the "donut hole," received a one-time, tax-free \$250 rebate check. Beginning 2011, eligible seniors receive a 50% discount when buying Medicare Part D covered brand-name prescription drugs. Further subsidies and discounts on brand-name and generic drugs over the next decade will continue till the coverage gap is closed in 2020. The ACA also increases the Medicaid drug rebate percentage for brand-name and generic drugs (although at different rates), and Medicaid managed care plans.

**Primary care.** The ACA provides a 10% Medicare bonus payment for primary care services and to general surgeons practicing in health professional shortage areas from January 1, 2011, through December 21, 2015. From January 1, 2013, until December 31, 2014, the ACA increases Medicaid payments for primary care services provided by primary care physicians to 100% of the Medicare payment rate, and is financed fully by federal funding.



*A new Medicare pilot program "bundles" services into one bill instead of paying for services separately.*

**Prevention benefits.** Effective January 2011, the ACA provides certain free preventive services (such as annual wellness visits) to Medicare beneficiaries and waives the Medicare deductible for colorectal cancer screening tests. In January 2011, the ACA provided 3-year grants to states to develop programs to provide Medicaid enrollees with incentives for chronic disease prevention through participation in comprehensive healthy lifestyle programs.

**Premiums.** There has been a small increase to the Medicare Part B monthly premium and a reduction in the Medicare Part D premium subsidy for higher income beneficiaries starting January 2, 2011.

**Medicare tax.** Effective January 1, 2013, the ACA has increased the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings exceeding a threshold amount. The threshold amount is \$200,000 for individual taxpayers, \$125,000 in the case of a married taxpayer filing a separate return, and \$250,000 for joint returns. It has also imposed a 3.8% tax on certain individuals, estates, and trusts. For an individual, the 3.8% assessment is on the lesser of (a) the individual's net investment income for the taxable year, or (b) the excess of the individual's modified adjusted gross income for the taxable year over the threshold amount. In the case of an estate or trust, the 3.8% assessment is on the lesser of (a) the estate or trust's undistributed net investment income for the taxable year, or (b) the excess of the estate or trust's adjusted gross income over the dollar amount at which the highest tax bracket begins for the taxable year. See [www.gpo.gov/fdsys/pkg/FR-2012-12-05/pdf/2012-29238.pdf](http://www.gpo.gov/fdsys/pkg/FR-2012-12-05/pdf/2012-29238.pdf) for details.

**Hospital readmissions.** Starting October 1, 2012, the ACA has reduced Medicare payments to hospitals as an incentive for hospitals to reduce excessive preventable readmissions.

**Hospital-acquired infections.** The ACA has prohibited federal payments to states for Medicaid services related to certain hospital-acquired infections starting July 2011. For similar reason, Medicare payments will be reduced by 1% starting 2015.

**Common to Medicare and Medicaid.** In 2010 the ACA established the Federal Coordinated Health Care Office to improve care coordination for dual-eligibles (individuals eligible for both Medicare and Medicaid). The Center for Medicare and Medicaid Innovation was established by January 1, 2011, to test new payment and delivery system models that reduce costs while improving quality of care. In January 2012, the ACA established procedures for screening, oversight, and reporting for providers and suppliers that participate in Medicare, Medicaid, and Children's Health Insurance Program to reduce fraud, waste, and abuse. Disproportionate Share Hospital (DSH) adjustment payments provide additional assistance to those hospitals that serve a significantly disproportionate number of low-income patients. Effective October 1, 2013, the ACA will initially reduce Medicare DSH payments by 75%, but then increase payments to providers based on a realigned payment system accounting for the percent of population still uninsured and the amount of uncompensated care provided. Similarly, effective October 1, 2013, the ACA will reduce states' Medicaid DSH, depending on each state's volume of uninsured and uncompensated care.

### To be implemented (2014 onwards)

Effective January 1, 2014, the ACA will expand Medicaid coverage to those not eligible for Medicare but earning less than 133% of the poverty level. States will receive 100% federal funding for the first three years to expand coverage, subsequently phasing down to 90% federal funding.

## Employers

### In effect (as of 2013)

**Small business tax credits.** Beginning January 2010, the ACA has provided tax credits to small businesses with no more than 25 full-time equivalent (FTE) employees and average annual wages of less than \$50,000 per FTE, and if the employers paid premiums for employee health insurance coverage. In tax years 2012 and 2013, the maximum tax credit is 35% of the non-tax-exempt employer's eligible premium expenses and 25% for tax-exempt employers. Beginning 2014, the credit will be increased to 50% and 35% respectively, for businesses that get insurance through the Small Business Health Options Program.

### To be implemented (2014 onwards)

Beginning January 2015 (originally slated for January 1, 2014; change announced on July 2, 2013), large businesses (with 50 or more full-time employees) that do not provide adequate health insurance coverage will be required to pay an assessment if at least one of their full-time employees receives premium tax credits to buy his or her own insurance. The assessment for a large employer that does not offer coverage will be \$2,000 per full-time worker beyond the first 30 workers. Large businesses that offer coverage but have at least one full-time employee receiving a premium tax credit will pay the lesser of either \$3,000 for each employee receiving a premium credit or \$2,000 for each full-time employee beyond the first 30 employees.

"Lookalike" health insurance websites are popping up online. Security experts advise *not* using a search engine such as Google or Bing to find official health insurance exchange sites or information. Consumers are encouraged to begin their health insurance search at the Washington State Insurance Commissioner's website at <http://www.insurance.wa.gov/> and follow links from there to be sure they've reached a legitimate website.

## Health Insurance Exchanges in Washington State

Creating state-based health insurance exchanges (or marketplaces) to provide affordable and competitive private health coverage is one of the key features of the ACA. States have three options: 1) establish a fully functional state-based exchange, 2) enter into a state-federal partnership exchange, or 3) default to a federally-facilitated exchange. All exchanges must be ready to begin enrolling consumers on October 1, 2013, and must be fully operational on January 1, 2014.

Washington is one of the seventeen states and District of Columbia to have declared an intent to create a fully functional state-based exchange. In December 2012, Washington State received a conditional approval from the federal Department of Health and Human Services to establish a state-based exchange. Conditional approval reflects the progress made towards deciding the structure and governance of facilitating exchange functions.

The Washington state exchange is funded by federal grants through 2014. Beginning January 2015, the ACA requires state-based health benefit exchanges to become financially self-sustaining.

Washington's online exchange is called the Healthplanfinder and its website is located at <http://wahbexchange.org/>. To inform Washington residents of upcoming changes, this website has already posted dates of future webinars and information from past webinars that discuss the new law and how the Healthplanfinder will work to enroll individuals in appropriate health plans. The webinars can be found at [www.wahbexchange.org/news-resources/webinar-](http://www.wahbexchange.org/news-resources/webinar-)

series/. A related Healthplanfinder website (<http://www.wahealthplanfinder.org/>) is designed to assist individuals, families, and small businesses (those with up to 50 employees) to use the web-based decision tools to compare and shop for insurance plans. Customer service and navigation or in-person assistance will be available.

This exchange will coordinate with public programs such as Medicaid, so that eligible low-income individuals or families may access savings on their insurance premiums and public programs at the same website.

Small businesses with up to 50 employees will be offered a menu of qualified health plans from different insurers and businesses may choose their level of contribution toward an employee's coverage. If a small business is eligible, the exchange will provide it with exclusive access to the small business health care tax credit from the Internal Revenue Service to help cover their monthly premiums.

The Washington State health exchange FAQ website is located at [www.wahbexchange.org/news-resources/frequently-asked-questions/](http://www.wahbexchange.org/news-resources/frequently-asked-questions/).

## References

Centers for Medicare and Medicaid Services. 2013. Consumer Information & Insurance Oversight: Essential Health Benefits Standard: Ensuring Quality, Affordable Coverage. <http://cciio.cms.gov/resources/factsheets/ehb-2-20-2013.html>.

Covington & Burling LLP. 2013. IRS Clarifies Family Health Coverage Mandates. *In* InsideCompensation: Developments in Employee Benefits and Executive Compensation. <http://www.insidecompensation.com/2013/02/25/irs-clarifies-family-health-coverage-mandates/>.

HealthCare.gov. 2013. The Affordable Care Act, Section by Section. <http://www.healthcare.gov/law/timeline/full.html#2013>.

Henry J. Kaiser Family Foundation. 2013. Establishing Health Insurance Exchanges: An Overview of State Efforts. <http://www.kff.org/healthreform/8213.cfm>.

Henry J. Kaiser Family Foundation. 2013. Health Reform: Health Reform Implementation Timeline. <http://healthreform.kff.org/timeline.aspx>.

Henry J. Kaiser Family Foundation. 2013. State Exchange Profiles: Washington. *In* Health Reform. <http://kff.org/health-reform/state-profile/state-exchange-profiles-washington/>.

Washington State Office of the Insurance Commissioner. 2013. Health Care Reform: New Coverage Options. <http://www.insurance.wa.gov/current-issues-reform/health-care-reform/>.

Washington State Office of the Insurance Commissioner Updates. 2012. Rule Making Starts for Essential Health Benefits. <http://wainsurance.blogspot.com/2012/07/rule-making-starts-for-essential-health.html>.

United States Department of the Treasury. 2012. New Investment Income Tax. *Federal Register* 77:234. [www.gpo.gov/fdsys/pkg/FR-2012-12-05/pdf/2012-29238.pdf](http://www.gpo.gov/fdsys/pkg/FR-2012-12-05/pdf/2012-29238.pdf).

United States Internal Revenue Service. 2013. Affordable Care Act Tax Provisions. <http://www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions>.



By **Bidisha Mandal**, School of Economic Sciences, Washington State University.

WSU Extension bulletins contain material written and produced for public distribution. Alternate formats of our educational materials are available upon request for persons with disabilities. Please contact Washington State University Extension for more information.

You may download copies of this and other publications from WSU Extension at <http://pubs.wsu.edu>.

Issued by Washington State University Extension and the U.S. Department of Agriculture in furtherance of the Acts of May 8 and June 30, 1914. Extension programs and policies are consistent with federal and state laws and regulations on nondiscrimination regarding race, sex, religion, age, color, creed, and national or ethnic origin; physical, mental, or sensory disability; marital status or sexual orientation; and status as a Vietnam-era or disabled veteran. Evidence of noncompliance may be reported through your local WSU Extension office. Trade names have been used to simplify information; no endorsement is intended. Published October 2013.