The Affordable Care Act
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On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA or PPACA) into law. The passage of this law was the culmination of more than a half century of struggle to develop a comprehensive system of health care for the American people. The Affordable Care Act passed after much fierce debate and much opposition from pharmaceutical companies and the health insurance industry. It contains many compromise provisions that were included in response to criticism from conservative opponents in and out of Congress.

The ACA is a long, complicated law that makes many, many changes to our health care system, some dramatic, some very small. The ACA will have a significant impact on hospitals, clinics and others who provide health care, especially to Medicare patients. The ACA will also significantly affect Americans who do not currently have health insurance. The impact on existing health insurance plans, including collectively bargained plans, though important, is much less dramatic.

Covering the Uninsured

One of the big problems that the ACA was intended to address was the fact that approximately 16% of Americans had no health insurance. Most Americans obtain their health insurance through an employer-provided plan or through Medicare (elderly and disabled) or Medicaid (low income). People without insurance tend to be working in low-paid or part-time jobs or unemployed. Their lack of health insurance means that they are at risk in several ways. Uninsured people who do need hospitalization or other expensive treatment may not find a hospital or doctor who is willing to treat them without a guarantee of payment. If they do get the care they need, the cost may spell financial disaster. Medical costs are a significant factor in most bankruptcies, even for people with insurance. Uninsured people tend not to get preventative care and may wait until a medical condition is critical, then go the Emergency Room. Care provided this way, is far more expensive than regular care in a doctor’s office. Much of the cost of care in an emergency room is uncompensated and hospitals pass along the cost of that care to insured patients. A 2009 report from Families USA estimated that an average

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1 The Affordable Care Act is sometimes referred to as “ObamaCare”, especially by opponents of the law. That label isn’t really accurate. President Obama didn’t write the law and the bill that eventually passed doesn’t have much resemblance to the proposals he made as a presidential candidate. It would be more accurate to call it “BaucusCare” since much of the bill that eventually became the ACA was written by Max Baucus, a Democratic Senator from Montana. The President, however, says he has grown fond of the ObamaCare label, so maybe it will stick.

2 A recent report suggests that medical bills are the single largest factor causing personal bankruptcies, affecting nearly 2 million people in 2013. http://www.cnbc.com/id/100840148
family health insurance premium was about $1,017 per year higher to cover the cost of uncompensated care.³

Over the years, many different ideas were advanced about how to solve this problem. Every other developed country has adopted some national plan to provide health care and/or health insurance coverage to its citizens. In some countries, Britain, for example, the government provides health care directly at little or no cost to citizens. In the US we use a similar model to provide health care to veterans. In other countries, Canada, for example, health care is provided through a mix of public and private doctors and hospitals, but the government provides health insurance to its citizens. In the US, we use a system like this to provide health insurance to the elderly and disabled (Medicare) and to low income people (Medicaid). In Germany, health care and health insurance are provided through a mix of public and private plans, with many citizens choosing the public health insurance option.

Congress did not adopt any of those models. Instead, the drafters of the ACA took their inspiration from Massachusetts. In 2006, under the leadership of Gov. Romney, Massachusetts developed a plan to provide universal coverage through private insurance companies. The Massachusetts plan got off to a bumpy start, but has proved successful, with more than 98% of people in Massachusetts now covered by insurance⁴ and health insurance premiums increasing at the same rate or slower than in other states.⁵

The ACA follows the Massachusetts model for dealing with the uninsured. All Americans will be required to obtain health insurance coverage for themselves and their family members (with a few very limited exceptions). This requirement, sometimes called an “individual mandate”, begins in 2014. Americans can satisfy this requirement by obtaining insurance under a group plan, typically an employer-sponsored plan, or by enrolling in a government-sponsored plan, Medicare or Medicaid, for example, or by purchasing insurance through new, state-based insurance “marketplaces” beginning on October 1, 2013.

Q. How is the individual mandate enforced? How will the government know whether someone has health insurance? What happens if they don’t?

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³ *Hidden Health Tax: Americans Pay a Premium*, Families USA, 2009.  
[http://familiesusa2.org/assets/pdfs/hidden-health-tax.pdf](http://familiesusa2.org/assets/pdfs/hidden-health-tax.pdf)

[https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Facts%2520and%2520Figures/Facts%2520and%2520Figures.pdf](https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Facts%2520and%2520Figures/Facts%2520and%2520Figures.pdf)

⁵ Conservative media have reported that premiums are “skyrocketing” in Massachusetts, but some stories include very creative math. In reality, premium increases have been modest in the last two years, but are expected to rise by 6-12% next year, very comparable to national rates.  
[http://www.boston.com/business/healthcare/2013/02/08/message-from-health-insurers-massachusetts-health-care-costs-are-heading/5GMUHK8qOr7VXv3ENWWF1O/story.html](http://www.boston.com/business/healthcare/2013/02/08/message-from-health-insurers-massachusetts-health-care-costs-are-heading/5GMUHK8qOr7VXv3ENWWF1O/story.html)
A. The ACA relies heavily on changes in the tax code to achieve its goals. Starting in 2014, individual income tax forms will have a place for the taxpayer to certify that all family members have insurance and to provide the plan name and number that covers them. The IRS will compare this information with reports from insurance companies and employers to confirm that it is accurate. People who do not obtain insurance will be subject to a tax penalty. The penalty is phased in, starting with the 2014 tax year, when the penalty will be $96/adult and $48/child or 1% of family income, whichever is higher. For the 2016 tax year and after, the penalty will be $695/adult, $347.50/child, up to $2085/family or 2.5% of family income, whichever is higher.\(^6\)

The IRS has proposed a rule which would waive the penalty, if the cost of the insurance for the whole family would exceed 8% of the family’s income.

Q. What about the 49 million people who don’t have insurance now? Where will they get insurance and how will they pay for it?

A. Starting in 2014 each of the 50 states is required to create an insurance “marketplace” where people can purchase health insurance. Despite what some people think, the ACA does not create any new government-run health insurance programs. The health insurance marketplaces are virtual shopping centers\(^7\) where individuals can purchase policies from private health insurance companies. The insurance marketplaces will have little direct impact on people who get their insurance through their employers, but it’s important to understand how they work, because it affects what employers are required or permitted to do.

Q. What’s the purpose of these “marketplaces”? What will they really accomplish?

A. There are several reasons why the marketplaces are important. First of all, the insurance policies sold through the marketplaces are standardized. All the policies will cover the same kinds of health care procedures and services. Four levels of coverage will be offered (platinum, gold, silver and bronze)\(^8\) but the only difference will be the amount of the co-pays. The same health care services will be covered under all marketplace plans. The intent is that standardizing the policies will make it easier for consumers to compare prices and thus increase price competition among insurance companies.

Second, prices will be standardized.\(^9\) Participating insurance companies will be required to sell insurance at a standard price to anyone who wants to buy it.

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\(^6\) To be more exact, the penalty is based on the amount of family income above the income tax filing threshold.

\(^7\) In many states, the marketplaces will operate primarily on-line in the form of a website where consumers can compare plans and prices easily, sort of like Expedia or Travelocity.

\(^8\) Platinum is a 90/10 plan, gold is 80/20, silver is 70/30, bronze is 60/40.

\(^9\) Actual marketplace premiums will not be released in Iowa until October 1.
without regard to the person’s current health condition or medical history.\textsuperscript{10} If participation in health insurance was voluntary, this “guaranteed issue” requirement could be a big problem for insurance companies, since the people most likely to buy insurance would be the ones who had the most health problems. However, since everyone is being required to buy insurance, including young, healthy people, the overall risk should “average out”.

Third, the state-run marketplaces will provide accurate and reliable information and education to consumers to help them make fully-informed decisions about their health insurance choices. Each state will train and license people called “Navigators” to advise consumers about their options and help them select the best plan. Navigators are paid by federal grants and not by insurance companies, so they can be truly neutral. Three organizations have been approved as navigators in Iowa: Visiting Nurse Services of Iowa, Planned Parenthood of the Heartland and Genesis Health System. It is expected that by increasing competition and better informing consumers, the marketplaces will help to reduce health insurance rates in the long run.

Q. Has the ACA had an effect on premium costs so far?

A. Maybe, but it’s probably too early to tell for sure. The ACA provision that will have the most impact on premium costs won’t go into effect until 2014. But there is some evidence to suggest that health insurance companies are concerned that if they raise premiums too much, their plans will not be competitive with plans available in the state marketplaces. Overall, premium increases in 2013 were lower than anticipated and in the states where marketplace plan premiums have been announced (New York, for example) those premiums are about 50% lower than comparable individual policies in the previous year.\textsuperscript{11}

Q. Will people really be able to afford to buy insurance in these marketplaces?

A. The ACA does several things to help make insurance affordable.

First, under the ACA, most middle and lower-income people without insurance will be eligible for a federal subsidy to help them pay the cost of insurance purchased in the marketplaces. These subsidies (called “refundable tax credits”)\textsuperscript{12} are available to individuals and families who make up to 400% of the federal

\textsuperscript{10} Prices may vary, within limits, based on age, family composition, tobacco use, and location. Other factors are excluded from consideration in setting premiums.

\textsuperscript{11} \url{http://www.offthechartsblog.org/expected-drop-in-new-york-health-insurance-premiums-highlights-importance-of-individual-mandate/}

\textsuperscript{12} Eligible individuals will receive a subsidy during the tax year based on their estimated income and will report their actual income on their tax form. Workers who experience a large increase or decrease in income may have to repay part of the tax credit that they receive or may be eligible for a tax refund.
poverty levels. The subsidy is available to offset the premium cost and to lower the out-of-pocket maximum for people with incomes below 200% of FPL. The amount of the subsidy is larger for lower income families. Here are some examples of how it will work:

<table>
<thead>
<tr>
<th>Family Income</th>
<th>$40,000</th>
<th>$50,000</th>
<th>$80,000</th>
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<tr>
<td>% of FPL</td>
<td>171%</td>
<td>213%</td>
<td>342%</td>
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<tr>
<td>Premium Limit (% of Income)</td>
<td>4.95%</td>
<td>6.77%</td>
<td>9.5%</td>
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<tr>
<td>Total Premium Cost</td>
<td>$12,130</td>
<td>$12,130</td>
<td>$12,130</td>
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<tr>
<td>Federal Subsidy</td>
<td>$10,148</td>
<td>$8,745</td>
<td>$4,530</td>
</tr>
<tr>
<td>Family's Actual Insurance Cost (Annual)</td>
<td>$1,982</td>
<td>$3,385</td>
<td>$7,600</td>
</tr>
<tr>
<td>Out of Pocket Max</td>
<td>$4,167</td>
<td>$6,250</td>
<td>$8,333</td>
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These examples are all for a family of four, with the parents of the family being 40 years old, non-smokers, with no additional regional cost factor. Premium estimates are for the Silver Plan.

You can estimate your own eligibility for a subsidy by using the calculator on the Kaiser Family Foundation website: 
http://healthreform.kff.org/subsidycalculator.aspx

Second, the ACA significantly expands eligibility for Medicaid, the government system that provides insurance to low income individuals and families. In Iowa, currently, Medicaid is open to individuals at or below 100% of FPL who also meet other criteria (minor children in the home, pregnant, etc.). The ACA expands Medicaid eligibility to all individuals and families who earn up to 138% of the federal poverty level regardless of whether they meet the other criteria for Medicaid. This expansion will mean that many of the “working poor” (people with low-wage or part-time jobs) will be eligible for Medicaid coverage. There is one “catch”, which is that each state must adopt the new Medicaid standards or the expansion won’t take place in that state. Some governors (including, initially, Iowa Gov. Branstad) have been opposed to expanding Medicaid coverage, even though the cost is paid by the federal government. The Iowa legislature has adopted a “compromise” plan, called the “Iowa Health & Wellness Plan”, to provide coverage for low income Iowans. Details of the plan are still in progress and the plan must be approved by the US Secretary of Health and Human Services before it goes into effect. The plan is described in Appendix A of this paper.

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13 In order for a married couple to be eligible for the subsidy, they must file a joint tax return.
14 The ACA actually specifies 133% of income as determined by Medicaid, which disregards the first 5% of income. In 2012, the federal poverty level was $11,170 for an individual and $23,050 for a family of four.
Finally, the ACA does not eliminate state children’s health insurance programs (S-CHIP) that already exist. In Iowa, the program is called HAWK-I. The *children* of many low-wage workers are eligible for coverage under HAWK-I. Although this is not a change, the continuing possibility of coverage under HAWK-I can be significant when a worker is trying to analyze the best insurance options for his/her family.

Q. The subsidies available in the marketplace may sound attractive, especially to lower paid workers. If the marketplaces are successful and the premiums are really affordable, can a worker “opt out” of insurance offered at work and buy his/her own plan through the marketplace in his/her state?

A. Yes, *but*... Most workers can buy insurance in their state marketplace, but there is one very important limitation. Individuals who are *offered* insurance through an employer are *not* eligible for a subsidy in the marketplace, as long as the insurance offered is both “adequate” and “affordable”. There’s more on those terms in the next section.

Q. Can employers purchase insurance for their employees through the marketplaces?

A. Yes. Small employer plans (100 or fewer employees) can purchase insurance through the marketplaces. States have the option of lowering the standard to 50 through 2015. After 2017, states have the option to allow larger employers to participate in the marketplace.

**What are employers required to do under the Affordable Care Act (ACA)?**

The President has recently announced that as a result of concerns raised by businesses, he has directed the IRS to delay enforcement of employer requirements until 2015. The provisions of the law described in this section remain in effect, but they will not be implemented until 2015.

Large employers (at least 50 employees)\(^{15}\) must either offer insurance to “substantially all”\(^{16}\) full-time workers or pay a tax penalty. The penalty is $2,000/worker/year, but the first 30 workers are excluded in the calculation of the penalty.\(^{17}\) Many supporters of the

\(^{15}\) For purposes of this requirement all workers are counted regardless of location. Part-time workers are counted based on their FTEs. Workers in subsidiaries are counted if they are part of the same “control group” as defined by the IRS.

\(^{16}\) Defined as at least 95%.

\(^{17}\) The penalty is $2,000 per full-time worker in 2014 and is adjusted for inflation annually after that. Part-time workers are not counted in the calculation of the penalty. The penalty does not apply unless at least one eligible worker receives a subsidy to purchase insurance in a marketplace.
ACA are concerned that this penalty is too low to really motivate reluctant employers to provide insurance to their workers. Pro-business advocates did not want any penalty at all. The relatively low amount of the “free rider tax” is just one of many compromises that was necessary in order to get the law passed.

Q. What does it mean to be full-time?

A. A full-time worker, for purposes of the ACA, means someone who works at least 30 hours per week on average. Employers are not required to offer insurance to workers who average less than 30 hours per week. In determining whether the worker has averaged 30 hours per week, the employer must count hours actually worked plus any paid leave (vacations, holidays, sick leave, etc.) and unpaid leaves of absence up to 160 hours.

Q. What about workers who don’t have a regular schedule, like construction workers or substitute teachers?

A. Workers with no fixed schedule may or may not be eligible for insurance, depending on how many hours they actually work on average. Employers have several options for dealing with employees with irregular hours. An employer can choose to offer insurance on a month to month basis, depending on whether the worker has enough hours each month. The IRS has issued advice for employers who want to comply with the law but don’t want to create administrative problems by taking a worker on and off insurance frequently. IRS Notices 2012-17 and 2012-58 permit an employer to use a longer time period to determine eligibility. An employer can adopt a longer “measurement period” of 3 to 12 months to determine eligibility. An employer would not have to offer insurance during the initial measurement period after an employee is hired. Following the measurement period, once eligibility is determined, that status would be maintained during a “stability period” which must be at least as long as the measurement period. For example, if the employer adopts a measurement period of 12 months, the employer would not have to offer insurance to a new employee during that time. If the worker averaged at least 30 hours a week during the measurement period, the employer would be required to offer insurance to the worker and continue it during the stability period which must be at least 12 months, regardless of how many hours the worker actually works during the stability period. An employer may use the same measurement and stability periods to determine eligibility for on-going employees who work variable hours.

Q. Does an employer have to use the same measurement and stability periods for everyone or can they use different periods for different kinds of employees?

A. The IRS notice says that employers can use different periods based on four criteria: (1) collective bargaining and non-bargaining; (2) salaried and hourly; (3) employed by different entities; and (4) employed in different states. However,
within each of those categories the measurement and stability periods have to be applied consistently. For example, the measurement period could be six months for hourly employees and 12 months for salaried employees, but it would have to be six months for all hourly workers and 12 months for all salaried workers.

Q. What about seasonal workers?

A. Employers are not required to offer insurance to seasonal workers, even if they work full-time. Seasonal is defined as working fewer than 120 days per year.

Q. How would this work for school bus drivers or food service workers who work nine months per year and work less than 40 hours per week?

A. The IRS has proposed a special rule for people who work for educational institutions. Their eligibility would be determined based on the number of hours that they work during the weeks that school is in session. They still have to meet the 30 hours per week threshold, but only during the school year. For example, a food service worker who regularly works 30 hours per week during the time that school is in session, will be considered to be full-time and must be offered insurance. A school bus driver whose regular schedule is four hours per day (20 hours a week), but who works extra hours for sports and other events, may be eligible if he/she averages at least 30 hours per week during the weeks that school is in session.

On the other hand, someone hired as “summer help” who only works for three months, would be considered to be seasonal and would not have to be offered insurance, even if that person works 40 hours a week during the summer months.

Q. Are there any minimum requirements for the insurance that is offered? Can an employer avoid the penalty if it offers a plan that doesn’t really cover much?

A. The plan that is offered must meet some coverage requirements. It must cover “minimum essential health services”. Those include doctor and hospital services, mental health, prescription drugs, etc. The plan offered cannot exclude any kind of medical treatment that is considered essential.

Q. Does the plan have to pay a reasonable amount of the cost of the essential health services?

A. Unfortunately, there are no minimum requirements for plan payment. As a result, an employer could avoid the $2,000/person penalty by offering a plan that would pay only 50% of the cost of covered medical treatment, for example. However, that approach may be risky, because of the second kind of penalty, described below.
Q. Is it mandatory that workers accept the insurance that is offered to them by their employer?

A. No. As long as the employer offers insurance to eligible workers, it does not matter to the employer whether the workers accept that offer or not. It does matter to the worker. Starting in 2014, most workers will be required to prove that they have health insurance coverage. Coverage could be obtained through the worker’s employer, or from the employer of a family member (spouse or parent), through a public plan like Medicare or Medicaid, or through a state-run “insurance marketplace”. However, keep in mind that if the worker turns down the insurance offered by the employer, the worker may be eligible to purchase insurance in an marketplace, but will not be eligible for a subsidy if the insurance offered by the employer was both “adequate” and “affordable”.

Larger employers (more than 200 employees) will be required to automatically enroll all eligible new employees in their health insurance plan, starting in 2014. Workers won’t have to do anything to be enrolled in the insurance plan, but they would have to take affirmative steps to “opt out” if they wish to decline the offered insurance.

Under some circumstances, employers that do offer insurance may still be subject to a penalty, if the insurance that is offered is not adequate or affordable. If an employer offers insurance, but one or more of its workers declines that offer and instead purchases insurance in a state marketplace and receives a subsidy, then the employer is liable for a penalty of $3,000 for each full-time worker who receives a subsidy. A worker who is offered insurance by an employer is only eligible for a subsidy if the insurance offered is either not “affordable” or not “adequate”.

The penalties are calculated using different formulas. An employer that offers insurance that is not affordable and adequate will be assessed a $3,000 penalty for each full-time worker who purchases insurance in a marketplace and receives a subsidy. An employer that doesn’t offer insurance to substantially all full-time workers will be assessed a $2,000 penalty for all full-time workers.

Q. What does “affordable” mean?

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18 Implementation of this provision had already been delayed until 2015, even before the other employer mandates were delayed.
19 The penalty is $3,000 per full-time worker in 2014 and is adjusted for inflation annually after that. Part-time workers are not counted in the calculation of the penalty. The penalty only applies to workers who obtain insurance through a state marketplace. An employer will not be assessed a penalty if the worker is covered by a public plan, like Medicare, Medicaid, or certain veterans’ health care plans.
20 The employer penalty of $3,000 for each worker who receives a subsidy cannot exceed the penalty that the employer would have had to pay if it didn’t offer insurance at all, i.e., no more than $2,000 times the total number of workers.
A. There is no specific amount (or percentage) that an employer has to pay. However, the insurance must be “affordable” to the worker, which means that the cost of the worker’s share of the single premium is no more than 9.5% of the worker’s family income.21 (There is no requirement that the family premium be “affordable.”) As a practical matter, this means that an employer who wants to avoid the penalty needs to pay a significant part of the single premium, especially for lower wage workers.

Q. Can employers pay different amounts toward the premium for different types or categories of workers?

A. Yes, most of the time. It is fine for an employer to contribute different amounts for single and family coverage, for example. An employer could choose to pay 80% of the premium for salaried personnel, but only 60% of the premium for hourly employees, but that may have some risks. If the employer contributes too little for lower paid workers, the insurance may no longer be “affordable” and the employer may be assessed a penalty. There are also IRS rules (which predate the ACA) that impose a tax on certain benefits paid to “highly compensated employees” if those benefits are not also provided to other kinds of workers. The ACA makes these “anti-discrimination provisions” also apply to health insurance. The rules for determining who is a highly compensated employee and for determining whether unlawful discrimination has occurred are complicated.

Q. What makes insurance “adequate” under the ACA?

A. The principal requirement is that the insurance must cover at least 60% of expected medical expenses. This is referred to as the actuarial value of the plan or “AV”. Measuring the AV of the plan is not as simple as it sounds. The AV is calculated by taking into account all of the medical costs that the worker might be responsible for (other than the premium). That might include, for example, co-payments for doctor visits or hospital visits, prescriptions and excluded costs (certain treatments or drugs not covered by insurance). The AV is a hypothetical measure, based on a standard set of possible services, not based on the worker’s actual experience.

**ACA Plan Requirements**

The ACA creates other requirement for health insurance plans, but not all requirements apply to all plans. The requirements vary depending on whether the plan is (1) a marketplace plan (2) a “grandfathered” group plan (3) a non-grandfathered or “new” group plan or (4) a self-insured plan, and whether the plan is a large or small plan. “Grandfathered” plans are group plans which existed on the day the law was signed.

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21 Since most employers will not have any way to determine the family income of their workers, the IRS has suggested that employers should look at whether the worker’s premium cost is more than 9.5% of the worker’s pay.
(March 23, 2010) and which have not been substantially modified. “New” plans are simply group plans that are not grandfathered. The following chart illustrates which requirements apply to which kinds of plans.

### ACA Health Insurance Plan Requirements

<table>
<thead>
<tr>
<th>Essential health services covered: Plans must cover preventive and primary care, emergency, hospital, physician, outpatient, maternity and newborn care, pediatric (including dental and vision), medical/surgical care, prescription drugs, lab, and mental health and substance abuse, effective in 2014. States set benchmarks within each category.</th>
<th>Marketplace Plans</th>
<th>Grandfathered Plans</th>
<th>New Group Plans</th>
<th>Self-Insured Plans</th>
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<tr>
<td>Yes</td>
<td>Yes</td>
<td>Small* group only</td>
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<th>Preventive services: Plans must offer first dollar coverage (no co-payment or deductible) for certain preventive services effective 2011. Birth control included in preventive services effective 2012.</th>
<th>Marketplace Plans</th>
<th>Grandfathered Plans</th>
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<tr>
<th>No lifetime or annual limits: Plans are prohibited from limiting the lifetime dollar value of benefits effective the first day of the next plan year beginning on or after Sept. 23, 2010. Annual limits are phased out and are eliminated completely beginning Jan. 1, 2014. Some plans have been granted waivers to the annual limit requirements through 2013.</th>
<th>Marketplace Plans</th>
<th>Grandfathered Plans</th>
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<th>Patient protections: Plans are prohibited from requiring a referral to see an OB-GYN and from requiring prior authorization or higher cost sharing for out-of-network emergency services, effective now.</th>
<th>Marketplace Plans</th>
<th>Grandfathered Plans</th>
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<tr>
<th>Pricing: Medical underwriting is prohibited and rating variation is only allowed based on age (3:1 ratio), tobacco (1.5:1.0), family composition and geography effective in 2014.</th>
<th>Marketplace Plans</th>
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<th>Dependents under age 26: Plans must allow adult children under age 26 to enroll in a parent’s plan effective now. Through 2013, adult children may only enroll in a parent’s grandfathered plan if they are ineligible for another employer-sponsored plan.</th>
<th>Marketplace Plans</th>
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<th>Plan administrative costs: Plans must provide rebates to consumers if the percentage of premiums spent on medical services falls below 85 percent for large group plans or 80 percent for small group and individual plans.</th>
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22 This chart is based on an earlier version included in Affordable Care Act: Summary of Provisions Affecting Employer- Sponsored Insurance, UC Berkeley Labor Center, June 2012.
Deductibles: Plans must limit deductibles to $2,000 for single coverage and $4,000 for family coverage beginning in 2014.

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*A small group plan is one that covers 100 or fewer employees.

Details of Selected Plan Requirements

Dependent Coverage: Starting in 2010, all plans must allow participants to enroll their children up to age 26. Coverage can continue until the last day of the plan year in which the child turns 26. Children may be enrolled regardless of whether they are students, whether they live with the parent who is covering them and regardless of whether the parent has claimed the child as a tax deduction. Married children may be enrolled, but not their spouses. Until 2014, children who are 19 to 26 are not eligible for coverage if they are offered insurance through their own employer.

Note that the ACA does not require plans to cover spouses, only children. It doesn’t prohibit spousal coverage either and most plans will continue to offer a family plan which would cover spouses.

Waiting Period: For plan years beginning on or after January 1, 2014, the maximum waiting period to be eligible for employer-sponsored insurance coverage is 90 days. The 90 days are counted from the time that the worker becomes eligible for insurance coverage (by being hired or by changing from part-time to full-time status, for example) until the worker is given an opportunity to enroll in the insurance plan.

The IRS has issued legal guidance about how to apply the 90 day waiting period limitation to workers with variable hours. According to Notice 2012-58, employers may adopt special qualifying rules for employees who work irregular hours as long as the rule is (1) a bona fide employment based condition and (2) is not designed to avoid compliance with the 90 day waiting period limitation. A plan may adopt a minimum hours requirement, before a worker is eligible for coverage. For example, the IRS says that a requirement that a worker work 1200 hours before coverage starts is permissible. In that case, coverage would have to start no later than the 91st day after the worker
completed 1200 hours\textsuperscript{23}. Or a plan could use the measurement period/stability period method of determining whether a worker is “full-time” for ACA purposes. The measurement period could be up to 12 months. In that case, insurance must be offered no later than the first day of the calendar month following the completion of 13 months of service.

**Pre-existing Conditions:** Coverage may not be denied based on medical history or limited to exclude pre-existing conditions for children who are under age 19, effective now, and for *everyone* in plan years beginning on or after January 1, 2014.

**Rescission:** Once a person is enrolled in an insurance plan, the insurance coverage cannot be cancelled by the insurance company based on anything except non-payment of premiums or fraud by the covered person. “Fraud” is defined as a deliberate misstatement of a significant fact by someone trying to obtain something that they would not otherwise be entitled to receive. For example, claiming that you are 22 instead of 55 in order to get a lower rate would be fraud. Inadvertently misstating your spouse’s birthdate by a month, or even a year, would not be fraud.

**Medical Loss Ratio:** Starting in 2012, the ACA limits the amount of “overhead” that an insurance company can charge. Large group plans must spend at least 85% of premiums on health care costs. In other words, an insurance company can’t charge more than 15% overhead for things like administrative costs and profits. If overhead is more than 15% the insurance company must refund the difference back to the plan sponsor (usually the employer). Small group plans (100 or fewer employees) and individual plans can charge up to 20% overhead. The medical loss ratio requirement does not apply to self-insured plans.

**“Grandfathering” Under the ACA**

Health insurance plans, including collectively bargained plans, that existed on the day that the ACA was signed into law (March 23, 2010) are considered to be “grandfathered.” Plans that are grandfathered do have to comply with some but not all of the requirements of the ACA. (See chart above.) Collectively bargained plans in effect on March 23, 2010 are grandfathered at least until the expiration of the collective bargaining agreement.

After the expiration of a collective bargaining agreement that was in effect on March 23, 2010, grandfathered status continues unless there is a substantial change in the insurance plan. A substantial change includes any of the following:

- **Elimination of benefits for certain conditions** (eliminating coverage for childbirth or cancer treatment, for example)

\textsuperscript{23} A minimum hours requirement of more than 1200 hours is considered to be “designed to avoid compliance” and is not permitted.
• Excessive increases in cost sharing, including any of the following:
  o An increase in the percentage of co-insurance (going from a 90/10 plan to 80/20 plan, for example)
  o An increase in the annual deductible or out-of-pocket limits by more than 15% plus medical inflation (for example, if medical inflation is 8% and the annual deductible was $500, the deductible amount could not be increased by more than 23%, which is $115)
  o An increase in the co-pay amount by more than $5 (in 2010 dollars) or 15% plus medical inflation, whichever is greater (if the current co-pay is $10, it could be increased to no more than $15, since $5 is more than medical inflation plus 15%)
  o An increase of more than 5% in the employee’s share of the premium (increasing the employees’ percentage of the premium from 20% to 30%, for example, would result in a loss of grandfathered status)

• Certain changes in annual benefit limits (prior to 2014)
  Most employers will want to keep their grandfathered status, if possible, unless it becomes too costly to do so. However, it will be difficult to do so for any extended period of time, since these limits are cumulative, not annual. For example, if the only plan change were a 2% increase in the employee’s share of the premium, the plan would retain its grandfathered status, but if the same increase was applied in subsequent years, the plan’s grandfathered status would end after the second year, since the cumulative increase would be 6% by the third year. Grandfathered status cannot be reestablished after it has been lost.

Tax changes under the ACA

The ACA contains a number of small but significant tax changes, some of which may affect employer-sponsored plans.

• The maximum contribution to a pre-tax Flexible Spending Account is reduced to $2500, effective 2013.
• Money in a Flexible Spending Account cannot be used for over-the-counter medications, effective 2011.
• The tax deduction for employers that subsidized Medicare Part D is eliminated, effective in 2013.

Taxes on health insurance under the ACA

When the ACA was being debated, conservatives insisted that it should pay for itself, in other words that it must contain cost savings and tax increases sufficient to offset the cost of subsidies, the cost of creating the marketplaces, etc. As a result, the ACA contains a number of new taxes and fees. Some are relatively minor, there is a new tax on tanning.
salons, for example. There are three new taxes on insurance companies that go into effect in 2014.

The smallest one is to fund the “Patient Centered Outcomes Research Institute” (PCORI). It starts at $1/covered life/year and gradually increases. The second smallest is the “Transitional Reinsurance Program” fee, which is $63/covered life/year for three years. The money generated by that tax will be used to help stabilize premiums in the marketplaces for individuals with pre-existing conditions. The money will be used to provide reinsurance for high risk individuals, and thereby protect insurance companies from the additional risks.24

The largest of the three is the “Health Insurance Providers Annual Fee”. Opponents of the ACA refer to it as the Health Insurance Tax (HIT). Insurance companies are concerned, in part because they are not certain how much it will be. The total amount of the fee will be $8 billion in 2014 and that amount is divided proportionally based upon the “net premiums” collected by each health insurance company in the US. For example, if Acme Insurance collected 1% of all the health premiums in the country, they would have to pay 1% of $8 billion or $80 million to the IRS. Of course insurance companies are not happy about that prospect, but keep in mind that the “HIT” money will be used to fund the state marketplaces, which are expected to provide 32-37 million new customers to private insurance companies. Also keep in mind that the tax is proportional to the premium charged, so insurance companies will have an additional incentive to keep premiums low. The Health Insurance Providers Annual Fee only applies to insurance companies and does not affect self-insured plans.

The other tax which is controversial is the excise tax on “high value” insurance plans sometimes referred to as the “Cadillac tax”. The tax is 40% of the value of the total cost of the insurance plan above the threshold set by the law. In 2018 the thresholds will be $10,200/year ($850/month) for a single plan and $27,500 ($2292/month) for a family plan.25 Starting in 2019, the thresholds will be increased annually by inflation plus 1%. Few collectively bargained plans will exceed these thresholds in 2018, but unless the formula is changed, or unless medical inflation slows dramatically, it is likely that a substantial number of collectively bargained plans will be classified as “high value” sometime in the 2020’s.26

The excise tax is on insurance companies (and plan administrators of self-insured plans), not on individual participants. However, it appears likely that insurance companies will find a way to pass this tax onto employers and workers.

25 For multiemployer plans, only the $27,500 threshold applies.
26 The tax on high value plans is one of the most unpopular parts of the law and there is a significant possibility that it will be repealed or revised before it goes into effect.
Reporting Requirements Under the ACA

W-2 Reporting. Under the ACA, employers are now required to specify the value of health insurance benefits on workers’ annual W-2 forms. This is an informational change only. Reporting the value of insurance benefits on the W-2 does not make them taxable. Implementation of this requirement is delayed for some employers.

Notification of Coverage Options. In September of 2013, employers will be required to give workers written notice of their insurance options at work and also of the possibility of coverage under the state insurance marketplaces.

Proof of “Essential Health Benefits”. Employers will have to report to the IRS annually, starting in 2015, in order to prove that the insurance plan offered by the employer includes the essential health services required by the ACA. Larger employers will also have to report compliance with the automatic enrollment provisions, etc.
Appendix A
Iowa Health & Wellness Plan

The Iowa Health & Wellness Plan (IHWP) is the official name of Iowa’s recently enacted alternative to the Medicaid expansion included in the ACA. On May 23, 2013, in the last few days of the legislative session, the legislature passed this law as part of a much larger appropriations bill (SF 446). The portion of the bill that creates the IHWP is relatively brief and many important details are left to the Iowa Department of Human Services to determine in administrative rules, which have not yet been written.

What is the Iowa Health & Wellness Plan? IHWP is a federally funded, state administered, plan which is intended to provide health insurance to low-income Iowans who do not meet all the eligibility requirements for Medicaid.

How does IHWP affect the Iowa Cares program? IHWP replaces Iowa Cares. Iowa Cares participants will be encouraged to enroll in IHWP. Unfortunately, funding for Iowa Cares expired on June 30, 2013, at the end of the fiscal year and IHWP will not become operational until January 1, 2014.

Who is eligible for IHWP? IHWP is open to low-income individuals who are residents of the State of Iowa and who are either U.S. citizens or lawful immigrants with at least five years permanent resident status. “Low-income” is defined for purposes of the IHWP as no more than 133% of the federal poverty level (FPL) for an individual or a family.

In order to enroll in IHWP, individuals must provide financial information and a valid Social Security number. Participants will also be required to release information about the insurance plan that they obtain through the marketplace. Once enrolled, participants will be required to pay a monthly fee. (More on that below.)

Individuals may not enroll in IHWP if they are eligible for “regular” Medicaid or if they have been offered insurance through their employer, if that insurance is “affordable” and “adequate” and meets the other requirements of the ACA.

When can you enroll and when does coverage start? Individuals can enroll at any time. Enrollment can occur on-line, through the same website that hosts the state’s marketplace. Iowa has proposed to adopt the streamlined test for eligibility based on adjusted gross income that should make enrollment fairly simple. There is no requirement to wait for an open enrollment period. Becoming eligible is considered to be a “qualifying event” as defined by HIPAA. Coverage starts on the first day of the month after enrollment. Coverage lasts for twelve months. Eligibility will be reviewed on an annual basis.

What kinds of health care services are covered under IHWP? All of the “essential health services” required by the ACA are covered, including doctor and hospital care,
preventative services, prescription drugs, mental health, etc. IHWP also covers any services that would be covered by the Iowa Medicaid program. Plan design is based on a modified version of the health plan offered to state employees.

**How much will participants have to pay?** Participants with income above 50% of FPL are required to meet the “financial participation” requirements established by DHS. Those rules haven’t been written yet, but the Medicaid Waiver Application describes what is planned.

Participants will be required to pay a co-pay of $10 for non-emergency services received in a hospital emergency room. (The idea is to discourage routine treatment in the ER.) The ER co-pay will *not* apply during the first year. **No other co-pays are permitted under the IHWP.**

Participants with incomes above 50% of FPL will also have to pay a monthly participation fee (like a premium) in the range of $10 to $20/month. The total annual cost sharing cannot exceed the limits contained in the ACA of 3% of family income. Participants who fail to pay the fee within 90 days, after being reminded of the consequences, may have their insurance cancelled and will have to reapply.

The monthly fee will be waived for all participants in the first year of eligibility. The monthly fee will be waived in subsequent years **if** the individual participates in “all required preventative care services and wellness activities” as specified by DHS in the as yet unwritten administrative rules. DHS says that these activities may include things like an annual physical, a health assessment, and “adherence and completion of a disease management program... for certain high risk participants”.

**How will IHWP work?** Participants in IHWP are divided into two categories.

**Iowa Wellness Plan (Medicaid Plus).** Participants whose income is at or below 100% of FPL will be enrolled in the expanded version of Medicaid created by the ACA. Participants will not be required to meet the other requirements of Medicaid (e.g., having a minor child in the home). Participants in the Iowa Wellness Plan will receive the same benefits as regular Medicaid participants, except for the participation fee. The Iowa Wellness plan will be administered by the Iowa Department of Human Services.

**Marketplace Choice.** Participants with income between 100% and 133% of FPL will be enrolled in a private insurance plan through the state marketplace. Eligibility to participate in Marketplace Choice will be determined by DHS, though the law says that DHS can contract out that function. Claims will be determined and paid by the private insurance company. Participants in Marketplace Choice will likely be eligible for a significant federal subsidy to cover most of the premium for their private insurance plan. Medicaid funds will be used to pay all (or most) of the premium that the individual would otherwise be required to pay.

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27 *Iowa Wellness Plan Medicaid Waiver Application*, July 2013, p. 7
Example:

A single individual makes $14,363 (125% of FPL). He is enrolled in a “Silver Plan” in the marketplace, which costs (hypothetically) $251/month. The direct federal subsidy would cover 90% of the premium. The individual’s premium would be limited to 2% of his income or $287/year ($23.94/month). However, under Marketplace Choice, the Iowa DHS would pay the individual’s share ($23.94) of the monthly premium using Medicaid funds.

**When will IHWP go into effect?** Iowa must obtain a Medicaid waiver from the U.S. Secretary of Health and Human Services before IHWP goes into effect. Iowa has submitted an application but it has not been approved by Secretary Sebelius. If the waiver is approved, IHWP would go into effect on January 1, 2014.