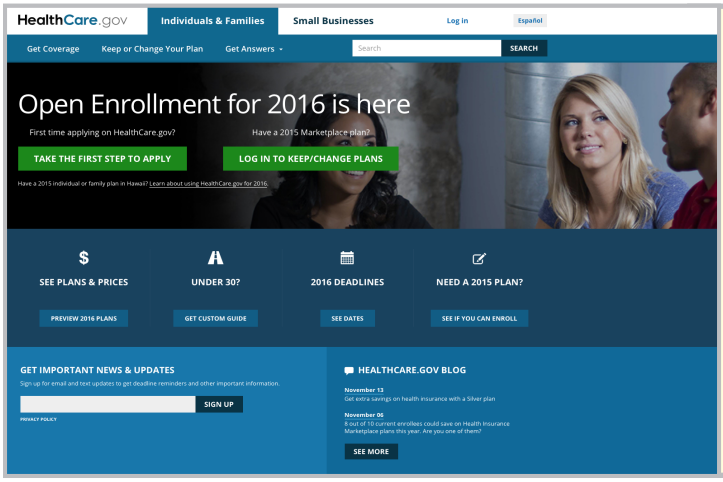
TAHP
The Texas Association of Health Plans

Representing health insurers, health maintenance organizations, and other related health care entities operating in Texas.

Understanding the Affordable Care Act



The Affordable Care Act (ACA) was signed into law in March of 2010. The ACA includes sweeping changes to the nation's health care coverage system and specifically to state insurance markets and their public health programs. The goal of the legislation was to expand access to insurance, reduce the rising costs of health care, improve the quality and efficiency of the health care delivery system, increase wellness and prevention initiatives, and expand consumer protections.

Under the ACA, consumers are able to shop for health insurance in online marketplaces called **Exchanges** during open enrollment, an annual window in which they can compare and buy or switch insurance policies and determine eligibility for financial assistance **(subsidies)** and public health insurance programs.

As a result of the ACA, all Texans who purchase coverage on their own have guaranteed access to health insurance even if they have **pre-existing conditions** (are already ill or injured) – much like "group" or employer coverage works today. No one can be denied coverage or be charged more because of a medical condition or family medical history.

The ACA provides **premium and cost-sharing subsidies** to help low and moderately low-income individuals buy individual health coverage in the new Exchanges (eligible individuals must be 100-400 percent of the **Federal Poverty Level**, or FPL, which is a uniform measure of income that is adjusted for inflation and released every year by the U.S. Department of Health and Human Services, HHS).

States also have the option to **expand coverage through Medicaid** to their lowest income adults (up to 133 percent of FPL). Texas and 19 other states have opted not to expand Medicaid due to concerns about increased costs and the need for additional Medicaid reforms.

Individual Mandate, Guaranteed Issue, and Open Enrollment

Many experts agree that broad participation in the health insurance system is needed to offset some of the cost increases associated with many of the new market reforms under the ACA. These reforms include **guaranteed issue**, which is the requirement that all health plans must accept every individual or employer who applies for coverage, and offer all available products in the applicable market, regardless of any individual's health status. To counter-balance the cost of **guaranteed issue** and coverage for **pre-existing conditions**, the ACA also mandates that all individuals are legally required to have health insurance that meets basic minimum standards, which is commonly referred to as the **individual mandate**. More simply stated, the goal of the **individual mandate** is to ensure that enough healthy people sign up for coverage to help cover the increased costs of covering sick individuals.

Exceptions to the Individual Mandate

The ACA provides some exceptions to the **individual mandate**, including an affordability exemption that applies if the minimum amounts consumers would have to pay for their premiums is more than 8 percent of their household income.

The Individual Mandate

2014	**$95.00 per adult and $47.50 per child** (up to $285.00 per family) or 1% of family income, whichever is greater.
2015	**$325.00 per adult and $162.50 per child** (up to $975.00 per family) or 2% of family income, whichever is greater.
2016	**$695.00 per adult and $347.50 per child** (up to $2,085.00 perfamily) or 2.5% of family income, whichever is greater.

Individuals who do not having minimum essential health coverage face a financial penalty, which is either a flat amount or a percentage of household income, whichever is greater. There are no criminal or civil penalties. The IRS can only withhold money from income tax refunds. The flat penalty amounts for later years will be indexed based on the cost of living.

Employer Penalty for Not Providing Coverage

The federal reforms do not have an employer mandate for coverage, but employers with 50-plus employees are assessed a fee of $2,000 per full-time employee (in excess of 30 employees) if they do not offer minimum coverage (at least 60 percent actuarial value- Bronze level plan) and they have at least one employee who receives a premium credit through an Exchange.

"The Link"

The health insurance industry has adamantly maintained that an individual mandate is critical in a guaranteed-issue market, because of the risk of **adverse selection**, which is what occurs when individuals only choose to purchase coverage when they are sick and forego it when they are healthy. Requiring individuals to have coverage increases the participation of young and healthy individuals, reducing the risk of the inevitable **adverse selection** and the resulting increased health care and premium costs.

If the **individual mandate** were to be eliminated but the **guaranteed issue** provisions were maintained, it is estimated that:

- **The number of people without health insurance would increase by about 14 million**
- **Premiums for policies in the individual market would increase by roughly 20 percent per year from 2017 to 2025**

Source: Congressional Budget Office (CBO) and staff of the Joint Committee on Taxation (JCT)

The Exchange and Subsidies

Exchange or Marketplace

The ACA allows states to create their own Health Insurance Marketplaces, commonly known as health insurance **Exchanges**. An Exchange is an organized marketplace for the purchase of health insurance, offering a group of standardized health plans that include a minimum level of **essential health benefits (EHP)**. Exchanges offer tools such as web sites and toll-free hotlines as resources for consumers and small businesses to compare health plans and sign up for coverage.

The ACA provides for states to create their own Exchanges or participate in the federally run Exchange. Texas is one of several states that did not create its own Exchange, so Texas consumers may seek coverage through the federal Exchange/marketplace.

There are technically two Exchanges. The most common reference to the Exchange is to the individual market. The other Exchange is for small employers, referred to as the SHOP Exchange (Small Business Health Options Programs and Purchasing Qualified Health Plans).

Health plans offered through an Exchange must include specific essential benefits at one of the metal levels (Platinum, Gold, Silver, or Bronze), which are category levels based on the plan's actuarial value.

Level	Actuarial Value of Benefit Package
Catastrophic	>60%
Bronze	60%
Silver	70%
Gold	80%
Platinum	90%

The Actuarial Value is the average percentage value of benefit costs in a health insurance plan that is expected to be paid by the insurance company. For example, for a Silver plan, a health plan will pay approximately 70 percent of the expected costs. The consumer pays the remaining 30 percent of expected health care costs through cost sharing, deductibles, and co-payments. This is why Bronze plans have the highest deductibles and other cost sharing, but have lower premiums, and Platinum plans will have the lowest deductibles, co-pays and other cost sharing, but have the highest premiums. In general, plans with lower cost sharing will have higher premiums, and vice-versa.

Catastrophic Plan

A catastrophic plan does not meet the actuarial standards of the four levels, but does cover the essential health benefits. Only individuals under age 30 and individuals for whom coverage is unaffordable may purchase a catastrophic plan.

Subsidies

The ACA provides **premium and cost-sharing subsidies** to help low- and moderate-income Americans afford health care coverage in the Exchange or marketplace. There are two types of subsidies available to Exchange enrollees: premium subsidies and cost-sharing subsidies. Premium subsidies are available on a sliding-scale to individuals and families with incomes between 100 percent to 400 percent of FPL. Additional cost-sharing subsidies are available for those with incomes below 250 percent of FPL to help reduce out-of-pocket costs, such as deductibles, co-pays, and co-insurance. While subsidies will help many families pay for health care coverage, they do nothing to reduce the actual cost of that coverage.

Congressional Budget Office Estimate of Premiums and Subsidies for Exchange Enrollees in 2016

Single Policy

Income Relative to Federal Poverty Level	Premium Cap as a Share of Income	Middle of Income Range	Enrollee Premium for the 2nd Lowest Cost Silver Plan	Premium Subsidy
100%-150%	2.1%-4.7%	$14,700	$300	94%
150%-200%	4.7%-6.5%	$20,600	$1,200	77%
200%-250%	6.5%-8.4%	$26,500	$2,000	62%
250%-300%	8.4%-10.2%	$32,400	$3,000	42%
300%-350%	10.2%	$38,300	$3,900	25%
350%-400%	10.2%	$44,200	$4,500	13%
400%-450%	NA	$50,100	$5,200	0%

Family Policy (Family of Four)

Income Relative to Federal Poverty Level	Premium Cap as a Share of Income	Middle of Income Range	Enrollee Premium for the 2nd Lowest Cost Silver Plan	Premium Subsidy
100%-150%	2.1%-4.7%	$30,000	$600	96%
150%-200%	4.7%-6.5%	$42,000	$2,400	83%
200%-250%	6.5%-8.4%	$54,000	$4,000	72%
250%-300%	8.4%-10.2%	$66,400	$6,100	57%
300%-350%	10.2%	$78,300	$7,900	44%
350%-400%	10.2%	$90,100	$9,200	35%
400%-450%	NA	$102,100	$14,100	0%

Source: Congressional Budget Office, Letter to the Honorable Evan Bayh, 2009; Staff of the Joint Committee on Taxation

The **premium tax credit** works by setting a cap on the amount an individual or family must spend on monthly premium payments if enrolling in a "benchmark" plan (the second-lowest cost Silver plan available on the Exchange). If the cost of the benchmark plan exceeds the applicable premium cap, then subsidies are available for amounts over the cap. The subsidy can be applied toward any (non-catastrophic) plan sold on the Exchange. An individual or family's subsidy amount does not vary by plan, so a consumer can purchase a plan that is more expensive than the benchmark plan and pay the additional cost, or purchase a less expensive plan to reduce their costs.

Subsidy Calculation Example

Pat is 45 years old and has an income of $29,175 per year (250% FPL)

Pat's costs are capped at 8.1% of income (250% FPL)

Second Lowest Cost Silver Plan for Pat = $280 per Month

Maximum Cost for Pat is $197 per Month

8.1% (FPL Cap) x $29,175 income = $197 per Month

Pat's Tax Credit is $83 per Month

$280 premium (Silver Plan) – $197 (Maximum cost for Pat) = $83 Subsidy per Month

Pat can use the $83-per-month subsidy toward the purchase of any Bronze, Silver, Gold, or Platinum Marketplace plan available

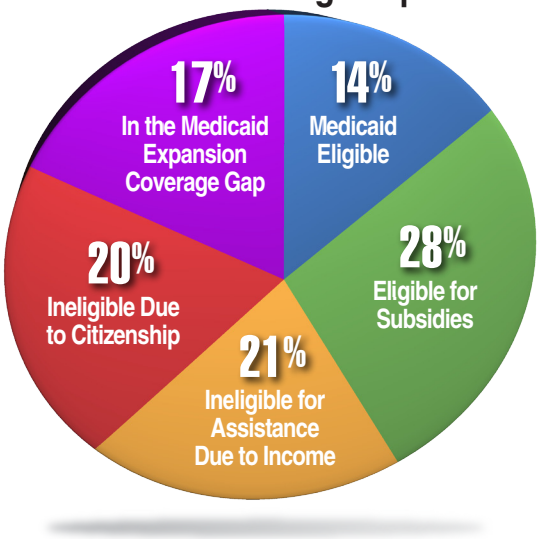
Source: Kaiser Family Foundation Explaining Health Care Reform: Questions About Health Insurance Subsidies Oct 27, 2014

Medicaid Expansion

One of the major coverage provisions in the ACA was the plan to expand Medicaid to cover everyone up to 133 percent of FPL — covering individuals whose incomes were too low for the subsides for the Exchange. Medicaid expansion was supposed to be mandatory nationwide, but the Supreme Court ruled that it was optional for states. If a state chooses to expand, the ACA mandates that the federal government must cover the entire cost of Medicaid expansion for the first three years of the program, 2014-2016. Starting in 2017, the federal government will pay 95 percent, progressively decreasing to 90 percent in 2020, where the match rate will remain.

Texas is one of 20 states that have chosen not to expand, leaving a large number of low-income uninsured individuals without any assistance for coverage. Because the ACA envisioned individuals who were low-income receiving coverage through Medicaid, it does not provide financial assistance for other coverage options to people below 100% of FPL. As a result, many adults in Texas and other states that did not expand Medicaid now fall into a category referred to as the **coverage gap**. The **coverage gap** includes individuals whose incomes are not high enough to receive a federal subsidy and too high to qualify for Medicaid. Almost 800,000 Texans or 17 percent of uninsured Texans fall in the "coverage gap".

Texas: Eligibility for Coverage Among Remaining Uninsured & Coverage Gap: 2014



Source: Kaiser Family Foundation analysis based on 2015 Medicaid eligibility levels and 2014 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC)

Essential Health Benefits

The ACA requires that all health insurance policies sold in the individual market (off and on the Exchange) and to small employers must cover a broad range of benefits, some of which were not included beforehand. As a result, individuals have access to more comprehensive coverage, but coverage that is more expensive.

The required benefits or the **essential health benefits** (EHB) package for "non-grandfathered" health insurance coverage are defined by 10 general categories.

The ACA requires states to pay for benefit mandates that exceed EHB. A state must fully reimburse an individual or insurance policy offered through the Exchange for enrollees receiving subsidies. This provision means that states must consider their cost when mandating any new health coverage benefit.

What Are Essential Health Benefits?

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

Setting Rates or Costs for Premiums

Prior to the ACA, health plans could set premium amounts based on their individual characteristics. Today, the ACA strictly limits how much a premium can very based on an individual's circumstances. Health status and **pre-existing conditions** can have no bearing on premiums. Any increases in health plan premiums are subject to federal rate review. Insurers can only consider these factors in setting premiums:

- Whether it is individual or family coverage
- Where the person lives (states are allowed to establish rating areas; Texas did)
- How old the person is (prices cannot vary by more than 3 to 1)
- Whether the person uses tobacco (prices cannot vary by more than 1.5 to 1)

Self-funded Coverage (ERISA or ASO Plans)

Self-funded ERISA plans are not traditional insurance and are not subject to the federal regulations on premium rates or EHB in the ACA. However, the ACA extended many of the new insurance regulatory requirements to this type of coverage including:

- **Out-of-network ER coverage**
- **Pediatrician access as primary care**
- **Ob-gyn access without a referral**
- **Appeals process**
- **Annual limit on out-of-pocket costs**
- **No cost sharing for preventive services**
- **Dependent coverage to age 26**
- **Uniform Glossary and Summary of Benefits and Coverage**
- **No preexisting condition exclusions**
- **No adjustment in premiums based on health status**
- **No waiting period in excess of 90 days**
- **No annual and lifetime dollar limits**

Medical Loss Ratio (MLR or the "80/20 Rule")

The **MLR** is an "80/20" requirement that was included in the ACA to ensure that health plans spend at least 80 percent of premium dollars on medical care. If an insurance company spends less than 80 percent of premium dollars (85 percent in the large group market) on medical care and efforts to improve the quality of care, the insurance company must rebate the portion of premium that exceeded this limit. Profits and administrative expenses such as agent and broker commissions, claims processing, marketing, employee salaries and other overhead costs may not exceed 20 percent of the premiums collected (15 percent in the large group market).

Emergency Coverage

Federal rules establish a baseline reimbursement level that health plans must pay to non-network (out-of-network) providers for emergency services. They must pay an amount equal to the greatest of:

- Median in-network rate
- Usual out-of-network rates or usual and customary amounts
- Medicare Rates

"Grandfathered Plans"

The ACA exempts "grandfathered" health plans from a number of its provisions, such as the requirements to cover preventive benefits without cost sharing or the new rules for small employer premium ratings and benefits. An employer-sponsored health plan can be grandfathered if it covered a worker when the ACA became law (March 23, 2010) and if the plan has not made significant changes that reduce benefits or increase employee costs since that time.

Health Insurance Tax

The ACA imposes various taxes and fees on health insurance issuers and self-insured group health plans in the U.S. These taxes and fees are passed on to consumers, and typically result in the form of higher premiums. One of the largest taxes that impacted the cost of coverage was the **Health Insurance Tax (HIT)**, which is an annual fee or excise tax on health insurers.

The ACA prescribes a fixed amount each year to be collected, and each health insurer subject to the **HIT** is required to pay an amount proportional to their insurance market share, as measured by total premiums. The IRS calculates each insurer's share annually and sends each insurer its final fee calculation no later than August 31 of that fee year, and the insurer must pay the fee by September 30.

In Texas, the insurance providers subject to this annual fee include HMOs and those that provide health insurance for Medicare Advantage, Medicare Part D, Medicaid and CHIP, and the state employee benefit systems. Unlike the private market, the insurers contracted with the state to manage the cost of the Medicaid and CHIP programs cannot pass on the cost to the consumer, so ultimately, the cost of the fee is borne by the state. The annual HIT imposed by the federal government raises the cost for families, employers, state government and taxpayers.

Cost of Annual Health Insurance Tax

- **2014: $8 billion**
- **2015: $11.3 billion**
- **2016: $11.3 billion**
- **2017: $13.9 billion**
- **2018: $14.3 billion**

About TAHP

The Texas Association of Health Plans (TAHP) is the statewide trade association representing private health insurers, health maintenance organizations, and other related health care entities operating in Texas. As the voice for health plans in Texas, TAHP strives to increase public awareness about our members' services, health care delivery benefits and contributions to communities throughout the state.

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