

FREQUENTLY ASKED QUESTIONS (FAQs)

What are the goals of the ACA?

The Affordable Care Act (ACA) has three primary goals: expand access to health insurance, protect patients against arbitrary actions by insurance companies, and reduce costs.

What was the reasoning behind the ACA?

The United States spends far more on health care than any other industrialized nation and the quality of health care is often much worse. Americans spend twice as much as most other countries on patient care, yet we have a higher rate of preventable deaths from illnesses. Too many Americans lack access to health care, and health insurance companies routinely curtail access to necessary services. The high cost of healthcare has also exacerbated fiscal problems for both the federal and state government. The cost of Medicare and Medicaid is a primary reason for the escalating government budget deficits.

From a fire service and EMS perspective, many indigent and uninsured Americans rely on 911 services and emergency room visits as their primary form of health care. This is inefficient, expensive and a drain on both fire-based EMS and emergency department resources. (It is estimated that the current cost of providing medical treatment to those without insurance is \$1000 for each health insurance policy issued in the US.)

To address these problems, policymakers on both the left and the right have proposed overhauling the health care system in several different ways over the years. However, as a compromise, rather than overhauling the entire healthcare payment system, a piecemeal approach was taken. The result is the ACA -- a law that is cumbersome, complex and can be very confusing. Not surprisingly, there is a great deal of misinformation surrounding the law.

Are patients' costs limited under ACA?

Starting in 2015, \$6250 will be the annual limit for all an individual's out-of-pocket costs, including co-pays, deductibles, and co-insurance.

What will be covered in the health insurance offered under health reform?

The Secretary of Health and Human Services (HHS) has defined a list of benefits health plans have to cover (referred to as **essential health benefits [EHBs]**), which includes a number of service categories specified in the health reform law: ambulatory services, emergency care, hospitalization, maternity and newborn care, prescription drugs, mental health and substance abuse services, rehabilitative services and devices, labs, chronic disease management, and oral and vision care for children.

Do all plans have to provide EHBs?

All non-grandfathered fully insured plans in the small group market are required to provide coverage for EHBs for plan years that begin on or after 1/1/14. (The "small group market"

meant plans covering 50 or fewer employees in 2013; some states are mandating that the 10 EHBs apply to plans covering 100 or fewer employees in 2014; starting in 2016, the 100 or fewer employee threshold applies to all states. You will need to check how your state is handling the transition.) No other plans are required to provide EHBs. Therefore, EHB requirements do not apply to administrative services only (ASO) plans (regardless of group size), fully-insured large group plans, or any grandfathered plans.

However, **IF** a plan covers EHBs, the plan cannot impose any annual or lifetime limits on the dollar value of those benefits. Visit limits are still allowed as long as there is no per visit dollar limit.

How will the minimum benefits be determined?

The minimum benefit requirement applies to new plans sold to small businesses (those with up to 100 workers) and individuals beginning January 1, 2014, but not to grandfathered coverage or to coverage provided by large employers.

How does the provision allowing young adults to remain on a parent's insurance work?

The ACA contains a provision that requires private insurers to continue offering dependent coverage of adult children until their 26th birthday. HHS regulations specify that a young adult can qualify for this coverage even if he or she is no longer living with a parent, is not a dependent on a parent's tax return, or is no longer a student. Both married and unmarried young adults can qualify for the dependent coverage extension, although that coverage does not extend to a young adult's spouse or children. For employer plans that were in place prior to March 23, 2010, young adults can only qualify for dependent coverage if they are not eligible for another employer-sponsored insurance plan.

Insurers that do not offer coverage to dependent children are not required to offer coverage to young adults.

The extension of dependent coverage to age 26 went into effect on September 23, 2010 for the first plan year beginning on or after that date.

Regulations also state that young adults who gain dependent coverage under the health reform law cannot be charged more for coverage than similar individuals who did not lose coverage due to the end of their dependent status. Young adults newly qualifying for coverage under the health reform law must also be offered the same benefits package as similar individuals who were already covered as dependents.

Before the ACA, some states required that private insurance extend coverage to young adults in their twenties. These state requirements did not extend to self-funded insurance plans, but the ACA is designed to apply to self-funded plans.¹

¹ Health plans vary. Traditional *fully-insured plans* are plans in which insurance companies assume the financial risk of paying for necessary health coverage. These plans are administered and controlled by insurers who collect premiums paid by the employer and then pay out claims based on the benefits in the employee's plan. Municipal *self-funded plans*, also called municipal 'self-insured' plans) are plans in which the employer or local government takes the place of the insurer by taking on

What protections are there in the ACA for people with pre-existing conditions?

Starting in 2014, all health insurers have to sell coverage to everyone who applies, regardless of their medical history or health status. Insurers are no longer allowed to charge more to individuals with pre-existing conditions, nor are they able to exclude coverage of those conditions from the insurance plans they sell. This rule is sometimes referred to as “guaranteed issue.”

The ACA has offered this protection for children with pre-existing conditions since September 23, 2010. Insurers cannot deny coverage to children due to their health status, nor exclude coverage for pre-existing conditions.

While adults did not have the same protections as children until 2014, the government set up a temporary national high-risk pool open to all U.S. citizens and legal residents who had trouble buying insurance due to a pre-existing condition and had been uninsured for at least six months. This federally subsidized coverage, officially known as the Pre-existing Condition Insurance Plan, provided temporary coverage for those individuals before January 2014.

How does the ACA affect unions’ collectively-bargained agreements?

The ACA was written to allow health plans subject to collective bargaining agreements (CBAs) to be able to maintain their grandfathered status through the end of the CBA. The law and regulations also include a special rule for collectively-bargained plans that gives additional flexibility to change insurers during the period of the CBA in effect on the date that the ACA was signed.

In the debates leading up to the passage of the ACA, President Obama promised that, “if you like your healthcare you can keep it.” That has not proven to be correct. While the president claimed in November 2013 that when he made that declaration he was thinking about the 95% of people who are covered by employer-based insurance plans (like most union members) and those with Medicare, the claim is not entirely true for those groups, either.

While many pundits claim that only those with substandard coverage are losing their health insurance, the truth is that certain provisions of the ACA will impact the plan design and, ultimately, the survival of high-quality employer-sponsored and union-negotiated plans – including many of our members’ plans.

Clearly, the ACA will force changes in virtually every insurance plan on the market today – whether you hold an individual policy or are in a group plan like most IAFF members, things are going to change. The questions that remain to be answered fully are: How many changes will there be? When will the changes occur? And how much will the changes help or hurt IAFF members?

the financial risk of covering the costs of any medical claim filed by employees. Local Union *self-administered plans* may also be referred to ‘self insured’ plans. For these plans, the union or a trust established by the union receives a finite sum of money from the employer/local government, and the union (or trust) itself bears the financial risk of paying for its members healthcare needs. In either of these self-insured arrangements, a third party administrator (TPA), in many cases an insurance company, may handle claims administration, processing, etc, but, the jurisdiction, the union, or the trust assumes the risk and responsibility to pay the claims.

Because of the dramatic effects of the ACA, many IAFF members can expect insurance carriers to notify them of changes in their policies, including span of coverage, benefits offered within the plans and the amount of out-of-pocket costs you will pay. Some of these changes will have to be negotiated with the local, particularly in jurisdictions where healthcare is a subject of bargaining. But in many cases, members can just expect to be notified by insurance carriers or employers of increases in costs and changes to benefits.

The IAFF is working with a coalition in labor, with other stakeholders and with our friends in Congress to amend the law to eliminate or lessen the negative effects of the ACA on your healthcare plans.

What is grandfathered status?

The ACA exempts most plans that existed on March 23, 2010 (the day the law was enacted) from some of the law's consumer protections. These plans are called "grandfathered" health plans and there is a possibility that you and your plan may qualify for this exemption. To find out, simply check your plan's materials starting with the first plan or policy year starting on or after September 23, 2010: health plans must disclose if they are grandfathered plans in all materials describing their health benefits, or you can check with your health plan's administrator.

If yours is a grandfathered plan, it is not required to comply with some of the protections in the ACA. Below is a list of provisions that DO and DO NOT apply to grandfathered plans:

The following ACA provisions DO apply to grandfathered plans:

- End lifetime limits on coverage.
- End arbitrary cancellations of health coverage.
- Must cover adult children up to age 26.
- Provide a Summary of Benefits and Coverage (a short, easy-to-understand summary of what a plan covers and costs.)

The following ACA provisions DO NOT apply to grandfathered plans:

- Cover preventive care for free.
- Guarantee your right to appeal.
- Protect your choice of doctors and access to emergency care.
- Be held accountable through Rate Review for excessive premium increases.

What will cause a plan to lose grandfathered status?

There are a number of events that can cause a plan to lose its grandfathered status. Grandfathered status may be terminated if, since March 23, 2010, your plan has made certain changes, including: eliminating all or substantially all benefits to diagnose or treat a particular condition; increasing a percentage cost-sharing requirement; increasing a fixed-amount cost-sharing requirement other than a copayment by more than medical inflation plus 15%; increasing a fixed-amount copayment for any service by more than the greater of \$5 adjusted for medical Inflation or medical inflation plus 15%; or decreasing the employer contribution rate by more than 5%.

How will the new expenses associated with the ACA be paid for?

The ACA includes a variety of fees and taxes, some of which negatively impact fire fighters. It imposes tax penalties on employers who refuse to offer healthcare to their workers and on individuals who refuse to purchase healthcare. The Act also imposes new taxes and fees on insurance companies (or the sponsors of self-insured plans), medical device

manufacturers and an assortment of other providers. Of greatest concern to fire fighters is the so-called "Cadillac" tax on high cost health plans, which is described in more detail below.

What is the excise tax on so-called "Cadillac" plans?

Perhaps the most troubling provision of the ACA for fire fighters is the *Excise Tax on High-Cost Coverage*, more commonly referred to as the "Cadillac Tax." Beginning in 2018, employer-based health plans will have to pay a 40% tax on premiums which exceed a certain cap (considering the share of the premiums paid by the employee, as well as the share provided by the employer). In 2018, these caps will be set at \$10,200 for an individual and \$27,500 for a family of four, and do not include any premiums associated with dental or vision coverage. Insurers or plan administrators pay the tax, but presumably the fee will be passed through to the employer and potentially even the employee.

So, if an individual plan costs \$11,200, a 40% tax on the amount above the cap (in this case \$1000) would be applied. ($\$11,200$ cost of plan – $\$10,200$ ACA cap = $\$1,000 \times 40\% = \400 tax.)

Although the tax has been nicknamed the "Cadillac Tax," it would more appropriately be called the "Chevy Tax" since the premium cap would affect many basic health plans that do not have luxury features. And each year, more and more plans will bump up against the cap. The thresholds are set to increase each year based on the consumer price index (CPI), but healthcare costs traditionally rise much faster than inflation. A Johns Hopkins study estimated that while only 16% of plans will be affected by the tax in 2018, that figure could grow to 75% by 2030.

It is not clear how insurance companies will respond to this onerous 40% excise tax on amounts above the threshold. Some people believe they will maintain their current plans, and simply pass the cost onto their customers. Others believe they will opt to find ways to reduce the cost of their plan to avoid paying the tax, by reducing benefits or requiring higher co-pays and deductibles. It is important to figure out whether any benefits currently provided may be handled so through a separate program, which could, in turn, bring the cost of the plan below levels triggering the Cadillac Tax.

The ACA allows for higher excise tax caps for plans covering employees in high-risk professions (including firefighting). In 2018, these caps will be \$11,850 for individuals and \$30,950 for a family of four. Unfortunately the "high risk" bump-up is not as simple or inclusive as it seems. According to the law, in order to take advantage of the higher caps, the "majority of employees" in the health plan must be in high-risk professions or retirees. This means that plans covering just fire and police would be eligible for the higher caps; however the higher cap will not apply to those fire fighters that are covered by a health plan that includes other municipal employees.

How does the government know how much healthcare premiums cost?

The IRS now requires employers to provide this information along with their tax filings. The amount will be reported on your W-2 form.

What other new fees are associated with the ACA?

The Patient-Centered Outcome Research Institute (PCORI) fee will be collected to help pay for the institute that was authorized by Congress to provide evidence-based research that is intended to help people make informed health care decisions. This costs \$2 per covered life between 10/1/2013 to 9/30/2014; from 10/1/2014 to 9/30/2019 it will be equal to the sum of the prior year, plus health care inflation. The PCORI fee will be paid by health insurance issuers and, in the case of self-insured plans, by the plan sponsor.

The Transitional Reinsurance Program Assessment Fee (sometimes known as the "belly button tax") is a temporary fee which will be collected to help stabilize premiums for insurers providing high-cost coverage to the individual market. This issue has been a major source of contention between organized labor and the Obama administration. The decision on implementing the fee was done through HHS. It is particularly troublesome since non-profit plans and their members are paying this tax to subsidize for-profit companies. The IAFF is working with other unions and our allies in Congress to address this issue. The assessment costs \$63 per individual enrolled in 2014, and HHS will make a determination as to how much the fee will be in 2015 and 2016. The fee will be paid by health insurance issuers or "TPAs on behalf of self-insured group health plans."²

These two fees apply to both grandfathered and non-grandfathered plans.

How will the ACA affect self-insured plans?

Fire fighters are covered by different types of health plans. Some health plans are fully administered and controlled by insurers who collect premiums paid by the employer and then pay out claims based on the benefits in the employee's plan. These are traditional *fully-insured plans* in which the insurance companies assume the financial risk of paying for necessary health coverage.

However, some fire fighters have their healthcare needs covered by arrangements other than traditional fully-insured plans. These plans are typically called self-insured plans.

For municipal self insured '*self-funded plans*', the employer/local government takes the place of the insurer by taking on the financial risk of covering the costs of any medical claim filed by employees.

For the local union self insured/ '*self-administered plans*', the union or a trust established by the union receives a finite sum of money from the employer/local government, and the union (or trust) itself bears the financial risk of paying for its members healthcare needs.

In either of these alternative arrangements, a third party administrator (TPA), in many cases an insurance company, may handle claims administration, processing, etc, but, the jurisdiction, the union, or the trust assumes the risk and responsibility to pay the claims.

Unfortunately, under the ACA, these various self-insured plans will face a number of negative impacts, administrative requirements and fees. It is important to know what these changes will look like and how they will affect IAFF members as the local and the employer interact throughout the year and during the collective bargaining process. For example, provisions like the "Cadillac tax," may present a challenge for self-insured plans. As the law stands currently, self-insured plans will not have access to the ACA's premium tax credits and cost-sharing reductions as other health plans. Without these subsidies, the fear is that these plans will be comparatively more expensive for union workers, forcing them off of their current benefit plans and into the state-run exchanges. The IAFF has vigorously

opposed the subsidy issue and fees associated with self-insured plans as they do not directly benefit fire fighters.

When are employers required to report the cost of healthcare on W-2s and how will it affect my taxes?

Employers are generally required to report the cost of group health coverage as of January 2013. The information reported in January relates to group health coverage provided in the previous tax year.

The reporting requirement is intended to be informational and provide employees with greater transparency into healthcare costs. The amounts reported are not taxable.

What will happen to the tax exclusion for employer-sponsored insurance?

The majority of Americans with healthcare coverage are receiving it from their employer. One of the things that make this decades-old exclusion so popular is that benefits provided by the employer are not counted as taxable income to the employee and similarly employee contributions toward their health care premiums are made on a pre-tax basis.

Fire fighters especially benefit from this tax break. Health plans for fire fighters are typically more costly and cover more benefits due to the high-risk nature of the profession. In fact, fire fighters will forgo higher salaries to increase or keep their existing health benefits – placing a high value on the need for quality and comprehensive coverage.

There have been repeated attempts to severely alter or even eliminate this tax exclusion. The 2008 presidential election, the 2010 health care debate, and the current fight to reform the tax code have provided opportunities for political candidates and elected officials to push for drastically altering the health care tax exclusion. So far, the IAFF has fought and won every attempt to protect this important tax benefit and will continue to do so now and in the future.

What do the actuarial values in the ACA mean?

The levels of coverage in the ACA are not defined using specific deductibles, copays, or coinsurance. Rather, they are specified using the concept of an “actuarial value” (AV). For example, a plan with an AV of 70% (referred to as a “silver” plan in the ACA) means that, on average, the plan will pay 70% of enrollees' healthcare expenses, while the enrollees themselves will pay 30% through some combination of deductibles, copays and coinsurance. (The estimate is based on a prediction made by the insurance company.) The higher the AV, the less patient cost-sharing the plan will have on average. The percentage a plan pays for any given enrollee will generally be different from the actuarial value, depending upon the healthcare services used and the total cost of those services. The details of the patient cost-sharing will likely vary from plan to plan.

Note: Bronze is at 60% AV, silver is at 70% AV, gold is at 80% AV, and platinum is at 90% AV.

What is a health insurance exchange?

Exchanges (also known as marketplaces) are organizations that are set up to create a more organized and competitive market for buying health insurance. The exchanges offer a choice of different health plans, certify plans that participate in the exchange and provide information to help consumers better understand their options.

The fate of the ACA rests on the ability of the federal government and the 17 states that are setting up their own exchanges to get the systems running properly and sign up individuals (especially young and healthy individuals) to buy insurance through them.

What happens in states which did not implement the ACA and set up an exchange?

In states that have not established their own exchange or implement the new insurance rules according to ACA standards, the federal government is performing those functions.

What is a private exchange?

Separate from the ACA's exchanges are private healthcare exchanges. Relatively new in practice, these "exchanges" are managed insurance marketplaces where multiple carriers compete by offering employees of a participating organization a choice of fully-insured group plans. Their goal is to increase competition, bring down prices and provide better services, just like the state exchanges. This new model is independent from the ACA and will not affect how the state exchanges are operated, nor will participants in private exchanges be eligible for tax subsidies.

Will fire fighters be forced to use the exchanges?

Employers, both public and private, may cease coverage for their employees and transition them onto the exchanges. However, it is important to remember that there is nothing that prevents employers from dropping health coverage for their employees before the employer mandate takes effect. So, any employer could have stopped employee health coverage prior to the passage of the ACA, unless prevented by an employment contract.

In the future, IAFF local leaders may need to be prepared to defend retaining their employer-provided coverage. (Benefits available on the exchanges will be less generous than many collectively-bargained plans.)

Should my I accept my employer's offer of a monetary stipend in exchange for eliminated or reduced health insurance coverage?

While some cities may offer their employees a stipend (especially if they propose dropping spouses from coverage), local leaders and individuals must carefully do the math to see how this will affect them. Contact the IAFF Labor Issues and Collective Bargaining Department to ask questions regarding bargaining your healthcare.

Will employers that don't provide health benefits have to pay a penalty?

The ACA imposes penalties on "large" employers (those with 50 or more full-time employees or equivalents) that do not offer insurance to their workers or that offer

coverage that is unaffordable. This provision is sometimes known as the “employer mandate.” (Note that the employer mandate also requires coverage to be offered to employees’ children under age 26, but it has no requirement for employees’ spouses or retirees.)

Large employers that do not provide coverage will be assessed a penalty beginning in 2015 if any one of their workers receives a tax credit when buying insurance on their own in a health insurance Exchange. Workers with income up to 400% of the FPL are eligible for tax credits. The employer penalty is equal to \$2,000 multiplied by the number of workers in the business in excess of 30 workers (with the penalty amount increasing over time)

In some instances, large employers that do offer coverage could be subject to penalties as well. If the coverage does not have an AV of at least 60% — meaning that on average it covers at least 60% of the cost of covered services for a typical population — or the premium for the coverage would exceed 9.5% of a worker's income, then the worker can obtain coverage in an exchange and be eligible for a tax credit. For each worker receiving a tax credit, the employer will pay a penalty of \$3,000 up to a maximum of \$2,000 times the number of workers in excess of 30 workers.

Regrettably, some businesses are skirting the law by scheduling workers to less than 30 hours per week. (30 or more hours is “full-time” for purposes of the employer mandate.) In addition to not providing health coverage, this practice obviously reduces a worker’s weekly wage and diminishes their standard of living. It is one of the most troubling unintended consequences of the ACA.

The relevant information for determining large employer status is the number of full-time equivalent employees (FTEs) of the entire municipality, unless the fire department has a separate and distinct plan. Unlike HIPAA, the ACA refers to the employer, not the plan, and municipalities have been found to still be obligated to provide healthcare even though they have put their fire fighters into a separate plan.

Are part-time fire fighters counted toward the employer mandate threshold of 50 employees?

Generally, the hours of employees who work less than 30 hours a week are to be counted under the employer mandate to determine whether a given employer has at least 50 FTEs. As a result, there was significant concern and speculation in the press in late 2013 about how the employer mandate would affect volunteer fire departments; some commentators thought volunteer fire fighters might be treated as “employees,” and the resulting obligation to offer health insurance coverage or pay a tax penalty would be a crippling expense that would force many volunteer and hybrid fire departments to close. To address these concerns, the Internal Revenue Service (IRS) on January 10, 2014 issued a statement saying its “forthcoming final regulations relating to employer shared responsibility generally will not require volunteer hours of bona fide volunteer firefighters and volunteer emergency medical personnel at governmental or tax-exempt organizations to be counted when determining full-time employees (or full-time equivalents).”

How does the ACA provide a discount of up to 30% for employees who participate in wellness programs?

Tax law allows insurance companies to offer premium discounts or rebates. Under the ACA, the maximum permissible reward under a health-contingent wellness program has increased from 20% to 30% of the cost of health coverage, and amount is further increased to a maximum reward of as much as 50% for programs designed to prevent or reduce tobacco use. Local leaders should inquire about the discount in departments where there are established wellness/fitness programs.

How will the ACA affect retired fire fighters?

Retirees under 65 who do not have access or can't afford to maintain their current coverage will have a new option to obtain coverage through the exchanges. The IAFF has long advocated for a way our retired members can access quality and affordable healthcare, and the exchanges might provide that avenue. Affiliates should determine whether this aspect of the ACA would benefit their retirees.

Upon retirement, if you choose to access an exchange for coverage, the federal government may provide you with tax subsidies to assist in purchasing your health insurance. These subsidies are available to individuals and families who are earning 100-400% of the federal poverty level (FPL).

If you do not qualify for these subsidies, the exchanges will still offer insurance options. To better understand the exchanges, subsidies and plans offered within, use this helpful "subsidy calculator" created by the Kaiser Family Foundation to find out what subsidies, if any, would be offered at various income levels.

The ACA offers another option for some pre-Medicare eligible retirees by expanding access to Medicaid. Starting in 2014, individuals under 65 with an income at or below 133% of the FPL are eligible for Medicaid, in the 26 or so states that chose to participate in the Medicaid expansion. In every state, individuals without children or disabilities are now guaranteed coverage without the need for a waiver. Go to the Medicaid.gov website to learn how the new Medicaid improvements work. Many long-time retirees whose pensions do not have cost of living escalators may benefit from this provision. Affiliates should determine if this option is appropriate for any of their current or former members.

Will retirees be eligible for subsidies to make health insurance more affordable?

Beginning in 2014, tax credits are available to U.S. citizens who purchase coverage in the new health insurance exchanges and who have income up to 400% of the FPL (\$45,960 for an individual or \$94,200 for a family of four in 2013). To be eligible for the premium tax credits, individuals must not be eligible for public coverage — including Medicaid, the Children's Health Insurance Program, Medicare, or military coverage—and must not have access to health insurance through an employer. (There is an exception in cases when the employer plan does not cover at least 60% of covered benefits on average or the employee share of the premium exceeds 9.5% of the employee's income.)

The premium tax credits are available when an individual purchases coverage and will be available regardless of whether or not an individual owes any taxes. The premium tax credits vary with income and are structured so that the premium an individual or family will

have to pay will not exceed a specified percentage of income, ranging from 2% for those with incomes up to 133% of the FPL (about \$15,281 for an individual) to 9.5% for those with incomes between 300% and 400% of the FPL (\$34,470 to \$45,960 for an individual).

The calculator below will help you estimate—based on income level, age, family size, and other factors—your eligibility for subsidies and how much you could spend on health insurance. **(Note: This calculator is meant only to provide an estimate. Since premiums and eligibility requirements vary, you should contact your state’s Medicaid office or exchange to get a more accurate picture of what you should expect.)**

<http://kff.org/interactive/subsidy-calculator/>

Does the ACA cut Medicare benefits?

Medicare’s guaranteed benefits will not be cut, but the reimbursement rates paid to health care providers for some services will be reduced. Any Medicare savings will be used to extend the solvency of the Medicare trust fund, reduce Medicare premiums and cost-sharing, improve or expand guaranteed Medicare benefits, or preserve access to service providers.

Will the ACA phase out Medicare’s Part D “Donut Hole”?

In 2013, the federal government began picking up larger and larger portions of the cost of both brand name and generic medications and will do so each year, until the coverage gap is finally phased out in 2020.

Who will be eligible for Medicaid?

Beginning in 2014, Medicaid programs (which provide health coverage to low-income Americans) in the 26 or so states which chose to expand Medicaid began to cover all individuals under age 65 with incomes up to 133% of the FPL (\$15,281 for an individual or \$31,321 for a family of four in 2013).

The ACA was intended to create a uniform Medicaid eligibility level and income definition across all states and eliminate a prohibition that prevented states from providing Medicaid coverage to adults without dependent children except under a waiver of federal rules. However, under the 2012 U.S. Supreme Court decision that upheld the ACA, each state is allowed to decide whether or not to participate in Medicaid expansion.

Will everyone have to carry health insurance?

Starting in 2014, under what’s known as the “individual mandate,” the ACA requires most people to have health insurance or pay a penalty if they don’t. (The U.S. Supreme Court upheld the constitutionality of the individual mandate in June 2012.) Coverage may include employer-provided insurance, coverage someone buys on their own, Medicare, or Medicaid.

Several groups are exempt from the requirement to obtain coverage or pay the penalty, including people who have to pay more than 8% of their income for health insurance and people with incomes below the threshold required for filing taxes (in 2012, \$9,750 for a single person).

Due to the problems that plagued HealthCare.gov after its launch on October 1, 2013, several groups called on the White House to delay the individual mandate. The argument was that uninsured individuals should not incur a tax penalty for failing to buy insurance while the mechanism through which they were supposed to be able to compare plans (known as an “exchange” or “marketplace”) is not functioning properly. The Obama administration declined to delay the individual mandate and instead focused on repairing HealthCare.gov, which functions as the exchange for the states which did not elect to set up their own exchanges.

What happens if people don't buy health insurance?

Under the individual mandate, the penalty for people who forgo insurance is the greater of two amounts: a specified percentage of income **or** a specified dollar amount. The percentages of income are to be phased in over time at 1% in 2014, 2% in 2015, and 2.5% starting in 2016. The dollar amounts are also phased in at \$95 in 2014, \$325 in 2015, and \$695 beginning in 2016 (with annual increases after that). The total penalty for the taxable year will not exceed the national average of the annual premiums of a bronze level health insurance plan offered through the health insurance exchanges.

How will people prove they have health insurance?

Health insurance plans will provide documents to people that they insure that will be used to prove that they have the minimum coverage required by law.

What is the 30-day readmissions penalty?

The ACA established the Hospital Readmissions Reduction Program, which requires the Centers for Medicaid & Medicare Services (CMS) to reduce payments to certain hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. Specifically, the penalty is for admission to a subsection(d) hospital within 30 days of a discharge from the same or another subsection(d) hospital, for the applicable conditions of Acute Myocardial Infarction (AMI), Heart Failure (HF) and Pneumonia (PN).

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html>