



EXPLAINING HEALTH CARE REFORM: Questions About Health Insurance Subsidies

Good health insurance is expensive, and its cost is out of reach for many lower and moderate income families, particularly if they are not offered health benefits at work. To make coverage obtainable for families that otherwise could not afford it and to encourage broad participation in health insurance, the Patient Protection and Affordable Care Act (PPACA) includes provisions to lower premiums and cost-sharing obligations for people with low and modest incomes. The adequacy of this assistance will be a key determinant of how many people will gain coverage and whether or not lower income people will be able to use the health insurance they obtain.

This summary describes the financial assistance provided under PPACA for people purchasing coverage on their own through health insurance exchanges. Expanded coverage for low income people through Medicaid and CHIP and new tax credits for small businesses offering health insurance are addressed in other reports.

What types of subsidies does PPA CA provide to people buying health insurance?

New eligibility rules enacted under PPACA – as revised by the recent Supreme Court decision on the law – give states the option of extending coverage in Medicaid to most people with incomes under 138% of poverty. For people with somewhat higher incomes (up to 400% of poverty), PPACA provides tax credits that reduce premium costs. People with incomes up to 250% of poverty also are eligible for reduced cost sharing (e.g., coverage with lower deductibles and copayments) paid for by the federal government. The premium tax credits and cost-sharing assistance will begin in 2014.

Who is eligible for premium tax credits?

Citizens and legal residents in families with incomes between 100% and 400% of poverty who purchase coverage through a health insurance exchange¹ are eligible for a tax credit to reduce the cost of coverage. People eligible for public coverage are not eligible for premium assistance in exchanges. In states without expanded Medicaid coverage, people with incomes less than 100% of poverty will not be eligible for exchange subsidies, while those with incomes at or above poverty will be. People offered coverage through an employer are also not eligible for premium tax credits unless the employer plan does not have an actuarial value of at least 60%² or unless the person’s share of the premium for employer-sponsored insurance exceeds 9.5% of income. People who meet these thresholds for unaffordable employer-sponsored insurance are eligible to enroll in a health insurance exchange and may receive tax credits to reduce the cost of coverage purchased through the exchange.

What is the amount of the tax credit provided to people?

The amount of the tax credit that a person can receive is based on the premium for the second lowest cost silver plan³ in the exchange and area where the person is eligible to purchase coverage. A silver plan is a plan that provides the essential benefits⁴ and has an actuarial value of 70%. (In PPACA, a 70% actuarial value means that on average the plan pays 70% of the cost of covered benefits for a standard population of enrollees.) The amount of the tax credit varies with income such that the premium that the person would have to pay for the second lowest cost silver plan would not exceed a specified percentage of their income (adjusted for family size), as follows:

Income Level	Premium as a Percent of Income
Up to 133% FPL	2% of income
133-150% FPL	3 – 4% of income
150-200% FPL	4 – 6.3% of income
200-250% FPL	6.3 – 8.05% of income
250-300% FPL	8.05 – 9.5% of income
300-400% FPL	9.5% of income

Note: The Federal Poverty Level (FPL) was \$10,830 for an individual and \$22,050 for a family of four through early 2010. For more information, please see the Department of Health and Human Services Poverty Guidelines, available at <http://aspe.hhs.gov/poverty/09poverty.shtml>.

A person who wants to purchase a plan that is more expensive would have to pay the full difference between the cost of the second lowest cost silver plan and the plan that they wish to purchase.

An example shows how the premium tax credits work. Assume:

- Pat is 45 years old and has an income in 2014 that is 250% of poverty (about \$28,735)⁵
- The cost of the second lowest cost silver plan in the exchange in Pat's area is projected to be about \$5,733
- Under PPACA, Pat would not be required to pay more than 8.05% of income, or \$2,313, to enroll in the second lowest cost silver plan.

The tax credit available to Pat would be \$3,420 (\$5,733 premium minus the \$2,313 limit on what Pat must pay).

Because health insurance premiums have typically grown more rapidly than income, PPACA adjusts the percent of premium that people are required to pay to reflect the excess of the premium growth over the rate of income growth. Beginning in 2019, if aggregate premiums and cost-sharing subsidies exceed 0.54% of GDP, the premium percentages would be further adjusted to reflect the excess of premium growth over CPI.

How will premium subsidies be provided?

Premium tax credits would be refundable and advanceable. A refundable tax credit is one that is available to a person even if he or she has no tax liability. An advanceable tax credit allows a person to receive assistance at the time that they purchase insurance rather than paying their premium out of pocket and waiting to be reimbursed when filing their annual income tax return.

PPACA requires exchanges to provide information to prospective enrollees about their eligibility for premium tax credits. The process through which people apply for premium tax credits will likely be established by the Secretary of Treasury through regulation.

How will cost-sharing subsidies be structured?

Cost-sharing subsidies protect lower income people with health insurance from high out-of-pocket costs at the point of service. PPACA provides for reduced cost sharing for families with incomes at or below 250% of poverty by making them eligible to enroll in health plans with higher actuarial values. The premium tax credits, discussed above, generally are based on a plan with an actuarial value of 70%. PPACA provides that people with lower incomes have their cost sharing reduced so that plan on average pays a greater share of covered benefits. The amount of additional protection varies with income, as follows:

Income Level	Actuarial Value
100-150% FPL	94%
150-200% FPL	87%
200-250% FPL	73%

PPACA sets maximum out-of-pocket spending limits (discussed below), but otherwise does not specify the combination of deductibles, copayments, and coinsurance that plans must use to meet the actuarial value requirements. So, for example, one plan may choose to have relatively higher deductibles but relatively low copayments for office visits and other services, while another plan may choose a lower deductible but higher copayments or coinsurance for each service. The Secretary of Health and Human Services may choose to address this issue through rulemaking.

As just noted, PPACA limits the total amount that people must pay out-of-pocket for cost sharing for essential benefits. Generally, the limits are based on the maximum out-of-pocket limits for Health Savings Account-qualified health plans (\$5,950 for single coverage and \$11,900 for family coverage in 2010), which will be indexed to the change in the Consumer Price Index until 2014 when the provision takes effect.⁶ After 2014, the limits will be indexed to the change in the cost of health insurance. People with incomes at or below 400% of poverty have their out-of-pocket liability capped at lower levels, as follows:⁷

Income Level	Reduction in Out-of-Pocket Liability
100-200% FPL	Two-thirds of the maximum
200-300% FPL	One-half of the maximum
300-400% FPL	One-third of the maximum

The limits on out-of-pocket maximum amounts means that a person with income of 150% of poverty purchasing coverage in the exchange would have the limit on their out-of-pocket spending reduced to at least two-thirds of the generally applicable maximum value (for example, if the provision were in effect in 2010, the out-of-pocket maximum for single coverage for such a person would be about \$1,981 for single coverage and \$3,963 for family coverage).

In combination, the two cost sharing provisions require health plans offering coverage to lower income people in the exchange to increase the actuarial value of the coverage of the plans that they receive, and to do so in a way that caps enrollee out-of-pocket liability within the specified levels.

How do subsidies affect the cost of reform?

The Congressional Budget Office (CBO) estimates the direct cost of premium and cost-sharing subsidies to be \$350 billion from 2010 to 2019, and \$8 billion in indirect costs.⁸ The cost of the subsidies is a function of the number of people that are eligible for subsidies, and how generous the subsidies are.

CONCLUSION

Subsidies to make insurance more affordable and increase insurance coverage are a key element of the Patient Protection and Affordable Care Act. Premium and cost-sharing subsidies of varying levels will be available to individuals and families with low to moderate incomes, making coverage and care more affordable. While many of the details on how they will be administered are forthcoming, most premiums subsidies will be delivered in the form of advanceable and refundable tax credits, while cost-sharing subsidies will increase the actuarial value of health plans. The Congressional Budget Office estimates that the subsidies will cost roughly \$350 billion between 2010 and 2019, although the overall effect of the Act is estimated to reduce the deficit over the same time period. These subsidies will provide assistance for low to moderate income families, enabling them to purchase coverage and gain better access to care.

For more information about the Patient Protection and Affordable Care Act, see the summary of the new health reform law at www.kff.org/healthreform/8061.cfm.

Resources

Center for Health System Change – Living on the Edge: Health Care Expenses Strain Family Budgets: www.hschange.org/CONTENT/1034/?topic=topic05

Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured – Approaches to Covering the Uninsured: A Guide: www.kff.org/uninsured/upload/7795.pdf

Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured – President Obama’s Campaign Position on Health Reform and Other Health Care Issues: www.kff.org/uninsured/kcmu112508oth.cfm

Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured – The Coverage and Cost Impacts of Expanding Medicaid: www.kff.org/medicaid/7901.cfm

Kaiser Family Foundation – Health Reform Side-by-Side: www.kff.org/healthreform/upload/healthreform_tri_full.pdf

Kaiser Family Foundation – Tax Subsidies for Health Insurance: www.kff.org/insurance/upload/7779.pdf

ENDNOTES

¹ Kaiser Family Foundation, “Explaining Health Care Reform: Questions About Health Insurance Exchanges.” Available at www.kff.org/healthreform/7908.cfm.

² For definition of Actuarial Value, please see “Glossary of Key Health Reform Terms,” available at www.kff.org/healthreform/7909.cfm.

³ For more information about the silver plan and other plans available in the exchange, please see “Explaining Health Care Reform: Questions About Health Insurance Exchanges,” available at www.kff.org/healthreform/7908.cfm.

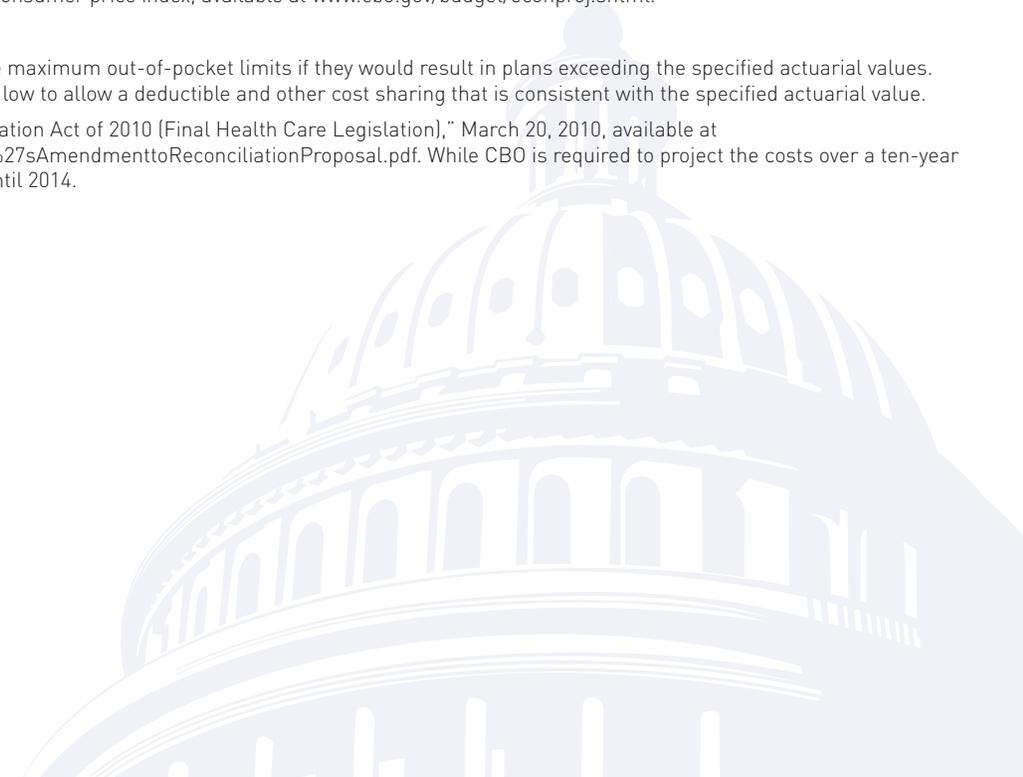
⁴ Essential benefits must include at least the following general services: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health benefits and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease managements, and pediatric services including oral and vision care.

⁵ Poverty projected based on projected change in consumer price index, available at www.cbo.gov/budget/econproj.shtml.

⁶ See 26 U.S.C. §22 3(g).

⁷ PPACA provides that the Secretary can adjust the maximum out-of-pocket limits if they would result in plans exceeding the specified actuarial values. This could happen if an out-of-pocket limit is too low to allow a deductible and other cost sharing that is consistent with the specified actuarial value.

⁸ Congressional Budget Office, “H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation),” March 20, 2010, available at www.cbo.gov/ftpdocs/113xx/doc11379/Manager%27sAmendmenttoReconciliationProposal.pdf. While CBO is required to project the costs over a ten-year time period, the subsidies will not be available until 2014.



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