

CHAPTER 6: AFFORDABLE CARE ACT (ACA)

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§ 6.1 Patient Protection and Affordable Care Act Overview

The Patient Protection and Affordable Care Act, and its amendment the Health Care and Education Reconciliation Act of 2010, were signed into law on March 23, 2010. These two laws collectively are referred to as the **Affordable Care Act (ACA)**. The law extended comprehensive health insurance coverage to uninsured individuals through three key ways:

- Expansion of the Medicaid program (§ 6.2 and chapter 2)
- Access to employer-provided health insurance (§ 6.3); and
- Implementation of the federal or state health insurance exchanges-aka the Marketplace (§ 6.4)

It is important to note that most individuals living with HIV, first should be evaluated for Medical Assistance (MA) coverage through the Pennsylvania Department of Human Services (DHS), before an assessment is made for Marketplace insurance through the Affordable Care Act (ACA). In addition, if clients are on or eligible for Medicare, they cannot enroll in Marketplace coverage. Any application to the Marketplace by a person who is income-eligible for MA will be sent to DHS for assessment of eligibility. Clients should be encouraged to call the AIDS Law Project for an assessment of their MA eligibility before they apply for health insurance coverage on the Marketplace.

HIV and ACA: Although HIV is not specifically referenced in the ACA, several provisions in the law are beneficial to people living with HIV, because they expand access to health insurance. Some of these provisions are listed below:

- Removes preexisting conditions for children and adults
- Removes *lifetime* dollar amount limit of most covered services
- Removes the *annual* dollar amount limit for most covered services in all job-related and individual health insurance plans
- Expands Medicare services and other private health insurance by implementing a free yearly wellness visit with preventive services. These services include tobacco use cessation counseling, screenings for cancer, diabetes, and other chronic diseases.
- Closes the coverage gap (known as the “donut hole”) for Medicare beneficiaries who need prescription drugs. Beginning this year (2020), Medicare beneficiaries will only pay 25% of their medication cost. (see Chapter 4 – Medicare for more information)
- Permits young adults to stay on their parents’ employment-related insurance until age 26.
- Develops the medical home health care model.

§ 6.2 Expanded Medicaid Eligibility

The ACA significantly expands Medicaid eligibility to **individuals under 65, who are not eligible for Medicare, and who do not meet the Medicaid income threshold and categorical requirements** (see below for more information). A state’s participation in the expanded Medicaid program is optional. Fortunately, Pennsylvania chose the option to expand Medicaid. The expansion mostly benefits low-income adults who are: age 19-64 and without dependents; children; pregnant; and parents/caregivers.

Prior to the ACA, Medicaid applicants, in addition to being low-income and meeting a resource test, also had to fit within a certain eligibility category such as elderly, disabled, children or pregnant women, etc. However, under the ACA Medicaid expansion, eligibility is based on income alone, without either a resource test or categorical requirement. This means that clients do not need to certify that they are disabled. Therefore, Medicaid expansion can be life-saving for low-income people with HIV who are NOT disabled but need access to healthcare to stay healthy. Medicaid expansion also benefits people who are found to be disabled and awarded SSD but are over the traditional Medicaid limit of 100% of the federal poverty income guideline and who must wait two years after being awarded SSD for Medicare coverage to begin.

Income Limits for Medicaid Expansion: Income eligibility for Medicaid expansion is calculated according to the *Modified Adjusted Gross Income* (MAGI) rules. MAGI is a combination of all earned and unearned income. There are some exceptions so, that in specific circumstances, not all income is counted. MAGI income counting is different from

the SSI income counting method that is used for disability-related Medical Assistance programs (e.g., MAWD, Healthy Horizons).

Individuals with income up to 133% of the FPIG calculated under the MAGI are eligible for Medicaid under ACA. In 2020, this amount is \$16,971 (annually) for an individual, \$22,929 for a couple, and \$34,846 for a family of four. Income will be calculated by giving a 5% deduction from the applicant’s gross income. Therefore, applicants may have income up to 138% FPIG and be eligible for Medicaid under the ACA.

NOTE:
For additional information on MAGI income counting methodology see Chapter 5.

Chart 6-1: Income level for 2020 for Medicaid expansion population		
Number of household members	133% of FPIG (annual)	138% of FPIG (annual)
1	\$16,971	\$17,609
2	\$22,929	\$23,791
3	\$28,888	\$29,974
4	\$34,846	\$36,156
5	\$40,804	\$42,338
6	\$46,763	\$48,521
7	\$52,721	\$54,703
8	\$58,680	\$60,886

Resources are not considered for Medicaid expansion eligibility. Although COMPASS and some paper applications still request information about resources, no applicant, who otherwise qualifies, should be denied MA for failing to provide resource information. Evidence of resources is still needed to qualify for a “traditional” category of MA such as MAWD and Healthy Horizons.

Medicaid benefit packages: Pennsylvania Medicaid has one adult benefit package for beneficiaries of either traditional Medicaid or Medicaid expansion. Every adult enrolled in Medicaid, whether under traditional Medicaid eligibility or Medicaid expansion will receive the benefits package included here:
http://services.dpw.state.pa.us/oimpolicymanuals/ma/health_care_benefit_packages.pdf

Medicaid applicants may apply online on COMPASS or complete Form PA-600 and submit to their local county assistance office. (see Chapter 2 for more information on how to apply for Medicaid).

§ 6.3 Access to Employer-Provided Health Insurance

Under the ACA, individuals with employer-provided health insurance may continue with that insurance coverage or they may purchase a plan on the Marketplace. However, employees should exercise caution in declining their employer's insurance and be aware of the following pitfalls in doing so: (1) The employer-provided insurance usually has a better package and more affordable premiums; (2) The employee will not be eligible to enroll in the employer-provided plan until the next year's open enrollment period; and (3) The employee will not qualify for a tax credit.

Employees who lose health insurance coverage because they have lost their job, will have the choice to either purchase COBRA coverage, purchase health insurance on the Marketplace (see § 6.4) or, if eligible, apply for Medicaid (§ 6.2).

Coverage for Adult Children Ages 18-26: The ACA also expands health insurance coverage by requiring employers to provide continuing insurance for employees' adult children, until they reach age 26, unless the child is eligible for insurance through their employment.

§ 6.4 The Health Insurance Marketplace

The Health Insurance Marketplace is a resource where individuals can compare health insurance plans for coverage and affordability, and also enroll in a plan. The Marketplace is available online at Healthcare.gov.

Pennsylvania has trained "exchange assisters" who are registered with the Pennsylvania Insurance Department who can help clients navigate the Marketplace application process. Assisters are not allowed to charge fees for providing Marketplace help.

Essential Benefits Package: All plans offered on the Marketplace must meet the Essential Benefits Package standard. This includes:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization
- Pregnancy, maternity and newborn care (both before and after birth)
- Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
- Prescription drugs

- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
- Laboratory services
- Preventative and wellness services and chronic disease management
- Pediatric services, including oral and vision care (Note: adult dental and vision coverage aren't essential health benefits)

Plans also must include birth control and breastfeeding coverage. The essential benefits standard is the minimum coverage requirement. Plans can choose to provide more coverage, including dental and vision benefits.

Marketplace Tiers: Insurers on the Marketplace sell their plans in a tiered system. Plan coverage is categorized into 4 tiers that reflect how the consumer and the plan will split the costs of healthcare services, as follows:

Chart 6-2: Marketplace Tiers		
<u>Category</u>	<u>Plan pays</u>	<u>Consumer pays</u>
Platinum	90%	10%
Gold	80%	20%
Silver	70%	30%
Bronze	60%	40%

Applicants enrolling in a Bronze or Silver plan will pay less in monthly premiums, but more in deductibles, copays, and coinsurances. Applicants enrolling in a Gold or Platinum plan will pay more in monthly premiums, but less in deductibles, copays and coinsurances.

Additional information on how costs are split can be found here:

<https://www.healthcare.gov/choose-a-plan/plans-categories/>.

Marketplace costs and help paying for them: Low to moderate-income individuals and families can receive some help to pay for Marketplace plan coverage. Applicants with income between 100% - 400% of the FPIGS are eligible to receive subsidies, differing in amounts, based on their income.

There are two (2) types of subsidies available to Marketplace enrollees. The first subsidy is the **premium tax credit**, which reduces an eligible enrollee's monthly health insurance premium. The second subsidy is the **cost-sharing subsidy**, which reduces an eligible enrollee's out-of-pocket costs for actual healthcare services received.

§ 6.5 Expanded Medicare Coverage under ACA

The ACA expands Medicare coverage in several ways, including (i) eliminating cost-sharing for preventive services, (ii) adding annual wellness visits and personalized

prevention plan services, (iii) limiting cost-sharing in Medicare Advantage plans, and (iv) ending the Part D coverage gap. Listed below are some ACA provisions that improve Medicare coverage:

- Eliminates cost-sharing for most preventative services, including:
 - Diabetes screening
 - Cholesterol and cardiovascular screenings
 - HIV screening for those who either request it or are at risk
 - Vaccinations for pneumonia and Hepatitis B
 - Annual flu shots
 - Annual mammograms for those aged 40 and older
 - Cervical cancer screenings, including a pap test and pelvic exam
 - Prostate and colorectal cancer screenings
 - Medical nutrition therapy to help manage diabetes or kidney disease
 - Bone mass measurement
 - Abdominal aortic aneurysm screening to check for bulging blood vessels
 - Adds annual free wellness visits and personalized prevention plan services for beneficiaries, who have had Medicare coverage for at least one year.

- Adds free smoking cessation counseling services through either inpatient or outpatient services.

- Improves the Medicare prescription drug program by:
 - Eliminating the Medicare Part D coverage gap-aka “donut hole”
 - Increasing the number of drugs covered in the Medicare drug formulary
 - Eliminating drug co-payments for Medicaid funded Home and Community-Based Services (Waiver services) enrollees. Prior to ACA only “**Dual Eligibles**” who were living in an institution – such as nursing home – did not owe copayments for drugs, but those receiving Waiver services at home did have to pay the drug co-pays. ACA eliminated this imbalance.
 - Eliminating prescription drug copayments for Medicare beneficiaries who are also enrolled in the Waiver program and receiving services at home.

§ 6.6 ACA Marketplace Enrollment Periods

Open enrollment is the yearly period when people may apply and enroll in health insurance. The *annual Open Enrollment Period* (OEP) for Marketplace plans runs from **November 1st through December 15th for coverage beginning on January 1st of the following year**. People who miss the OEP will have to wait for the next OEP to enroll for the following year.

However, some people will be eligible for a *Special Enrollment Period* (SEP). The SEP is a time outside the OEP when people can sign up for health insurance, because they have experienced certain life events, including marriage, divorce, having a baby, adopting a

child, death, moving, or losing insurance coverage. Depending on the SEP type, people may have 60 days before or 60 days after the event to enroll in a plan.

For a complete list of SEP life-changing events click here:

<https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/>

Also see:

<https://www.insurance.pa.gov/Coverage/Documents/Health/Insurance%20Special%20Enrollment%20Brochure.pdf>

§ 6.7 ACA and the Ryan White Program

Under the ACA, Ryan White funded programs continue to be necessary to fill gaps in affordability and access to essential care, treatment, and services. These gaps include coverage for oral health service, support services to link clients to care, or coverage for patients with prescription drugs that may not be covered by Medicare, Medicaid, or private insurance.