Life Guide

The Affordable Care Act (ACA)

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Beginning in 2014, most U.S. citizens and legal residents must purchase or be provided by an employer with minimum essential health coverage or be subject to a penalty.

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What Is the Affordable Care Act?

The Affordable Care Act, or ACA, is the nation's health insurance reform law, initially enacted in March 2010 and being gradually phased in over a period of years.

The Patient Protection and Affordable Care Act (PPACA) was signed into law by President Obama on March 23, 2010. Later that same month, legislation to remove or modify some provisions of the original PPACA, the Health Care and Education Reconciliation Act of 2010 (the Reconciliation Act), was passed by Congress and signed into law by President Obama on March 30, 2010. **These two pieces of legislation have come to collectively be known as the Affordable Care Act (ACA).**

Core Principles of the Affordable Care Act

The ACA has five core principles that it is designed to achieve. The degree to which it achieves these five principles will depend on implementation, compliance with and enforcement of the law's requirements and, in all probability, future legislation that addresses flaws that become apparent as the law is implemented:

☐ **Impose an Individual Mandate:** Most individuals not covered by Medicare or Medicaid are required to have health insurance or pay a penalty ("play or pay"). In addition, insurance companies are no longer able to deny coverage for pre-existing conditions, rescind existing health insurance coverage when a person gets sick or impose annual or lifetime limits on benefits.

☐ **Strive to Provide Affordable Coverage:** Lower-income individuals and families, together with some middle-income individuals and families, receive financial assistance to help pay for health insurance. In addition, insurance companies have to annually report the share of premium dollars spent on actual medical care and provide customer rebates for plans that spend a lower percentage of premium dollars on medical services than that required by the ACA.

☐ **Require an Employer Mandate:** With the exception of small businesses, employers that do not provide qualifying health insurance coverage will be subject to an additional tax. Small employers will be encouraged to provide health care coverage through a new tax credit.

☐ **Cover Preventive Health Services:** New group health insurance plans, as well as individual health insurance policies, have to provide "first dollar" coverage for certain preventive services and immunizations.

☐ **Transform the Health Care Delivery System:** Provide funding for research and demonstration projects to test payment and service delivery models designed to reduce health care costs and improve the quality of care provided.

Financing the Affordable Care Act

While there are estimates as to what the ACA will cost and how much of that cost will be offset by new taxes and fees, realistically it's impossible to predict at this point in time with any accuracy what impact health care reform will have on family budgets. The hope is that the current legislation, together with possible future changes, will transform an industry that currently pays doctors and hospitals based on the volume of services provided to a system that rewards medical providers on the basis of health care outcomes, resulting in lower health care costs. In reality, however, the legislation doesn't include any proven strategies for tackling what many consider to be the biggest concern: health care costs that are rising at twice the rate of inflation.

What we do know, however, is that to help finance the cost of health care reform, **the Affordable Care Act includes a number of taxes and fees that will take effect over a period of years,** including:

Beginning in 2010:

☐ Limits on the deduction of compensation paid by health insurance providers to high-level executives begin to phase in; and

☐ 10% tax on qualified indoor tanning services provided on or after July 1, 2010.

Effective Dates Ranging from 2011 to 2014:

☐ Effective January 1, 2011, the cost of over-the-counter medicines and drugs cannot be reimbursed from flexible spending arrangements (FSAs) or health savings accounts (HSAs); and

☐ Annual nondeductible fees imposed on certain health-related industries, such as medical device manufacturers and importers, sales of brand-name pharmaceuticals and health insurance providers.

Beginning in 2013:

☐ An increase in Medicare payroll taxes paid by higher-income taxpayers;

☐ An increase in the threshold for the itemized medical expense deduction from 7.5% to 10% of adjusted gross income;

☐ A new 3.8% Medicare contribution tax on certain investment income above specified income threshold amounts; and

☐ Annual contributions to health flexible spending accounts (FSAs) are limited to $2,500, indexed for inflation in future years.

Beginning in 2014:

☐ "Shared responsibility payments" apply to non-exempt individuals who do not purchase minimum essential health care coverage; and

☐ An annual fee is assessed on certain health insurance providers.

Beginning in 2015:

☐ "Shared responsibility payments" apply to certain employers that do not offer health care coverage to their full-time employees.

Beginning in 2018:

☐ 40% excise tax on "high dollar" health insurance plans goes into effect.

ACA Impact on Individuals and Families

The impact of the Patient Protection Act on you and your family depends to a large extent on your age, for whom you work, the amount and sources of your income and your health status:

- ☐ **Young Adults:** Beginning in 2014, young adults have to purchase health insurance unless they qualify for an exemption. Young adults under age 30, however, have access to less expensive catastrophic coverage. In addition, since 2010, young adults up to age 26 have been allowed to stay on their parent's health plans.

- ☐ **Non-Elderly Adults:** Unless they qualify for an exemption, beginning in 2014, all U.S. citizens and legal residents are required to have qualifying health care coverage or pay a penalty…the individual mandate. Insurers are no longer able to turn down people with pre-existing conditions or charge them higher premiums. Health insurance plans cannot impose annual limits on the amount of coverage an individual may receive and premium rating variations can be based only on age, premium rating area, family composition and tobacco use. Lower-income earners who earn less than 400% of the federal poverty level are eligible for subsidies to help purchase coverage. The lowest-income earners (up to 138% of the federal poverty level) are eligible for Medicaid, regardless of whether or not they have children or a disability, if the state in which they reside has elected to participate in the ACA Medicaid expansion.

- ☐ **Employees of Large Companies:** Participation in an employer's large group health plan generally will satisfy the individual mandate. Beginning in 2015, large employers (those with 50 or more employees) are not required to provide health care coverage, but those that don't may have to make "shared responsibility payments." Existing benefit packages are grandfathered, but must still meet certain requirements. New plans have to meet minimum requirements, including limits on out-of-pocket spending.

- ☐ **Employees of Small Companies:** A business with fewer than 50 employees is not required to provide health care coverage. A business with 25 or fewer employees, however, may qualify for a federal tax credit to help with the cost of providing health insurance.

- ☐ **Higher-Income Individuals:** Additional Medicare taxes are paid by higher-income individuals on their wages, as well as on net investment income.

- ☐ **Senior Citizens:** Medicare has added free preventive services and the Medicare Part D prescription drug coverage gap will slowly be closed by 2020. Higher-income Medicare beneficiaries pay higher Medicare Part B premiums for medical insurance. Medicare currently covers about 38 million people and, as a result, has tremendous clout in the way medical care providers are paid. As a result, expect to see Medicare pilot programs designed to develop and implement new approaches to how medical care providers are compensated.

Health Insurance Recap

Insurance protects you from high costs when something bad happens. In the case of health insurance, no one plans to get sick or hurt, but most people need to get treated for an illness or injury at some point, and health insurance helps pay these costs. You get health insurance to protect you and your family when you need medical care.

When you understand how health insurance works, it helps you be a better informed consumer so you can find coverage that fits your needs.

What Is Health Insurance?

Health insurance is a contract between you and your insurance company. You buy a plan or policy, or one is provided through your employer, and the insurance company agrees to pay part of your medical expenses when you get sick or hurt. Even when you need care that costs more than you pay in premiums and deductibles, insurance will cover the care you need. A standard health insurance policy also gives you access to preventive care to keep you healthy, like vaccines and check-ups, plus many plans also cover prescription drugs.

Health Insurance Helps You Pay for Care

Even a brief hospitalization or emergency room visit can cost thousands of dollars. Having health insurance can help protect you from unexpected costs like these.

Your insurance policy will show what types of care, treatments and services are covered, including how much the insurance company will pay for different treatments in different situations. The Affordable Care Act also requires that insurance companies provide standardized summaries of benefits and coverage so you can easily understand and compare plans.

What You Pay for Health Insurance

You'll usually pay a premium every month for health insurance, and you may also have to meet a deductible once each year before the insurance company starts to pay its share. How much you pay for your premium and deductible is based on the type of insurance you have.

While premium cost is important, you also need to evaluate how much you will have to pay when you receive medical services. Examples include:

- **Deductible:** How much you pay before your insurance coverage starts.
- **Coinsurance or copayments:** What you pay out-of-pocket for services after you pay the deductible. For example, you may have to pay 20% of each charge (coinsurance) or the first $20 for each medical service received (copayment).
- **Out-of-pocket maximum**: How much in total you'll have to pay in a calendar year before the insurance policy fully pays for your covered medical expenses.

What your policy covers is often directly related to how expensive the health insurance policy is. The policy with the cheapest premium may not cover as many services and treatments and/or have higher deductibles, coinsurance and copayments.

5 Things to Know About Health Insurance

1. There are many kinds of private health insurance policies. Different kinds of policies can offer very different kinds of benefits, and some can limit which doctors, hospitals, or other providers you can use.

2. You may have to pay coinsurance or a copayment as your share of the cost when you receive a medical service. Coinsurance is usually a percentage amount (for example, 20% of the total cost). A copayment is usually a set dollar amount (for example, you might pay $10 or $20 for a prescription or doctor's visit).

3. You may have to pay a deductible each plan year before your insurance starts to pay. For example, let's say you have a $200 deductible. You go to the doctor and the total cost is $250. You pay the first $200 to cover the deductible, and then your insurance starts to pay its share.

4. Many health insurance plans contract with networks of hospitals, doctors, pharmacies, and health care providers to take care of people in the plan. Depending on the type of policy you buy, your plan may only pay for your care when you get it from a provider in the plan’s network, or you may have to pay a bigger share of the bill if you receive services "out of network."

5. You may see products that look and sound like health insurance, but don’t give you the same protection as full health insurance. Some examples are policies that only cover certain diseases, policies that only cover you if you’re hurt in an accident, or plans that offer you discounts on health services. Don’t mistake insurance-like products for full comprehensive insurance protection. Full health insurance usually covers most medical problems.

The Individual Mandate

Beginning on January 1, 2014, the Affordable Care Act required all non-exempt U.S. citizens and legal residents to have qualifying health coverage or pay a tax penalty.

The individual mandate makes it possible for everyone, including people with pre-existing conditions such as cancer, diabetes and heart disease, to get health insurance. Without the individual mandate requirement, there is the risk that only people who are sick and need insurance would purchase it. Healthy people could then wait until they get sick to purchase coverage, which would make premiums very expensive. By requiring healthy people to be covered by health insurance or pay a tax penalty, the individual mandate requirement is predicted to bring down the average health insurance premium cost for everyone.

"Shared Responsibility" Tax Penalty

Individuals who are not exempt from the individual mandate and are not covered by qualifying health insurance are subject to a tax penalty:

- **2014:** ***Greater of*** $95 per adult and $47.50 per child under age 18 (maximum of $285 for a family) or 1% of family income.
- **2015:** ***Greater of*** $325 per adult and $162.50 per child under age 18 (maximum of $975 for a family) or 2% of family income.
- **2016:** ***Greater of*** $695 per adult and $347.50 per child under age 18 (maximum of $2,085 for a family) or 2.5% of family income.
- **After 2016:** The penalty amounts are increased annually by the cost of living.

For purposes of the "shared responsibility" tax penalty, income is defined as total income in excess of the income tax return filing threshold (about $10,000 for an individual and $20,000 for a family). In addition, the penalty is prorated by the number of months without coverage and there is no penalty for a single gap in coverage of less than three months in a year. Finally, the penalty is capped at the national average premium for "Bronze" coverage in a Health Insurance Marketplace (see page 10). Insurance companies report to the IRS the names, addresses and tax ID numbers of individuals with coverage. The IRS is then able to enforce the penalty on uncovered individuals by docking tax refunds. Tax liens or levies are not allowed.

Exceptions to the Individual Mandate

The following individuals are exempt from the individual mandate:

- members of a religion opposed to acceptance of benefits from a health insurance policy;
- undocumented immigrants;
- people who are incarcerated;
- members of Indian tribes;
- those with family income below the threshold for filing an income tax return (about $10,000 for an individual and $20,000 for a family); and
- those who would have to pay more than 8% of their income for health insurance, after taking into account any employer contributions or premium tax credits.

Where to Get Health Insurance

In order to satisfy the individual mandate, people have access to health insurance through the following sources:

- ☐ **From an Employer:** The most common way of getting health insurance has been and continues to be through an employer-sponsored group plan. Generally speaking, employers contribute toward the cost of the premiums, with employees paying the balance of the premiums plus other cost-sharing features such as deductibles, copayments and coinsurance.
- ☐ **From a Health Insurance Marketplace:** The Affordable Care Act created Health Insurance Marketplaces available in each state through which individuals and small businesses can purchase qualifying health insurance policies from private insurance companies and may receive premium tax credits to help pay the cost of the insurance. For coverage starting in 2015, open enrollment runs from November 15, 2014 through February 15, 2015.
- ☐ **From a Grandfathered Plan:** Many health care plans that existed before the Affordable Care Act was signed into law do not contain some of the law's consumer protections and would not be qualifying health care plans under the ACA's individual mandate. The Act, however, exempts most plans that existed on March 23, 2010, the day the law was enacted, from some of the law's consumer protections, which preserves consumers' rights to keep the coverage they already had before health care reform and satisfy the individual mandate. If you have health coverage – individual or through an employer - from a plan that existed on March 23, 2010 — and that has covered at least one person continuously from that day forward — your plan may be considered a "grandfathered" plan. These plans can lose their grandfathered status if they make certain significant changes that reduce benefits or increase costs to consumers.
- ☐ **From Medicaid/CHIP:** Medicaid and CHIP are public programs that provide health care coverage to specific categories of lower-income adults and children. Medicaid coverage is available to all U.S. citizens and some legal residents under age 65 who meet specific income requirements, assuming the state in which the individual resides did not opt out of the ACA Medicaid expansion. The Affordable Care Act maintains the Children's Health Insurance Program (CHIP) eligibility standards currently in place through 2019 and extends CHIP funding until October 1, 2015, with authority for the program extended through 2019.
- ☐ **From Medicare:** Individuals 65 and older, together with some younger individuals with qualifying disabilities, continue to receive health care coverage through Medicare.
- ☐ **From TRICARE/Veterans Health Program:** Uniformed Service members, retirees and their families receive health care benefits through TRICARE. Veterans separated from the service under any condition other than dishonorable may qualify for VA health care benefits.

The Health Insurance Marketplace

With key parts of the ACA becoming effective in 2014, the Health Insurance Marketplace allows individuals and small businesses to compare private health insurance plans, get answers to questions, find out if they are eligible for tax credits to purchase private insurance or for health programs like Medicaid or the Children's Health Insurance Program (CHIP) and, finally, to enroll in a health plan that meets their needs.

Each state has its own Health Insurance Marketplace through which insurance companies compete for your business. States can create and operate their own Marketplace, use a Marketplace operated by the Department of Health and Human Services (HHS), or choose to partner with HHS to run some functions of their Marketplace.

For coverage starting in 2015, State Health Insurance Marketplaces are scheduled to be available for **open enrollment beginning on November 15, 2014 and ending on February 15, 2015.** You can also purchase a health plan outside of your State Marketplace on the "open market" or through a private insurance exchange.

Benefits and Protections

If your health plan is subject to ACA requirements, you and your family may be eligible for some important preventive services at no additional cost to you, services such as:

- Blood pressure, diabetes, and cholesterol tests
- Many cancer screenings, including mammograms and colonoscopies
- Counseling on such topics as quitting smoking, losing weight, eating healthfully, treating depression, and reducing alcohol use
- Regular well-baby and well-child visits, from birth to age 21
- Routine vaccinations against diseases such as measles, polio, or meningitis
- Counseling, screening, and vaccines to ensure healthy pregnancies
- Flu and pneumonia shots

In addition, a "Patient's Bill of Rights" is in effect, providing you with certain protections, including:

- You cannot be denied health insurance because of a pre-existing condition.
- Your coverage cannot be cancelled or rescinded if you get sick.
- Lifetime limits on essential health benefits are banned for all new health insurance plans.
- Annual limits on essential health benefits are phased out.
- Premium rating variations can be based only on age, premium rating area, family composition and tobacco use and insurers must justify annual premium increases of 10% or more.
- You can seek emergency care at a hospital outside of your health plan’s network.

Qualified Health Plans

Under the Affordable Care Act, an insurance plan that is certified by a Health Insurance Marketplace provides essential health benefits, is a standardized plan, and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold

Essential Health Benefits

Health plans offered in the individual and small group markets, both inside and outside of State Marketplaces, must include items and services within at least the following 10 categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services, such as occupational and speech therapy, and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management, and
10. Pediatric services, including oral and vision care

Standardized Plans

It can be difficult to compare health insurance plans that have different benefits and out-of-pocket costs. The Affordable Care Act addresses this problem by standardizing the types of benefits and cost-sharing allowed in health plans offered by private health insurers through the Health Insurance Marketplace into four levels of coverage.

Each plan level must cover the same minimum essential health benefits, but the amount of cost-sharing required will vary among the plan levels, as will the premiums charged (***general rule***...the higher the percentage of benefit costs paid by the plan, the higher the premium for that health plan):

- ***Bronze plans*** must cover 60% of the benefit costs of the plan, meaning the insured is responsible for paying the remaining 40%.
- ***Silver plans*** must cover 70% of the benefit costs of the plan, leaving the insured to pay the remaining 30%.
- ***Gold plans*** must cover 80% of the benefit costs of the plan, leaving the insured to pay the remaining 20%.
- ***Platinum plans*** must cover 90% of the benefit costs of the plan, leaving the insured to pay the remaining 10%.

2014 Out-of-Pocket Limits (Cost-Sharing Reductions)

All of the standardized qualified health plans must limit your annual out-of-pocket costs, including deductibles, copayments or coinsurance, to an amount no greater than the limits for high-deductible Health Savings Account (HSA) plans (in 2014, the HSA limit is $6,350 for an individual and $12,700 for a family). **NOTE:** Some group health plans have been granted a waiver and will not be required to limit annual out-of-pocket costs until 2015.

In addition, out-of-pocket limits must be reduced to the following levels for those with incomes up to 400% of the Federal Poverty Level (FPL):

- ***100% to 200% of the FPL:*** The annual out-of-pocket limit is reduced to one-third of the HSA limits ($2,116 for an individual and $4,233 for a family in 2014).
- ***200% to 300% of the FPL:*** The annual out-of-pocket limit is reduced to one-half of the HSA limits ($3,175 for an individual and $6,350 for a family in 2014).
- ***300% to 400% of the FPL:*** The annual out-of-pocket limit is reduced to two-thirds of the HSA limits ($4,234 for an individual and $8,467 for a family in 2014).

The Federal Poverty Level (FPL) is the set minimum amount of gross income that a family or individual needs for food, clothing, transportation, shelter and other necessities. The FPL is determined by the Department of Health and Human Services (HHS) and varies according to family size. The number is adjusted for inflation each year and reported annually. Many public assistance programs define eligibility income limits as some percentage of FPL. Here are selected 2013 FPL annual amounts for all states except Alaska and Hawaii:

Percent of 2013 Federal Poverty Level (used for 2014)				
Family Size	**100%**	**200%**	**300%**	**400%**
1	$11,490	$22,980	$34,470	$45,960
2	$15,510	$31,020	$46,530	$62,040
3	$19,530	$39,060	$58,590	$78,120
4	$23,550	$47,100	$70,650	$94,200
5	$27,570	$55,140	$82,710	$110,280
6	$31,590	$63,180	$94,770	$126,360
7	$35,610	$71,220	$106,830	$142,440
8	$39,630	$79,260	$118,890	$158,520

2015 Out-of-Pocket Limits (Cost-Sharing Reductions)

All of the standardized qualified health plans must limit your annual out-of-pocket costs, including deductibles, copayments or coinsurance, to an amount no greater than the limits for high-deductible Health Savings Account (HSA) plans (in 2015, the HSA limit is $6,450 for an individual and $12,900 for a family).

In addition, out-of-pocket limits must be reduced to the following levels for those with incomes up to 400% of the Federal Poverty Level (FPL):

- ***100% to 200% of the FPL:*** The annual out-of-pocket limit is reduced to one-third of the HSA limits ($2,150 for an individual and $4,300 for a family in 2015).
- ***200% to 300% of the FPL:*** The annual out-of-pocket limit is reduced to one-half of the HSA limits ($3,225 for an individual and $6,450 for a family in 2015).
- ***300% to 400% of the FPL:*** The annual out-of-pocket limit is reduced to two-thirds of the HSA limits ($4,300 for an individual and $8,600 for a family in 2015).

The Federal Poverty Level (FPL) is the set minimum amount of gross income that a family or individual needs for food, clothing, transportation, shelter and other necessities. The FPL is determined by the Department of Health and Human Services (HHS) and varies according to family size. The number is adjusted for inflation each year and reported annually, typically in February. Many public assistance programs define eligibility income limits as some percentage of FPL. Here are selected 2014 FPL annual amounts for all states except Alaska and Hawaii:

Percent of 2014 Federal Poverty Level (used for 2015)				
Family Size	**100%**	**200%**	**300%**	**400%**
1	$11,670	$23,340	$35,010	$46,680
2	$15,730	$31,460	$47,190	$62,920
3	$19,790	$39,580	$59,370	$79,160
4	$23,850	$47,700	$71,550	$95,400
5	$27,910	$55,820	$83,730	$111,640
6	$31,970	$63,940	$95,910	$127,880
7	$36,030	$72,060	$108,090	$144,120
8	$40,090	$80,180	$120,270	$160,360

Catastrophic Plans

Catastrophic plans, which have lower premiums, can be purchased by young adults up to age 30, as well as by those who are exempt from the individual mandate. These plans will cover the essential health benefits, but only after a high deductible is met. The deductible cannot exceed the limits for high-deductible Health Savings Account (HSA) plans. Preventive benefits and coverage for three primary care visits, however, are exempt from the deductible.

Premium Tax Credit

Individuals and families who qualify can take a premium tax credit to help them afford health insurance coverage purchased through a Health Insurance Marketplace. The premium tax credit is refundable, so taxpayers who have little or no income tax liability can still benefit. The credit also can be paid in advance to a taxpayer's insurance company to help cover the cost of premiums.

Who Is Eligible for a Premium Tax Credit?

The premium tax credit is generally available to U.S. citizens and legal residents with incomes between 100% and 400% of the Federal Poverty Level (FPL). This means that middle-income individuals and families, as well as those in lower-income groups, will receive financial help in purchasing private health plans through the Health Insurance Marketplace. The premium tax credit makes up the difference between the amount an individual is required to pay and the amount the plan charges in premiums. Specific requirements include:

- Household income between 100% and 400% of the FPL (see pages 11-12 for information on the Federal Poverty Level).
- Covered individuals must enroll in a ***qualified health plan*** through a state Health Insurance Marketplace.
- Covered individuals must be ***legally present*** in the United States and ***not incarcerated***.
- Covered individuals ***must not be eligible*** for other qualifying coverage, such as ***Medicare***, ***Medicaid***, or ***affordable*** employer-sponsored health coverage.
- ***Individuals who are eligible for, but not enrolled in employer-sponsored health insurance*** if (a) the insurance is ***unaffordable*** (i.e., the self-only premium exceeds 9.5% of income); or (b) the insurance ***doesn't provide a minimum value*** (i.e., it fails to cover 60% of total allowed costs.

What Is the Premium Tax Credit Amount?

The premium tax credit amount is generally equal to the difference between the premium for the benchmark plan and the taxpayer's expected contribution:

- ***Benchmark Plan:*** The benchmark plan is the second-lowest-cost plan in the Marketplace that would cover an individual or family at the "silver" level of coverage (see Standardized Plans on page 10).
- ***Income Eligibility:*** Income eligibility for the premium tax credit will be based on the previous year's income tax return. It may also be possible to verify income through pay stubs or other documentation.

- ***Expected Contribution:*** The expected contribution is a specified percentage of the taxpayer's household income...the amount the taxpayer is expected to pay toward the premium. The expected contribution will increase as household income increases:

Income (as a % of FPL):	Up to 133%	133% to 150%	150% to 200%	200% to 250%	250% to 300%	350% to 400%
Expected Contribution:	2% of income	3-4% of income	4-6.3% of income	6.3-8.05% of income	8.05-9.5% of income	9.5% of income

- ***Limits:*** If a plan that is less expensive than the benchmark plan is chosen, the actual amount paid for coverage will be less than the expected contribution (as illustrated in Example 2 below). Since the premium tax credit is based on a benchmark plan, older Americans (ages 55 – 64) who face higher premiums will receive a greater premium tax credit (see Example 3 below). The credit is capped at the premium for the plan chosen...no one will receive a credit that is larger than the amount they actually pay for their plan.

Hypothetical Premium Credit Examples

The premium credit amount is generally equal to the difference between the premium for the benchmark plan and the taxpayer's expected contribution:

Example 1: A family of four with household income of $50,000 purchases the "silver" level benchmark plan; no tobacco use

Household Income in 2014	212% of FPL
Unsubsidized Benchmark Plan Premium	$8,290
Maximum Expected Contribution %	6.73%
Expected Contribution for the Premium	$3,365 (6.73% of household income; pays 41% of the premium)
Premium Tax Credit	$4,295 (pays 59% of the premium)

Example 2: A family of four with household income of $50,000 purchases the less expensive (and less comprehensive) "bronze" level plan; no tobacco use

Household Income in 2014	212% of FPL
Unsubsidized "Bronze" Plan Premium	$6,180
Maximum Expected Contribution %	3.25%
Expected Contribution for the Premium	$1,625 (3.25% of household income; pays 26% of the premium)
Premium Tax Credit	$4,555 (pays 74% of the premium)

Example 3: A family of four, two adults between the ages of 55 and 64, with household income of $50,000 purchases the "silver" level benchmark plan; no tobacco use

Household Income in 2014	212% of FPL
Unsubsidized Benchmark Plan Premium	$14,687
Maximum Expected Contribution %	6.73%
Expected Contribution for the Premium	$3,365 (6.73% of household income; pays 23% of the premium)
Premium Tax Credit	$11,322 (pays 77% of the premium)

How Is the Premium Tax Credit Paid?

The premium tax credit is advanceable, refundable and subject to reconciliation each year.

- ***Advanceable:*** An advanceable tax credit allows people to receive the benefit of the credit at the time they purchase health insurance, rather than paying the premium out of pocket and waiting to be reimbursed when filing their income tax return. The premium tax credit will be paid directly to insurance companies by the Department of the Treasury on a monthly basis. No payments are made directly to consumers.

- ***Refundable:*** The premium tax credit is refundable so taxpayers who have little or no income tax liability can still benefit.

- ***Reconciliation:*** Taxpayers receiving the premium tax credit must file an income tax return. Because the premium tax credit is based on the previous year's income, there is a reconciliation process when taxpayers file their tax returns for the actual year in which they received the tax credit. If a taxpayer was "under-credited," an additional credit will be returned to the taxpayer. If there was an excess credit, the taxpayer is liable for the overpayment, subject to caps ranging from $600 for married taxpayers ($300 if single) with household income under 200% of FPL to $2,500 for married taxpayers ($1,250 if single) with household income from 300% to 400% of FPL. Taxpayers who end the year with household income below 100% of FPL will not be required to repay any overpayment of the advance credit.

Estimating the Premium Tax Credit

The Henry J. Kaiser Family Foundation has a subsidy calculator that can be used to estimate the amount of any premium tax credit subsidy to which you might be entitled. It is located at http://kff.org/interactive/subsidy-calculator/.

Federal Tax Subsidies in Action

How Federal Tax Subsides Work to Make Private Health Insurance Affordable for Low- and Moderate-Income Individuals and Families:

Premium Tax Credit (13-15)

Provides financial help in purchasing private health plans through a Health Insurance Marketplace by making up the difference between the amount individuals are required to pay and the amount the plan charges in premiums. Generally available to U.S. citizens and legal residents with incomes between 100% and 400% of the Federal Poverty Level (FPL).

Cost-Sharing Reduction (11-12)

Limits annual out-of-pocket costs to an amount no greater than the limits for high-deductible Health Savings Account (HSA) plans. Further reduces out-of-pocket limits for those with incomes up to 400% of the Federal Poverty Level (FPL).

Application

Individual uses a Health Insurance Marketplace to select a health plan and applies for premium tax credit and cost-sharing reduction at the Health Insurance Marketplace during open enrollment periods (November 15, 2014-February 15, 2015).

Premium Payment

If the individual qualifies, a premium tax credit is paid in advance on a monthly basis directly to the health plan. Individual pays the balance of the premium due to the health plan.

Cost-Sharing Reduction

People with income from 100% to 400% of the FPL pay two-thirds, one-half or one-third of the maximum annual out-of-pocket cost for the plan in which they enroll.

Reconciliation

When the individual files an income tax return for the actual year in which he/she received the premium tax credit, underpayments and overpayments are reconciled.

Medicaid and the ACA

Medicaid is the nation's health insurance program available to some lower-income U.S. citizens and jointly funded by the federal and state government. Previous Medicaid rules required coverage for certain groups of individuals, such as low-income children and some of their parents, poor pregnant women, certain low-income seniors and some individuals with disabilities who are under age 65. Other groups were excluded, such as low-income, able-bodied parents, low-income adults without children and low-income individuals with chronic illness who did not meet Medicaid disability standards.

The Affordable Care Act essentially divides the uninsured into three groups:

1. Those whose income is high enough to afford to purchase private health insurance without financial assistance (income above 400% of FPL);
2. Those who can afford to purchase private health insurance with financial assistance in the form of the premium tax credit (income from 100% to 400% of FPL); and
3. Those who can't afford to purchase private health insurance (income up to 138% of FPL).

As originally written, it was the intention of the ACA to cover this last group through Medicaid by redefining Medicaid eligibility according to income and age alone, instead of a combination of income, age and participation in an eligible group. Beginning in 2014, states were going to be required to extend Medicaid to all individuals between the ages of 19 and 65 with incomes up to 138% of the Federal Poverty Level (FPL), with the federal government paying 100% of the cost of the expansion until 2017, 95% in 2017, 94% in 2018, 93% in 2019 and 90% in 2020 and beyond. A state that didn't comply with Medicaid expansion risked losing **all** of its federal Medicaid funding.

Legal challenges to the ACA eventually made their way to the Supreme Court which, in 2012, upheld the Affordable Care Act, but **gave the states the option to opt out of Medicaid expansion without risk to their current federal Medicaid funding.** As a result, individuals with incomes below 138% of the FPL who are not currently covered by Medicaid will need to check with their state's health and human services department to see if their state is participating in the Medicaid expansion.

States Participating in the Medicaid Expansion

If your state is participating in the Medicaid expansion, all newly eligible adults will be guaranteed a benchmark benefit package that meets the essential health benefits requirement of policies available through the Health Insurance Marketplaces.

Beginning no later than 2014, U.S. citizens and certain legal noncitizens with **incomes up to 138% of FPL** will be eligible for Medicaid. Anyone who applies for premium credits through a Health Insurance Marketplace and is determined to be eligible for Medicaid will be enrolled by the Marketplace in Medicaid. Any lawfully-present noncitizens who have incomes below 100% of FPL and are ineligible for Medicaid due to their alien status will be deemed to have income at 100% of FPL and will be eligible for premium credits through a Health Insurance Marketplace.

Note: Some states are participating in the Medicaid expansion, but adapting it in such a way as to meet their unique needs. This might even include providing funding to enable newly-eligible Medicaid recipients to purchase private insurance through the state's Health Insurance Marketplace.

	Percent of Federal Poverty Level			
	2013 (used in 2014)		2014 (used in 2015)	
Family Size	100%	138%	100%	138%
1	$11,490	$15,856	$11,670	$16,105
2	$15,510	$21,404	$15,730	$21,707
3	$19,530	$26,951	$19,790	$27,310
4	$23,550	$32,499	$23,850	$32,913
5	$27,570	$38,047	$27,910	$38,516
6	$31,590	$43,594	$31,970	$44,119
7	$35,610	$49,142	$36,030	$49,721
8	$39,630	$54,689	$40,090	$55,324

States Opting Out of the Medicaid Expansion

If a state opted out of participating in the Medicaid expansion and an individual was not already eligible for Medicaid, that individual is not eligible for Medicaid.

- ***Income up to 100% of the FPL:*** Since the original ACA legislation assumed that individuals with incomes up to 100% of the FPL would be covered by Medicaid, the law expressly disallows premium credits for these individuals. As a result, individuals who would have been newly-eligible for Medicaid coverage in 2014 (1) did not receive that coverage if the state in which they resided opted out of the Medicaid expansion and (2) they are not eligible for premium credits to use in purchasing private insurance.
- ***Income from 100% to 138% of FPL:*** Individuals with income from 100% to 138% of the FPL who would have been newly-eligible for Medicaid coverage in 2014 did not receive Medicaid coverage if the state in which they resided opted out of the Medicaid expansion. They are, however, eligible to use the premium tax credit to purchase private insurance through their state Health Insurance Marketplace.

Note: Beginning in 2015, the Affordable Care Act will tax larger employers that do not provide health benefits to lower-income employees who then receive a premium tax credit. In those states that opt out of the Medicaid expansion, companies with 50 or more employees may be liable for tax penalties if they do not provide health benefits to their employees who make between 100% and 138% of the FPL and those employees then sign up for premium tax credits through a Health Insurance Marketplace.

Employer-Sponsored Health Plans

Prior to passage of the Affordable Care Act, most Americans under age 65 with health care insurance received it through an employer- or union-sponsored health plan, either as an employee or as a dependant of a covered worker, and that's likely to continue once the ACA is fully implemented.

"Play-or-Pay" Provision

While no employer is forced by the Affordable Care Act to provide health insurance, there is a "play-or-pay" provision that requires employers with 50 or more full-time employees to offer employer-sponsored health care coverage to their full-time employees or pay a "shared responsibility" penalty. Employers with fewer than 50 full-time employees are not subject to the penalty.

Employer-Sponsored Health Plan Requirements

The Affordable Care Act contains a variety of new requirements that may impact the employer-sponsored heath care coverage provided to employees. All of the following provisions are now in effect:

- Adult children under age 26 must be allowed to enroll in a parent's plan;
- Waiting periods of more than 90 calendar days before coverage begins are banned;
- Medical underwriting is prohibited and premium rating variation is only allowed based on age, tobacco use, family composition and geography.
- Prohibition against lifetime and annual limits on the dollar value of coverage (some group health plans, however, have been granted a waiver and will not be required to limit annual out-of-pocket costs until 2015);
- Availability of specified preventive services without cost sharing;
- Out-of-pocket costs cannot exceed the Health Savings Account limit ($6,350 for an individual and $12,700 for a family in 2014; $6,450 for an individual and $12,900 for a family in 2015);
- Plans may be required to limit deductibles, generally to $2,000 individual/$4,000 family coverage in 2014, $2,050 for individual/$4,100 family coverage in 2015;
- Plans must include a package of essential health benefits; and
- Employer-sponsored health insurance must be "affordable."

Under the Affordable Care Act, **"affordable" employer-sponsored health insurance** requires an employee contribution of **less than 9.5%** of household income for an employee-only plan that covers at least 60% of medical costs on average. Any employees who must contribute more than 9.5% of household income can decline the employer-sponsored coverage and apply for premium tax credits through a Health Insurance Marketplace (see pages 13-14). If, however, employer-sponsored self-only coverage costs less than 9.5% of household income, then both employees and their family members are **not eligible** for subsidies through a Marketplace, regardless of whether or not family coverage is "affordable."

Grandfathered Plans

Employer-sponsored health care plans in existence as of March 23, 2010, the date the Affordable Care Act was signed into law, are grandfathered in regard to many of the requirements outlined on the previous page.

DO Apply to Grandfathered Plans:	DO NOT Apply to Grandfathered Plans:
► Adult children under age 26 must be allowed to enroll in a parent's plan; and ► Prohibition against lifetime limits and, in group plans, annual limits on the dollar value of coverage.	► Preventive health benefits with no cost sharing; ► Stronger appeals processes; and ► Letting insureds choose their primary doctor.

If an Employer-Sponsored Health Plan Is Grandfathered…

Grandfathered plans must provide a statement to all enrollees, notifying them that the plan is grandfathered and outlining the benefits provided.

In order to maintain its grandfathered status, a health care plan **cannot**:

- Eliminate all or almost all benefits to diagnose and treat certain health conditions;
- Increase the plan's coinsurance percentage;
- Increase the plan deductible by more than 15% plus medical inflation;
- Increase co-payments by more than $5 adjusted for medical inflation or 15% plus medical inflation, whichever is greater; or
- Increase the employees' share of the premium by more than 5%.

A health care plan that loses its grandfathered status must then comply with all the consumer protections that apply to new health care plans, as outlined on page 19. It is anticipated that, over time, most plans will make changes and lose their grandfathered status.

If You Have Employer-Sponsored Health Plan Coverage…

Chances are that you will meet the individual mandate requirements through your employer-sponsored health care plan. Expect to receive additional information from your employer and employer-sponsored plan about the Affordable Care Act and your health care coverage by October 1 of each year.

Step 1:

Do any of the following apply to you?:

- Member of a religion opposed to acceptance of benefits from a health insurance policy;
- An undocumented immigrant;
- Incarcerated;
- Member of an Indian tribe;
- Family income below the threshold for filing an income tax return (about $10,000 for an individual and $20,000 for a family); or
- Someone who would have to pay more than 8% of your income for health insurance, after taking into account any employer contributions or premium tax credits.

YES → **You are exempt from the individual mandate. There is no penalty for being without health insurance.**

NO

Step 2:

Are you insured through any of the following sources?:

- Medicare;
- Medicaid or CHIP;
- TRICARE;
- The veteran's health program;
- A plan offered by an employer;
- A qualified health plan that you purchased on your own that is at least at the Bronze level (see page 10); or
- A grandfathered plan in existence before the ACA was enacted (March 23, 2010).

YES → **The requirement to have health insurance is satisfied and no penalty is payable.**

NO

Step 3:

Are you planning to purchase a qualified health plan, possibly with federal tax subsidies, through a Health Insurance Marketplace (page 9), or through another source?

YES → **The requirement to have health insurance is satisfied and no penalty is payable.**

NO

Step 4:

There is a "shared responsibility" tax penalty for being without health insurance...see page 7.

Tax Impact on Higher-Income Taxpayers

The Affordable Care Act includes two Medicare-related tax increases that took effect in 2013, impacting higher-income taxpayers.

Medicare Payroll Tax Increase

Prior to 2013, the Medicare Part A payroll tax was 2.9% of all wages, with the employee and the employer each paying 1.45%.

Effective January 1, 2013, the Medicare Part A payroll tax on wages increased by 0.9% on wages over $200,000 for single taxpayers and over $250,000 for married taxpayers filing jointly. The increase applies **only to the employee portion** of the Medicare Part A payroll tax. For example:

- A **single person** making $300,000 in wages will pay a total of $5,250 into Medicare...1.45% of the first $200,000 ($2,900) plus 2.35% of the next $100,000 ($2,350). The employer will continue paying 1.45% of $300,000 or $4,350.
- A **married couple** making $500,000 in wages will pay a total of $9,500 into Medicare...1.45% of the first $250,000 ($3,625) plus 2.35% of the next $250,000 ($5,875). The employer will continue paying 1.45% of $500,000 or $7,250.

Medicare Contribution Tax on Unearned Income

Higher-income taxpayers are subject to a 3.8% Medicare contribution tax on unearned or net investment income, which includes interest, dividends, rents, royalties, gain from disposing of property, and income earned from a trade or business that is a passive activity. Self-employed individuals, as well as estates and trusts, are also liable for this tax. While distributions from qualified retirement plans are exempt from paying the new tax, income from non-qualified annuities is subject to the tax.

The tax applies to single taxpayers with modified adjusted gross income (MAGI) in excess of $200,000 and to married taxpayers filing jointly with a MAGI in excess of $250,000. MAGI includes wages, salaries, tips and other compensation, dividend and interest income, business and farm income, realized capital gains, and income from a variety of other passive activities and certain foreign earned income.

Taxpayers with modified adjusted gross income **below** the $200,000 single/$250,000 married filing jointly thresholds are **not** subject to the 3.8% unearned income Medicare contribution tax.

For taxpayers whose MAGI **exceeds** the thresholds, the amount of tax owed is equal to 3.8% multiplied by the **lesser** of (1) net investment income or (2) the amount by which their MAGI exceeds the thresholds:

Tax = 3.8% X [lesser of (MAGI - $200,000/$250,000 or net investment income)]

While the Affordable Care Act does not require employers to provide their employees with access to employer-sponsored health care plans, the ACA does include incentives and penalties intended to (1) minimize disruptions of the existing employer-provided health care system and (2) to encourage smaller employers to provide their employees with access to employer-sponsored health care plans.

"Play-or-Pay" System (Employer Mandate)

Under the Affordable Care Act's "play-or-pay" or "shared responsibility" system, larger employers, defined as those with **50 or more full-time equivalent non-seasonal employees (FTEs)**, are subject to two basic rules, now scheduled to take effect on **January 1, 2015** for employers with 100 or more FTEs and on **January 1, 2016** for employers with at least 50 FTEs:

- **If an employer does not offer health care coverage meeting certain standards to all full-time employees** and ***any one full-time employee*** receives tax-subsidized coverage through a Health Insurance Marketplace, the employer must pay a $2,000 penalty for ***every full-time employee over 30***.
- **If an employer does offer health care coverage, but a full-time employee obtains tax-subsidized coverage through a Health Insurance Marketplace**, the employer must pay a $3,000 penalty ***for that employee***. While any employee is free to decline to participate in an employer-sponsored health care plan and, instead, purchase coverage through a Health Insurance Marketplace, ***a premium tax credit (tax-subsidized coverage) is available only if*** the employee's required contribution to the employer's plan for single coverage is more than 9.5% of the employee's income ***or*** the employer-sponsored plan pays less than 60% of the cost of covered services.

Full-Time Equivalent Employees (FTEs)

According to the Affordable Care Act, only "large" employers are subject to the "play-or-pay" requirements, with a **large employer defined** as an employer who employed **an average of at least 50 full-time equivalent employees (FTEs)** during the previous calendar year. While the penalties associated with the "play-or-pay" requirements do not take effect until January 1, 2015 or January 1, 2016, employers are advised to record employee hours during the previous year in order to determine if they will be subject to the employer mandate. FTEs are calculated as follows:

- **Full-time employees** are defined as having worked on average ***at least 30 hours per week***, with full-time ***seasonal employees*** who work under 120 days during the year ***excluded*** from the calculation.
- **Part-time employees** (i.e., those working less than 30 hours per week) ***are not excluded*** from the calculation. Instead, the ***hours worked by part-time employees are converted into FTEs*** and used in the calculation to determine if an employer is a large employer for ACA purposes. This is done by adding up the total hours worked by part-time employees during a month and dividing the total by 120. The result is added to the number of full-time employees to arrive at the number of FTE employees for Affordable Care Act large employer requirements.

FTE Example

Let's say we have a business with 42 full-time employees (30 or more hours per week) that also has 15 part-time employees who all work 20 hours a week (or 80 hours a month). The hours worked by part-time employees are equivalent to 10 FTEs:

15 part-time employees X 80 hours = 1,200 hours / 120 = 10 FTEs

In our example, the business would be considered a "large" employer for ACA purposes, with 52 FTEs (42 full-time employees plus 10 FTEs based on the number of part-time hours worked).

Owner of Multiple Entities

The owner of multiple entities, such as a franchise owner with several restaurants, is treated as a ***controlled group*** for ACA purposes. This means that if one individual or entity owns, or has a substantial ownership interest in, several franchises, all of those franchises are essentially considered as ***one entity*** and the employees in each of the franchises must be ***aggregated*** for purposes of determining large employer "play-or-pay" status.

Application of Penalties

The calculation of FTEs as described above serves ***one purpose only***...to determine if an employer is considered a "large" employer for purposes of the Affordable Care Act "play-or-pay" requirements.

Any penalties actually assessed apply only to full-time employees. The employer in our earlier example would be considered a large employer for the "play-or-pay" requirements, but would be liable for a penalty only if at least one of its ***full-time employees*** – individuals working on average 30 or more hours per week - obtains coverage through a Health Insurance Marketplace and receives a premium tax credit. ***Part-time employees are not included in actual penalty calculations and an employer will not pay a penalty for any part-time worker who receives a premium tax credit through a Health Insurance Marketplace.***

Employer-Sponsored Health Plan Requirements

Beginning in 2014, new employer-sponsored health care plans must meet the qualified health plan requirements outlined on page 19. These include extension of family coverage to adult children under age 26, prohibition of annual and lifetime limits on the dollar value of coverage, required coverage of preventive services without cost sharing, a waiting period no longer than 90 days and certain consumer protections.

Other considerations faced by large employers that offer employer-sponsored health care plans include:

- Employers will need to decide whether to adjust plan benefit or contribution amounts in order to pass the affordability test and, beginning in 2015 or 2016, to avoid the potential $3,000 per employee penalty (see page 23).
- Some employer-sponsored health care plans are discriminatory, providing "richer" benefits to more highly-compensated employees. Plans that do not remove such discriminatory coverage face penalties beginning in 2015 or 2016: $100 per day for each non-highly compensated employee who is not eligible for the "richer" benefits, with a maximum penalty of $500,000.
- It is not unusual for employer-sponsored health care plans to exclude some full-time employees, typically those with lower incomes. These employees will have to be included beginning in 2015 or 2016.

"Grandfathered" Plans

Some of the new rules do not apply to "grandfathered" health care plans...those in existence when the Affordable Care Act was signed into law on March 23, 2010. Since there are very tight limits on changes that can be made to a plan and have it retain its grandfathered status, expectations are that not very many plans will remain grandfathered in the coming years.

See page 20 for more information on grandfathered plans.

"Cadillac" Plans

Beginning in 2018, employer-sponsored health care plans with a plan cost per enrollee that exceeds a cap will face a 40% excise tax. The 40% excise tax is initially set at the amount by which the costs of the plan per enrollee exceed $10,200 for single workers and $27,500 for family coverage. These caps may end up being higher if health care costs rise faster than currently projected.

While insurers or plan administrators will have to pay the 40% excise tax, the reality is that the cost will probably be passed through to employers. Employers offering so-called "Cadillac" plans may begin revising them prior to 2018 when the excise tax first becomes payable.

Finally, the $10,200/$27,500 thresholds will be increased by $1,650/$3,450 for retiree health plans (age 55 and over who are not Medicare-eligible) and for certain high-risk jobs.

The Affordable Care Act defines "small" employers as those with fewer than 50 full-time equivalent employees (FTEs). Small employers are exempt from the ACA "play-or-pay" penalties. There are, however, incentives to some small employers to offer health care coverage to their employees.

Small Business Health Options Program (SHOP)

While the initial availability date may vary by state, a Small Business Health Options Program – or SHOP – that offers small businesses and their employees new choices will become available in each state. Through the SHOP, employers will be able to offer employees a variety of Qualified Health Plans (see page 10), and their employees can choose the plans that fit their needs and their budget.

Starting in 2014, SHOP or a merged SHOP and individual Health Insurance Marketplace (see page 9) may be offered in your State. Businesses with up to 100 employees will be eligible, although States can limit participation to businesses with up to 50 employees until 2016.

When fully implemented, SHOPs are intended to help small businesses by:

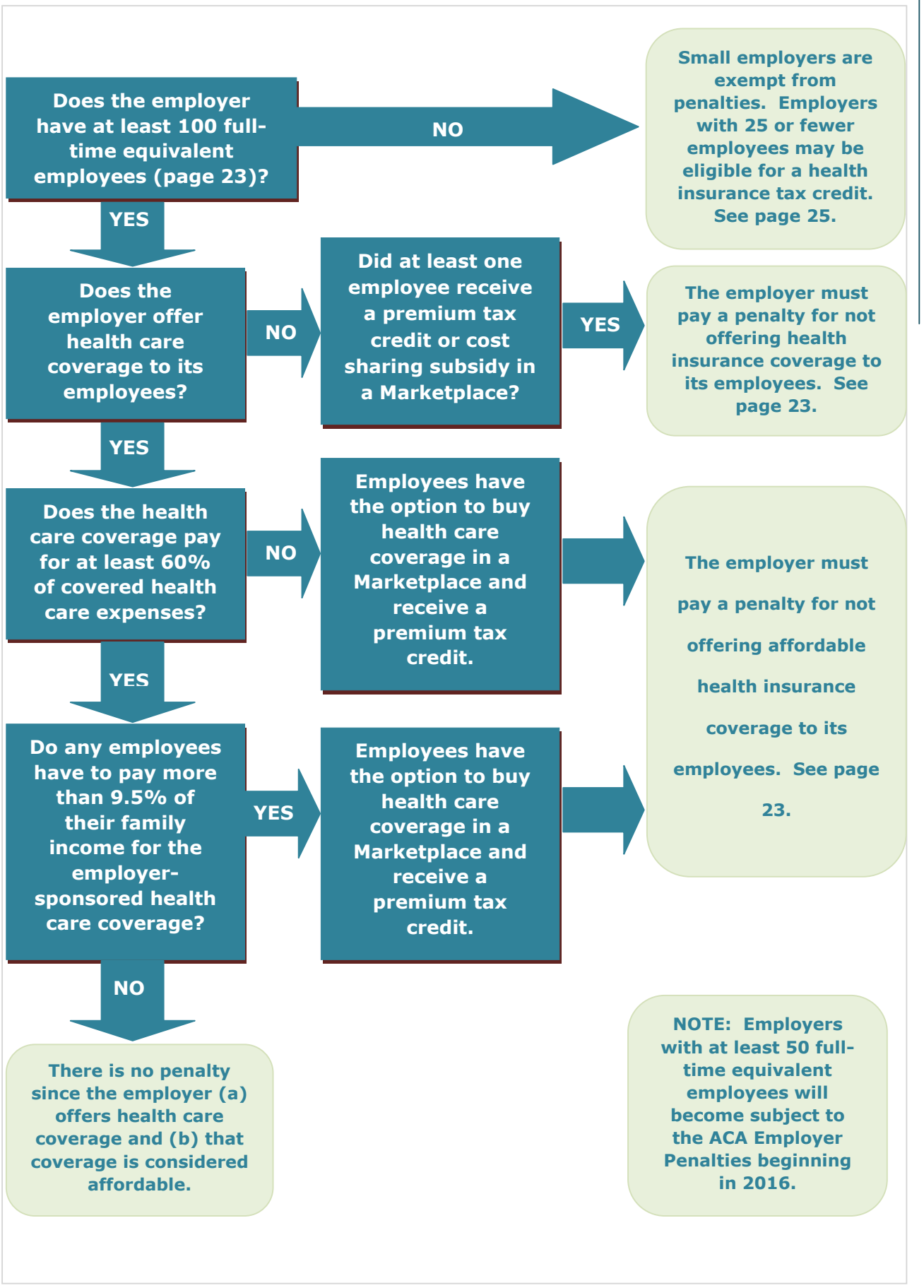
- **Simplifying Choices**: SHOPs will provide side-by-side comparisons of Qualified Health Plans, their benefits, premiums, and quality.
- **Expanding Employee Options**: SHOPs will enable small businesses to offer their employees a choice of Qualified Health Plans from several insurers, much as large employers can.
- **Preserving Employer Control**: Small businesses will be able to decide whether and when to participate in SHOP. It will be possible to choose how much the business will contribute toward employees' coverage, and make a single monthly payment via SHOP rather than to multiple plans.
- **Lowering Costs**: SHOP has the potential to save money by spreading insurers' administrative costs across more employers. In addition, a small business may be eligible for small business tax credits when it offers health coverage for its employees through a SHOP.

Small Business Tax Credit

Small businesses with 25 or fewer full-time equivalent employees (see page 23) and average annual wages below $50,000 may receive a tax credit for offering health insurance to their employees and contributing at least 50% of the cost of the premiums. The credit is up to 50% of employer contributions (35% for tax-exempt organizations) and is available for two consecutive years for employers that purchase the coverage through a SHOP/Health Insurance Marketplace.

The credit varies by employer size and average wage...employers with 10 or fewer FTEs and average wages of $25,000 or less receive the full 50% credit (35% if tax exempt), with the credit gradually phasing out as number of employees and average wages increase.

ACA Employer Penalties (2015)



Additional Information

Additional information about the Affordable Care Act can be found at:

- **HealthCare.gov** (http://www.healthcare.gov/)
- **Kaiser Family Foundation: Health Reform** (http://kff.org/health-reform/)
- **Congressional Research Service: Potential Employer Penalties Under the Patient Protection and Affordable Care Act (ACA)** (http://www.fas.org/sgp/crs/misc/R41159.pdf)
- **IRS: Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act** (http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act)
- **IRS: Affordable Care Act Tax Provisions** (http://www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions)
- **Medicaid.gov: Affordable Care Act** (http://www.medicaid.gov/AffordableCareAct/Affordable-Care-Act.html)

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