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Federal Health Care Law
Frequently Asked Questions for Consumers

Disclaimer:
Many of the responses to these questions are based on information currently available from the federal government. Federal guidance on the Affordable Care Act changes often and the Office of the Commissioner of Insurance (OCI) will update this document as new information becomes available.

This FAQ is intended to provide information on how your health insurance plan in Wisconsin may be affected by the federal health care law known as the Affordable Care Act (ACA).

Glossary of Terms

(Terms reflect those used in this document.)

Essential Health Benefits (EHB):
The minimum level of covered services insurers must offer in the individual and small group markets beginning January 1, 2014.

Benefits in the following categories must be covered:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral (i.e., dental) and vision care.

Insurers are not allowed to impose annual or lifetime limits on essential health benefits.

Large group health insurance plans are not required to cover essential health benefits. However, if a large employer chooses to offer a health insurance plan that includes

essential health benefits, the plan cannot impose any annual or lifetime limits on those benefits.

In 2013, the federal government identified UnitedHealthcare's Choice Plus Definity HSA Plan (A92NS) as Wisconsin's benchmark plan.

A copy of the Wisconsin EHB benchmark plan can be found at:

http://oci.wi.gov/healthcare_ref/ehb_certificate.pdf

FPL:
FPL means the federal poverty level. It is an income amount in dollars set by the federal government and varies based on family size (so the federal poverty level for an individual is a lower dollar amount than the federal poverty level for a family of four). Individuals with incomes below the poverty level are believed to be lacking the resources to meet their basic needs.

Guaranteed Issue:
A requirement that health insurers sell a health insurance policy to any person who requests coverage.

Federal Exchange:
The federal exchange is a federal Web site that allows consumers to: (1) check their eligibility for government assistance programs, including any subsidies available to help pay for private health insurance; (2) compare health insurance plans based on cost; and (3) link consumers to insurers for the purchase of health insurance after they choose a plan they are interested in.

The federal government refers to the federal Web site as both an "exchange" and a "marketplace." In an effort to limit confusion, this document and Wisconsin will continue to use the term "exchange."

The Web address for the federal exchange is www.healthcare.gov

Open Enrollment Period:
Open enrollment is a limited time period during which insurers are required to offer insurance coverage to any applicant (i.e., guaranteed issue). This is required of insurers both inside and outside the federal exchange.

The annual enrollment period (for benefit years starting on or after January 1, 2015) is November 15, 2014, through February 15, 2015.

Private Health Insurance Market:
This refers to the Wisconsin health insurance market offering health insurance plans outside of the federal exchange.

Premium Tax Credits:
These are federal tax credits provided to certain eligible individuals and families to artificially reduce the actual premium charged by insurers.

General Health Insurance Market FAQs

(Responses apply to plans sold through the federal exchange or in the private health insurance market outside of the federal exchange.)

1. **What are the major changes I need to know about?**
   There are a number of major changes for comprehensive health insurance plans effective January 1, 2014. These include the following:

   - Insurers must sell a health insurance policy to any person who applies for coverage, except in cases where fraudulent information is provided by the applicant. This is called guaranteed issue.
   - Insurers are prohibited from excluding or limiting coverage for a preexisting condition. A preexisting condition is a health condition an individual has before purchasing a health insurance plan.
   - Insurers may only take four items into account when pricing their products. These are: (1) whether the policy provides individual or family coverage; (2) the area of the state the policy is sold; (3) age; and (4) tobacco use.
   - Plans are required to offer "essential health benefits." See the "Glossary of Terms" section for more detail.
   - Plans are categorized into one of four different levels, which the federal government calls "metal tiers." Consumers will know the level of coverage expected by a plan based on the metal tier assigned to it. The percentages attached to each metal tier represent the average percentage of expected costs a plan will cover for the average individual. The metal tiers include: bronze plans covering 60%; silver plans covering 70%; gold plans covering 80%; and platinum plans covering 90%.
   - All plans will limit in-network out-of-pocket expenses to $6,450 for self-only coverage and $12,900 for family coverage.
   - Insurers have the option to sell their plans through the federal exchange, as well as selling health insurance plans through the traditional health insurance market like they do today.

2. **Is the federal government requiring me to purchase health insurance?**
   Yes, beginning January 1, 2014, individuals of all ages must have health insurance or pay a penalty. The federal government refers to this tax as the "individual shared responsibility payment."

   The penalty is set to increase each year as follows:

   - In 2014 it is the greater of $95 per adult or 1% of taxable income.
   - In 2015 it will be the greater of $325 per adult or 2% of taxable income.
   - In 2016 it will be the greater of $695 per adult or 2.5% of taxable income.
   - After 2016 the tax penalty increases annually based on a cost-of-living adjustment.

   A person will pay 1/12 of the total annual penalty for each month without coverage. The penalty for a child is half that of an adult.

3. I have heard that some people may qualify for an exemption from the federal tax or "individual shared responsibility payment" related to not having health insurance. Is this true?

Yes, individuals meeting certain circumstances may be exempt from the federal tax or individual shared responsibility payment. You may qualify for an exemption if:

- You are uninsured for less than 3 months of the year.
- The lowest-priced coverage available to you would cost more than 8% of your household income.
- You do not have to file a tax return because your income is too low.
- You are a member of a federally recognized tribe or eligible for services through an Indian Health Services provider.
- You are a member of a recognized health care sharing ministry.
- You are a member of a recognized religious sect with religious objections to insurance, including Social Security and Medicare.
- You are incarcerated (either detained or jailed) and not being held pending disposition of charges.
- You are not lawfully present in the U.S.

Further information on how to claim these exemptions is available on the healthcare.gov Web site.

Alternatively, if you have any of the circumstances below, you may qualify for a "hardship" exemption:

- You were homeless.
- You were evicted in the past 6 months or were facing eviction or foreclosure.
- You received a shut-off notice from a utility company.
- You recently experienced domestic violence.
- You recently experienced the death of a close family member.
- You experienced a fire, flood, or other natural or human-caused disaster that caused substantial damage to your property.
- You filed for bankruptcy in the last 6 months.
- You had medical expenses you could not pay in the last 24 months, which resulted in substantial debt.
- You experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member.
- You expect to claim a child as a tax dependent who has been denied coverage in Medicaid and CHIP, and another person is required by court order to give medical support to the child. In this case, you do not have to pay the penalty for the child.
- As a result of an eligibility appeals decision, you are eligible for enrollment in a qualified health plan (QHP) through the exchange, lower costs on your monthly premiums, or cost-sharing reductions for a time period when you were not enrolled in a QHP through the exchange.
- You were determined ineligible for Medicaid because your state did not expand eligibility for Medicaid under the Affordable Care Act.

- Your individual insurance plan was cancelled and you believe other exchange plans are unaffordable.
- You experienced another hardship in obtaining health insurance.

Further information about filing an application for a hardship exemption is available on the healthcare.gov Web site https://www.healthcare.gov/exemptions/.

Also see the IRS's guidance:

http://www.irs.gov/uac/Individual-Shared-Responsibility-Provision

For more information on those exemptions, below is a link to an IRS FAQ:

http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision

4. **Will consumers be able to keep their health insurance with their current health insurance company?**
Many health insurance companies will continue to sell health insurance in Wisconsin. However, there are insurers who have left the market or have restricted their service areas due in part to costly changes the federal government requires insurers to take on starting in 2014.

5. **Will consumers be able to keep their current health insurance plan (benefits) if they like it?**
State and federal law allows insurers the option of renewing their 2013 plans until 2016. This means consumers may be allowed to keep their current coverage through at least 2017. If the insurer you had for the 2013 plan year chose to continue offering that same plan, you should have received a notification from the insurer indicating this. If the insurer stopped offering the plan you had in 2013, you should have received notification from the insurer letting you know the coverage is no longer available and that you should plan to purchase coverage during the open enrollment period.

According to the Center for Consumer Information & Insurance Oversight, if you have been notified that your health insurance policy will be cancelled and you believe that the individual market health plan options available in your area are unaffordable, you will be eligible for a hardship exemption and will be able to enroll in catastrophic coverage available in your area. Please visit this link for more information http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cancellation-consumer-options-faq-01-03-2014.pdf.

For consumers who get their coverage from an employer, there will likely be fewer changes in your plan than the individual insurance market but many will see their current plan change.

6. **Will premiums increase? If so, by how much?**
It appears premiums will continue to increase in 2015 for many consumers. The federal government is imposing significant fees and other requirements onto insurers as a condition of being in compliance with the federal health care law. Consumers will feel the impact of these federal requirements through premium increases.

While there is no question that some consumers will have subsidies and may not pay higher rates, someone will pay for the increased premiums whether it is the consumer or the federal government.

It is important to note that a number of factors will impact how much of an increase an individual consumer will pay. The best way to determine how much you will pay is to review the plan options available both on the federal exchange and in the private health insurance market. All of the health insurers selling health insurance plans in Wisconsin are listed on the OCI Web site at http://oci.wi.gov/healthcare_ref/find_health_insurer.htm.

7. **Will consumers receiving premium tax subsidies be impacted by these premium increases?**
Premium tax subsidies will not change an individual's premium, but they will decrease how much premium the individual pays. The amount depends on how much of a subsidy the consumer gets from the federal government. It is quite possible that even with subsidies many consumers, particularly those closer to 400% of the federal poverty level (FPL), will pay more than they would if insurers did not have to adjust their premiums to reflect federally imposed fees and other requirements resulting from federal health care reform.

8. **I bought my health insurance policy through the federal exchange. What will happen when my policy renews in 2015?**
The federal government has ordered that your insurer send you a notice that includes information on your new premium and an estimate of any advanced premium tax credit you will receive. It is important to note that these numbers are likely inaccurate. The only way to find out your actual cost and premium tax credit is to re-enroll through the exchange.

9. **Will plans without the essential health benefits be available?**
If you had an individual health insurance plan in 2013 and the insurer has allowed you to continue to renew the plan, it is possible that the plan does not contain all of the essential health benefits.

Catastrophic plans are not required to meet the essential health benefits (see "Glossary of Terms" for more detailed information on essential health benefits). However, federal law only allows individuals under the age of 30, and those meeting certain other federal exemptions, to access those plans. For example, according to a January CCIIO Q and A document, if you have been notified that your health insurance policy will be cancelled and you believe that the individual market health plan options available in your area are unaffordable, you will be eligible for a hardship exemption and will be able to enroll in

catastrophic coverage available in your area. For more information, visit http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cancellation-consumer-options-faq-01-03-2014.pdf.

In most cases, premiums for catastrophic plans will be less expensive because they will cover fewer benefits and require the consumer to take on more of the out-of-pocket expenses through co-pays and higher deductibles. These plans will likely attract individuals who need coverage due to the law but do not need a lot of coverage.

10. Are large group plans required to cover essential health benefits (EHBs)?
No, large group plans are not required to cover EHBs. However, if a large group plan provides coverage for any EHBs, the plan is prohibited from imposing annual or lifetime dollar limits on those benefits. Plans may impose non-dollar limits, such as limits on the number of doctor visits, that are at least actuarially equivalent to any annual dollar limits contained in the benchmark plan.

11. How does an insurer know whether its large group plan offerings contain EHBs?
Insurers may refer to any state's EHB benchmark plan when identifying whether its large group plans contain EHBs. As stated in the response to the question above, large group plans are not required to cover EHBs. However, if a large group plan provides coverage for any EHBs, the plan is prohibited from imposing annual or lifetime dollar limits on those benefits.

There is no requirement for large group plans to cover benefits at the level provided in the benchmark plan or add benefits not currently covered by the large group plan.

Any large group insurance plan choosing another state's benchmark plan must continue to cover Wisconsin state mandated benefits in accordance with state law. A large group plan may continue to impose dollar limits on a state mandated benefit if the chosen EHB benchmark plan does not include the Wisconsin mandated benefits.

Individual and small group health plans must provide benefits contained in the Wisconsin benchmark plan and do not have the option to choose a different state's benchmark plan.

12. Will consumers be able to purchase coverage at any time throughout the year?
Individuals and families interested in purchasing coverage in the individual market that first becomes effective in 2015 can purchase health insurance coverage through the private market or the federal exchange during the annual open enrollment period that runs from November 15 through February 15.

There are also special enrollment periods in 2014 for an individual or family if they experience a "triggering event." Examples of common triggering events include: (1) loss of minimum essential coverage; (2) gaining or becoming a

dependent; (3) newly gaining citizenship; and (4) becoming newly eligible for premium tax credits. Individuals and families generally have 60 days from the time of a triggering event to enroll in new or different health insurance coverage.

For individuals and families purchasing coverage through their employer, there will be no changes in timeframes.

13. What are navigators and will individuals and families be able to use navigators to purchase health insurance?

Navigators are federally funded entities and individuals who help consumers determine their eligibility for public assistance programs. They also help consumers compare health insurance options displayed on the federal exchange Web site after consumers input their preferences.

In addition to federal training and licensure requirements, navigators serving Wisconsin consumers must obtain a state navigator license by completing 16 hours of state-specific training and successfully pass a state examination.

All navigators licensed in Wisconsin are registered with OCI and are listed on the OCI Web site. If you are uncertain whether the person you are working with is a navigator, you should look for their name on the OCI Web site at http://oci.wi.gov/navigator/naventities-registered.htm. If you have concerns with a navigator's conduct, please complete a consumer complaint form located at https://ociaccess.oci.wi.gov/complaints-public/.

By law, navigators are prohibited from selling health insurance. They are available to help individuals check for eligibility into public assistance programs through the federal exchange and help individuals interested in purchasing health insurance view plan options displayed on healthcare.gov, the federal exchange Web site.

Even for consumers interested in purchasing health insurance through the federal exchange, navigators are not permitted, by law, to recommend one plan over another. Only state-licensed health insurance agents can provide advice and sell health insurance.

For a list of permitted and prohibited activities related to navigators, review the July 26, 2013, bulletin posted to the OCI Web site at: http://oci.wi.gov/bulletin/0713navigator.htm.

14. What are "Certified Application Counselors (CACs)"? Can they sell health insurance?

CACs, like navigators, help individuals check their eligibility for public assistance programs. CACs also help consumers sort through the health insurance plans that display on the federal exchange Web site after consumers enter their preferences.

CACs are not federally funded but must work for an organization designated by the federal government as a CAC entity. CACs must complete federal training

and examination requirements as well as the same state training and examination requirements necessary for a Wisconsin navigator license. CACs are registered with the Office of the Commissioner of Insurance and are listed on the OCI Web site at http://oci.wi.gov/navigator/cac-registered.htm.

If you have concerns with a CAC's conduct, please complete a consumer complaint form located at https://ociaccess.oci.wi.gov/complaints-public/.

Under state and federal law, CACs and navigators are not qualified to and cannot legally sell health insurance or provide advice to consumers about which health insurance plan best meets their needs. Only state-licensed health insurance agents may sell and provide advice about health insurance coverage.

Private Health Insurance Market (Outside of the federal exchange) FAQs

1. **I understand there will be a federal exchange, but will I still be able to purchase health insurance in the private market outside of the federal exchange?**
   Yes. There are many insurers offering plans in the private health insurance market. Consumers are encouraged to research options in the private market before committing to a purchase through the federal exchange. A map detailing all of the insurers selling health insurance in Wisconsin by county is posted on the OCI Web site. A table with contact information for each insurer is also provided. You can find the map and the table at http://oci.wi.gov/healthcare_ref/find_health_insurer.htm.

2. **Will I be penalized if I purchase health insurance in the private market rather than through the federal exchange?**
   No, you will not be penalized for purchasing health insurance in the private health insurance market outside of the exchange. There are no penalties associated with where you purchase your health insurance. The only penalty is a federal tax for not purchasing health insurance at all. This is explained further in question number two under General Health Insurance Market FAQs.

3. **How can consumers purchase plans in the private health insurance market? Can they still use agents?**
   Consumers can purchase plans through the private market directly from an insurer or through a licensed health insurance agent.

   Navigators, Certified Application Counselors, or any other type of assister are prohibited, by law, from selling health insurance policies.

4. **Is there a difference between health insurance plans offered in the private health insurance market vs. those available through the federal exchange?**
   For the most part, health insurance plans offered in the private health insurance market and the exchange must follow the same market rules. Depending on the area of the state you live in, there are likely more plan options available in the private health insurance market because not all insurers sell their plans through the federal exchange. Additionally, those that

do sell plans through the federal exchange may also offer additional plan options in the private health insurance market.

Exchange FAQs

1. **Are insurers required to sell their plans through the federal exchange?**
   No, and some have chosen to only sell their plans in the private health insurance market. For this reason, it is important for consumers to understand all of their options. Consumers may seek help from a state-licensed health insurance agent to ensure they choose a plan that best suits their needs.

   A map detailing all of the insurers selling health insurance in Wisconsin by county is posted on the OCI Web site. A table with contact information for each insurer is also provided. You can find the map and the table at http://oci.wi.gov/healthcare_ref/find_health_insurer.htm.

2. **Are consumers required to purchase health insurance through the federal exchange?**
   No. Consumers may purchase health insurance in either the private health insurance market or through the federal exchange. It will be important for consumers to use resources, such as state-licensed health insurance agents, to understand whether plans sold in the private health insurance market meet their needs better than those plans available through the federal exchange.

3. **If purchasing health insurance through the federal exchange, can consumers still purchase health insurance through an agent?**
   Yes, agents continue to assist individuals and families in purchasing health insurance coverage. Agent services are available for consumers interested in purchasing coverage either in the private health insurance market or through the federal exchange.

   For consumers interested in purchasing coverage through the federal exchange, agents will be able to help people understand whether it may be in their best interest to instead purchase coverage in the private health insurance market.

4. **When can consumers purchase health insurance through the federal exchange?**
   Individuals and families can enroll in individual health insurance coverage through the exchange during the *annual* enrollment period (for benefit years starting on or after January 1, 2015) from November 15, 2014, through February 15, 2015.

   There are also special enrollment periods for an individual or family if they experience a "triggering event." Common examples of triggering events include: (1) loss of minimum essential coverage; (2) gaining or becoming a dependent; (3) newly gaining citizenship; and (4) becoming newly eligible for premium tax credits. Individuals and families generally have 30 days from the time of a

triggering event to enroll in new or different health insurance coverage. A 60-day timeframe is provided for individuals who lose eligibility for Medicaid.

5. **What will it cost to participate in the federal exchange?**
   There is no fee to individuals and families using the federal exchange. However, the federal government will charge insurers a fee to sell their products through the federal exchange. That fee, coupled with other fees and regulatory requirements the federal government is imposing on insurers, has resulted in significant increases in health insurance premiums.

   See FAQ number six under General Health Insurance Market FAQs above.

6. **Can insurers charge more (or less) for policies sold through the federal exchange?**
   No, insurers must charge the same for similar plans whether they are sold through the federal exchange or in the private health insurance market.

7. **What is the federal Small Business Health Options Program (SHOP) Exchange?**
   It is the federal health insurance exchange for small employers. Small employers can either purchase their health insurance plan for their employees in the private health insurance market or through the federal SHOP Exchange. Additional FAQs for small employers and their employees are also available from OCI.

Premium Tax Credits FAQs

1. **Who is eligible for federal premium tax credits?**
   Iindividuals and families with incomes between 100% and 400% of the federal poverty level (FPL), or $11,670 to $46,680 for individuals and $23,850 to $95,400 for a family of four.

   The premium tax credit is available to people who have no tax liability and can be paid directly to the individual's insurance company to help artificially reduce the cost of health insurance.

   Below is a link to a premium tax credit calculator available on the Kaiser Family Foundation Web site:

   http://healthreform.kff.org/subsidycalculator.aspx

2. **Are consumers who purchase health insurance in the private health insurance market outside of the exchange eligible for federal premium tax credits?**
   No. The federal government only offers premium tax credits if health insurance is purchased through the federal exchange, although Governor Walker has requested that premium tax credit eligibility be expanded to include plans in the private health insurance market, although Governor Walker has requested that premium tax credit eligibility be expanded to include plans in the private health insurance market.