Federal Health Care Law
Frequently Asked Questions for Insurers

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.

1. When are insurers selling individual plans required to make their rate and form filings?
For insurers selling individual plans only outside of the federal exchange, Wisconsin requires that all rates and forms be filed with the Office of Commissioner of Insurance at least 30 days prior to the effective date. Under federal law, insurers selling plans in the individual market must submit each year a single risk pool rate filing effective January 1 and may only introduce new plans and revise rates effective January 1 for the following calendar year.

For insurers selling plans on the federal exchange only or both on and off the federal exchange, the Office of the Commissioner of Insurance is required to complete its rate and form filing reviews by July 31, 2014. Therefore, Wisconsin requires that insurers selling plans on the federal exchange file forms with the Office of the Commissioner of Insurance by June 30, 2014. Per federal exchange guidance, insurers selling plans on the federal exchange must file rates with the Office of the Commissioner of Insurance by June 27, 2014.

Following is the timeline for individual market rate filings:

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<th>Individual Market</th>
<th>Rate Filing Deadline (for companies seeking QHP certification)</th>
<th>Rate Filing Deadline (for companies with plans subject to open enrollment)</th>
<th>Rate Filing Deadline (for companies with all plans guaranteed available for all of 2015)</th>
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<td>June 27, 2014*</td>
<td>November 14, 2014</td>
<td>December 1, 2014</td>
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* OCI’s review of annual SRP filings is generally complete within 60 days of receipt. Filings are reviewed in order of receipt. ERRP program requirements provide that OCI rate review findings be reported to the federal exchange by July 31, 2014.

Updated: March 10, 2014
2. When are insurers selling small group plans in 2014 and/or 2015 required to make their rate and form filings?

For insurers selling small group plans only outside of the federal exchange, Wisconsin requires that all rates and forms be filed with the Office of Commissioner of Insurance at least 30 days prior to the effective date. Under federal law, insurers selling plans in the small group market must submit each year a single risk pool rate filing effective January 1. Insurers selling plans in the small group market may introduce new plans and revise rates each calendar year quarter following the January 1 submission (April 1, July 1, October 1).

For insurers selling plans on the federal exchange only or both on and off the federal exchange in 2015, the Office of the Commissioner of Insurance is required to complete its rate and form filing reviews by July 31, 2014. Therefore, Wisconsin requires that insurers selling plans on the federal exchange in 2015 file forms with the Office of the Commissioner of Insurance by June 30, 2014. Per federal exchange guidance, insurers selling plans on the federal exchange must file rates with the Office of the Commissioner of Insurance by June 27, 2014.

Following is the timeline for small group market rate filings:

<table>
<thead>
<tr>
<th>Small Group Market</th>
<th>Type of Rate Filing</th>
<th>Possible Effective Dates</th>
<th>Rate Filing Deadline</th>
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<td>Quarterly</td>
<td>July 1, 2014</td>
<td>30 days prior to rate change effective date*</td>
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<td></td>
<td>October 1, 2014</td>
<td>* OCI’s review of quarterly SRP filings is generally complete within 45 days of receipt. Filings are reviewed in order of receipt. Federal exchange requirements provide that changes to the QHP Rate Data Template be submitted 45 days before the filing effective date. The federal exchange will not accept a revised Template until the OCI review is complete.</td>
<td></td>
</tr>
</tbody>
</table>

| Annual (for companies seeking QHP certification) | January 1, 2015 | June 27, 2014* |
|                                                    |                | * OCI’s review of annual SRP filings is generally complete within 60 days of receipt. Filings are reviewed in order of receipt. ERRP program requirements provide that OCI rate review findings be reported to the federal exchange by July 31, 2014. |

| Annual (for companies offering plans off-exchange only) | January 1, 2015 | December 1, 2014 |
3. **If an insurer files an application for QHP (qualified health plan) certification, is the insurer required to participate in the federal exchange?**

   No. A qualified health plan designation is required to participate in the federal exchange, but it does NOT commit an insurer to participate in the federal exchange. CCIIO has indicated that an insurer will not be committed to participate on the federal exchange until they sign a contract to participate in fall 2014.

4. **What is the deadline for an insurer to decide to participate (or not participate) in the federal exchange?**

   An insurer who wishes to participate in the federal exchange must file their rates with OCI by June 27 and have their forms reviewed by July 31. An insurer is NOT committed to participate in the federal exchange until a contract is signed with the federal government in fall 2014.

   An insurer that has filed rates and forms to participate in the federal exchange and subsequently decides not to participate may re-file their rates and forms with OCI as long as the filing meets the December 1 deadline.

5. **Does the private health insurance market have the same open enrollment time frame as the federal health insurance exchange?**


   Minimally, insurers must meet the open enrollment time frames required by the law. Insurers may add additional open enrollment time frames for products sold off the federal exchange if done on a non-discriminatory basis.

   There are also special enrollment periods 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.

6. **What are Wisconsin’s essential health benefits requirements?**

   The federal government has established the essential health benefits requirements on behalf of the state. Wisconsin information can be found here: [http://cciio.cms.gov/resources/data/ehb.html#wisconsin](http://cciio.cms.gov/resources/data/ehb.html#wisconsin)

   The plan language is located here: [http://oci.wi.gov/healthcare_reform.htm](http://oci.wi.gov/healthcare_reform.htm)

7. **Will OCI follow the process outlined in the final essential health benefits (EHBs) regulation that allows actuarial equivalent substitutions within a benefit category?**

   Yes. Insurers are allowed to substitute actuarial equivalent benefits. However, insurers are reminded that those substitutions must be non-discriminatory.
8. Recognizing that federal law prohibits annual or lifetime dollar limits on essential health benefits, can insurers replace dollar limits with other limitations, such as actuarially equivalent visit limits?
Yes. Insurers may make actuarially equivalent substitutions, in some cases, if the substitution falls within the rules of the essential health benefits. It is also important to note that, in some cases, there may be no actuarially equivalent substitution.

9. 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 that are at least actuarially equivalent to any annual dollar limits contained in the benchmark plan. Imposing visit limitations is an example.

10. 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 question 9, 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.

11. How will pediatric dental work?
The U. S. Department of Health and Human Services (HHS) provided guidance regarding coverage of pediatric dental services in the preamble of its final rule, "Patient Protection and Affordable Care Act, Standards Related to Essential Health Benefits, Actuarial Value and Accreditation," stating:

Plans outside of the Exchange may offer EHB that exclude pediatric dental benefits if they are 'reasonably assured' that such coverage is sold only to individuals who purchase Exchange-certified stand-alone dental plans.

OCI is concerned that this inconsistent treatment may result in consumer harm, create confusion within Wisconsin’s competitive health insurance market,
and create an unfair competitive advantage for health insurance plans operating inside of the federal exchange. Specifically, OCI is concerned that consumers may be harmed by purchasing a product they thought contained all EHBs.

Therefore, to ensure that consumer choice is not adversely impacted for those purchasing health insurance outside of the federal exchange and to ensure a competitive marketplace for insurers offering health insurance policies inside and outside the federal exchange, all insurers offering comprehensive individual or small group health insurance plans in Wisconsin must disclose, prior to the sale of the policy, whether the plan covers pediatric dental benefits.

Providing this notice with all health insurance policies sold inside the federal exchange or in the outside market will provide reasonable assurance for health insurers that consumers are obtaining the coverage they need and want.

For more information, please see our bulletin:

http://oci.wi.gov/bulletin/0413peddental.htm

12. How will habilitative services be defined?
The benchmark plan selected for Wisconsin does not include a definition of or coverage for habilitative services. In accordance with 45 C.F.R. §156.115 (a) (5) (i) and (ii), insurers may either: (i) provide parity by covering habilitative services that are similar in scope, amount, and duration to benefits covered for rehabilitative services; or (ii) report to HHS its definition of habilitative services.

When defining "habilitative services" insurers should consider that insureds are provided the Glossary of Health Insurance and Medical Terms as part of the Summary of Coverage and Benefits (as required by §2714 of the ACA), that defines "habilitative services" as:

Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

For more information, please consult our bulletin on the issue:

http://oci.wi.gov/bulletin/0413habilitativeserv.htm

13. What are the requirements for a prescription drug formulary?
CCIO requires that insurers cover prescription drugs in at least each pharmaceutical class, but that insurers must match the same number of drugs available in each class as the benchmark plan.
14. Will the state review policy language or rely on certification of compliance?
Wisconsin will continue to require insurers to certify compliance with key aspects of Wisconsin and federal law. We are not anticipating changing from our "file and use" approach to an approach that will require prior approval. However, we will continue to verify compliance through an analysis of complaints, market conduct examinations, and targeted market conduct examinations.

15. Is there potential that additional rate review will be done at the federal level even though Wisconsin has an effective rate review program?
No. Wisconsin now has an effective rate review process for all markets including association group coverage.

16. Will policy language variables be allowed as long as the policy also includes the EHB?
We do not anticipate any change to our requirements that allow these variables provided the variables meet all the requirements of state and federal law.

17. What are options for insurers who unexpectedly attract a substantial portion of the market and find that they cannot financially sustain additional members?
Federal law requires insurers to accept every employer and individual in the state that applies for coverage, subject to certain exceptions. These exceptions allow issuers to restrict enrollment in coverage: (1) to open and special enrollment periods; (2) to employers with eligible individuals who live, work or reside in the service area of a network plan; (3) in certain situations involving limited network capacity and limited financial capacity.

18. Are agents required to be appointed with all of the health insurers selling products on the federal exchange?
No. Agents need to be appointed with insurers whose products they plan to sell. All state appointment laws remain in effect.

19. Are small employers required to purchase health insurance for their employees? Are there penalties for not offering coverage?
Employers with fewer than 50 employees are not required to purchase health insurance for their employees. There are no penalties for not offering coverage.

20. Are large employers required to offer health insurance to their employees? Are there penalties for not offering coverage?
Federal law requires employers with 50 or more employees who work the equivalent of 30 or more hours per week to offer affordable health insurance to their employees. The federal government refers to this as "shared responsibility for employers."

The health insurance offered must cover at least 60% of expected claims costs. Additionally, an employee's share of the premium for self-only coverage should not exceed 9.5% of the employee's income.
Employers, with 50 or more full-time equivalent employees, who do not offer their employees health insurance coverage could face a penalty of $2,000 per employee (but the employer is exempt from penalties on the first 30 employees). If an employer offers coverage but the coverage is not deemed “affordable” (the employee’s share of the health insurance premium exceeds 9.5% of the employee’s income for self-only coverage), employers may face a penalty of $3,000 for each employee that accesses subsidized coverage through the federal exchange. The total penalties for not offering affordable coverage cannot exceed the penalty for not offering insurance coverage at all.

While the effective date for the penalties associated with the shared responsibility requirement was previously expected to be January 1, 2014, the federal government announced that it will phase in this requirement as follows:

- Employers with 100 or more employees that offer coverage to at least 70% of its employees in 2015, and any calendar months during the 2015 plan year that fall in 2016, will not be subject to the $2,000 penalty referenced above. They may still be subject to the $3,000 penalty for not offering affordable coverage. For the 2016 plan year, employers must offer coverage to 95% of its employees.

- Employers with 50 to 99 employees are not subject to the shared responsibility penalties in 2015 or any calendar month during the portion of the 2015 plan year that falls in 2016.

The determination of whether an employer is subject to the federal requirement to offer health insurance and the extent to which any penalties apply is very complex. It is recommended that employers contact a tax professional to understand these issues. Licensed health insurance agents can also be helpful.

Below is a link to the final IRS regulation on employer requirements: Shared Responsibility for Employers Regarding Health Coverage.

https://www.federalregister.gov/articles/2014/02/12/2014-03082/shared-responsibility-for-employers-regarding-health-coverage

21. **Will small employers be able to purchase health insurance at any time throughout the year?**
Yes. Health insurers must allow an employer to purchase health insurance coverage at any point during the year.

However, in the private health insurance market, if a small employer is unable to comply with employer contribution or group participation rules, health insurers may choose to limit enrollment of that employer to an annual enrollment period that begins November 15 and extends through December 15 of each year. SHOP will limit enrollment to that same time frame for employers who are unable to meet the SHOP participation requirement of 70%.
22. **Are all small employers eligible for the federal small business tax credits?**

No. The following requirements must be met for an employer to qualify for the federal small business tax credits: (1) the employer must have fewer than 25 full-time employees; (2) the average annual wages of employees must be less than $50,000; and (3) the employer must pay at least half of the insurance premiums.

The tax credit is worth **up to** 50% of the employer’s contribution toward employees’ premium costs (up to 35% for tax-exempt employers). The tax credit is highest for companies with fewer than 10 employees who are paid an average of $25,000 or less. Additionally, the credit is only available to small employers purchasing health insurance through SHOP. Today, to purchase a plan offered on the SHOP, an employer must work directly with a licensed health insurance agent or an insurer.

Below is a link to Internal Revenue Service FAQs on the small business tax credit. OCI is not responsible for the accuracy of the information provided at that site.


23. **If employees have access to health insurance coverage through their employer, are they eligible for federal health care premium tax credits?**

No, unless the employee’s share of the premium is more than 9.5% of their household income or the coverage does not meet minimum requirements.

24. **Are there participation rates that must be met as a condition of purchasing small group coverage in either the private health insurance market or SHOP?**

Insurers offering coverage in the private health insurance market may impose participation rates consistent with state law.

State law does not allow a small employer insurer to impose more stringent requirements than the following:

- For a small employer with more than 10 eligible employees, 70% of the group.
- For a small employer with 10 eligible employees, 6 eligible employees.
- For a small employer with 8 or 9 eligible employees, 5 eligible employees.
- For a small employer with 7 eligible employees, 4 eligible employees.
- For a small employer with 5 or 6 eligible employees, 3 eligible employees.
- For a small employer with 2 to 4 eligible employees, 2 eligible employees.

The federal Center for Consumer Information and Insurance Oversight (CCIIO) has indicated the federal SHOP will use a participation rate of 70%.
25. **Will individuals and families be able to use navigators to purchase health insurance?**
No. Navigators, by law, 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 assess whether one plan may be better for a consumer than 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](http://oci.wi.gov/bulletin/0713navigator.htm).

26. **What are “application counselors” and “assistors”? 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 both state and federal training as well as pass state and federal examinations. State training and examination requirements for CACs are the same as navigator requirements. 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](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/](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.

27. **Can small employers purchase health insurance from the private health insurance market? Can they still use agents?**
Yes, small employers can purchase health insurance from the private health insurance market either directly from an insurer or with the help of a licensed health insurance agent.
28. **Can sole proprietors purchase group health insurance in the outside market?**  
No. Neither federal nor state law allow insurers to sell small group health insurance plans to sole proprietors. This is the case whether coverage is purchased through the private health insurance market or SHOP.

29. **When are policies sold to individuals and groups required to be compliant with ACA provisions?**  
Insurers have some discretion. Insurers selling plans with an effective date on or after January 1, 2014, must ensure those plans are compliant. State and federal law allowed insurers to renew non-ACA compliant plans in 2013, with a plan year that began in 2013 and ends in 2014. An OCI bulletin is available on this issue at [http://oci.wi.gov/bulletin/1113healthplans.htm](http://oci.wi.gov/bulletin/1113healthplans.htm).

30. **Are insurers allowed to have renewal dates that are shorter than one year? Long than one year?**  
Prior to January 1, 2014, insurers were allowed to offer early renewals to policyholders. Federal law specifies that insurers are not allowed to offer renewal periods longer than one year. However, non-ACA compliant plans are not subject to this rule.

31. **If a consumer has a renewal date after the open enrollment period, will they be allowed their own special enrollment period?**  
Yes, if their current plan is no longer available for renewal.

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

The premium tax credit is refundable so taxpayers who have little or no income tax liability can still receive the tax benefit.

Below is a link to a premium tax credit calculator available on the Kaiser Family Foundation Web site. OCI is not responsible for the accuracy of the information provided at that site.


33. **Are consumers who purchase health insurance in the outside market eligible for federal premium tax credits?**  
No. The federal government only offers premium tax credits if health insurance is purchased through the federal exchange.