Federal Health Care Law
Frequently Asked Questions for Consumers

Disclaimer:
Many of the responses to these questions are based on what the Office of the Commissioner of Insurance (OCI) knows today from the federal government. There are many details the federal government has not yet shared with states, which will be important for consumers, employers and insurers to know going into 2014. As additional information becomes available, OCI will update these questions and responses.

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 Patient Protection and Affordable Care Act (PPACA).

Glossary of Terms
(Terms reflect those used in this document.)

Essential Health Benefits (EHB):
The minimum level of coverage insurers in the individual and small group markets must offer 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 and vision care.

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

Updated: July 29, 2013
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.

Each state must identify their Essential Health Benefit Benchmark plan. Insurers must offer benefits that are substantially similar to the benchmark plan.

The federal government has identified a plan sold by UnitedHealthcare as Wisconsin's benchmark. It is their Choice Plus Definity HSA Plan (A92NS).

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


**FPL:**
FPL means the federal poverty level. This level is set by the 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.

**Health Insurance Exchange:**
A federal Web site that will allow 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 quality; and (3) link consumers to insurers for the purchase of health insurance after they choose a plan they are interested in.

The federal government has recently attempted to change the name from Health Insurance Exchanges to “Health Insurance Marketplaces.” However, in an effort to limit confusion between the federal Exchange Web site and the private insurance marketplace, this document and Wisconsin will continue to use the term “Exchange.”

**Navigators:**
Federally funded individuals who help consumers determine their eligibility for public assistance programs. They also help consumers compare health insurance options displayed on the Exchange Web site after consumers input their preferences.

Navigators are not permitted to provide advice to consumers about which health insurance plan to choose and are not allowed to sell insurance.
Open Enrollment Period:
Open enrollment is a limited time period during which insurers are required to offer insurance coverage to any applicant. This is required of insurers both inside and outside the Exchange. Under the law, individuals will first be able to purchase coverage during the initial open enrollment period which is scheduled for October 1, 2013, through March 31, 2014.

Following the first year, the annual enrollment period (for benefit years starting on or after January 1, 2015) is October 15 through December 7 of the preceding year.

Private Health Insurance Marketplace:
This refers to the Wisconsin health insurance market offering health insurance plans outside of the 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 Exchange or in the private health insurance marketplace outside of the 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 will be required to offer “essential health benefits.” See the “Glossary of Terms” section for more detail.
   - Plans will be 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 portion 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 $6,250, for self-only coverage.
   - Insurers will have the option to sell their plans through the federal health insurance Exchange, in addition to selling their plans in the marketplace 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 penalty is set to increase each year as follows:

- In 2014 it will be 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.

There are federal exemptions from having to purchase health insurance. For more information on exemptions, below is a link to an IRS FAQ:


3. **After January 1, 2014, will consumers be able to keep their health insurance with their current health insurance company?**
It is likely that many health insurance companies will continue to sell health insurance in Wisconsin. However, there is a real potential that an insurance company may decide to stop doing business because of costly changes the federal government requires insurers to take on starting in 2014.

4. **Will consumers be able to keep their current health insurance plan (benefits) if they like it?**
For most people who buy their own individual insurance, the answer is likely not. The new federal law will only allow insurers to sell plans that the federal government allows. These new benefits required by the federal law are typically more extensive than consumers buy today, and therefore will be more expensive. For consumers who get their coverage from an employer, there will likely be less changes in your plan than the individual insurance market but many will see their current plan change.

5. **Will premiums increase? If so, by how much?**
While it is difficult to accurately predict, it is safe to say yes, premiums will increase for most 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.

The Society of Actuaries has recently estimated that the change in the average monthly costs for non-group coverage after federal health care reform is implemented is 80%. Please note that this is just an estimate. Costs could be
higher or lower than the 80% based on other factors. However, it is a safe assumption that premiums will rise significantly.

6. **Will consumers receiving premium tax subsidies be impacted by these premium increases?**
   That depends on where consumers get their coverage today and how much of a subsidy they get 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.

7. **I have recently heard that people with incomes between 100% and 200% of the FPL will no longer be eligible for Medicaid in 2014. Instead, these individuals will have the option of purchasing health insurance with a premium tax credit through the Exchange. Will the premium increases discussed above impact those individuals?**
   No. Individuals eligible for the federal premium tax credit who are at 100% of the FPL cannot be required to pay more than approximately $19.00 a month. Individuals at 200% of the FPL cannot be required to pay more than approximately $117.00 a month.

8. **Will plans without the essential health benefits be available?**
   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 exemptions from the federal mandate to purchase insurance, to access those plans.

   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 of a lot of coverage.

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. **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 2014 can purchase health insurance coverage through the private marketplace during the initial open enrollment period, which begins October 1, 2013, and ends March 31, 2014.

Following the initial open enrollment period, there will be an annual open enrollment period in subsequent years that runs from October 15th through December 7th. Coverage purchased during the annual open enrollment period will be effective on January 1st of the following year.

There are also special enrollment periods for an individual or family if they experience a “triggering event.” 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 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.

12. **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 Exchange and help individuals interested in purchasing health insurance view plan options displayed on the Exchange Web site.

Even for consumers interested in purchasing health insurance through the 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.
13. **What are “Application Counselors” and “Assistors”? Can they sell health insurance?**

Application Counselors and Assistors, like Navigators, will help individuals check their eligibility for public assistance programs. Application Counselors and Navigators will also help consumers sort through the health insurance plans that display on the Exchange Web site after consumers enter their preferences.

Application Counselors, Assistors 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.

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**Private Marketplace (Outside of the Exchange) FAQs**

1. **I understand there will be a federal Exchange but will I still be able to purchase health insurance in the private marketplace outside of the Exchange?**

   Yes. In fact, it is likely there will be more insurers and plan options available in the private marketplace outside of the Exchange. Consumers are encouraged to research options in the private marketplace before committing to a purchase through the Exchange.

2. **Will I be penalized if I purchase health insurance in the private marketplace rather than through the federal Exchange?**

   No, you will not be penalized for purchasing health insurance in the private marketplace 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 from the private insurance marketplace? Can they still use agents?**

   Consumers can purchase plans through the private marketplace directly from an insurer or through a licensed health insurance agent.

   Yes, health insurance agents will be available to help consumers purchase health insurance, like they do today.

   Navigators, Application Counselors, and Assistors are not permitted, by law, to sell health insurance policies.

4. **Will there be a difference between health insurance plans offered in the private marketplace vs. those available through the federal Exchange?**

   It is expected that there will be more plan options available in the outside marketplace because not all insurers will choose to sell their plans through the Exchange. Additionally, those that do sell plans through the Exchange may also offer different plan options in the outside market.
Exchange FAQs

1. Are insurers required to sell their plans through the federal Exchange?
   No. It is anticipated that only some insurers currently offering health insurance plans will choose to sell their plans through the Exchange. For this reason, it will be 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.

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

3. If purchasing health insurance through the federal Exchange, will consumers still be able to purchase health insurance through an agent?
   Yes, agents will continue to assist individuals and families in purchasing health insurance coverage, as they do today. Agent services will be available for consumers interested in purchasing coverage either in the private outside marketplace or through the Exchange.

   For consumers interested in purchasing coverage through the Exchange, agents will be able to help people understand whether it may be in their best interest to instead purchase coverage in the private outside marketplace.

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 initial open enrollment period, beginning October 1, 2013, and ending March 31, 2014. Health insurance coverage for plans purchased during that timeframe begins in 2014.

   Following this initial open enrollment period, there will be an annual open enrollment period that runs from October 15th through December 7th of each year. Coverage purchased during the annual open enrollment period will be effective on January 1st of the following year.

   There are also special enrollment periods for an individual or family if they experience a “triggering event.” 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 have 60 days from the time of a triggering event to enroll in new or different health insurance coverage.
5. **What will it cost to participate in the federal Exchange?**

There is no fee to individuals and families using the Exchange. However, the federal government will charge insurers a fee to sell their products through the Exchange. That fee, coupled with other fees and requirements the federal government is imposing on insurers, will result in significant increases in health insurance premiums.

The Society of Actuaries has recently estimated that the change in the average monthly costs for non-group coverage after federal health care reform is implemented is 80%. Please note that this is just an estimate. Costs could be higher or lower based on other factors. However, it is a safe assumption that premiums will rise significantly.

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 Exchange or in the private marketplace outside of the Exchange.

7. **What is the federal Small Business Health Options Program (SHOP) Exchange?**

It is the health insurance Exchange for small employers. Small employers after January 1, 2014, can either purchase their health insurance plan for their employees in the private market or through the 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?**

Individuals and families with incomes between 100% and 400% of the poverty level, or $11,945 to $43,320 for individuals and $23,681 to $88,200 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. The credit also can be paid in advance to a taxpayer's insurance company to help cover the cost of health insurance premiums.

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 marketplace 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 Exchange.