FAQ: Frequently Asked Questions about Health Insurance in Wisconsin

Relating to Changes in the Affordable Care Act (ACA) & BadgerCare/Medicaid

TABLE OF CONTENTS

Marketplace & Financial Assistance

- What are the health insurance metal tiers in the Marketplace and why do they matter?
- What is a "Catastrophic Plan" and who can get them?
- Is there any limit on the total amount of cost-sharing charges that an enrollee in a marketplace health insurance plan has to pay?
- Who qualifies for a Premium Tax Credit (PTC)?
- How do you get a Premium Tax Credit (PTC)? And how does it work?
- Is there a payment "grace period" for people who get a Premium Tax Credit (PTC) through the Marketplace?
- What is the Cost-Sharing Assistance on the Marketplace? Who qualifies? And how do I get it?
- Can people who qualify for the federal tax subsidies for their Marketplace coverage choose any of the plans?
- How much will the maximum out-of-pocket limit be after 2014?
- Is dental coverage included in the health insurance plans on the Marketplace?
- Is mental health covered in the health insurance plans offered in the Marketplace?

Special Populations

- Are the elderly or individuals on Medicare affected by the ACA?
- Can lawfully present immigrants get coverage through the Marketplace? Are they eligible for the financial assistance on the Marketplace?
- Do undocumented immigrants, who have been excluded from purchasing insurance in the Affordable Care Act marketplace, have to pay a penalty for not purchasing insurance?
- Will lawfully present immigrants be subject to the individual mandate tax penalty for not having insurance?
- Are there any changes to veterans' benefits?
- What happens if you have a disability?
- What if I'm on HIRSP in Wisconsin?
- How does the ACA impact the LGBT community?
- Are there changes to Tribal Health Coverage?
- Are residents of U.S. territories subject to the tax penalty for not having health insurance?
- Are US citizens living abroad subject to the tax penalty for not having health insurance?

Small Businesses

- Are small businesses required to offer health insurance to their employees?
- What is the SHOP?
- What are the benefits to a small business of using the SHOP?
- How will the SHOP work?
- What are the Small Business Tax Credits?
- What businesses qualify to use the SHOP exchange?
- Can someone who is self-employed buy coverage in the Marketplace and also deduct their premium cost for tax purposes?

EMPLOYER SPONSORED INSURANCE

Q: Am I obligated to enroll in my employer-provided (or employer-sponsored) insurance plan?

A. NO, but if you choose to purchase coverage through the Marketplace instead of your employer you will not be eligible for federal subsidies if your employer-sponsored plan meets the "affordability" and "minimum value" tests. Though you would not be eligible for subsidies, you can still choose to purchase your insurance through the marketplace rather than with your employer.

Q. What is the "minimum value test" (sometimes called "minimum essential coverage" test)?

A. An employer-sponsored insurance plan meets the "minimum value" test if, on average, it pays at least 60% of total allowed costs.

Q. How is it determined whether or not employer-sponsored insurance (ESI) is "affordable"?

A. IRS's final rule states that if the cost of premiums for *self-only coverage* for an employee doesn't exceed 9.5% of the taxpayer's household income then the coverage is considered affordable for the family, even if that coverage does not take into account the cost of coverage for all family members. As a result, other family members could be excluded from eligibility for premium tax credits or cost-sharing subsidies when the employed family member is determined to have an "affordable offer" of employee-only coverage. This is a significant concern to children and families who could be left not only without an affordable coverage option through an employer but also ineligible for subsidized Marketplace coverage. Example: If an employer offers an employee-only plan with premiums that cost 8% of an employee's total household income, then other family members who could be included on one of the employer's plans are deemed to have "affordable" access to coverage, even if the employer's family plan would cost 15% of the employee's household income.

Q. What if an employer offers individual coverage that passes the affordability and minimum value test but the employer doesn't offer *any* kind of family coverage? Is the family still ineligible for the subsidies in the Marketplace?

A. If an employer offers individual coverage for an employee that meets the affordability and minimum value test but does *not* offer any kind of family coverage, then the rest of the family is eligible for Premium Tax Credits on the Marketplace but the employee is not.

Similarly, if an employer offers individual coverage for an employee that meets the affordability and minimum value test *and* the employer offers individual + kids coverage that does or does not meet the threshold (it doesn't matter if the premium for the individual + kids coverage costs less than 9.5% of household income), then the employee and kids would *not* be eligible for Premium Tax Credits on the Marketplace. However, if there was a spouse and the employer did not offer full family coverage, then the spouse *would* be eligible for Tax Credits on the Marketplace.

Q. Why do I keep hearing something about an 8% affordability test if the test for Employer-Sponsored Coverage is 9.5% of household income for self-only coverage?

A. There are 2 separate affordability tests that determine different things. Put simply, the first test determines whether or not someone with employer-sponsored insurance is eligible for financial assistance (Premium Tax Credit and Cost-Sharing assistance) on the Marketplace. The second test determines whether or not someone is subject to a tax penalty if they don't take coverage from an employer or find some other form of insurance.

Test #1 (9.5%): As previously described, one of the two tests to determine whether or not an individual is eligible for Premium Tax Credits or Cost-Sharing on the Marketplace is to determine if their employer-sponsored insurance costs less than 9.5% of their household's income for self-only/employee-only coverage (meaning insurance for just the worker). If the premiums for an employer's employee-only plan would cost less than 9.5%

of household income (and also meets the minimum value test), all family members who could be covered by that employer are deemed to have affordable coverage and would not be eligible for financial assistance on the Marketplace, even if a family plan would cost far more than 9.5% of family income.

Test #2 (8%): As described, everyone will be required to have health insurance starting in 2014 (with some exceptions), and they could be subject to a tax penalty if they could obtain affordable insurance. However, "affordable" for the purposes of the tax penalty is set to a lower threshold of 8% of family income so that fewer people are subject to a tax penalty if they don't take their employer's offer of insurance or find other affordable insurance. In this test, each individual is assessed separately. For example, if an employer offers an employee-only plan that costs 7% of household income and a family plan that costs 14% of household income, then the employee is subject to the individual mandate (because the offer is less than 8% of household income) but the other family members are exempt from the tax penalty (because the offer is more than 8% of household income). In this example, the family would not be eligible for financial assistance in the Marketplace, but they would also not be subject to a tax penalty for not having insurance. This affordability test doesn't only look at the cost of employer coverage. Someone could be subject to the mandate if they could get coverage through the Marketplace that would cost less than 8% of household income (after taking into account any financial assistance through tax subsidies.)

Q. **Are there any incentives in the law to encourage employers to offer insurance to their employees?**

A. Yes. Beginning in 2015, large employers (those with 50 or more full-time equivalent workers) will face a penalty if any of their full-time workers qualify for a Premium Tax Credit (see below for information on the PTC). If the firm does not offer coverage at all, the penalty is $2000 for each full-time worker beyond the first 30 workers. If the firm offers coverage that is not affordable, the penalty is the lesser of (1) $3000 for each full-time worker who receives a credit or (2) $2000 for each full-time worker in the firm beyond the first 30. A full-time worker is defined as an employee who works 30 or more hours, so 2 employees working 15 hours per week would qualify as one full-time equivalent (FTE) employee. Small employers (those with fewer than 50 full-time workers) can get coverage through the Small Business Health Options Program (see below for more information on the SHOP exchange) but are not required to offer coverage to their employees (see Small Businesses section below).

Q. Do the consumer cost limits like the out-of-pocket maximum apply to employer-sponsored insurance and all plans moving forward or just Marketplace plans?

A. Moving forward, all non-grandfathered plans, including employer-sponsored insurance, have to put limits on out of pocket costs in 2014. In 2014, the maximum is $6,350 for an individual and $12,700 for a family.

Employer sponsored plans are grandfathered until they lose grandfathered status by making certain changes that reduce benefits or increase costs to consumers (such as changes to co-pays, benefits, the amount the employer pays toward coverage, etc.). The removal of grandfathered status of a plan means they have to comply with ACA's out of pocket maximum rules at that point. To learn more about the rules for "grandfathered" plans, go here.

Also, in 2014, plans with separately administered benefits that have separate out of pocket maximums (or even no limit) can maintain those separate limits (or lack of limits), so long as no one limit is greater than $6,350 or $12,700. Typical application of this is medical benefits and separately administered prescription drug benefit. Although mental health benefits are often separately administered, the one year delay does not apply to MH benefits. There can be no separate limit on that coverage due to the Mental Health Parity and Addiction Equity Act (MHPAEA).

Q. Do all employer sponsored insurance plans also need to have open enrollment right now so that employees who are eligible can enroll and not face a penalty?

A. No, if an individual missed the open enrollment period in 2013, they will have to wait until the next open enrollment period for their employer sponsored insurance or have a qualifying event (birth, job change, etc), which might not coincide with the Marketplace open enrollment. If the worker had an offer from their employer that was "minimum essential coverage" (MEC), then indeed they would not be able to get a subsidy in the Marketplace. But s/he could buy coverage in the Marketplace *without* a subsidy and avoid the tax penalty (although keep in mind the penalty is very low the first year: $95 or 1% of family income). The SHOP exchange (available for small businesses) parallels individual enrollment and is open through March 2014.

Q. Does the no-cost preventative care piece also apply to self-insured plans?

A. Yes, the no-cost preventive care applies to fully and self-funded/insured plans (though it does not yet apply to any plans who continue to have "grandfathered status").

Q. What if I have COBRA coverage? Does an offer of COBRA coverage make me ineligible for subsidies?

A. When you leave a job, you may be able to keep your job-based health coverage for a period, usually up to 18 months – this is called COBRA. If you have COBRA continuation health coverage, you can keep it or you can decide to buy a Marketplace insurance plan. When you have COBRA coverage, you usually have to pay the entire premium yourself, plus a small administrative fee. After you leave your job your former employer no longer pays for any of your insurance costs. In the Marketplace, you may be able to get financial assistance to lower your coverage costs, even if you dropped or turned down COBRA coverage.

INDIVIDUAL MANDATE

Q. What is the individual mandate?

The individual mandate is a provision in the health care reform law that requires you, your children and anyone else you claim as a dependent for tax purposes to have health insurance, beginning in 2014, or to pay a penalty when you file your taxes.

Q. By what date do I need to have insurance in order to avoid the tax penalty?

A. Generally speaking, in order to avoid the penalty for not having insurance when you file your 2014 taxes you will need to have insurance coverage by *at least* March 31st, 2014. However, there is an exception to that rule in 2014 for people who obtain private insurance coverage through the Marketplace. In that case you can avoid the penalty by purchasing coverage up until March 31, 2014, even if that plan doesn't start until May 1, 2014.

Q. How much is the penalty for not having insurance?

A. This penalty will be assessed retrospectively when an individual files taxes for the year.

2014	Greater of $95 per adult, or 1% of taxable income.
2015	Greater of $325 per adult, or 2% of taxable income.
2016	Greater of $695 per adult, or 2.5% of taxable income.
Post 2016	Penalty increases annually based on a cost of-living adjustment.

Q. Is there a minimum standard for insurance that meets this requirement?

A. Yes, but it's a low standard; nearly all health insurance meets the test, which is referred to as the "minimum essential coverage" (MEC) test. MEC includes the following:

- Employer-sponsored coverage (including COBRA coverage and retiree coverage)
- Coverage purchased in the individual market, including a qualified health plan offered by the Health Insurance Marketplace (also known as an Affordable Insurance Exchange)
- Medicare Part A coverage and Medicare Advantage plans
- Most Medicaid coverage
- Children's Health Insurance Program (CHIP) coverage
- Certain types of veterans health coverage administered by the Veterans Administration
- TRICARE
- Coverage provided to Peace Corps volunteers
- Coverage under the Nonappropriated Fund Health Benefit Program
- Refugee Medical Assistance supported by the Administration for Children and Families
- Self-funded health coverage offered to students by universities for plan or policy years that begin on or before Dec. 31, 2014 (for later plan or policy years, sponsors of these programs may apply to HHS to be recognized as minimum essential coverage)
- State high risk pools for plan or policy years that begin on or before Dec. 31, 2014 (for later plan or policy years, sponsors of these program may apply to HHS to be recognized as minimum essential coverage)

Minimum essential coverage does not include plans providing only limited benefits, such as coverage only for vision or dental care, Medicaid covering only certain benefits such as family planning, workers' compensation, or disability policies.

Q: Who is not subject to the individual mandate penalty for not having insurance?

A. IRS RULE: Exemptions to the fee for not having coverage may be granted for the following reasons:

- No Filing Requirement: You are not required to file a tax return because your income is too low (In 2013, those earning less than $10,000 for individuals and $20,000 for families in 2013 are not required to file a tax return).
- Short Coverage Gap: You went without coverage for less than three consecutive months during the year. In general, a gap in coverage that lasts less than three months qualifies as a short coverage gap. If an individual has more than one short coverage gaps during a year, the short coverage gap exemption only applies to the first gap.
- Unaffordable Coverage Options: You can't afford coverage because the minimum amount you must pay for the premiums is more than 8.0 percent of your household income.
- No Medicaid Expansion in Your State: Your state did not choose to expand Medicaid up to 133% of poverty and your income falls below that threshold (THIS IS THE CASE IN WISCONSIN so adults between 100-133% of poverty will not be subject to the tax penalty for not having insurance).
- Religious Conscience: You are a member of a recognized religious sect that is conscientiously opposed to accepting any health insurance benefits.
- Health Care Sharing Ministry: You are a member of a recognized health care sharing ministry.
- Indian Tribes: You are a member of a federally recognized Indian tribe.
- Hardship: The Department of Health and Human Services certified that you suffered a hardship that makes you unable to obtain coverage.
- Incarceration: You are currently in a jail, prison, or correctional facility.
- Not Lawfully Present: You are not a U.S. citizen, U.S. national, or an immigrant lawfully present in the U.S.

BADGERCARE/MEDICAID

Q. Who qualifies for BadgerCare/Medicaid under the new guidelines?

A. Generally, qualifying for BadgerCare depends on who you are (a child, pregnant woman, childless adult, elderly, disabled, etc.) and/or your income.

There are no changes to BadgerCare/Medicaid coverage for individuals who fit into the "Elderly, Blind or Disabled" category of Medicaid. For most others, the determination is made based on income and there are some changes. Children and pregnant women with an income at or below 306% of the Federal Poverty Limit (FPL – see end of document for poverty level guidelines) qualify for BadgerCare coverage in Wisconsin (though there are sliding scale premiums for children between 200% and 306% of FPL). Parents and adults without dependent children (childless adults) with an income at or below 100% FPL will qualify for BadgerCare coverage. Individuals who do not meet these income limits and don't fit into the "elderly, blind or disabled" category of Medicaid should seek insurance through the Marketplace if coverage is not available or affordable through an employer.

Q. What happens if you're on BadgerCare but then your income goes above the eligibility threshold (306% for children and pregnant women and 100% for adults without dependent children)?

A. If your income goes above the BadgerCare income limit (300% for children and pregnant women and 100% for parents and adults without dependent children), you will be eligible for coverage in the Marketplace, and you might also be eligible for financial assistance such as the Premium Tax Credits and the out-of-pocket Cost-Sharing Assistance. In addition to being eligible for coverage on the Marketplace, there is also a Medicaid category known as Transitional Medical Assistance (TMA) that currently allows a parent whose income rises above the poverty level to remain on BadgerCare for 12 months. The federal law that sets the duration of TMA at 12 months expires on April 1, 2014, 2014, and if Congress does not extend it, TMA will shrink to 4 months. Currently, Wisconsin charges premiums to parents in TMA if their income is over 133% of the federal poverty level, but in April 2014 the state plans to begin also charging premiums to parents in TMA with incomes between 100% and 133% of FPL, once they have been in TMA for 6 months (assuming Congress extends the law allowing TMA for up to 12 months).

Q. Is child support counted as income in the Medicaid/BadgerCare and Marketplace eligibility determinations?

A. No. If you receive child support payments, that money will not be counted as income under the new eligibility standards. See the section on MAGI for more information about what does and does not count as income.

Q. Is child support subtracted from income for those making payments in the Medicaid/BadgerCare and Marketplace determinations?

A. No. If you make child support payments, they will not subtracted from your income to determine eligibility for BadgerCare or Marketplace subsidies.

INCOME DETERMINATION

Q. How is income calculated?

A. Income is calculated using your household's MAGI (Modified Adjusted Gross Income), which is the total of your adjusted gross income (Line 37 on your Form 1040) and any additional tax-exempt interest income you may have. Your stock portfolio or other assets (except for income that's generated from assets) are not included in this calculation. For the most part, anything that counts as income on your tax returns will count when determining subsidy eligibility. (See below for more about MAGI).

Q. What is Modified Adjusted Gross Income (MAGI)?

A. MAGI stands for Modified Adjusted Gross Income and it's a new tax-based measure to determine income eligibility for Medicaid programs like BadgerCare and eligibility for Premium Tax Credits (premium assistance) for insurance purchased through the new Marketplace. Modified Adjusted Gross Income is generally your household's adjusted gross income plus any tax-exempt Social Security, interest, and foreign income you have. It's used to determine your eligibility for lower costs on Marketplace coverage, and for Medicaid and the Children's Health Insurance Program (CHIP). You don't have to figure out this income yourself. The math will be done for you when you apply through the Marketplace or your state agency. This is a simple version of the MAGI calculation equation:

MAGI = Adjusted Gross Income (AGI, as defined by IRS) + Excluded foreign income + Tax exempt interest + Non-taxable Social Security benefits

Q. Who does MAGI apply to?

A. MAGI rules apply to almost everyone except for seniors (people 65 and over) and most people with disabilities. For the "Elderly, Blind or Disabled" (EBD) Medicaid group, the current income counting rules apply.

Q. How does MAGI differ from current Medicaid rules?

MAGI methodology differs from current Medicaid rules in several ways including:

- Some income that is currently counted is not counted
- Elimination of asset/resource limits
- Elimination of income disregards
- New household rules result in changes in whose income is counted (e.g. step-parents' income will be counted)

Some forms of income *not* counted under MAGI that *were* counted under former Medicaid rules:

- Salary deferrals (flexible spending, cafeteria and 401(k) plans)
- Child support received
- Alimony paid
- Veterans' benefits
- Workers' compensation
- Gifts & inheritances
- TANF & SSI

Household income = Sum of MAGI of all individuals in the household who are required to file a tax return
*Income of children and tax dependents not counted unless expected to be required to file a tax return

MARKETPLACE & FINANCIAL ASSISTANCE

A. Marketplace health insurance plans have to fit within one of the "metal" tiers or be a "catastrophic" plan (See Catastrophic Plan question for more information). Organizing health insurance plans into levels based on the level of coverage they provide can help enrollees compare different plan options and decide which one is best for them. Most people will be able to decide between several different plan options within each metal tier. The metal levels also ensure that a basic level of coverage will be available and all plans offered in the Marketplace are required to cover some basic Essential Health Benefits and cover preventative care at no cost to the consumer.

Platinum plans have the highest premiums but the lowest copayments and deductibles. Bronze plans have the lowest premiums but the highest copays and deductibles. The percentage shown for each of the four tiers

represents the average portion of expected costs a plan will cover for an average population. Federal standards require insurers participating in the marketplace or exchange to offer plans in at least the silver and gold levels.

Plan Level	Actuarial Value	Meaning the plan is:
Platinum	90%	Expected to cover 90% of the cost of benefits on average
Gold	80%	Expected to cover 80% of the cost of benefits on average
Silver	70%	Expected to cover 70% of the cost of benefits on average
Bronze	60%	Expected to cover 60% of the cost of benefits on average

Q. What is a "Catastrophic Plan" and who can get them?

A. Catastrophic plans were created as an option for younger people. These plans have a very high deductible (equal to the out-of-pocket maximum, which is $6,350 for an individual in 2014). This means that, with the exception of preventive services that have to be provided without any cost-sharing charges and at least three primary care physician visits per year (with enrollee cost-sharing allowed for all care that's non-preventive), enrollees would generally pay the full cost of any medical care they might need until they spend $6,350. Individuals who purchase a catastrophic plan are not eligible for Premium Tax Credits.

Catastrophic health insurance plans may be attractive to people who: 1) want to pay as low a premium as possible, 2) do not expect to need much health care, and 3) are not eligible for Premium Tax Credits. People younger than 30 years old are eligible to enroll in a catastrophic plan. People 30 years old and older are eligible to enroll in a catastrophic plan if they are exempt from the requirement to purchase health insurance or pay a penalty (the "individual mandate" – see individual mandate question above) because they lack access to affordable coverage or have experienced a hardship.

Q. Is there any limit on the total amount of cost-sharing charges that an enrollee in a marketplace health insurance plan has to pay?

A. Yes. There is a "maximum annual limitation on cost-sharing," or a maximum out-of-pocket limit, that applies to all marketplace health insurance plans. This is the maximum amount that an enrollee is required to pay for all cost-sharing charges (including the deductible, copayments and/or coinsurance) during the course of a year. The health law requires each plan to have a maximum out-of-pocket amount that applies to covered benefits delivered by in-network providers. For 2014, the maximum annual amounts are $6,350 for an individual and $12,700 for a family. Insurers may set out-of-pocket limits that are lower than these maximum amounts. The limit does not apply to care from out-of-network providers.

Q. Who qualifies for a Premium Tax Credit (PTC)?

A. This is a NEW federal program that uses tax credits to reduce premium costs for Qualified Health Plan (QHP) enrollees (individuals who get health insurance through the Marketplace). This is designed for people who meet certain financial criteria and don't have access to other coverage options.

Eligibility:

- Income between 100% and 400% of the Federal Poverty Level (FPL)
    - $23,550 - $94,200 for a family of four in 2013.
- Must purchase a Qualified Health Plan (QHP) on the exchange.
    - All plans offered on the exchange are QHPs.
- Must be ineligible for government-sponsored coverage or affordable employer-sponsored insurance.

Q. How do you get a Premium Tax Credit (PTC)? And how does it work?

A. To receive a Premium Tax Credit (APTC), an individual or family must go to the Marketplace and input their financial, household and other information. The Marketplace will determine if the individual or family qualifies for PTC or other financial assistance. The individual or family will be told the maximum amount of PTC they can receive and then they can shop in the Marketplace for different plans that meet their needs. If the individual or family chooses a less expensive plan, the PTC will cover more of their premium costs. If the individual or family chooses a more expensive plan, the PTC will cover less of their premium costs (but the individual or family will have lower copays and deductibles). Family members cannot apply separately for subsidies; all family members participating in the exchange are treated as a unit when the subsidies are calculated.

The PTC can be taken in advance (as a month to month subsidy so the immediate monthly cost of the premium is less) or in the form of a refund at the end of the year when taxes are filed. If taking the tax credit in advance, there is a risk of having to re-pay any overpayments made to you. For this reason, *any* changes in income must be reported as soon as possible to the Marketplace to ensure a significant tax reimbursement will not be required at the end of the year.

Q. Is there a payment "grace period" for people who get a Premium Tax Credit (PTC) through the Marketplace?

A. There is a 3 month grace period for premium payments for individuals who get a Premium Tax Credit for their health insurance through the Marketplace. This means that individuals have up to 3 months to make full payment of their premiums but if the individual does not pay the full cost of all past-due premium payments by the end of the third month, then their coverage is retroactively terminated to the last day of the first month of the grace period. Insurers are only required to pay for the costs that the enrollee incurred during the first month of the grace period and can deny payment of any other services incurred in the following two months. The individual/enrollee would be responsible for any medical costs incurred during the last two months of the grace period. The insurance company must inform the enrollee's provider that the enrollee has lapsed in premium payments.

Q. What is the Cost-Sharing Assistance on the Marketplace? Who qualifies? And how do I get it?

A. Cost-Sharing Assistance on the Marketplace is a new federal program that helps reduce out-of-pocket costs for enrollees in QHPs. Federal subsidies are paid directly to insurers to reduce deductibles, co-insurance, and/or copayments (out-of-pocket) costs.

Eligibility:

- Individuals must have income below 250% FPL.
    - If an individual's income goes above 250% at some point during the year, they should report this change to the Marketplace. However, there is not currently a penalty that will be assessed during tax filing if an individual does not report this change.
- Must purchase a SILVER level plan when choosing a health insurance plan on the Marketplace.

Q. Can people who qualify for financial assistance for their Marketplace coverage choose any of the plans?

A. There are 2 types of financial assistance available to certain individuals (depending on their income) who purchase insurance through the Marketplace: 1) Premium Tax Credits and 2) Cost-Sharing Assistance. To be eligible for Cost-Sharing Assistance (for individuals below 250% FPL), people must choose the silver plan. People who qualify for the Premium Tax Credits (income below 400% FPL) can enroll in any health plan offered through the Marketplace and use their PTC to help pay for their premium payments. However, the federal government calculates the amount of the PTC based on what the cost of a silver plan would be. Thus, if an individual chooses a cheaper, bronze-level plan then the PTC would cover more of their premium, and if they purchase a more expensive gold or platinum-level plan, then the PTC would cover less of their premium.

Q. Does a married couple have to file their taxes jointly in order to qualify for the Advanced Premium Tax Credit?

A. Yes, as this Health Affairs blog succinctly states: "The ACA prohibits married couples who file separately rather than jointly from receiving premium tax credits. This poses problems where filing a joint return is not possible, for example because of domestic violence, abandonment, or other circumstances. This issue will be addressed by future rulemaking." However, "further rulemaking" has not yet been released, therefore it is required that married couples file jointly to receive the Premium Tax Credit.

Q. How much will the maximum out-of-pocket limit be after 2014?

A. In 2015 and subsequent years, the amount of the maximum out-of-pocket limit for a health insurance plan covering an individual will be adjusted to account for changes in the cost of private health insurance compared to 2013. HHS will announce the maximum amount in an annual notice. The amount of the maximum out-of-pocket limit for a family plan will always be double the amount set for an individual plan.

Q. Is dental coverage included in the health insurance plans on the Marketplace?

A. Under the health care law, dental insurance is treated differently for adults and children 18 and under. Dental coverage for children is an Essential Health Benefit; This means it must be available as part of a health plan or as a free-standing plan. This is not the case for adults. Insurers don't have to offer adult dental coverage. You do not need to have dental coverage to avoid the tax penalty for not having health insurance. Dental coverage is available two ways:

1. *Health plans that include dental coverage.* In the Marketplace, dental coverage will be included in some health plans. You'll be able to see which plans include dental coverage when you compare them. You'll also see what the dental benefits are. If a health plan includes dental coverage, you will pay one premium for everything. The premium shown for the plan includes both health and dental coverage.
2. *Separate, stand-alone dental plans.* In some cases separate, stand-alone plans will be offered. You may want to choose this option if the health coverage you plan to enroll in doesn't include dental coverage, or if you want different dental coverage. If you choose a separate dental plan, you'll pay a separate, additional premium for the dental plan. The Wisconsin Marketplace will have an optional stand-alone dental plan available.

Q. Is mental health covered in the health insurance plans offered in the Marketplace?

A. The Essential Health Benefits are benefits that are covered in *every* insurance plan offered in the Marketplace. Among other things, these benefits include mental health and substance use disorder services, behavioral health treatment, substance abuse medical services, mental health-related physicians services and prescription drug coverage, and depression and substance abuse screenings (at no cost). In addition, the ACA prohibits plans from discriminating coverage based on the type of provider making a referral or treatment. The ACA expands the state/federal mental health parity to individual and small group plans, and states have the option of requiring coverage over and above the Essential Health Benefits.

Q. Since premiums can only be adjusted based on age, location, smoking status and family/single plan, what are the rate areas in Wisconsin that help determine what someone will pay based on location?

A. There are 16 rate areas in Wisconsin. This OCI pdf shows the rate areas.

Q. Is there a list of which contraceptives are covered under the no copay rule?

A. The law requires plans to cover all FDA-approved birth control methods without co-pays. This includes pills, the Ring, the Patch, injectables (the Shot), implants, intrauterine devices (IUDs), and sterilization procedures. Plans must cover without cost sharing all brand name contraceptives without generic equivalents or where the generic equivalent is medically inappropriate for a woman. Also, certain religious employers are exempt from the birth control requirement.

While all FDA-approved methods are covered without cost-share under the health reform law, that does not mean all contraceptives. The methods covered by the pharmacy benefit are hormonal (e.g. birth control pills), barrier (i.e. diaphragms), emergency contraceptives (i.e. "morning after" pills) and select over-the-counter (OTC) contraceptives. To know exactly what contraceptives are covered, someone would have to consult their plan.

Q. Is the no-cost preventative care piece also true for self-insured plans?

A. The no-cost preventive care applies to fully and self-funded/insured plans. However, this provision does not apply to grandfathered plans until they lose their grandfathered status by making sufficient changes to plan benefits or prices.

Q. Given that insurance companies will be subject to a rate review if they increase a plan's premium 10% or more, could they just raise the premium multiple times in a year so that it ultimately goes over the 10% review threshold?

A. The rate increase is measured over a 12-month period, so if a plan raises premiums by a certain percentage a few times a year, rate review would be triggered if the increase in a 12-month period is greater than 10% or a special state-specific threshold. WI applied for a state-specific threshold and was denied so the trigger remains at 10%. This is in the IRS Regulation: regs 45 CFR S. 154.210.

Q. Does this premium review requirement apply to Medicare supplements?

A. Rate review applies to issuers offering health insurance coverage in the individual market and small group market (45 CFR 154.103). Grandfathered plans are excluded here until they lose their grandfathered status by making sufficient changes to the plan benefits or price. Nearly 80% of Medicare supplemental plans (Medigap plans) are sold in the individual market so the premium rate review requirement would apply to the Medicare supplemental plans that are offered in the individual and small group markets, which is a large chunk of the Medigap market.

SPECIAL POPULATIONS

Q. Are the elderly or individuals on Medicare affected by the ACA?

A. The ACA does not affect eligibility for Medicare or for the category of Medicaid that covers the elderly and people with disabilities (EBD Medicaid). However, the law makes some Medicare enhancements and includes a change in the prescription drug coverage premium for higher income seniors:

- You get more preventive services, for less. Medicare now covers certain preventive services, like mammograms or colonoscopies, without charging you for the Part B coinsurance or deductible. You also can get a free yearly "wellness" visit.

- You can save money on brand-name drugs. If you're in the donut hole, you'll also get a 50% discount when buying Part D-covered brand-name prescription drugs. The discount is applied automatically at the counter of your pharmacy—you don't have to do anything to get it. The donut hole will be closed completely by 2020.
- Your doctor gets more support. With new initiatives to support care coordination, your doctor may get additional resources to make sure that your treatments are consistent.
- The ACA ensures the protection of Medicare for years to come. The life of the Medicare Trust fund will be extended to at least 2029—a 12-year extension due to reductions in waste, fraud and abuse, and Medicare costs, which will provide you with future savings on your premiums and coinsurance.
- Medicare Part D premiums will increase for high-income seniors. The law increases premiums for a relative small number of people receiving prescription drug coverage in Medicare Part D – those who have incomes of more than $85,000 ($170,000 for a couple).

Q: Can *lawfully present* immigrants get coverage through the Marketplace? Are they eligible for the financial assistance on the Marketplace?

A. Yes, lawfully present immigrants may access coverage through the Marketplace (and can get subsidies if their income is below 400% of FPL), but undocumented immigrants cannot.

Normally to be eligible for a Premium Tax Credit, individuals must have an income between 100%-400% FPL; however, there is an exception for lawfully present immigrants. Immigrants with incomes below 100% FPL who are lawfully present and ineligible for Medicaid because of their immigration status may be eligible for a Premium Tax Credit on the Marketplace. They must also meet all of the other Premium Tax Credit eligibility criteria that apply to individuals with incomes above 100% of FPL (such as not having access to Employer Sponsored Insurance, planning to file a tax return, not claimed as a dependent, etc).

Q: Do *undocumented* immigrants, who have been excluded from purchasing insurance in the Affordable Care Act marketplace, have to pay a penalty for not purchasing insurance?

A. No. The IRS recently issued a final rule implementing the individual responsibility provision of the ACA, including an exemption for individuals who are not lawfully present in the U.S. (Ref: section 5000A(d)(3) of the Internal Revenue Code, as added by section 1501 of the Affordable Care Act.)

Q. Will lawfully present immigrants be subject to the individual mandate tax penalty for not having insurance?

A. Yes, lawfully present immigrants are subject to the tax penalty for not having insurance.

Q. Will lawfully present immigrants who fill out their family information on the Marketplace as required (including information about other immigrant family members) trigger any action or enforcement from Immigration and Customs Enforcement (ICE)?

A. No, ICE released some new guidance to clarify that immigrant parents can enroll their children and other eligible family members in health insurance programs under the Affordable Care Act without triggering immigration enforcement activity.

This is from their statement released on Oct 25th 2013:
"Consistent with the ACA's, the SSA's, and implementing regulations' limitations on the use of information provided by individuals for such coverage, and in line with ICE's operational focus, ICE does not use information about such individuals or members of their household that is obtained for purposes of determining eligibility for such coverage as the basis for pursuing a civil immigration enforcement action against such individuals or members of their household, whether that information is provided by a federal agency to the Department of

Homeland Security for purposes of verifying immigration status information or whether the information is provided to ICE by another source."

Q. Are there any changes to veterans' benefits?

A. The law does *not* change veterans' benefits or out-of-pocket costs.

The law does, however, allow veterans who are enrolled in VA to *also* enroll in health insurance coverage through the Marketplace for those who want additional coverage. The ACA also allows family members of veterans who are not enrolled in VA care to access coverage through the Marketplace. If a veteran is enrolled in VA health care, they meet the *Minimum Essential Coverage* standard so they would not be subject to the tax penalty. However, this also means that they would not be eligible for any premium/cost-sharing assistance if they were to *also* enroll in a health plan through the marketplace. The same is true for any family members who are enrolled in VA care (family members of veterans who were severally disabled or who died in service). Family members who are not enrolled in coverage can get coverage through the marketplace and may qualify for Medicaid or premium/cost-sharing assistance on the marketplace. There are *many* uninsured veterans so this is a valuable opportunity for uninsured veterans (those not covered under VA care or other insurance) to access health insurance.

Q. What happens if you have a disability?

A. Depending on the type and degree of disability and a person's income and assets, individuals can either seek health insurance through the "Elderly, Blind or Disabled" (EBD) Medicaid category or, due to the ACA's provision that insurers can no longer reject applications due to pre-existing conditions, individuals with disabilities can access private insurance either through an employer or the Marketplace. To access EBD Medicaid, there are certain income and asset tests that are required to determine eligibility.

Q. What if I'm on HIRSP in Wisconsin?

A. Wisconsin's Health Insurance Risk-Sharing Plan (HIRSP) was designed to offer a health insurance coverage plan for individuals who had pre-existing conditions and were thus denied from other types of insurance coverage. However, due to the Affordable Care Acts provision that insurers can no longer deny applications due to pre-existing conditions, Wisconsin passed a state budget that ends the Health Insurance Risk-Sharing Plan. The language approved in the budget established the last day of coverage for HIRSP as December 31, 2013, which under the ACA was also going to be the last day for a much smaller federal high-risk pool. However, that deadline was extended to March 31st, 2014 for both the state and federal high-risk pools. Individuals currently enrolled in HIRSP should seek insurance coverage through their employer or the Marketplace by March 15th in order to begin coverage on April 1st to avoid a gap in coverage.

Q. How does the ACA impact the LGBT community?

A. The ACA makes sure that affordable health insurance is available in every state to individuals and families who cannot afford expensive care. In general, fewer families with parents who are LGBT have health insurance than families in the general population because many employers do not offer coverage for same-sex partners or their children. It can be very costly for parents who are LGBT to insure their entire families. Thanks to the ACA, many more children with parents who are LGBT will be able to access the coverage that they need. The ACA bans Health Insurance Marketplaces and the plans sold in them from discriminating on the basis of sexual orientation and gender identity. Transgender people will also have increased access to coverage without being denied based on their gender identity or expression. Before the ACA, transgender people or people living with HIV could be dropped from or denied coverage. After January 1, 2014, people living with HIV will be able to get health coverage that includes their treatment plan, and being transgender will no longer be considered a pre-existing condition.

In addition, the federal website designed to help all consumers find the health insurance best suited to their needs makes it easy to locate health insurers that cover domestic partners. HealthCare.gov's insurance and coverage finder now includes a "same-sex partner" filter, allowing same sex couples to eliminate plans which would not cover both people from the list of plans available in their area. Consumers looking for information on domestic partner coverage will also have access to HealthCare.gov's regular features, such as the ability to sort based on the enrollment, a plan's out-of-pocket costs or other categories. The same-sex partner filter is also available for small employers looking for information on the small group market.

The Center for Consumer Information & Insurance Oversight (CCIIO) released guidance requiring all Health Insurance Marketplaces/Exchanges to recognize valid same sex marriages when determining eligibility for Advance Premium Tax Credits (APTCs) and Cost Sharing Reductions (CSRs). Married couples must file joint federal income tax returns to be eligible for APTCs/CSRs. Now, same sex couples who are legally married in one state can move to a state that does not recognize their marriage and nonetheless remain eligible for APTCs/CSRs.

Q. Is Wisconsin's Department of Health Services going to recognizes same-sex marriages for the purposes of determining household size for BadgerCare Plus eligibility?

A. The Centers for Medicare & Medicaid Services (CMS) issued guidance that allows states to decide whether to recognize same sex marriages for purposes of Medicaid/CHIP eligibility. So, if a legally married same sex couple lives in a state that does not recognize their marriage, the state may choose to not recognize their marriage for purposes of Medicaid/CHIP eligibility. As a result, same sex married couples may have different household sizes for Marketplace and Medicaid eligibility determinations. These discrepancies will generate both administrative burdens and eligibility gaps.

At this time, Wisconsin will not recognize same sex marriages when determining household size. However, the use of MAGI to determine income will require the state to look at tax dependent relationships so if there are children claimed as tax dependents in the care of adults regardless of household composition, it could result in a similar household size determination as it would for a heterosexual married couple. DHS is aware that this is an issue and they are reviewing the options, but there are not policy changes in place at this time.

Q. Are there changes to Tribal Health Coverage?

A. The Health Insurance Marketplace benefits American Indians and Alaska Natives (AI/ANs) by providing opportunities for affordable health coverage. This coverage can be through Medicaid, the Children's Health Insurance Program (CHIP), or a private health plan bought in the Marketplace.

<u>If you're a member of a federally recognized tribe:</u>

- If you buy private insurance in the Health Insurance Marketplace, you won't have to pay out-of-pocket costs like deductibles, copayments, and coinsurance if your income is up to around $70,650 for a family of 4 ($88,320 in Alaska). (These are 2013 figures, and likely to be slightly higher in 2014.)
- You can enroll in Marketplace health insurance any month, not just during the yearly open enrollment period.

<u>If you're an American Indian or Alaska Native or are otherwise eligible for services from the Indian Health Service, tribal program, or urban Indian health program:</u>

- You have special cost and eligibility rules for Medicaid and the Children's Health Insurance Program (CHIP) that make it easier to qualify for these programs.
- If you don't have health insurance, you won't have to pay the fee that most other people without health insurance must pay starting in 2014.

If you enroll in a private health insurance plan through the Health Insurance Marketplace:

- You can get (or keep getting) services from the Indian Health Service, tribal health programs, or urban Indian health programs.
- You can also get services from any providers on the Marketplace plan.

Q. Are residents of U.S. territories subject to the tax penalty for not having health insurance?

A. All bona fide residents of U.S. territories are treated by law as having Minimum Essential Coverage. They also are not required to take any action to comply with the individual mandate. The U.S. territories include Puerto Rico, U.S. Virgin Islands, American Samoa, Guam and the Northern Mariana Islands.

Q. Are US citizens living abroad subject to the tax penalty for not having health insurance?

A. Yes. However, U.S. citizens who live abroad for a calendar year (or at least 330 days within a 12 month period) are treated as having Minimum Essential Coverage for the year (or period). These are individuals who qualify for an exclusion from income under section 911 of the Code. See Publication 54 for further information on the section 911 exclusion. They need take no further action to comply with the individual shared responsibility provision and avoid the tax penalty for not having Minimum Essential Coverage.

SMALL BUSINESSES

Q. Are small businesses required to offer health insurance to their employees?

A. No. Small businesses (with fewer than 50 FTE employees – FTE is considered 30 hours per week) are not required to offer insurance to their employees. However, to encourage small businesses to offer coverage to their employees, the federal government created the SHOP exchange which is meant to give small businesses better purchasing power and therefore better prices. (Obama Administration officials announced on Feb. 10, 2014 that the government will not enforce the mandate for businesses with 50 to 99 workers until 2016.)

Q. What is the SHOP?

A. A SHOP exchange is a Web portal where small businesses with no more than 50 employees (FTE) can shop for and buy private health insurance for their employees. Eligible employers that pursue this platform are required to offer SHOP insurance coverage to all full-time employees.

Q. What are the benefits to a small business of using the SHOP?

A. SHOP Exchanges are expected to offer small businesses more competitive benefit plan options, similar to those that large company group plans provide – giving small businesses the advantage of larger group purchasing power.

Additionally, small businesses participating in a SHOP exchange may be eligible for a tax credit up to 50 percent of their premium payments if they have 25 or fewer full-time employees whose average annual wages do not exceed $50,000. Tax-exempt organizations are eligible for a tax credit up to 35 percent.

While it is still too early to tell exactly how competitive the exchanges will be, tax credits coupled with group rates in the exchanges may help small businesses to provide more cost-effective workplace benefits.

Q. How will the SHOP work?

A. Starting in 2015, SHOP exchanges will provide a premium aggregation service and will send a single invoice to the employer. These exchanges will offer two models:

1. *Employer-Choice* (available in 2014): The employer selects the plans, and employees can then choose from the employer's selected options.
2. *Employee-Choice* (delayed until 2015): The employer selects an actuarial value level and employees can select from any available plans at the employer's selected coverage level (60, 70, 80 or 90 percent coverage) on the SHOP exchange.

Q. Is it true that the SHOP Marketplace for Small Businesses is postponed?

A. The online portion of the SHOP exchange will not be available until November 2014. DHHS chose to delay this component of the small business provisions, but the tax credit is still increasing to 50% in 2014 and small businesses can still enroll through the SHOP using a paper application or an insurance broker/agent. There are a variety of other SHOP timeline questions that are well answered in this Health Affairs blog post and there are some very useful questions and answers in this document about it from DHHS.

Q. Is there an open-enrollment period for the SHOP Marketplace that small businesses should be aware of?

A. SHOP enrollment is available for small businesses on an on-going basis. In addition, the 'open enrollment' period for employees is chosen by the small business owner - there are no requirements. However, small businesses that don't meet the minimum enrollment threshold of 70% of eligible employees enrolling in coverage can enroll in the SHOP during the same open enrollment period as the individual Marketplace (Nov 15th-Dec 15th in 2014) in order to be eligible for SHOP coverage that begins in 2015.

Q. What is the small business tax credit and how do you qualify?

A. The small business tax credit helps small businesses and small tax-exempt organizations afford the cost of covering their employees and is specifically targeted for those with low- and moderate-income workers. The credit is designed to encourage small employers to offer health insurance coverage for the first time or maintain coverage they already have. In general, the credit is available to small employers that pay at least half the cost of single coverage for their employees.

You may qualify for tax credits if you (as a small business) offer coverage through SHOP:

- If you have fewer than 25 full-time equivalent (FTE = 40 hours per week) employees making an average of about $50,000 a year or less, you may qualify for a small business health care tax credit.
- Starting in 2014, the tax credit is worth up to 50% of your contribution toward employee premium costs (up to 35% for tax-exempt employers). This will make the cost of providing health coverage lower.
- Beginning in 2014, the small business health care tax credit is available only if you get coverage through SHOP.
- If you plan to use SHOP, you must offer coverage to all of your full-time employees – generally those working 30 or more hours per week on average.

The credit will be available to eligible employers for two consecutive taxable years. If you have questions about the SHOP Marketplace for businesses with 50 or fewer employees, call 1-800-706-7893 (TTY users: 1-800-706-7915). Hours: Monday through Friday, 9 a.m. to 7 p.m. EST. Agents and brokers may also use this number.

Q. How does a small business determine their employees' average annual salary and how many full-time equivalent (FTE) employees it has?

A. The IRS has a lovely, easy(ish) to understand Q & A document answering this exact question. It is designed to help small businesses begin to make these calculations so they can understand their options. It includes a

discussion about part-time employees, seasonal workers and much more. Check it out here: http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-Questions-and-Answers:-Determining-FTEs-and-Average-Annual-Wages

Q. What businesses qualify to use the SHOP exchange?

A. All businesses with 50 or fewer employees (FTE) can use the SHOP exchange. Although states may choose to allow employers with 51 to 100 workers to get coverage in the SHOP exchange, Wisconsin has not done so. In 2017 and later, states may choose to allow employers of any size to get coverage in the SHOP exchange.

Q. Does a small business still get the Tax Credit if they offer insurance that meets the requirements but nobody in the small business actually takes the insurance?

A. No, in order to be eligible for the credit, a small employer must pay premiums on behalf of employees enrolled in a Qualified Health Plan through SHOP. See more on that provision from IRS.

Q. Can someone who is self-employed buy coverage in the Marketplace and also deduct their premium expenses for tax purposes?

A. No, not if they are getting the Premium Tax Credit (PTC) to subsidize their Marketplace coverage. They cannot double dip. However, if they aren't eligible for or don't get subsidized coverage, they can still deduct the expense of their premiums.

2014 FEDERAL POVERTY LEVELS (annual income)

Household Size	100%	133%	200%	250%	306%	400%
1	$11,670	$15,521	$23,340	$29,175	$35,710	$46,680
2	15,730	20,921	31,460	39,325	48,134	62,920
3	19,790	26,321	39,580	49,475	60,557	79,160
4	23,850	31,721	47,700	59,625	72,981	95,400
5	27,910	37,120	55,820	69,775	85,405	111,640
6	31,970	42,520	63,940	79,925	97,828	127,880
7	36,030	47,920	72,060	90,075	110,252	144,120
8	40,090	53,320	80,180	100,225	122,675	160,360
For each additional person, add	$4,060	$5,400	$8,120	$10,150	$12,424	$16,240

Any errors or omissions are the fault of WCCF alone. Information for this FAQ was compiled from the following sources:

Center on Budget and Policy Priorities, Health Reform beyond the Basics
The Commonwealth Fund
FamiliesUSA.org
Familyequity.org
Healthcare.gov
Hirsp.org
IRS.gov
Medicare.gov
National Indian Health Board: nihb.org
Robert Wood Johnson Foundation, Deborah Bachrach and Jocelyn Guyer
Wisconsin Department of Health Services
Wisconsin Office of the Commissioner of Insurance

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