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Federal Health Care Law Frequently Asked Questions for Agents

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.

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.

Note: Insurers are not allowed to impose annual or lifetime limits on essential health benefits. Large employers are not required to offer essential health benefits but also cannot impose annual or lifetime limits on any essential benefits they do cover.

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

Updated: October 8, 2014

Small Group Market:

Health insurance sold to employers with between 2 and 50 employees. In 2016 the small group market will be redefined as employers with up to 100 employees.

You may have seen or heard the federal government reference the small group market as including employers with 1 to 100 employees. Federal law allows a state to retain its current definition of small group until 2016. Wisconsin will continue to retain its current definition of 2 to 50. Note that the federal definition's reference to "1" includes a business owner plus one employee. This is the same as the state definition's reference to "2," which also includes the business owner plus one employee.

Sole proprietors are not able to purchase small group coverage. This is addressed further in question 24 below.

Large Group Market:

Health insurance sold to employers with more than 50 full-time equivalent employees. In 2016 the definition will change to employers with more than 100 full-time equivalent employees.

Out-of-Pocket Maximum:

The maximum amount of money a consumer will pay for in-network benefits. The law limits in-network cost-sharing to \$6,450 for self-only coverage and \$12,900 for families. For example, if billed charges were \$20,000, the insurer would pay \$13,550 and a consumer would pay no more than \$6,450 (for self-only coverage).

Private Health Insurance Market:

This refers to the Wisconsin health insurance market offering health insurance plans outside of the federal exchange and the SHOP Web sites.

Small Business Health Options Program (SHOP):

The federal health insurance exchange for employers with between 2 and 50 full-time equivalent employees. It is a federal Web site that allows employers to compare health insurance plans based on cost. In 2015, it will also include an "employee choice" option, which will allow the employer to set a contribution level and allow each employee to make their own coverage choices.

In 2016, SHOP will be available to small employers with up to 100 full-time equivalent employees.

General Health Insurance Market FAQs

(Responses apply to plans sold through SHOP or in the private 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 that became effective January 1, 2014. These include the following:

- Insurers must sell a health insurance policy to any person who applies for coverage during open enrollment, except in cases where fraudulent information is provided by the applicant.
- Insurers must continue selling health insurance plans to any eligible small business who applies for coverage, except in cases where fraudulent information is provided. During open enrollment, small businesses that are not eligible for coverage due to not meeting participation requirements may purchase coverage.
- Insurers are prohibited from excluding or limiting coverage for a preexisting condition.
- Insurers may only take four items into account when pricing their products. These are: (1) whether the policy provides individual or family coverage; (2) the area of the state the policy is sold; (3) age; and (4) tobacco use.
- Plans are required to offer “essential health benefits.” See the “Glossary of Terms” section for more detail.
- Plans are categorized into one of four different levels, which the federal government calls “metal tiers.” Consumers will know the level of coverage expected by a plan based on the metal tier assigned to it. The percentages attached to each metal tier represent the average 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%.
- Plans in all markets (individual, small group, and large group) will be required to limit in-network out-of-pocket expenses to \$6,450 for self-only coverage and \$12,900 for family coverage.
- Insurers have the option to sell their plans through the SHOP in addition to selling their plans through the traditional health insurance market, like they do today.

2. Will my client’s current plans change January 1, 2014?

No. The plans may change upon renewal, but in certain cases “grandfather plans” may not change initially. However, they will have the option to change plans during open enrollment.

3. Will individuals be able to purchase coverage in the individual market at any time?

No. Insurers are only required to offer coverage during specified open enrollment time frames. There are certain “special enrollment” time frames depending on specific circumstances.

4. Will groups be able to purchase coverage throughout the year?

Yes. The small group market will continue to function with year-round guaranteed issue.

5. Will the outside market have the same open enrollment time frame as the health insurance exchange?

Yes. The Office of the Commissioner of Insurance (OCI) interprets the language of both the ACA and the proposed rule as giving health insurers operating outside of the exchange in the individual market the option of limiting

enrollment to open and/or special enrollment periods. If, however, a plan limits enrollment to open and/or special enrollment periods, the time for enrollment must mirror the open enrollment periods in the exchange which are proposed as follows:

- Initial open enrollment period—October 1, 2013, through March 31, 2014.
- Annual enrollment period—for benefit years starting on or after January 1, 2015, October 15 through December 7 of the preceding year.

6. Can an insurer have different open enrollment time frames than those specified?

Minimally, insurers must have the same open enrollment time frames as the exchange and the rest of the market. An insurer may add additional open enrollment time frames, if desired.

7. Will agents be allowed to participate on the exchange?

Yes. Insurers are required to pay the same commission levels on and off the exchange.

8. How will pediatric dental work?

On the exchange, insurers are not required to embed pediatric dental benefits in their plans so long as a dental plan is available to purchase on the exchange. Off the exchange, the benefits can be provided via contract with another insurer or by the insurer itself. We are exploring further options off the exchange.

9. What will it cost to participate in the exchange?

The initial estimate from the federal government is that the exchange will cost 3.5% of premium for all policies sold on the exchange. It will be paid by the insurer and not by your clients.

10. Can insurers charge more (or less) for policies sold through the exchange?

No. Similar plans must be priced the same on and off the exchange after taking into account any benefit differences.

11. What kind of training will I need to sell on the exchange?

The federal government has developed Web-based training for agents. Information is located at:

<http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/a-b-resources.html>

12. Will I need to be appointed with every company on the exchange?

No. Neither state law or federal law requires an agent to represent every insurer on the exchange.

13. How do I know if an employer is a large employer or a small employer?

Under state and federal law, the size of an employer is determined by the number of employees. Employers with more than 50 employees—whether the employees are working full time or part time—are considered “large” employers.

Employers with 2 to 50 total employees are considered small employers. For example, an employer with only 3 full-time employees and 60 part-time employees would be considered a large employer. If the employer had 45 full-time employees and 3 part-time employees, the employer would be considered a small employer.

In 2016, the definition of small employer will change to 2 to 100 lives.

14. Are 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.”

In order to be “affordable” (as defined by federal regulations), the health insurance offered must cover at least 60% of expected claims costs (i.e., a bronze level plan) and an employee’s share of the premium for self-only coverage cannot exceed 9.5% of the *employee’s* income.

Under the law, 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 can exempt the first 30 employees from the penalty). If an employer offers coverage but it is not affordable (the health insurance costs the employee more than 9.5% of the employee’s income for self-only coverage), the employer may face a penalty of \$3,000 for each employee but only if the employee accesses subsidized coverage through the federal exchange. The total penalty for not offering affordable coverage cannot exceed what the employer’s penalty would have been if the employer did not offer 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. The employer may still be subject to the \$3,000 penalty for not offering affordable coverage if the employees access subsidized coverage in the exchange. At this point, the federal government has announced that for the 2016 plan year, employers must offer coverage to 95% of their 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.

Federal law does not require employers with fewer than 50 employees to offer health insurance coverage.

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.

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>

15. My client is an employer with some full-time and part-time employees. How do I know which employees my client is required to offer health insurance to?

Your client will want to assess whether they will be considered to have at least 50 full-time equivalent employees once the federal calculation for determining an employer's number of full-time equivalent employees is finalized.

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

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

16. My client is an employer with more than 50 total employees, but when I calculate the number of full-time equivalent employees, they would not be subject to the employer mandate. Is this possible?

Yes. An employer may be required to purchase coverage in the large group market but may not be subject to the mandate. This is because the federal government has two separate definitions of a large employer. For example, an employer could have 11 full-time employees and 40 part-time employees (under 20 hours each). If the employer purchases health insurance, it must be in the large group market, but the employer would not be subject to the employer mandate. Of course, the federal government has waived the employer mandate for employers with fewer than 100 workers in 2015.

17. As an agent, when should I start thinking about my small employer client's options for offering health insurance coverage to their employees for the 2015 plan year?

If your client offered health insurance to their employees at any time in 2013, they may have the option to renew that plan even though the plan may not be ACA compliant. State and federal guidance allows insurers to offer these plans for renewal through at least 2016. Of course, it is important for employers to shop around for the best option, but understand once a non-ACA compliant plan is terminated, federal rules prohibit an employer from recovering that plan.

If your client wishes to choose a different plan, or is offering coverage for the first time, the client is able to purchase coverage in the small group market throughout the year. There is no set enrollment period like the individual market. However, 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%. Small group plans are available both through SHOP and the private health insurance market.

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

Insurers offering coverage in the private 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 & Insurance Oversight (CCIIO) has indicated the federal SHOP will use a participation rate of 70%.

19. As a small employer, if my client decides to continue offering health insurance coverage to their employees, will they see a rate increase?

They will likely see a rate increase. Beginning for plans effective in 2014, insurers must have a single risk pool for its plans and can only take a few factors 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, (4) tobacco use, (5) plan design differences, and (6) network cost differences.

Additionally, the federal government is imposing significant regulatory fees and other requirements onto insurers as a condition of being in compliance with the federal health care law. Consumers, including small employers, will feel the impact of these federal requirements through premium increases.

20. As a small employer, my client is not required to offer health insurance. If they do not offer their employees health insurance coverage, will their employees be better off because of federal subsidies?

That may or may not be the case. Many variables must be considered, such as the employees' out-of-pocket expenses under the plan offered, their personal circumstances, premiums of the individual plans available in this year, etc. In some cases, the amount the employee pays for the coverage offered will be less expensive than the cost of coverage for the employee if he or she purchases coverage through the federal exchange, even with premium tax credits.

21. I have heard that some employers are looking at self-funding health care for their employees. Is this something my small employer client should consider?

Small employers should look at all options available to them, including the option to self-fund. In doing so, it will be important to consult someone who is an expert in this area.

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 whose employees are paid an average of \$25,000 or less. Additionally, the credit is only available to small employers purchasing health insurance through SHOP.

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.

<http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-Questions-and-Answers:-Calculating-the-Credit>

23. Are my small employer client's employees eligible for federal health care premium tax credits (in the individual exchange)?

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 actuarial value requirements.

24. My client is a sole proprietor. Can they purchase small group coverage either through the private market or SHOP?

No. Neither federal nor state law allows insurers to sell small group health insurance plans to sole proprietors. This is the case whether coverage is purchased through the private market or SHOP.

Given the federal mandate requiring individuals to have health insurance, they will likely need to purchase an individual health insurance policy either from the private market or through the federal exchange (or obtain coverage under their spouse's plan, obtain public assistance, file for an exemption, etc.).

25. 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.

26. How does an insurer know whether its large group plan offerings contain EHBs?

Insurers may choose from any state's EHB benchmark plan when identifying whether its large group plans contain EHBs. As stated in the response to question 25, 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. As a result, employers will want to know whether their large group plan covers EHBs for the purposes of determining whether annual or lifetime dollar limits will be prohibited or applied to various 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. The only requirement is that the EHBs must be covered without imposing any annual or lifetime dollar limits.

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.

Private Health Insurance Marketplace (outside of SHOP) FAQs

1. Will small employers be penalized for purchasing health insurance from the private market rather than through the Small Business Health Options Program (SHOP)?

No, there are no penalties associated with purchasing health insurance from the private market. There are no penalties associated with where small employers or individuals purchase health insurance.

2. How can small employers purchase health insurance from the private market? Can they still use agents?

Yes, small employers can continue to purchase health insurance from the private market either directly from an insurer or with the help of a licensed health insurance agent.

Navigators and Application Counselors are not permitted, by law, to sell health insurance policies. Questions 5 and 6 below further explain the role of navigators and application counselors.

3. If my clients do not purchase their insurance coverage through SHOP, will they be able to keep their plans?

State and federal law allowed insurers the option of renewing their 2013 plans until 2016 and extending into 2017. If the insurer you had for the 2013 plan

year chooses to continue offering that same plan into 2015, you should receive a notification from the insurer indicating this. If the insurer stops offering the plan you had in 2014, you should receive notification from the insurer letting you know the coverage is no longer available and that you should plan to purchase new coverage.

Federal SHOP Exchange FAQs

1. What is the federal Small Business Health Options Program (SHOP)?

It is the federal health insurance exchange for employers with up to 50 full-time equivalent employees. It is important to note that while SHOP is only for small employers, the definition of small employer is different for SHOP than the definition used in the outside market. The SHOP exchange will use the same employee calculation used to count employees for the “shared responsibility payment.” As a result, large employers, who do not normally qualify for the small group market, may qualify for coverage in the SHOP exchange. For example, an employer with 15 full-time employees and 40 part-time employees would be a large group in the outside market but could qualify for SHOP coverage.

Like the federal exchange available to individuals, SHOP is a federal Web site that allows employers and employees to compare health insurance plans based on cost.

2. Are health insurers required to sell their plans through the federal SHOP?

No and some have chosen to only sell their plans in the private health insurance market. For this reason, it is important for small employers to understand all of their options.

Agents can help their small employer clients choose a plan that best suits their needs.

3. Are small employers required to purchase a health plan for their employees through SHOP?

No, health insurance for employees may be purchased in the private market, through SHOP or not at all. It is important for small employers to understand and compare all options available to them. Agents can help small employers compare options and determine which plan best meets their needs.

4. Can small employers utilize licensed health insurance agents to purchase health insurance through SHOP?

Yes, licensed health insurance agents can help small employers compare and determine which health plan best meets their needs. This is true whether they are interested in purchasing coverage in the private health insurance market or through SHOP.

Licensed health insurance agents can compare plans in the private health insurance market against those offered in SHOP to determine whether a better plan option may be available in the private health insurance marketplace.

5. What are navigators? Can small employers use navigators instead of agents to purchase health insurance?

Navigators are federally funded entities and individuals who are charged with helping consumers in a variety of ways. Navigators can help a consumer determine their eligibility for public assistance programs including any federal subsidies. Navigators may also help consumers, including small employers, compare health insurance options displayed on the federal exchange Web site and SHOP after consumers input their preferences.

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

All navigators licensed in Wisconsin are registered with OCI and are listed on the OCI Web site at <http://oci.wi.gov/navigator/naventities-registered.htm>. If you have concerns with a navigator's conduct, please complete a consumer complaint form located at <https://ociaccess.oci.wi.gov/complaints-public/>.

By law, navigators are prohibited from selling health insurance and cannot recommend one plan over another to a consumer. 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>.

6. What are “Certified Application Counselors (CACs)”? Can they sell health insurance?

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

CACs are not federally funded but must work for an organization designated by the federal government as a CAC entity. CACs must complete federal training and examination requirements as well as the same state training and examination requirements necessary for a Wisconsin navigator license. CACs are registered with the Office of the Commissioner of Insurance and are listed on the OCI Web site at <http://oci.wi.gov/navigator/cac-registered.htm>.

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

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

7. How does SHOP work? Do employers or employees choose the health insurance plan?

For 2014, small employers choosing to purchase coverage through SHOP compare plans, on their own or with the help of a licensed agent, and choose a plan that meets their needs. Small employers interested in purchasing a plan available on the SHOP must directly purchase the plan from a licensed health insurance agent or insurer. The small employer offers the chosen plan to its employees.

In 2015, a small employer purchasing coverage through SHOP will have the option to define a dollar amount it would like to contribute towards its employee's monthly health insurance premium (i.e., defined contribution). In this case, an employer will also choose a metal tier from which each employee may purchase a plan. Employees will then go to SHOP to compare and select a plan in the metal tier authorized by their employer.

8. What does it cost to participate in SHOP?

There is no fee for small employers using SHOP. However, the federal government charges insurers a fee to sell their products through SHOP. That fee, coupled with other regulatory fees and requirements the federal government is imposing on insurers, has contributed to increased health insurance premiums.

9. Can insurers charge more (or less) for policies sold through SHOP?

No, insurers must charge the same amount for the same plan whether the plan is sold through SHOP or in the private market outside of SHOP.

10. If my client has fewer than 50 employees today, but increases the number of employees above 50 after they have purchased a small group plan through SHOP, what happens?

They will remain eligible to purchase health insurance through SHOP because they had 50 or fewer employees at the time they initially purchased coverage through SHOP.

11. My client is an employer with over 50 employees but fewer than 100. How will they be affected in 2016 when the definition of small group increases to 100?

Beginning in 2016, they will be eligible to purchase small group health insurance coverage both in SHOP and in the private market.

12. In addition to this FAQ, are there other resources available for me to learn more about SHOP?

Yes, the links below will take you to external resources for information on small employer issues and federal health care reform. Please note that OCI does not take any responsibility for the content included on these Web sites.

IRS Affordable Care Act News Releases, Multimedia and Legal Guidance
<http://www.irs.gov/uac/Affordable-Care-Act-of-2010-News-Releases-Multimedia-and-Legal-Guidance>

National Federation of Independent Business Healthcare Playbook
<http://www.nfib.com/Portals/0/PDF/AllUsers/advocacy/ppaca-healthcare-law-guide-nfib.pdf>

U.S. Department of Labor Patient Protection and Affordable Care Act Information
<http://www.dol.gov/ebsa/healthreform/>

U.S. Small Business Administration Health Care Reform Page
<http://www.sba.gov/healthcare>