The Affordable Care Act

(Summary of Major Insurance Provisions and Implementation in Wisconsin)

Informational Paper 51

Wisconsin Legislative Fiscal Bureau

January, 2019

The Federal Affordable Care Act

(Summary of Major Insurance Provisions and Implementation in Wisconsin)

Prepared by

Jon Dyck

Wisconsin Legislative Fiscal Bureau
One East Main, Suite 301
Madison, WI 53703
http://legis.wisconsin.gov/lfb

The Federal Affordable Care Act

(Summary of Major Insurance Provisions and Implementation in Wisconsin)

The federal Patient Protection and Affordable Care Act, enacted on March 23, 2010, and the Health Care and Education Reconciliation Act, enacted on March 31, 2010, made comprehensive changes to the private health insurance market and to publicly funded health care programs in the United States. Together, these acts are commonly referred to as the Affordable Care Act (ACA).

In December 2018, a federal district court in Texas declared the entire ACA unconstitutional based on the court's interpretation of the Act's individual insurance mandate provision. However, the provisions of the Act remain in force since the court did not enjoin the enforcement of its provisions pending an expected appeal. This paper summarizes the provisions of the Act with the expectation that its provisions will continue to be operative during the appeals process.

The ACA seeks to make healthcare coverage available to all individuals and families, and to establish minimum standards for that coverage. To accomplish these goals, the act employs several policy mechanisms. This paper provides a description and relevant data on the key provisions, organized in the following sections.

ACA Insurance Regulations. The ACA requires insurers to issue policies to all individuals, regardless of health status, and prohibits insurers from setting premiums based on health status. In order to prevent discrimination based on health status, the act requires policies to cover a standardized set of benefits, regardless of the likelihood that any particular person will use or need a particular service within that set of benefits. These and other health insurance requirements are frequently referred to as the ACA's insurance market reforms.

Qualified Health Plans and Health Benefit Exchanges. In order to facilitate the purchase of insurance in the individual market (coverage not provided through an employer or association), the ACA establishes health benefit exchanges. Health plans offered on an exchange must be certified as a qualified health plan, meeting certain minimum standards for coverage and out-of-pocket costs.

Premium Tax Credits and Cost-Sharing Subsidies. The act provides financial assistance, in the form of premium tax credits, to individuals with low or moderate household income to facilitate their purchase of health insurance policies in the individual market. Insurers are required to reduce out-of-pocket costs for certain low income consumers with plans purchased on the market exchange.

Employer Insurance Mandate and Individual Mandate. In order to maximize employer-sponsored coverage, reduce federal subsidy costs, and establish broad risk pools, the ACA includes provisions that require certain employers to provide healthcare coverage for employees, and a provision requiring individuals to obtain insurance coverage. These provisions are enforced with penalties for failure to meet requirements. (With the enactment of P.L. 115-97, beginning in plan year 2019, individuals who fail to obtain insurance coverage will not be subject to a financial penalty.)

Medicaid Expansion. In order to provide coverage for individuals with very low income, the ACA provides enhanced federal matching funds to states to expand Medicaid coverage to low-income individuals and families that were not previously

covered under the program. As a result of a U.S. Supreme Court decision subsequent to the passage of the ACA, the expansion of coverage is an option of the state, rather than mandatory.

Wisconsin Healthcare Stability Plan. In order to reduce insurance premiums in the individual market and to encourage insurers to offer plans on the individual market exchange, Wisconsin has established a reinsurance program to lower insurers' costs of covering individuals with high-cost claims.

ACA Insurance Regulations

This section summarizes several of the most significant provisions enacted in the ACA that relate to the private health insurance market. Most of these provisions, frequently referred to as "insurance market reforms," are codified in Title 27 of the Public Health Service Act ("Requirements Relating to Health Insurance Coverage"). In addition to a summary of the principal market reforms, this section provides information on some important exceptions to the market requirements.

Generally, the insurance market reforms are intended to provide universal access to insurance, regardless of health status, and with a standardized set of benefits. Because all purchasers of insurance are included in a single risk pool (within a given market), and premiums are not based on health status or prior service utilization, the cost of medical services are spread broadly among all premium payers, including both persons with low healthcare needs and persons with high needs.

The insurance market reforms apply differently depending upon if the plan is purchased in the individual market (where an individual or a family purchases coverage from an insurer), in the small group market (where employers with up to 50 employees purchase a single plan that provides coverage for all of their employees), or in the large group market (insurance policies purchased by employers with 51 or more employees). In addition, some of these provisions apply to employer-sponsored, self-funded health plans. In each case, the applicability of the provision is noted. The term "health plan" refers to all insurance policies and self-funded plans. Unless otherwise noted, these provisions first took effect for 2014 plans.

Insurance Market Reforms

Guaranteed Issue and Renewal. Under the ACA, insurance issuers offering policies in the group or individual market must sell policies to anyone who applies for the coverage, regardless of the age, gender, or health status of the individual. Issuers must also renew, or continue in force, coverage at the option of the employer or individual. Plans may, however, restrict enrollment to certain open enrollment periods. Under limited circumstances, a plan may be exempt from the guaranteed issue requirement, such as if the plan does not have an adequate network capacity or financial resources to serve additional enrollees.

Preexisting Condition Exclusions. The ACA prohibits health plans from imposing any preexisting condition exclusions. A preexisting condition exclusion is a limitation of benefits relating to a medical condition that existed before an individual's date of enrollment for coverage. The provision took effect for children under 19 years of age on September 23, 2010, and for adults on January 1, 2014.

Premium Rate Restrictions. Insurers selling policies in the individual and small group market may not base premiums on the health status of the covered individual. Premiums may vary only by the following factors: (a) whether the coverage is provided for an individual or a family; (b) geographic rating areas (regions designated by each state that insurers must uniformly use as part of their rate-setting); (c) age, with rates varying by a ratio of no more than three to one for adults; (d) tobacco use, with the rates varying by a ratio of not more than

1.5 to one.

Coverage of Essential Health Benefits. The ACA requires insurance plans sold in the individual and small group market to include coverage of medical services in each of the following general categories, termed the "essential health benefits" (EHB): (a) ambulatory patient services; (b) emergency services; (c) hospitalization; (d) maternity and newborn care; (e) mental health and substance use disorder services, including behavioral health treatment; (f) prescription drugs; (g) rehabilitative and habilitative services and devices; (h) laboratory services; (i) preventive and wellness services and chronic disease management; and (j) pediatric services, including oral and vision care. In addition, the ACA requires the U.S. Department of Health and Human Services (DHHS) to ensure that the scope of the EHB is equal to the scope of benefits provided under a typical employer plan.

DHHS rules direct each state to identify a single EHB "benchmark plan" from among several options: (a) the largest health plan by enrollment in any of the state's three largest small group insurance products; (b) any of the largest three employee health benefit plan options by enrollment offered to state employees; (c) any of the largest three national federal employees health benefit program plan options by enrollment; or (d) the plan with the largest commercial non-Medicaid enrollment offered by a health maintenance organization in the state. If a state does not choose one of these benchmarks, the default benchmark plan for the state is the largest small group plan described under (a).

For plan year 2019, Wisconsin's benchmark plan is a Choice Plus Plan, offered by UnitedHealthcare Insurance Company.

The use of standardized benefits is intended to spread the cost of these services broadly throughout the risk pool, as well as prevent insurers from employing practices that encourage enrollment of one type of consumer over another (relatively healthy versus unhealthy) based on benefit design. This has the effect of increasing the cost of insurance for individuals or groups with lower health needs and decreasing the cost for individuals or groups with higher needs, relative to a situation in which risk pools are segmented and benefit packages are more variable.

Single Risk Pool. In the insurance business, a risk pool is the group of enrollees that are used as the basis of establishing premiums. Accordingly, premiums must be set so that premium payments are sufficient to pay all medical costs and administrative costs for all enrollees in the pool. Under the ACA, insurers are required to treat all of its enrollees in a state in the individual market and its enrollees in a state in the small group market as single risk pools (one risk pool for each type of market).

For the purposes of this provision, insurers are required to develop a base rate for each pool, which represents the average premium for the pool. Adjustments to the base rate are allowed, in order to establish the actual premiums for individual enrollees, but only within specified limits. Permissible adjustments include: (a) geographical rating differences to reflect local variations in medical costs; (b) differences in plan design, such as the amount of cost-sharing required; and (c) the adjustments allowable under the ACA's rate restrictions provisions, such as for age and tobacco use.

The single risk pool requirement is intended to prevent insurers from using different plan designs to segment individuals who differ by health status into different risk pools and then charging higher premiums for those with greater health needs.

Medical Loss Ratios. The ACA requires health insurance plans to annually report to DHHS the percentage of premium revenue the plan collected that was spent on medical claims (the plan's medical loss ratio, or MLR). Plans in the individual and small group market must meet a minimum MLR of 80%; plans in the large group market must meet a minimum MLR of 85%. Insurance plans that do not meet those standards must provide rebates to

policyholders. These requirements first took effect in 2011. For that plan year, insurers provided rebates exceeding $10.1 million to Wisconsin residents, although more recently, rebates have declined as plans have generally come into compliance with MLR requirements.

Prohibition on Policy Rescissions. The ACA prohibits health plans from cancelling coverage (the "rescission" of the policy) once an individual is enrolled in the plan, except in situations where an individual performs fraud or intentional misrepresentation. This provision first applied to coverage beginning September 23, 2010.

Limit on Waiting Periods. The ACA prohibits health plans from establishing a "waiting period" that exceeds 90 days. A waiting period is the time between an individual's eligibility determination and when the policy's coverage begins.

Coverage of Dependents under Age 26. The ACA requires health plans that provide coverage of dependent children to make that coverage available for any adult child under the age of 26, including adult children who are not enrolled in school, adult children who are not listed as dependents on their parents' tax returns, and those who are married. This provision first applied to plan years beginning after September 23, 2010.

Annual and Lifetime Benefit Limits. Under the ACA, no health plans issued or renewed after September 23, 2010, may include a lifetime limit on the dollar value of benefits available to the policyholder. In addition, the ACA phased out annual limits included in plans and policies, so that currently no annual limits may be imposed.

Coverage of Preventive Services. The ACA requires health plans to provide coverage for certain preventive services without any cost-sharing requirements (such as deductibles, co-insurance, or copayments). These preventive services include the following: (a) certain evidence-based services recommended by the U.S. Preventive Services Task Force; (b) immunizations recommended by the Centers for Disease Control and Prevention; (c) care and screenings for infants, children, and adolescents in guidelines supported by the Health Resources and Service Administration (HRSA); and (d) additional preventive care and screenings for women not described above, as provided in the HRSA guidelines. These provisions became effective on September 23, 2010.

Applicability of Market Reforms to Grandfathered and Transitional Health Plans.

Health insurance policies sold in the individual or small group market that were in effect prior to the passage of the ACA, known as grandfathered plans, and policies that were purchased after the passage of the ACA but prior to 2014, known as transitional plans (or also "grandmothered" plans), are exempt from the following market regulations: (a) guaranteed issue and renewal; (b) the prohibition against preexisting condition exclusions (in the individual market only); (c) premium rate restrictions; (d) coverage of essential health benefits; and (e) the single risk pool requirement.

To retain this exempt status, plans must not have major changes in coverage, including changes to covered benefits or cost sharing policies.

Grandfathered plans can remain in effect indefinitely, but cannot be sold to new individuals or new employers (although new employees can be added to an employer's existing grandfathered policy). Originally, transitional plans, which were created by administrative action rather than by the ACA itself, were prohibited from being renewed after 2014. However, DHHS has issued a series of extensions to allow policies to be renewed, if permitted by the state. The Wisconsin Office of the Commissioner of Insurance has allowed renewal of transitional plans.

Since these plans cannot be sold to new individuals or employers, the number of persons covered has declined over time (in addition to individuals or

employers seeking other coverage, some insurers have stopped issuing such policies). The number of persons covered by grandfathered plans in Wisconsin has declined from approximately 23,000 in 2014 to 7,000 at the end of 2017, while the number of persons covered by transitional plans has declined from approximately 280,000 in 2014 to 140,000 at the end of 2017.

Applicability of Market Reforms to Short-Term Plans

Short-term, limited duration health insurance policies are typically intended to provide coverage for individuals who face gaps in other coverage, such as when a person switches from one job to another. Short-term insurance is excluded from the federal definition of health insurance coverage in the Public Health Services Act, and is, therefore, exempted from the individual and group market reforms. Because such plans are not required to issue or renew coverage and may be designed to provide only certain benefits, they may be particularly attractive to relatively healthy individuals who do not need comprehensive coverage, but may not be available to individuals with greater health needs.

In 2016, DHHS issued administrative rules that prohibited short-term plans from having a coverage period of three months or more and prohibited any short-term plan from being renewed. The Department argued that some insurers were, by issuing short-term plans for up to a year and then renewing those policies, attempting to subvert the ACA's market reforms. By engaging in selective issuance and renewal practices in selling short-term plans, these insurers were, in effect, removing healthy individuals from the ACA-compliant single risk pool.

Citing a need for additional insurance options, DHHS issued new rules in 2018 that reversed the 2016 restrictions, thus allowing short-term plans to be issued for up to 12 months, and also allowing an enrollee to renew the coverage, at the company's option, up to a total of 36 months of coverage for any one policy.

Although federal law and rules do not prohibit a state from placing duration or renewability limits on short-term plans, or from imposing other requirements, Wisconsin law does not have any such limits or requirements. Unlike for other individual market plans, Wisconsin law does not require insurers to renew short-term plans.

Applicability of Market Reforms to Association Health Plans

An association health plan provides health coverage for the employees of a group of employers who are members of an association, such as a trade organization. In 2018, the federal Department of Labor (DOL) developed a new administrative rule that changed various requirements related to association health plans. These changes, taking full effect after April 1, 2019, affect the applicability of the ACA's market reforms to such plans.

The DOL rule makes two principal changes that could increase participation in association health plans, and which may, in turn, reduce participation in the ACA-compliant individual and small group markets. First, the rule allows sole proprietors (a business owner with no employees) to join an association and purchase a health insurance policy through the association. Previously, DOL had interpreted applicable federal law as precluding an association health plan from providing coverage to sole proprietor members. This change may allow individuals who would otherwise purchase an individual market plan to purchase insurance through the association that is not subject to individual market rules.

Second, the rule loosens the criteria that must be met in order to form an association for the purpose of offering an association health plan. Under prior DOL guidance, an association had to meet certain criteria to be considered a "bona fide" association. Generally, members of the association had to have a "commonality of interests" that is unrelated to the provision of health benefits, and the association had to exist primarily for purposes unrelated to the

provision of health benefits to the employees of association members. In contrast, the new DOL rule allows the formation of an association for the primary purpose of offering a health plan, provided the association has at least one substantial business purpose unrelated to the provision of health benefits. In addition, the rule allows the commonality of interest standard to be met by either having a common trade, industry, line of business, or profession, or by having a principal place of business in the same state or same metropolitan area.

A secondary effect of this change is that some small employers (50 or fewer employees) may be able to offer insurance to their employees through an association that is subject to large group market rules, rather than small group market rules. This is because a bona fide association is considered a single entity for the purpose of providing health coverage and the total number of employees for all members of the association is used to determine which set of insurance market rules are applicable to that coverage. An association that does not meet the bona fide standard is not treated as a single entity for the purpose of providing health coverage, and so the market rules applicable to each employer member is determined by the number of its own employees. By loosening the standard for becoming a bona fide association, more individual employer members (including sole proprietors) will be able to access insurance coverage for their employees that is subject to the large group market rules. Unlike health insurance sold in the individual and small group market, large group plans are not subject to the ACA's premium rating restrictions, single risk pool, and essential health benefits requirements.

The DOL rules include provisions that are designed to prohibit associations from discriminating in membership, eligibility for benefits, and premiums based on any health factor. The rule prohibits, for instance, an association health plan from charging higher premiums to one member employer than another because its employees or covered dependents have more chronic medical conditions. An association health plan may, however, charge different premiums for different groups within the association using factors that are not considered health factors, including age, gender, or occupation, a practice that is not permitted in the ACA-compliant individual and small group market.

Qualified Health Plans and Health Benefit Exchanges

One of the key provisions of the ACA is the establishment of health benefit exchanges to facilitate the purchase of health insurance policies in the individual market. The principal feature of a health benefit exchange is a website that allows individuals to compare features and prices of health insurance policies, and then enroll in and purchase a policy. The exchanges also facilitate the disbursement of tax credits to certain eligible individuals to lower the cost of premiums (described in the next section).

Establishment of Exchanges. Under the ACA a state may establish an exchange to facilitate the purchase of insurance, or use the exchange established by the federal government for some or all of the exchange functions. In 2018, 12 states (including the District of Columbia) established their own state-based exchanges, 28 states, including Wisconsin, used the federal exchange, and 11 states chose to divide exchange functions between the federal exchange and the state.

The ACA requires the exchange, at a minimum, to undertake all of the following: (a) certify health plans as a "qualified health plan" (described below); (b) operate a toll-free telephone hotline; (c) maintain a website for the comparison of qualified health plans; (d) assign a rating to each qualified health plan offered through the exchange; (e) use a standardized format for presenting health benefits plan options; (f) inform individuals about eligibility

for public programs such as Medicaid, and enroll eligible individuals in those programs; (g) determine the cost of coverage after applying premium tax credits; (h) transfer to the U.S. Department of Treasury and to employers certain information regarding individuals who participate in the exchange; and (i) establish the "navigator" program, where entities receive grants to conduct educational and enrollment activities.

Each exchange establishes an open enrollment period for each plan year. During the open enrollment period, consumers may purchase coverage without restrictions. For 2019 coverage purchased on the federally-facilitated exchange, the open enrollment period started on November 1, 2018, and ended on December 15, 2018. Some individuals may enroll in a plan after the open enrollment period ends because they qualify for a special enrollment period due to several types of qualifying events. Examples of these qualifying events include a marriage or divorce, the birth or adoption of a child, a change in residency, or losing other health coverage due to the loss of a job or losing eligibility for Medicaid coverage. Any plan in which an individual enrolls during a special enrollment period terminates on December 31 of the plan year.

The following table shows the number of Wisconsin individuals who enrolled in a plan in each open enrollment period for the first five years.

Plan Year	Enrollment
2014	139,815
2015	207,349
2016	239,034
2017	242,863
2018	225,435

Enrollment during the 2018 open enrollment period fell from the prior year by approximately 7% in Wisconsin and by about 4% nationwide. Reductions in participation are likely due to a combination of factors, such as a shorter enrollment period, fewer participating insurers, and large increases in premiums for some individuals.

Appendix 1 provides additional information on enrollment in Wisconsin's federally-facilitated exchange during the open enrollment period for the 2018 coverage year, as compiled by the DHHS Office of the Assistant Secretary for Planning and Evaluation, as of March, 2018.

Appendix 2 provides information on the type of exchange that operated in each state in 2018 and the number of individuals who selected an exchange plan during open enrollment. In addition, the table indicates the status of Medicaid expansion in each state, which is discussed later in this paper.

Out-of-Pocket Limits and Cost-Sharing for Exchange Plans. The ACA defines four "metal tiers" for plans that differ in terms of the actuarial value of the benefits provided under the plan. The actuarial value represents the average value of the benefits covered by plan over an average population. In other words, the plan with a 60% actuarial value will pay roughly 60% of the health care costs for everyone covered by the plan. The ACA defines the following coverage tiers: (a) bronze, which covers 60 percent of the full actuarial value of the benefits under the plan; (b) silver, which covers 70 percent; (c) gold, which covers 80 percent; and (d) platinum, which covers 90 percent. In general, plans with high actuarial values charge higher premiums, but have lower cost-sharing requirements than plans with lower actuarial values.

In addition to the four metal tiers, insurers may also sell "catastrophic plans" to individuals under 30 years of age. These plans must provide the essential health benefits package only after the enrollee reaches the maximum out-of-pocket spending limit.

For all plans sold on the exchange, the ACA limits the maximum annual out-of-pocket amount that an enrollee could pay in cost-sharing requirements for covered benefits to no more than the limits that apply to plans that qualify the enrollee to open a health savings account. In 2019, these limits are $7,900 for an individual plan and $15,800 for a

family plan.

Qualified Health Plan Status. In order to be offered on an exchange, an insurance policy must be certified as a "qualified health plan" (QHP). The ACA establishes standards for QHPs, including cost-sharing and maximum benefit standards, and a set of benefits the plans must cover (the essential health benefits, or EHBs). All policies sold on an insurance exchange and in the individual market outside a government exchange must meet these QHP standards.

A health insurance issuer that offers a QHP must offer at least one plan in the silver level and gold level in the exchange, and charge the same premium rate on and off the exchange for the same QHP.

Premium Tax Credits and Cost-Sharing Subsidies

Premium Assistance Tax Credits. Individuals and families may qualify for tax credits to help pay for health insurance premiums if they meet all of the following criteria: (a) purchase coverage through a health benefit exchange; (b) have household income between 100% and 400% of the federal poverty level (FPL); (c) may not obtain "affordable coverage" through an eligible employer plan that meets "minimum value" requirements (generally, premiums for self-only coverage of no more than 9.86% of household income for 2019, and actuarial value of at least 60%); (d) do not qualify for coverage through a government program; (e) if married, file a joint tax return (with limited exceptions); and (f) cannot be claimed as a dependent by another person.

The premium tax credits, which are established and administered by the IRS, cap the amount that the individual is expected to contribute for premiums, based on the individual's household income. These percentages were set by the ACA for 2014 and are adjusted annually thereafter using a factor that takes into consideration the rate of health insurance premium growth relative to general inflation rate. The limits are lower for lower income levels, such that lower income individuals receive higher credits. The following table shows the income limits used to calculate premium tax credits for the 2019 plan year.

Percent of FPL	Percentage of Income Expected to Pay for Premium*
Up to 133%	2.08%
133% to 150%	3.11% to 4.15%
150% to 200%	4.15% to 6.54%
200% to 250%	6.54% to 8.36%
250% to 300%	8.36% to 9.86%
300% to 400%	9.86%

*Percentage increases within this range as income increases.

Although an enrollee can receive a tax credit for the purchase of a plan of any "metal tier," the premium tax credit amount that a household receives is based on the cost of second-lowest cost silver plan available. For that reason, individuals may pay less in premiums than the specified percentage of their income if they apply the tax credit to the purchase of a less-expensive policy (for instance, a bronze plan), or may pay more than the specified percentage if they apply the tax credit to a more-expensive plan (such as a gold or platinum plan).

Based on information an individual provides at the time of application for coverage, the insurance exchange estimates the amount of the premium tax credit that the individual may claim. The applicant must then determine what portion of the estimated tax credit should be paid in advance directly to the insurance company to reduce monthly premium payments. Enrollees who choose to have all or some of their tax credit paid in advance are required to reconcile, on the following year's federal income tax forms, the amount of these payments with amounts that can be claimed based on the actual household income and family size.

Appendix 3 shows the 2018 federal poverty levels, and examples of the monthly premiums that low- and moderate-income families were expected to pay for second-lowest cost silver plan in 2018 after the application of the premium tax credits.

Cost-Sharing Reductions. Individuals in families with income between 100% and 250% of the FPL may be eligible for cost-sharing subsidies. For these purposes, "cost-sharing" refers to copayments, coinsurance, and deductibles. To qualify for these subsidies, an individual must enroll in a QHP with the silver level of coverage offered through the insurance exchange. This differs from the premium tax credits, which an enrollee may apply to a plan of any tier.

The following table provides the scale for cost-sharing subsidies. These subsidies have the effect of increasing the actuarial value of the plan. This decreases a plan's out-of-pocket spending requirements.

Percent of FPL	Amount of Actuarial Value of the Plan after Subsidy
100% to 150%	94%
150% to 200%	87
200% to 250%	73
250% to 400%	No Subsidy

For example, an individual with household income between 100% and 150% of the FPL would be responsible, on average, for paying 6% of the covered expenses, rather than 30% of expenses that would otherwise be expected to be paid by individuals who purchase a silver plan.

Additionally, individuals who qualify for cost sharing reductions have their annual maximum out-of-pocket costs reduced. The adjusted out-of-pocket maximums for 2019 are shown in the following table.

	2019 Out-of-Pocket Maximum	
Percent of FPL	Individual	Family
100% to 200%	$2,600	$5,200
200% to 250%	6,300	12,600

To implement the cost-sharing reduction provision, the ACA requires insurers to reduce out-of-pocket costs for qualifying individuals and then requires DHHS to make payments to insurers as reimbursement for the cost of providing the subsidies. Initially, DHHS made these payments, but the U.S. House of Representatives challenged the payments in federal court on the grounds that the Congress had not provided a specific appropriation for doing so. The court ruled in favor of the House of Representatives, and while the judge initially stayed the order enjoining DHHS from making payments pending appeal, DHHS announced in 2017 that it would no longer make payments.

Since insurers continue to be required to provide cost-sharing reductions to eligible consumers, insurers have responded by increasing premiums to cover the cost of the subsidies. Generally, the higher cost associated with absorbing the cost-sharing reduction has been added to premiums for silver level plans, since eligibility for cost-sharing reductions is only available for these plans. The associated increase in silver premiums has had the effect, in turn, of increasing the amount of federal premium tax credits available to consumers, since the level is based on the premium for silver plans.

Employer Insurance Mandate

The ACA imposes a financial penalty on certain employers who do not provide health insurance that meets minimum standards. These penalties are formally known as "employer shared responsibility payments," but the provision is typically called the "employer mandate." The

purpose of the mandate is to create a disincentive for employers to rely on federal financial assistance to their employees (in the form of premium tax credits) to cover the healthcare costs of their employees, in place of providing a health plan as part of an employee benefit.

The employer mandate penalty applies to "applicable large employers," which, for the purposes of this provision, is an employer with at least 50 full-time employees (or an equivalent combination of full-time and part-time employees) in the preceding calendar. The ACA defines full-time employees as employees that work 30 or more hours per week.

The amount of the employer responsibility payment is calculated in one or two ways (but not both for the same employer). In both cases, the responsibility for making a payment is triggered if any full-time employee receives a premium tax credit through an exchange. Since eligibility for a premium tax credit is tied, in part, to the availability of employer-sponsored plan that meets minimum standards for affordability and value (described in the previous section), the failure of the employer to offer such coverage to that employee results in the penalty being assessed.

The employer mandate penalty will be assessed using the first calculation method if the employer fails to provide minimum essential coverage to at least 95% of its full-time employees and dependents. Under this method, the total penalty is equal to an adjusted employee count times a per employee charge. The adjusted count is the total number of full time employees minus 30. The per employee charge was set initially at $2,000 per employee for calendar year 2015, but is adjusted annually by a measure of insurance premium inflation. In calendar year 2018, the per employee charge is $2,320. For an employer that offers coverage in some months but not others during the calendar year, a prorated penalty is calculated separately for each month for which coverage was not offered.

The second method for calculating the employer mandate penalty applies if the employer offers coverage to at least 95% of their full-time employees, but, nevertheless, have at least one full-time employee who receives a premium tax credit. This could be the case if the employer does not offer coverage to all full-time employees, of if the coverage offered does not meet the minimum standards for affordability and value. In this case, the penalty equals the number of full-time employees that received a tax credit times a per person charge, which was $3,480 in 2018. A prorated monthly penalty is charged based on the number of employees receiving tax credits in a given month. An employer who offers coverage can never be penalized an amount that exceeds the amount that the employer would owe if it did not offer coverage.

Appendix 4 provides several examples of how the employer shared responsibility payments are calculated.

Individual Insurance Mandate

As originally passed, the ACA imposed a monetary penalty on individuals who do not maintain health insurance. Although this penalty, known as the individual mandate, has now effectively been repealed by an act of Congress (reduced to $0 beginning for plan year 2019), this section provides a brief description of the penalty to provide a historical understanding of the law.

The individual mandate was intended to avoid adverse selection in the individual insurance market. Adverse selection occurs in an insurance market when individuals who perceive that they are unlikely to need medical services forego insurance coverage, only later buying coverage when they find they have a greater need for medical care. If individuals only purchase insurance when they expect to need significant medical care, the average, per person cost of medical services for

persons in the risk pool increases, thereby increasing premiums. This effect may worsen over time if increasing premiums lead more individuals with an expectation of lower costs to drop out of the market. By requiring individuals from across the spectrum of health needs to purchase insurance, the individual mandate was intended to spread the cost of higher needs individuals more broadly.

Prior to 2019, applicable individuals who did not maintain minimum essential coverage for a period of three or more continuous months in a year were assessed a penalty for each month they were without coverage. For coverage year 2018, the annualized penalty amount equaled the greater of the following: (a) $695 per adult, and $347.50 per child, up to a maximum of $2,085 per family; or (b) 2.5 percent of the amount by which an individual's gross household income exceeds that year's filing threshold.

Wisconsin Healthcare Stability Plan

During the 2017-19 session, the Wisconsin Legislature passed Act 138, creating the Wisconsin Healthcare Stabilization Plan (WHSP), a state reinsurance program for the individual insurance market. A reinsurance program or policy protects insurers against the costs associated with very high-cost claims or individuals by paying a portion of those claims. Reimbursement for high-cost claims serves to both reduce insurer uncertainty associated with high-cost enrollees, as well as to reduce the total cost of medical claims that must be supported with premium revenue.

Program Structure and Payment Parameters

The WHSP was modeled off of the ACA's transitional reinsurance program, which made reinsurance payments for the 2014, 2015, and 2016 plan years. That temporary program, like the WHSP, pays a certain percentage of the total claims (the "coinsurance rate") for an individual that fall between a minimum "attachment point" and a maximum "reinsurance cap."

The following sample individuals illustrate the calculation of a reinsurance payments under WHSP. For the purposes of these examples, the reinsurance program has a coinsurance rate of 80%, with an attachment point of $50,000 and a reinsurance cap of $250,000.

- Individual 1 has total costs during the plan year of $100,000. The amount above the attachment point is $50,000 ($100,000 minus $50,000), so the reinsurance program pays the insurer $40,000 (80% times $50,000). Since the total of the plan year claims are below $250,000, the reinsurance payment is not limited by the reinsurance cap.

- Individual 2 has total costs during the plan year of $300,000. The amount between the attachment point and the reinsurance cap is $200,000 ($250,000 minus $50,000), so the reinsurance program pays the insurer $160,000 (80% times $200,000). Since this individual has claims that exceed the reinsurance cap, the insurer receives the maximum amount of reinsurance payment allowed with these particular parameters.

The actual parameters for WHSP are established by the Wisconsin Office of the Commissioner of Insurance (OCI), based on the amount of funding available for the program and an estimate of the total number of claims from eligible insurers. For 2019, the first year of the program, Act 138 directs OCI to set the attachment point at $50,000 and the reinsurance cap at $250,000 (as in the example above), and to set the coinsurance rate at between 50% and 80%. Based on actuarial analysis prepared for the program, OCI set the 2019 coinsurance rate at 50%. For future years, OCI has the authority to set all parameters based on an assessment of funding available for the program.

An insurer may receive a reinsurance payment on behalf of an enrollee in a non-grandfathered policy sold in the individual market. Payments are

made by August 15 of the year following the plan year (for instance, by August 15, 2020, for the 2019 plan year). If total claims for payment exceed the amount of funding available for that plan year, OCI will prorate payments to each insurer in proportion to their share of the total of all eligible claims.

Program Funding

Act 138 limits the annual funding for reinsurance payments to $200,000,000. This amount may be increased by the Legislature's Joint Committee on Finance upon request of OCI.

Funding for the reinsurance payments is provided with federal and state funds. Federal funding is provided for the program under a provision of the ACA, typically known as a "Section 1332 waiver." Under Section 1332, a state may request that DHHS waive certain ACA market regulations in order to experiment with different healthcare delivery options. DHHS is required, prior to approving any waiver request, to ensure that the state's request will not increase the federal deficit, reduce the extent or scope of insurance coverage, or increase individuals' out-of-pocket costs. Wisconsin's Section 1332 waiver application requests waiver of the ACA's single risk pool requirement, since a portion of medical claims are effectively excluded from the pool for the purposes of calculating premiums.

Section 1332 specifies that states may request pass-through funding equal to federal savings resulting from the state's waiver plan. In the case of the reinsurance program, reinsurance payments to insurers are expected to lower average premiums for individual plans sold on the insurance exchange. This reduction in premiums will, in turn, reduce the amount of premium tax credits paid to individuals by the federal government. These savings (with certain adjustments accounting for secondary effects) are passed along to the state for the reinsurance program.

Under Act 138, the difference between federal pass-through funding and the $200,000,000 reinsurance total will be paid from the state's general fund. An actuarial analysis prepared for the waiver application estimated that the state would receive approximately $166 million in federal funds, leaving approximately $34 million to be paid by the state. This amount is subject to change, based on the actual amount of federal funding received by the state.

Medicaid Expansion

As passed, the ACA would have required all states' Medicaid programs to provide coverage to all adults under the age of 65 in families with household income up to 133% of the FPL, beginning January 1, 2014. [For the purposes of determining Medicaid eligibility under the ACA, household income equals modified adjusted gross income, plus a 5% income disregard, effectively setting the federal income standard at 138% of the FPL.]

The ACA requirement that states expand Medicaid eligibility standards was one subject of the U.S. Supreme Court decision in *National Federation of Independent Business et al v. Sebelius*. The Court found the mandatory expansion of Medicaid unconstitutional. As a result, each state may decide whether to expand its Medicaid program to the levels described in the ACA.

For states that choose to expand coverage, the ACA provides enhanced federal matching funds for any "newly-eligible" group that did not qualify for full Medicaid coverage prior to December 1, 2009. For newly-eligible individuals, the ACA funded 100% of benefit costs in calendar years 2014 through 2016. This enhanced rate decreases gradually until reaching 90% in 2020 and subsequent years. These federal matching rates are considerably higher than the standard matching rates (the federal medical assistance percentage, or

FMAP). The standard FMAP for each state is based on the state's per capita income, and ranges from a minimum of 50% for states that have relatively high per capita income to in excess of 70% in low per capita income states. Wisconsin's FMAP is approximately 59%.

Wisconsin did not adopt the ACA's income eligibility thresholds and so has not qualified for enhanced federal matching rates. However, the state made various changes to income eligibility standards in 2014, relative to the state's previous eligibility thresholds. Prior to the enactment of 2013 Wisconsin Act 20 (the 2013-15 biennial budget act), parents and caretaker relatives with household income under 200% of the FPL qualified for full Medicaid coverage under the state's BadgerCare Plus program, while adults without dependent children were not eligible for coverage.

Act 20 set the income eligibility standard for both adults with dependent children and childless adults at 100% of the FPL. This had the effect of reducing the eligibility standard from 200% to 100% of the FPL for adults with dependent children, while providing eligibility for all adults without dependent children with income up to 100% of the FPL. Adults with income above 100% of the FPL and no access to other affordable coverage may purchase subsidized coverage through the insurance exchange.

As of the end of 2018, there were approximately 155,000 parents and caretaker relatives and approximately 150,000 adults without dependent children covered under the Wisconsin Medicaid program.

As the enhanced FMAP for newly-eligible populations is only available to states that increase their maximum income standard to 133% of the FPL, the state does not receive the enhanced federal funding available under the ACA. Instead, the cost of most services provided to adults enrolled in BadgerCare Plus are funded at the state's regular FMAP rate (currently, approximately 59% with federal funds and 41% with state funds).

Appendix 3 shows the Medicaid expansion status of each state. As of the end of 2018, 36 states and the District of Columbia had adopted the full Medicaid expansion, while 14 states, including Wisconsin, had not adopted full expansion.

Additional Resources

Additional information on the ACA and its implementation in Wisconsin is available through the following resources:

Federal Health Insurance Exchange
www.healthcare.gov

Wisconsin Office of the Commissioner of Insurance (OCI)
https://oci.wi.gov/Pages/Consumers/HealthCareReform.aspx

U.S. Department of Health and Human Services (DHHS)
www.hhs.gov/healthcare

DHHS Centers for Medicare and Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight
www.cms.gov/cciio/index.html

U.S. Internal Revenue Service (IRS)
www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions-Home

APPENDIX 1

Selected Information Regarding Plan Selections in Wisconsin's Exchange During the 2018 Plan Year Open Enrollment Period (November 1, 2017 to December 15, 2017)

Total Number of Individuals Enrolled in a Qualified Health Plan	225,435
Number Who Qualified for Financial Assistance	189,521
Percent Who Qualified for Premium Tax Credits	84%
Number Who Also Qualified for Cost Sharing Reductions	97,982
Percent Who Qualified for Cost Sharing Reductions	43%

Enrollment by Age and Gender

	Number	Percent
Less than 18	14,100	6.3%
18 through 25	18,379	8.2
26 through 34	35,876	15.9
35 through 44	32,302	14.3
45 through 54	41,986	18.6
55 through 64	81,630	36.2
65 and Older	1,162	0.5
Total	225,435	100.0%
Female	121,187	53.8%
Male	104,248	46.2
Total	225,435	100.0%

Enrollment by Plan Metal Level

Bronze	75,342	33.4%
Silver	121,876	54.1
Gold	25,752	11.4
Platinum	411	0.2
Catastrophic Plans	2,054	0.9
Total	225,435	100.0%

APPENDIX 2

2018 Exchange Enrollment During Open Enrollment By Exchange Type and State And Medicaid Expansion Status

States with State-Based Exchanges

State	Exchange Enrollment	Full Medicaid Expansion*
California	1,521,524	Yes
Colorado	161,764	Yes
Connecticut	114,134	Yes
District of Columbia	19,289	Yes
Idaho	101,073	Yes**
Maryland	153,584	Yes
Massachusetts	267,260	Yes
Minnesota	116,358	Yes
New York	253,102	Yes
Rhode Island	33,021	Yes
Vermont	28,463	Yes
Washington	243,227	Yes
Subtotal	3,006,533	12 Yes

States with Exchanges That Are Supported By, Or Fully Operated By DHHS

State	Exchange Enrollment	Full Medicaid Expansion*
Alabama	170,211	No
Alaska	18,313	Yes
Arizona	165,758	Yes
Arkansas	68,100	Yes
Delaware	24,500	Yes
Florida	1,715,227	No
Georgia	480,912	No
Hawaii	19,799	Yes
Illinois	334,979	Yes
Indiana	166,711	Yes
Iowa	53,217	Yes
Kansas	98,238	No

State	Exchange Enrollment	Full Medicaid Expansion*
Kentucky	89,569	Yes
Louisiana	109,855	Yes
Maine	75,809	Yes**
Michigan	293,940	Yes
Mississippi	83,649	No
Missouri	243,382	No
Montana	47,699	Yes
Nebraska	88,213	Yes**
Nevada	91,003	Yes
New Hampshire	49,573	Yes
New Jersey	274,782	Yes
New Mexico	49,792	Yes
North Carolina	519,803	No
North Dakota	22,486	Yes
Ohio	230,127	Yes
Oklahoma	140,184	No
Oregon	156,105	Yes
Pennsylvania	389,081	Yes
South Carolina	215,983	No
South Dakota	29,652	No
Tennessee	228,646	No
Texas	1,126,838	No
Utah	194,118	Yes**
Virginia	400,015	Yes**
West Virginia	27,409	Yes
Wisconsin	225,435	No
Wyoming	24,529	No
Subtotal	8,743,642	25 Yes 14 No
All States and D.C.	11,750,175	37 Yes 14 No

*Income eligibility of 133% of the federal poverty level for adults.
**State had adopted full expansion by legislation or referendum, but had not yet implemented by the end of 2018.

APPENDIX 3

Annual Income at Various Percentages of the 2018 Federal Poverty Level, By Family Size

Family Size	Annual Family Income Based on Percentage of FPL						
	100%	133%	150%	200%	250%	300%	400%
One	$12,140	$16,146	$18,210	$24,280	$30,350	$36,420	$48,560
Two	16,460	21,892	24,690	32,920	41,150	49,380	65,840
Three	20,780	27,637	31,170	41,560	51,950	62,340	83,120
Four	25,100	33,383	37,650	50,200	62,750	75,300	100,400
Five	29,420	39,129	44,130	58,840	73,550	88,260	117,680
Six	33,740	44,874	50,610	67,480	84,350	101,220	134,960

Family Size	Monthly Premium After Premium Tax Credit, by Family Size*						
	100%	133%	150%	200%	250%	300%	400%
One	$20	$41	$61	$128	$205	$290	$387
Two	28	55	83	174	278	393	525
Three	35	70	105	220	351	497	662
Four	42	84	126	265	424	600	800
Five	49	98	148	311	496	703	938
Six	57	113	170	357	569	806	1,075

*Assumes family purchases second-lowest cost silver plan available. Children under age 19 in families with income up to 300% of the FPL are eligible for Medicaid coverage.

APPENDIX 4

Examples of Employer Shared Responsibility Payments, Using 2018 Penalties

Example	Firm Size (FTE Employees)	Offered Coverage?	Number of FTE Employees that Received a Premium Tax Credit	Calculation of Payment (for the Year)	Amount for Year
1	100	No	0	As no employee received the premium assistance tax credit, no payment.	$0
2	100	No	40	(100 FTE employees - 30 FTE employees) x ($2,320 per FTE employee)	162,400
3	100	Yes	5 for 12 months each	($3,480 per FTE employee receiving tax credit) x 5 FTE employees that received premium tax credit	17,400
4	100	Yes*	60 for 12 months each	($3,480 per FTE employee receiving tax credit) x 60 FTE employees = $208,800. This exceeds the maximum for the employer [(100 FTE - 30 FTE employees x ($2,320 per FTE employee) = $162,400], so the employer would pay the maximum.	151,200
5	100	Yes*	40 for six months each	($3,480 per FTE employee/12 months) x six months x 40 FTE employees that received the tax credit for each of the six months	69,600
6	45	No	25	As the employer has fewer than 50 FTE employees, there is no payment.	0

*In these examples, coverage is offered to at least 95% of full-time employees, but because it does not meet minimum standards for value and affordability for some employees, those employees are eligible to purchase insurance on the exchange with premium tax credits.