The Federal Affordable Care Act

(Summary of Major Insurance Provisions and Implementation in Wisconsin)

Informational Paper 51

Wisconsin Legislative Fiscal Bureau

January, 2017

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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).

The ACA is intended to reduce the number of U.S. citizens who lack health care coverage, primarily by: (a) making private health care coverage more attainable for persons who may have previously been excluded from coverage for health through insurance market regulations; (b) providing subsidies to qualifying individuals and families that purchase private health care policies on state or federally-run health benefit exchanges; (c) providing opportunities and fiscal incentives for states to provide health care coverage to additional individuals under their Medicaid and children's health insurance (CHIP) programs; (d) establishing broader risk pools by requiring most individuals to maintain healthcare coverage or be subject to financial penalties; and (e) creating financial penalties for certain employers that fail to provide their employees affordable coverage that meets minimum coverage requirements.

This paper summarizes the major provisions of the ACA (incorporating a small number of subsequent modifications to the law) that affect private health insurance coverage available to Wisconsin residents, and provides information on 2016 enrollment in plans available through Wisconsin's federally-facilitated Marketplace. It also summarizes changes to the state's BadgerCare Plus eligibility standards that took effect on April 1, 2014, in response to the enactment of the ACA.

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"). To the extent that current state law would prevent the application of a provision of the ACA (for instance, where state law allows for certain pre-existing condition exclusions), federal law supersedes state statutes.

The insurance market reforms apply differently depending upon if the plan is purchased in the individual market (where individual or 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. The regulations described below apply in all three cases, unless otherwise indicated. Health insurance plans that were in effect prior to the passage of the ACA and that have remained essentially unchanged since that time, known as "grandfathered" plans, are generally exempt from these requirements. Grandfathered plans in the individual market, however, can no longer enroll new individuals (other than new dependents of persons who are covered under a grandfathered plan).

Preexisting Condition Exclusions. The ACA prohibits 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.

Guaranteed Issue and Renewal. Under the ACA, health plans must sell health insurance policies to anyone who applies for the coverage, regardless of the health status of the individual, age, gender, or other factors. Health plans 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.

Premium Rate Restrictions. Insurers must establish premiums for individual and small group plans that 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 not varying by a ratio of more than three to one for adults; (d) tobacco use, with the rates not varying by a ratio of more than 1.5 to one. Consistent with prior federal law, group plans may offer incentives based on enrollee participation in wellness programs to reduce the cost of the enrollee's coverage. Wellness incentives must be reasonably designed to promote health and prevent disease and must give eligible individuals the opportunity to earn a reward at least once per year.

Medical Loss Ratios. The ACA requires health plans to annually report to the U.S. Department of Health and Human Services (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%. Health 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. For plan year 2015 (the latest year for which data were available at the time of publication), five insurers selling policies on the individual market in Wisconsin owed premium refunds totaling $742,480 to 23,502 consumers. All insurers in the small and large group markets met the MLR standards.

Prohibition on Policy Rescissions. The ACA prohibits the retroactive cancellation of group or individual coverage (the "rescission" of the policy) once an individual is enrolled in that plan or coverage, 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 small or large group 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 group or individual coverage that provides 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.

Prior provisions in state law that extended dependent coverage to dependents up to the age of 27 only applied to fully-insured employer-based

coverage (where an employer purchases a policy from an insurer) and individual insurance policies. However, self-funded private employer plans (where the employer pays for health benefits from its own funds) are not subject to state mandates. The ACA dependent coverage provision applies to all private employer-based coverage, regardless of the type of coverage arrangement an employer chooses.

Annual and Lifetime Benefit Limits. Under the ACA, no plans and policy 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.

Wisconsin's statutes contain several mandates that require private insurance policies provide certain services, including certain preventive services. However, the state's insurance mandates for preventive services do not apply to self-funded private employer plans, while the ACA provision applies to all employer plans. State mandates remain in place, and continue to apply to all plans other than self-funded plans.

Prohibition on Discrimination Based on Salaries. The ACA includes provisions that are intended to prevent employer-sponsored group health plans from discriminating in favor or highly-compensated employees, either with respect to eligibility for the plan or benefits offered under the plan. Current federal rules that prohibit discrimination currently apply to self-funded plans, but not group health plans. To date, the Internal Revenue Service (IRS) has not promulgated rules to implement this provision, and has indicated that it will not enforce the ACA provision until rules are in effect.

Grandfathered Employer-Based and Individual Health Plans. The ACA defines "grandfathered health plans" as health plans in effect on the date of the law's enactment, and initially exempts these plans from some of the provisions of the act. However, all grandfathered plans are required to comply with the prohibition on lifetime limits on benefits, the prohibition on rescissions, required coverage of dependent children up to age 26, and MLR requirements.

Individual and Employer Mandates

The ACA requires most individuals to maintain health coverage or pay a penalty, a provision commonly referred to as the "individual mandate." The law also imposes penalties on certain employers whose employees receive federal tax credits to purchase coverage, commonly referred to as the "employer mandate." This section describes each of these mandates.

Individual Mandate. The ACA generally requires individuals to obtain "minimal essential coverage," which includes all of the following: (a) any government-sponsored program, such as Medicare or Medicaid; (b) coverage under an eligible employer-sponsored plan; (c) plans offered in the individual insurance market; (c) grandfathered health plans; or (d) other health plans, recognized by the DHHS Secretary in coordination with the

Secretary of the Treasury. Minimum essential coverage does not include plans with a limited scope of benefits (such as dental), plans where health care benefits are secondary (such as workers' compensation plans), plans that only cover a specified condition, and Medicare supplemental insurance plans.

Beginning January 1, 2014, the ACA requires "applicable individuals" to maintain minimum essential health insurance coverage. The law defines an applicable individual as any individual other than the following: (a) an individual granted an exemption based on religious beliefs; (b) an individual that is not a U.S. citizen, or an alien lawfully present in the U.S.; or (c) an individual that is incarcerated, other than incarceration pending the disposition of charges.

Applicable individuals who do not maintain minimum essential coverage for a period of three or more continuous months in a year may be assessed a penalty ("shared responsibility payment") for each month an individual is without coverage. For coverage year 2016, the annualized penalty amount equals 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. An adult who can claim a child or another individual as a dependent for federal income tax purposes is responsible for making the payment if the dependent does not have coverage or an exemption.

Beginning in 2017, the flat fee penalty will be indexed to the consumer price index. All penalties assessed are payable through an individual's annual tax return. If a taxpayer fails to pay a penalty, the IRS will notify the taxpayer and may attempt to collect the amount owed by reducing the amount of their tax refund for that year or future years. Failure to pay the individual mandate penalty is not grounds for criminal prosecution or additional penalties.

The ACA caps the penalty for noncompliance at the national average premium for bronze-level health plans offered through exchanges, adjusted to reflect family size. (The designation of plans by "metal tiers" is discussed later in this paper.) For 2015, this average premium was $2,484 per individual per year. If a taxpayer is required to pay a penalty for more than one individual, the monthly amount is multiplied by the number of individuals subject to a penalty.

Certain applicable individuals are not subject to penalties if they lack minimum essential coverage, including the following: (a) an individual whose required contribution for coverage is unaffordable (for 2016, the contribution exceeds 8.13% of that individual's household income); (b) an individual with household income below the filing threshold; (c) a member of an Indian tribe; or (d) any applicable individual who the DHHS Secretary determines has suffered a hardship with respect to the capability to obtain coverage for any month. Other exemptions are specified by rule, such as an exemption for individuals who are not eligible for medicaid (MA) solely as a result of a state's decision not to provide MA coverage for adults in families with income up to 133% of the FPL, and other specified situations.

In June, 2013, the DHHS Centers for Medicare and Medicaid Services (CMS) provided more specific guidance with respect to granting hardship exemptions. These hardship exemptions apply to multiple specific situations, including when an individual becomes homeless, has received a shutoff notice from a utility company, or recently experienced domestic violence.

Individuals may claim certain types of exemptions by requesting certification through the health insurance exchange (such as an exemption for religious reasons), by either requesting certification through the exchange or through a tax filing (such as a hardship exemption), or exclusively through a tax filing (such as an affordability exemption).

The constitutionality of the individual mandate was one subject of the U.S. Supreme Court decision in *National Federation of Independent Business et al v. Sebelius*. The Court ruled that the mandate was a legitimate use of Congress's taxing power.

Employer Mandate. The ACA authorizes the IRS to assess penalties ("employer shared responsibility payments") to certain employers that fail to offer their full-time employees affordable minimum essential coverage, and if any full-time employee receives a premium tax credit for exchange-based coverage.

For the purposes of this provision, an employer that had an average of at least 50 full-time employees (or an equivalent combination of full-time and part-time employees) in the preceding calendar year is an "applicable employer." The ACA defines full-time employees as employees that work 30 or more hours per week.

An employer must make a shared responsibility payment to the IRS 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, the failure of the employer to offer such coverage to that employee results in the penalty being assessed. To meet the minimum affordability standard, the employee's required contribution to the premium for self-only coverage must not exceed a specified percentage of the taxpayer's household income (9.66% in 2016). To meet or minimum value requirements the plan must have an actuarial value of at least 60%, meaning that the plan pays for, on average, 60% of medical costs.

The amount of the employer responsibility payment depends upon the amount of employee health coverage that the employer offers. Employers that do not offer coverage to at least 95% of their employees and have at least one full-time employee who receives a premium tax credit must pay an annual penalty per full-time employee. In 2016, the penalty is $2,160 per employee, an amount that is adjusted annually according to increases in health insurance premiums. The employer's first 30 employees are excluded from the assessment. 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.

Employers that offer coverage to at least 95% of their employees but have at least one full-time employee who receives a premium tax credit must pay a penalty equal to $3,240 (in 2016) for each full-time employee that received a tax credit (also adjusted annually). 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 1 provides several examples of how the employer shared responsibility payments are calculated.

Qualified Health Plans and Essential Health Benefits

The ACA establishes standards for qualified health plans (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 a state- or the federally-run insurance exchange and in the individual market outside a government exchange must meet these QHP standards.

The ACA defines a QHP as a health plan certified to meet standards established by the DHHS Secretary, which includes minimum criteria specified in the ACA. 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.

Out-of-Pocket Limits and Cost-Sharing. 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.

The ACA limits the maximum annual out-of-pocket amount that an enrollee could pay in cost-sharing requirements for covered benefits in a QHP to no more than the limits that apply to plans that qualify the enrollee to open a health savings account. In 2016, these limits were $6,850 for an individual plan and $13,700 for a family plan.

Essential Health Benefits. The ACA directs the DHHS Secretary to define the benefits that a QHP must offer, and requires that the plan must include at least the following general categories: (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 DHHS Secretary to ensure that the scope of the EHB is equal to the scope of benefits provided under a typical employer plan.

DHHS rules directed 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-MA 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).

Wisconsin's benchmark plan is the Choice Plus Plan, offered by UnitedHealthcare Insurance Company.

Under the ACA, if a state chooses to establish a new insurance mandate, the state is required to fund the additional cost for the mandated benefit to individuals who purchase qualified plans in the exchange.

Catastrophic Plans. The ACA permits insurers to sell "catastrophic plans" to individuals under 30 years of age, and to individuals who are exempt from the individual mandate. These plans must provide the essential health benefits package only after the satisfaction of the maximum out-of-pocket cost-sharing amounts (in 2016, $6,850) and coverage for at least three primary care visits. Qualifying individuals may purchase catastrophic plans to comply with the individual mandate.

Health Benefits Exchanges

The ACA created health benefit exchanges (Marketplaces), through which consumers can obtain information and purchase coverage in QHPs. In addition, federal tax credits to help purchase

coverage are generally only available to individuals who purchase plans offered through the Marketplaces. This section discusses the establishment of Marketplaces by states and the federal government, and the premium and cost-sharing assistance available through them.

Establishment of Marketplaces. The ACA requires each state, no later than January 1, 2014, to establish a Marketplace to facilitate the purchase of QHPs. If a state does not establish its own Marketplace, the ACA directs DHHS to establish and operate the state's Marketplace.

The ACA requires the Marketplace, at a minimum, to undertake all of the following: (a) certify health plans as QHPs; (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 Marketplace; (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, or cost-sharing reductions; (h) certify that an individual is exempt from the individual mandate due to a lack of an affordable coverage option, or other exemption; (i) transfer to the U.S. Department of Treasury and to employers certain information regarding individuals who participate in the Marketplace; and (j) establish the "navigator" program, where entities receive grants to conduct educational and enrollment activities.

In 2016, 12 states and the District of Columbia established their own state-based Marketplaces. Twenty-seven states, including Wisconsin, chose not to establish an exchange, and DHHS performed the functions relating to the state's exchange ("federally-facilitated Marketplaces"). Eleven states chose to divide Marketplace functions between DHHS and the state ("Partnership Marketplaces"). For the 2016 plan year, 16 insurers offered plans on Wisconsin's federally-facilitated Marketplace.

Each Marketplace establishes an open enrollment period for each plan year. During the open enrollment period, consumers may purchase coverage without restrictions. For 2017 coverage purchased on the federally-facilitated Marketplace, the open enrollment period started on November 1, 2016, and ended on January 31, 2017. However, for coverage beginning on January 1, 2017, the deadline was December 15, 2016. 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 MA. 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 three years.

Plan Year	Enrollment
2014	139,815
2015	207,349
2016	239,034

Appendix 2 provides additional information on enrollment in Wisconsin's federally-facilitated Marketplace during the open enrollment period for the 2016 coverage year, as compiled by the DHHS Office of the Assistant Secretary for Planning and Evaluation, as of March, 2016.

Appendix 3 provides information on the type of exchange that operated in each state in 2016. The appendix also indicates the number of individuals who selected a Marketplace plan during open enrollment. In addition, the table indicates the status of Medicaid expansion (described below) in each state.

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 the Marketplace; (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 (premiums for self-only coverage of no more than 9.66% of household income, 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.

In 2016, the premium tax credits, which are established and administered by the IRS, cap the amount the individual is expected to contribute for premiums, based on the individual's household income, according to the schedule shown in the table below. As the percentages are adjusted annually, the 2016 percentages are slightly higher than the percentages that applied in calendar year 2015.

Percent of FPL	Percentage of Income Expected to Pay for Premium*
Up to 133%	2.03%
133% to 150%	3.05 % to 4.07 %
150% to 200%	4.07 % to 6.41 %
200% to 250%	6.41 % to 8.18 %
250% to 300%	8.18 % to 9.66%
300% to 400%	9.66%

*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 Marketplace 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 4 shows the 2016 federal poverty levels, and examples of calculations of the monthly premiums that low- and moderate-income families were expected to pay for second-lowest cost silver plan in 2016 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 co-payments, coinsurance, and deductibles. To qualify for these subsidies, an individual must enroll in a QHP with the "silver level" of coverage offered through the Marketplace. 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 (the actuarially determined value of benefits covered

by the plan rather than cost-sharing paid by the policyholder). 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. In 2016, the out-of-pocket limits for plans offered in the Marketplace are $6,850 for an individual and $13,700 for a family. This limit does not count premiums, expenses for non-essential health benefits, and amounts owed for services provided outside a plans' approved provider network.

Based on rules promulgated by CMS, the ACA reduced maximum out-of-pocket costs in 2016 as shown in the following table.

	2016 Out-of-Pocket Maximum	
Percent of FPL	Individual	Family
100% to 200%	$2,250	$4,500
200% to 250%	5,400	10,900

Medical Assistance -- BadgerCare Plus Eligibility Changes

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.

As of 2016, 31 states and the District of Columbia had adopted the ACA Medicaid expansion and 19 states had not. Appendix 3 shows the Medicaid expansion status of each state.

For states that 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 to 95% in 2017, 94% in 2018, 93% in 2019, and 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 58%.

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, unless they had enrolled in the BadgerCare Plus Core Plan for childless adults with income under 200% of the FPL, prior to September, 2009, when DHS ended new enrollment in that program.

The Legislature considered the issue of Medicaid income eligibility standards for nondisabled, non-elderly adults as part of its 2013-15 biennial budget deliberations and established the income standard at 100% of the FPL, effective January 1, 2014. 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 Marketplace.

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 58% with federal funds and 42% with state funds).

In response to the difficulties experienced by individuals attempting to purchase subsidized private coverage through the federal health insurance marketplace in the fall of 2013, the Legislature delayed the Medicaid eligibility changes from January 1, 2014, to April 1, 2014, by enacting 2013 Wisconsin Act 116. As a result, parents with incomes between 100% and 200% of the FPL did not lose Medicaid eligibility, and adults without dependent children with income below 100% of the FPL did not gain Medicaid eligibility, until April 1, 2014.

As of August of 2016, there were 171,100 parents and caretaker relatives covered under Wisconsin Medicaid program and 144,400 adults without dependent children.

Additional Resources

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

Federal Health Insurance Marketplace
www.healthcare.gov

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

Wisconsin Department of Health Services (DHS)
www.dhs.wisconsin.gov/health-care/index.htm

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

Examples of Employer Shared Responsibility Payments, Using 2016 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 ($2,160 per FTE employee)	151,200
3	100	Yes	40 for 12 months each	($3,240 per FTE employee receiving tax credit) x 40 FTE employees that received premium tax credit	129,600
4	100	Yes	60 for 12 months each	($3,240 per FTE employee receiving tax credit) x 60 FTE employees = $194,400 This exceeds the maximum for the employer [(100 FTE - 30 FTE employees x ($2,160 per FTE employee) = $151,200], so the employer would pay the maximum.	151,200
5	100	Yes	40 for six months each	($3,240 per FTE employee/12 months) x six months x 40 FTE employees that received the tax credit for each of the six months	64,800
6	45	No	25	As the employer has fewer than 50 FTE employees, there is no payment.	0

APPENDIX 2

Selected Information Regarding Plan Selections in Wisconsin's Marketplace During the Open Enrollment Period (November 1, 2015 to January 31, 2016)

Total Number of Individuals Enrolled in a Qualified Health Plan	239,034
Number Who Qualified for Financial Assistance	201,323
Percent Who Qualified for Premium Tax Credits	84%
Number Who Also Qualified for Cost Sharing Reductions	129,189
Percent Who Qualified for Cost Sharing Reductions	54%

Enrollment by Age and Gender

	Number	Percent
Less than 18	15,741	6.6%
18 through 25	21,308	8.9
26 through 34	39,818	16.7
35 through 44	34,600	14.5
45 through 54	48,080	20.1
55 through 64	78,598	32.9
65 and Older	499	0.2
Total	238,644	100.0%
Female	127,828	53.5%
Male	111,206	46.5
Total	239,034	100.0%

Enrollment by Plan Metal Level

Bronze	55,771	23.4%
Silver	168,470	70.6
Gold	11,004	4.6
Platinum	1,611	0.7
Catastrophic Plans	1,722	0.7
Total	238,578	100.0%

Note: The data in these tables is taken from county-level reports compiled by the Centers for Medicare and Medicaid Services (CMS). In some cases, CMS omits data breakouts in very small counties to avoid disclosing potentially personally-identifying information. For this reason, in some cases the sum of the category totals is less than the total number of individuals enrolled in a plan.

APPENDIX 3

2016 Marketplace Enrollment During Open Enrollment By Marketplace Type and State And Medicaid Expansion Status

States with State-Based Marketplaces

State	Marketplace Enrollment	Full Medicaid Expansion*
California	1,575,340	Yes
Colorado	150,769	Yes
Connecticut	116,019	Yes
District of Columbia	22,693	Yes
Idaho	101,073	Yes
Kentucky	93,666	Yes
Maryland	162,177	Yes
Massachusetts	213,883	Yes
Minnesota	83,507	Yes
New York	271,964	Yes
Rhode Island	34,670	Yes
Vermont	29,440	Yes
Washington	200,691	Yes
Subtotal	3,055,892	13 Yes

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

State	Marketplace Enrollment	Full Medicaid Expansion*
Alabama	195,055	No
Alaska	23,029	Yes
Arizona	203,066	Yes
Arkansas	73,648	Yes
Delaware	28,256	Yes
Florida	1,742,819	No
Georgia	587,845	No
Hawaii	14,564	Yes
Illinois	388,179	No
Indiana	196,242	Yes
Iowa	55,089	Yes
Kansas	101,555	No

State	Marketplace Enrollment	Full Medicaid Expansion*
Louisiana	214,148	Yes
Maine	84,059	No
Michigan	345,813	Yes
Mississippi	108,672	No
Missouri	290,201	No
Montana	58,114	Yes
Nebraska	87,835	No
Nevada	88,145	Yes
New Hampshire	55,183	Yes
New Jersey	288,573	Yes
New Mexico	54,865	Yes
North Carolina	613,487	No
North Dakota	21,604	Yes
Ohio	243,715	Yes
Oklahoma	145,329	No
Oregon	147,109	Yes
Pennsylvania	439,238	Yes
South Carolina	231,849	No
South Dakota	25,999	No
Tennessee	268,867	No
Texas	1,306,208	No
Utah	175,637	No
Virginia	421,897	No
West Virginia	37,284	Yes
Wisconsin	239,034	No
Wyoming	23,770	No
Subtotal	9,625,982	19 Yes 19 No
All States and D.C.	12,681,874	32 Yes 19 No

* Income eligibility of 133% of the federal poverty level for adults.

APPENDIX 4

Examples of Monthly Required Premium Contributions, By Family Size*
Plan Year 2016

Family Size	Annual Family Income Based on Percentage of FPL						
	100%	133%	150%	200%	250%	300%	400%
One	$11,880	$15,800	$17,820	$23,760	$29,700	$35,640	$47,520
Two	16,020	21,307	24,030	32,040	40,050	48,060	64,080
Three	20,160	26,813	30,240	40,320	50,400	60,480	80,640
Four	24,300	32,319	36,450	48,600	60,750	72,900	97,200
Five	28,440	37,825	42,660	56,880	71,100	85,320	113,760
Six	32,580	43,331	48,870	65,160	81,450	97,740	130,320

Family Size	Monthly Required Premium Contribution, by Family Size						
	100%	133%	150%	200%	250%	300%	400%
One	$20	$40	$60	$127	$202	$287	$383
Two	27	54	82	171	273	387	516
Three	34	68	103	215	344	487	649
Four	41	82	124	260	414	587	782
Five	48	96	145	304	485	687	916
Six	55	110	166	348	555	787	1,049

*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.