LEGISLATIVE
FISCAL BUREAU

STATE OF WISCONSIN

JANUARY 2023

Informational Paper #56

The Affordable Care Act

Summary of Major Insurance Provisions and Implementation in Wisconsin

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(Summary of Major Insurance Provisions
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(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 healthcare programs in the United States. Together, these acts are commonly referred to as the Affordable Care Act (ACA).

The ACA seeks to increase availability of healthcare coverage for 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 This paper provides a description and relevant data on the key provisions, as originally enacted or modified by subsequent acts. The paper is 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), 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. [Federal acts passed in 2021 and 2022 temporarily removed income caps on premium tax credit eligibility, potentially making credits available to consumers with higher income.] 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, with penalties for failure to meet requirements. As originally enacted, the act also included a provision requiring individuals to obtain insurance coverage, although Congress subsequently modified the individual mandate provision so that, beginning in plan year 2019, individuals are no longer subject to a financial penalty for not having insurance.

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 exceptions to the market requirements for grandfathered and transitional plans. Most of the changes to the insurance regulations first took effect for 2014 plans.

Generally, the insurance market regulations 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 ACA's provisions apply differently depending upon the type of insurance market. For the purposes of health insurance regulation, federal law distinguishes between the group market, in which coverage is purchased by employers on behalf of their employees, and the individual market, in which coverage is purchased directly by individuals or families. The group market is further subdivided into the small group market and the large group market, based on the number of employees that the employer has. The small group market refers to coverage for employers with up to 50 employees, whereas the large group market refers to employers with 51 or more employees. States have the option to set the threshold between the small and large group markets at 100 employees, but most states, including Wisconsin, use the 50 employee standard.

In addition to governing the health insurance market, some ACA regulations apply to employer-sponsored, self-funded health plans. The term "health plan" refers to all insurance policies and employer self-funded 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.

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" (EHBs): (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 EHBs is equal to the scope of benefits provided under a typical employer plan.

To implement this requirement, each state is required to designate a "benchmark plan" to use as a standard for coverage of the essential health benefits. Generally, DHHS rules direct each state to identify a 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).

Beginning in 2020, states were given more options for designating the benchmark plan, including choosing a benchmark plan used in another state, or substituting one or more benefit categories from its 2017 benchmark using benefits established in another state's benchmark plan.

Wisconsin's benchmark plan is a Choice Plus Plan, offered by United-Healthcare 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 equal to the difference between the minimum MLR and actual MLR. These requirements first took effect in 2012.

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.

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.

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

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 (exemption applies only in the individual market); (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, as individuals or employers have moved to fully compliant coverage or as insurers have stopped issuing such policies. The number of persons covered by grandfathered plans in Wisconsin has declined from approximately 22,800 in 2014 to 2,500 at the end of 2021, while the number of persons covered by transitional plans has declined from approximately 280,900 in 2014 to 58,200 at the end of 2021.

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. For 2023, 17 states and the District of Columbia established their own state-based exchanges, 30 states, including Wisconsin, used the federal exchange, and three 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.

The exchange establishes an open enrollment period for each plan year. During the open enrollment period, consumers may purchase coverage without restrictions. For 2023 coverage purchased on the federally-facilitated exchange, the open enrollment period started on November 1, 2022, and ended on January 15, 2023. However, to have coverage in effect by January 1, 2023, the person must have enrolled on or before December 15, 2022; after that date (coverage obtained between December 16, 2022, and January 15, 2023), coverage began on February 1, 2023.

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.

Table 1 shows the number of Wisconsin individuals who enrolled in a plan in each open enrollment period for the first nine years.

Table 1: Number of Plans Selected During Open Enrollment

Plan Year	Enrollment
2014	139,815
2015	207,349
2016	239,034
2017	242,863
2018	225,435
2019	205,118
2020	195,498
2021	191,702
2022	212,209

Appendix 1 provides additional information on enrollment in Wisconsin's federally-facilitated exchange during the open enrollment period for the 2022 coverage year.

Open enrollment data indicate the number of individuals who purchase a plan prior to the plan year, but these data are not necessarily representative of the number who maintain individual plan coverage throughout the year. Some individuals who select a plan during open enrollment drop that coverage during the year, either because they obtain other coverage, drop all coverage (become uninsured), move outside the state, or die. On the other hand, some individuals purchase an exchange plan during the year if they qualify for a special enrollment period. On balance, the average number of plans in effect during the plan year typically decreases somewhat through the course of the year.

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, leaving the other 40% to be covered through consumer cost sharing (deductibles, copayments, and coinsurance). 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 amount of cost sharing that an individual or family can be required to pay for covered benefits. In 2023, the maximum cost sharing amounts are $9,100 for an individual plan and $18,200 for a family plan. The individual limit applies to each family member in 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 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 for the same QHP sold on and off the exchange.

Premium Tax Credits and Cost-Sharing Subsidies

Premium Assistance Tax Credits. Individuals and families may qualify for a premium tax credit (PTC) to help pay for health insurance premiums for coverage purchased through a health benefit exchange. To qualify for a PTC, a person must not have coverage through a government program (such as Medicare or Medicaid), nor have access to "affordable coverage" through an employer plan that meets "minimum value" requirements. For the purpose of this eligibility limitation, an employer plan is considered affordable if the premium for the employee's coverage is no more than 9.12% of household income for 2023, and the plan has an actuarial value of at least 60%. Prior to the 2023 plan year, an employer's dependents were not eligible for premium tax credits if the individual coverage for the employee meets the affordability test, even if adding dependents to the policy would increase the employee's cost of the family coverage to above the affordability threshold. Under new federal rules, in effect beginning in 2023, an employee's dependents are eligible for premium tax credits if the cost of family coverage exceeds the affordability threshold.

The premium tax credits, which are administered by the Internal Revenue Service, are based on the difference between the premium that the individual would pay for the silver-level plan that has the second lowest premium on the exchange, and a specified percentage of the individual's household income. These so-called "applicable percentages" vary by income level, such that lower income individuals receive higher credits.

Figure 1 shows the PTC formula, along with an illustration of the calculation for a sample individual. In the example, the individual lives in a single-person household, and has an annual income of $27,200, or $2,267 per month, and the monthly premium for a second-lowest silver plan is $600. This income places the person at approximately 200% of the FPL.

The applicable percentage multiplied by monthly income is equal to the net amount that the individual pays (after the application of the PTC) if that person selects the silver plan with the second-lowest premium. That is, in the example shown in Figure 1, the person would pay a net monthly premium of $147.13 (6.49% multiplied by $2,267) for the second-lowest silver plan, regardless of the actual premium of that plan. But since the PTC remains the same regardless of which plan is selected, the net premium could be higher if the person selects a plan with a higher premium than the second-lowest silver plan, such as a more expensive silver plan or a gold plan. Conversely, the premium could be lower if the person applies the credit to a less expensive plan, such as a bronze plan.

The applicable percentages were set by the ACA for 2014, but are adjusted annually thereafter using an indexing factor that takes into consideration the rate of health insurance premium growth relative to general inflation rate.

Under a provision of the federal American Rescue Plan Act of 2021 (ARPA), the applicable percentages were temporarily decreased for plan years 2021 and 2022, which has the effect of increasing the value of the premium tax credit. This formula change was then extended to apply through plan year 2025 under a provision of the Inflation Reduc-

Figure 1: Premium Tax Credit Formula and Sample Calculation

[2nd Lowest Silver Premium] - [(Applicable Percentage) X (Income)] = Premium Tax Credit

[$600]	-	[(6.49%)* X ($2,267)]	=	$452.87

* Applicable percentage for a person at 200% of the FPL for the 2020 plan year, the last year for which the original formula was in use.

Table 2: Premium Tax Credit Applicable Percentages by Income Range, ACA formula for 2020 and Revised Formula for 2021 through 2025

	Percentage of Monthly Income	
Percent of FPL	2020 Plan Year	2021 through 2025
100% to 133%	2.06%	0.0%
133% to 150%	3.09% to 4.12%	0.0%
150% to 200%	4.12% to 6.49%	0.0% to 2.0%
200% to 250%	6.49% to 8.29%	2.0% to 4.0%
250% to 300%	8.29% to 9.78%	4.0% to 6.0%
300% to 400%	9.78%	6.0% to 8.5%
Over 400%	No credit	8.5%

tion Act of 2022. Among the changes, ARPA reduces the applicable percentage to 0.0% for individuals with a household income below 150% of the FPL, meaning that persons in this income range can purchase the second-lowest silver plan without owing a monthly premium. In addition, while the ACA limits eligibility for premium tax credits to individuals with a household income below 400% of the FPL, ARPA provides tax credits for individuals above 400% of the FPL during the applicable years.

Table 2 compares the applicable percentages for the premium tax credit, by income level, for the 2020 plan year under the ACA's original tax credit formula, with the applicable percentages for plan years from 2021 to 2025, as established by ARPA.

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. That is, if a person's actual annual household income was higher than the estimate of income on which the advanced premium tax credit was based, the individual is required to repay a portion of the credit when filing the federal income tax return (although ARPA waived the reconciliation requirement for the 2020 plan year).

Appendix 2 shows the 2022 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 2022 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 decreasing a plan's out-of-pocket spending requirements, which increases the actuarial value of the plan.

For example, individuals within the income range between 100% and 150% of the FPL are responsible, on average, for paying 6% of the covered expenses, rather than 30% of expenses that would

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

otherwise be expected to be paid by individuals who purchase a silver plan.

Although plans may vary in how the subsidies affect cost-sharing parameters, all plans must adopt the same out-of-pocket maximums. The adjusted 2023 out-of-pocket maximums are shown in the following table.

Percent of FPL	2023 Out-of-Pocket Maximum Individual	Family
100% to 200%	$3,000	$6,000
200% to 250%	7,250	14,500

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 stopped doing so in 2017 as a result of legal disputes relating to the Department's authority to do so. Since insurers continue to be required to provide cost-sharing reductions to eligible consumers, insurers have responded by increasing premiums to absorb 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. Thus, although the federal government no longer pays insurers directly for the cost sharing reductions, the cost is paid indirectly by the federal government through higher premium tax credits.

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 year. 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 their dependent children. 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 2023, the per employee charge is $2,880. 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, or if the coverage offered does not meet the minimum standards for affordability and value for at least some employees. In this case, the penalty equals the number of full-time employees that received a tax credit times a per person charge, which is $4,320 in 2023. 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 under this method an amount that exceeds the amount that the employer would owe if it did not meet the 95% coverage test under the first calculation method.

Appendix 3 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. Wisconsin is one of 16 states that have a reinsurance program for exchange plans, as of the 2023 plan year.

Program Structure and Payment Parameters

The WHSP, which first applied to the 2019 plan year, 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. These examples use the parameters established for the 2023 plan year: a coinsurance rate of 50%, with an attachment point of $45,000 and a reinsurance cap of $141,685.

- Individual 1 has total costs during the plan year of $100,000. The amount above the attachment point is $55,000 ($100,000 minus $45,000), so the reinsurance program pays the insurer $27,500 (50% times $55,000). Since the total of the plan year claims is below $141,685, the reinsurance payment is not limited by the reinsurance cap.

- Individual 2 has total costs during the plan year of $200,000. Since this total cost exceeds the reinsurance cap, the reinsurance payment is determined by multiplying the coinsurance rate (50%) times the difference between the cap and the attachment point ($141,685 minus $45,000, or $96,685). The result, $48,342.50, is the maximum amount of reinsurance payment allowed with these particular parameters.

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, 2023, for the 2022 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

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 federal funding equal to federal savings resulting from the state's waiver plan, frequently referred to as "federal pass-through" funds. 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 WHSP, the difference between the total amount of reinsurance claims and the federal pass-through funding is paid with an appropriation from the state's general fund.

OCI is required to set the annual program parameters such that total reinsurance payments will equal a specified target expenditure. Act 138 originally established the reinsurance target at

$200,000,000 per year, but this target was increased to $230,000,000 by 2021 Act 58, beginning for plan year 2022.

In establishing payment parameters, OCI relies on estimates of the number of individuals who will have high-cost medical claims, but actual reinsurance payments may end up being more or less than the targeted expenditure. If expenditures are greater than the target, OCI can prorate payments so that expenditures do not exceed the target. Or, alternatively, OCI may submit a request to the Joint Committee on Finance for authority to exceed the target. In May of 2022, the Committee approved a request to exceed the target for the 2021 plan year, up from $200,000,000 to $205,000,000. Actual reinsurance payments totaled $202,811,300.

Table 3 shows the reinsurance target, the payment parameters, actual payments, and funding for each year for which information was available at the time of publication.

Wisconsin's original Section 1332 waiver covers a five-year period from 2019 through 2023. On August 5, 2022, OCI submitted a request to DHHS to extend the waiver for an additional five years, from 2024 through 2028. On December 1, 2022, DHHS approved the waiver extension.

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

Table 3: Wisconsin Healthcare Stability Plan Payment Parameters and Reinsurance Expenditures by Plan Year

	Plan Year				
	2019	2020	2021	2022	2023
Target Expenditure	$200,000,000	$200,000,000	$200,000,000	$230,000,000	$230,000,000
Attachment Point	$50,000	$40,000	$40,000	$40,000	$45,000
Reinsurance Maximum	250,000	175,000	175,000	175,000	141,685
Co-Insurance Rate	50%	50%	48%	50%	50%
Actual Reinsurance Payments	$174,254,400	$183,483,600	$202,811,300	--	--
Federal Pass-Through Funding	127,726,300	141,955,200	202,811,300*	--	--
State GPR	46,528,100	41,528,400	0	--	--
Fiscal Year of Expenditure	2020-21	2021-22	2022-23	2023-24	2024-25

* For plan year 2021, the state received federal pass-through funding of $229,175,400, exceeding total reinsurance payments for that plan year. DHHS allowed excess pass-through funding to be carried over for 2022 plan year reinsurance payments.

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 60%.

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 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 has not received 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.

As of the end of 2022, 39 states and the District of Columbia had adopted the full Medicaid expansion, while 11 states, including Wisconsin, had not adopted full expansion. In addition to Wisconsin, the following states had not adopted full expansion: Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, Tennessee, Texas, and Wyoming.

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), general ACA-related topics
https://oci.wi.gov/Pages/Consumers/HealthCareReform.aspx

OCI's Wisconsin Healthcare Stability Plan
https://oci.wi.gov/Pages/Consumers/HealthcareStabilityPlan.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 2022 Plan Year Open Enrollment Period (November 1, 2021 to January 15, 2022)

Total Number of Individuals Enrolled in a Plan	212,209
Number Who Qualified for Premium Tax Credits	187,555
Percent Who Qualified for Premium Tax Credits	88%
Number Who Also Qualified for Cost Sharing Reductions	72,746
Percent Who Qualified for Cost Sharing Reductions	34%

Enrollment by Age

	Number	Percent
Less than 18	12,264	5.8%
18 through 25	14,056	6.6
26 through 34	29,216	13.8
35 through 44	30,044	14.2
45 through 54	34,834	16.4
55 through 64	90,562	42.7
65 and Older	1,233	0.5
Total	212,209	100.0%

Enrollment by Plan Metal Level

Bronze	95,401	45.0%
Silver	83,092	39.2
Gold	30,396	14.3
Platinum	1,800	0.8
Catastrophic Plans	1,520	0.7
Total	212,209	100.0%

Enrollment by Percentage of Federal Poverty Level (FPL)

Under 100% of FPL	985	0.5%
100% to 150% of FPL	38,070	30.6
150% to 200% of FPL	36,277	17.1
200% to 250% of FPL	30,919	14.6
250% to 300% of FPL	24,228	11.4
300% to 400% of FPL	40,365	19.0
400% to 500% of FPL	13,869	6.5
Over 500% of FPL	15,926	7.5
Income Unreported	11,570	5.5
Total	212,209	100%

APPENDIX 2

Annual Income and Expected Monthly Premium at Various Percentages of the 2022 Federal Poverty Level, By Family Size

Family Size	Annual Family Income Based on Percentage of FPL						
	100%	133%	150%	200%	250%	300%	400%
One	$13,590	$18,075	$20,385	$27,180	$33,975	$40,770	$54,360
Two	18,310	24,352	27,465	36,620	45,775	54,930	73,240
Three	23,030	30,630	34,545	46,060	57,575	69,090	92,120
Four	27,750	36,908	41,625	55,500	69,375	83,250	111,000
Five	32,470	43,185	48,705	64,940	81,175	97,410	129,880
Six	37,190	49,463	55,785	74,380	92,975	111,570	148,760

Family Size	Maximum Monthly Premium after Premium Tax Credit, by Percentage of FPL, for Second-Lowest Silver Plan						
	100%	133%	150%	200%	250%	300%	400%
One	$0	$0	$0	$45	$113	$204	$385
Two	0	0	0	61	153	275	519
Three	0	0	0	77	192	345	653
Four	0	0	0	93	231	416	786
Five	0	0	0	108	271	487	920
Six	0	0	0	124	310	558	1,054

*Based on the second-lowest cost silver plan available. Actual premium may be lower or higher if the family selects a different plan. Also, the premium paid will be lower if the actual unsubsidized premium is lower than the amounts shown.

APPENDIX 3

Examples of Employer Shared Responsibility Payments, Using 2023 Penalties

Example	Firm Size (FTE Employees)	Offered Coverage to at Least 95% of FT Employees?	Number of FT 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 FT employees - 30 FT employees) x ($2,880 per employee)	201,600
3	100	Yes	5 for 12 months each	($4,320 per FT employee receiving tax credit) x 5 FT employees that received premium tax credit	21,600
4	100	Yes**	60 for 12 months each	($4,320 per FT employee receiving tax credit) x 60 FT employees = $259,200. This exceeds the maximum for the employer [(100 FT employees - 30 FT employees x ($2,880 per employee) = $201,600], so the employer would pay the maximum.	201,600
5	100	Yes**	40 for six months each	($4,320 per FT employee/12 months) x six months x 40 FT employees that received the tax credit for each of the six months	86,400
6	45	No	25	As the employer has fewer than 50 FTE employees, there is no payment.	0

Note: For the purposes of determining applicability of the employer shared responsibility payments, the number of the employer's full-time-equivalent (FTE) employees is used. However, the calculation of the payment is based on the number of full-time (FT) employees.

* In this example, the total number of full-time employees, rather than the number receiving a premium tax credit, is the basis for the penalty calculation.

** 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.