Becoming CAC or Navigator in Wisconsin

Part 2: Exam Study Guide

Introduction

- The following materials are one person's attempt to help you study for the exam.
- The Wisconsin Office of the Commissioner of Insurance has published an Intermediary Guide to Wisconsin Insurance Law which is an official and compressive guide. Focus on chapters 1-4.
- Failing the exam is normal. Most people pass on their second or third attempt.

Big Picture Exam Tips

- There are many questions with negative stems.
  - Which of the following is NOT ...
  - What is NOT included in…..
- Watch for answers that don't belong.
  - Often you'll see answers that sound official but do not make any sense.
- Give common sense responses. Don't over think it.
  - Consumers have privacy and confidentiality protections
  - Intermediates face consequences (e.g. fines, licensee revocation) if they don't protect PII/PHI.
  - Discrimination isn't allowed
  - Consumers have a right to request information

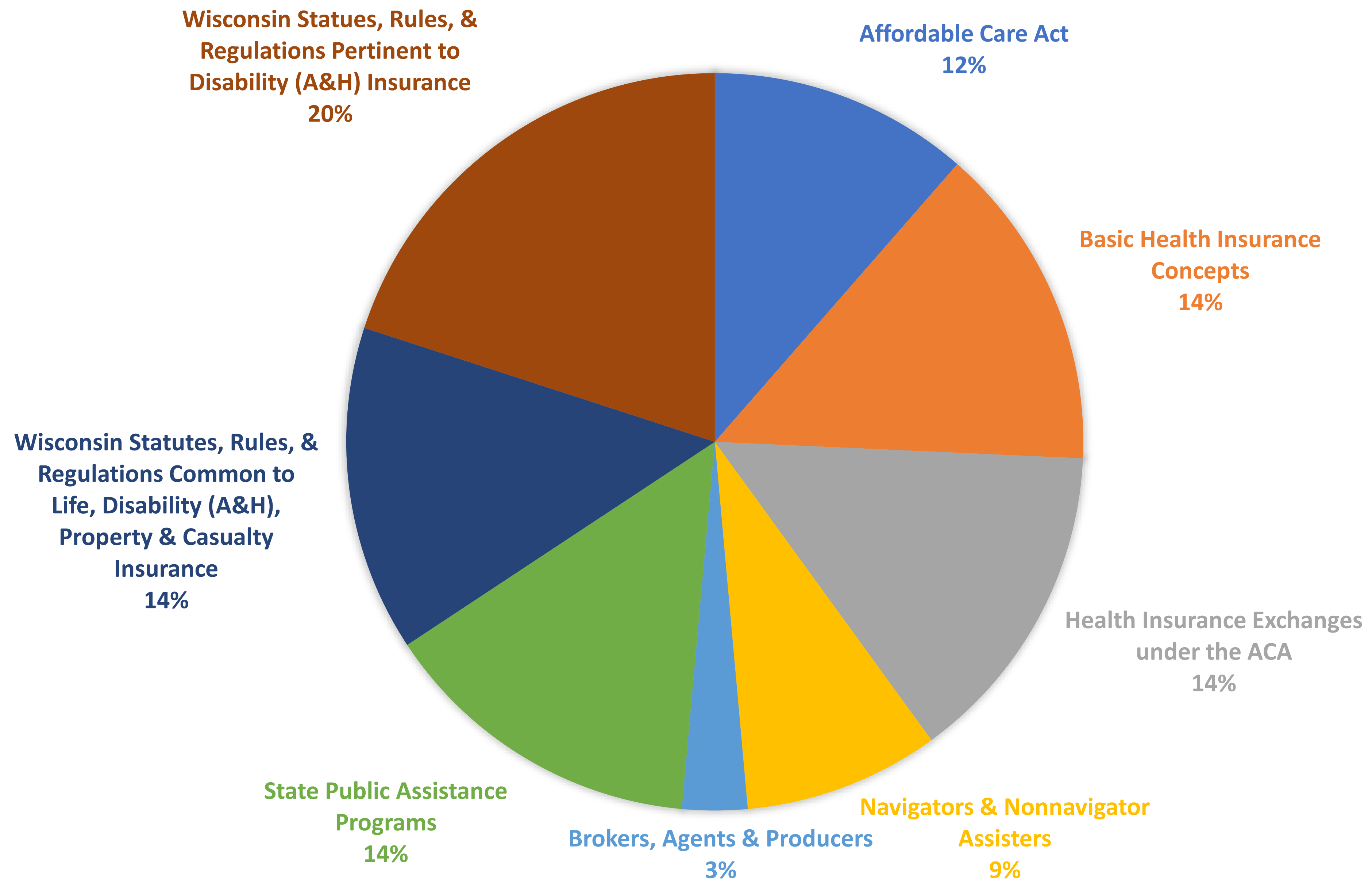
Exam Concepts

- Affordable Care Act
- Basic Health Insurance Concepts
- Health Insurance Exchanges under the ACA
- Navigators and Nonnavigator Assisters
- Brokers, Agents and Producers
- State Public Assistance Programs
- Wisconsin Statutes, Rules, and Regulations Common to Life, Disability (A&H), Property and Casualty Insurance
- Wisconsin Statues, Rules, and Regulations Pertinent to Disability (A&H) Insurance

Key Terms

Be able to explain each of these terms:

- Premium
- Deductible
- Out of Pocket Maximum
- Copayment
  - fixed amount
- Coinsurance
  - percentage
- Intermediary
  - Agent
  - Broker
  - Certified Application Counselor
  - Navigator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12%
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Exam Overview

- 35 multiple choice questions
- One hour time limit
- Taken on a computer either at a testing site or remote
- Available in English, Spanish and Hmong
- Special accommodations are available. You may submit a request here: https://psi-cdexp.zendesk.com/hc/en-us/requests/new?ticket_form_id=360000150872.

Exam Study Materials

1. An Intermediary's Guide to Wisconsin Insurance Law
   - Chapters 1-4
2. Navigator Exam Outline
   - Available on the PSI portal once you create an account.
3. Adam's Navigator Exam Recorded Study Session
   - 31 minutes long and contains tips for exam taking.
4. This Exam Study Slide Deck

Intermediary Guide to
Wisconsin Insurance Law

30th Edition

September 2021

Wisconsin Limited Line: Navigator
Series 22-14
35 questions – 1-hour time limit
1.0 Affordable Care Act (ACA) 10% (4 Items)
Major Provisions
Market wide Reforms
Guaranteed Issue
Essential Health Benefits
No annual limits for essential benefits
Coverage for pre-existing conditions
All plans have certain levels of coverage (platinum, gold, silver and bronze)
2.0 Basic Health Insurance Concepts 15% (5 Items)
Types of comprehensive health insurance plans
Health Maintenance organization plans (HM
Preferred provider organization plans (PPO)

ACA/Exchanges – Key Reminders

- What factors determine consumer's Marketplace premium
  - Age
  - Where You Live (Geography, i.e. County)
  - Family Size
  - Smoking/Tobacco (up to 50% increase in premium)
- Metal tiers
  - Bronze: 60/40
  - Silver: 70/30
  - Gold: 80/20
  - Platinum 90/10

Exam Study Slides

Developed Fall 2021

Updated Fall 2022

Disability (Accident & Health) Insurance

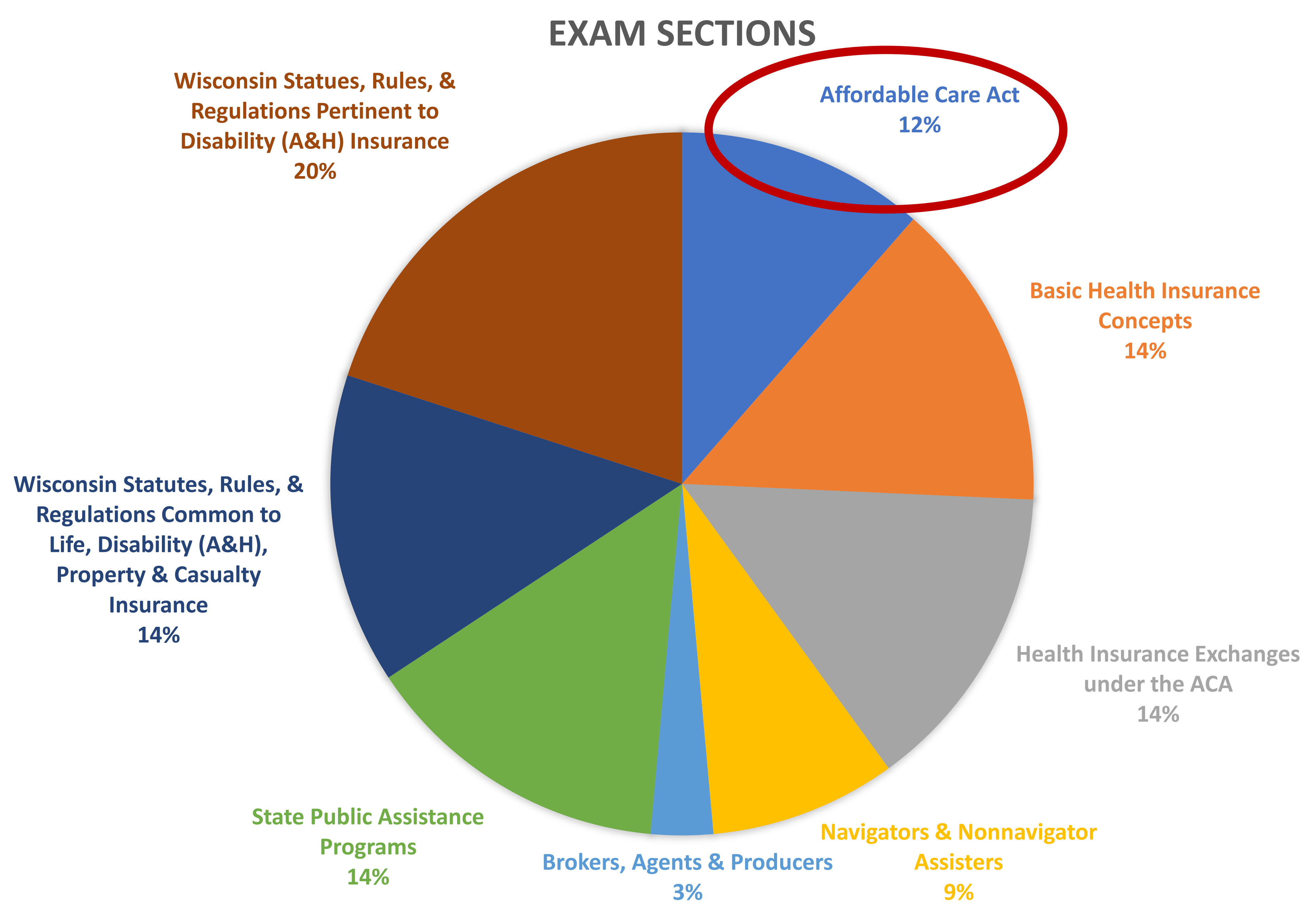
Disability (accident & health) insurance is generally defined as any type of insurance that covers policy claims involving:

- (1) medical and surgical expenses;
- (2) indemnities for loss of income due to accident or health;
- (3) accidental death and disability;
- (4) hospital care; and
- (5) long-term care

When you see the statement, "every group disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy" think **health insurance policy**.

Affordable Care Act

4 Questions on Exam focused on major provisions, reforms, guarantee issue, EHBs, coverage for pre-existing conditions and plan metal levels.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Major Provisions

- The ACA/PPACA/Obamacare addresses quality of care, cost of care, accessibility and gaps in insurance coverage.
- Enacted March 2010 with some reforms beginning in 2014.
- Reforms include:
  - prohibiting lifetime dollar limits and annual dollar limits on essential health benefits (EHBs)
  - required coverage of specific preventive services with no cost-sharing
  - guaranteed issue of health insurance policies
  - Prohibiting preexisting condition limitations

Market Wide Reforms

- Prohibits lifetime dollar limits and annual dollar limits on essential health benefits (EHBs);
- Requires coverage of specific preventive services with no cost-sharing;
- Guarantees availability of insurance regardless of age, health status, gender, and other factors;
- Requires insurance companies to spend at least 80% of the money they take in from premiums on health care costs and quality improvement activities. The other 20% can go to administrative, overhead, and marketing costs. The 80/20 rule is sometimes known as Medical Loss Ratio, or MLR;
- Prohibits preexisting condition limitations.

Guaranteed Issue

A requirement that health plans must permit you to enroll regardless of:

- health status
- age
- gender
- other factors that might predict the use of health services

Note the guaranteed issue doesn't limit how much you can be charged if you enroll.

Essential Health Benefits (EBHs)

- Essential health benefits (EHBs) are a set of health care service categories that must be covered beginning 2014 by all comprehensive individual and small group health plans subject to the ACA sold on and off the exchange.

Essential Health Benefits (EBHs)

Effective January 1, 2014. Essential health benefits must include items and services within at least the following 10 categories:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management
- pediatric services, including oral and vision care.

Essential Health Benefits (EBHs)

- EHBs also include all Wisconsin mandated benefits. Mandated benefits are Wisconsin laws that require health coverage for specific treatments on medical conditions (see Mandated Benefits in health Insurance Policies Fact Sheet from WI OCI).
- There are no annual limits for essential health benefits.

Coverage for Pre-Existing Conditions

All Marketplace plans must cover treatment for pre-existing medical conditions.

- No insurance plan can reject you, charge you more, or refuse to pay for essential health benefits for any condition you had before your coverage started.
- Once you're enrolled, the plan can't deny you coverage or raise your rates based only on your health.
- If you're pregnant when you apply, an insurance plan can't reject you or charge you more because of your pregnancy. Once you're enrolled, your pregnancy and childbirth are covered from the day your plan starts.
- Grandfathered plans don't have to cover pre-existing conditions or preventive care.

Grandfathered Plans

Grandfathered plans are health insurance plans that **were in place before March 23, 2010**, when the ACA was signed into law. These plans are allowed to continue and are not required to meet ACA requirements as long as no major changes are made to plan provisions.

What to know about Grandfathered Plans:

- Grandfathered plans are exempted from many changes required under the Affordable Care Act.
- Plans or policies may lose their grandfathered status if they make certain significant changes that reduce benefits or increase costs to consumers.
- New employees and new family members may be added to grandfathered group plans after March 23, 2010.

Excepted Benefits Under the ACA

1. **Non-health coverage**
   - Accident-only coverage (e.g., automobile or accidental death and dismemberment insurance)
   - Disability insurance
   - Workers' compensation insurance
2. **Limited health benefits**
   - Dental coverage
   - Vision coverage
   - Long-term care benefits (e.g., nursing home)
3. **Specific disease or illness coverage**
   - Coverage for a specific disease or illness (e.g., cancer insurance)
   - Hospital indemnity (insurance that pays the holder if they are hospitalized)
4. **Supplemental health benefits**
   - Separate insurance policies that are supplemental to Medicare or Armed Forces health care coverage.

Metal Levels or Metal Tiers

The ACA provides that health plans be categorized into one of four different metal tiers. The tiers represent the average portion of expected costs a plan will cover for an average population.

Bronze

60% approx. coverage

Silver

70% approx. coverage

Gold

80% approx. coverage

Platinum

90% approx. coverage

Catastrophic Health Plans

Catastrophic health plans are another category of ACA plan available to eligible individuals who are under age 30 or who qualify for a hardship exemption.

actuarial values below those of the bronze tier

Example

Gold
80% approx. coverage

Silver
70% approx. coverage

Bronze
60% approx. coverage

Catastrophic
actuarial values below those of the bronze tier

2021 INDIVIDUAL AND FAMILY BENEFIT PLAN DESIGNS *Base Plans*

Common Ground Healthcare Cooperative (CGHC) is proud to partner with **Aurora Health Care, Bellin Health, ThedaCare, Door County Medical Center, Children's Wisconsin,** and **St. Joseph Hospital – Milwaukee.**

	Calendar Year Deductible		Out of Pocket Maximum			Provider Visits Copay/Coinsurance In-Network					Prescription Drugs			
Envision EPO Plan Name	Single	Family	Single	Family	Coinsur-ance	PCP[1]	Specialist	Urgent	Emergency[2]	Quickcare Fast Care	Tier 1	Tier 2	Tier 3	Specialty
Gold 1800/80 Envision 87416WI0030019	$1,800	$3,600	$6,500	$13,000	20%	$25	$50	$75	$300	$15	$10	$50	$100 after ded	30% after ded
Gold 2000/80 Envision 87416WI0030020	$2,000	$4,000	$8,550	$17,100	20%	$40	$60	$75	$300	$15	$10	$50	$100 after ded	30% after ded
Silver 4000/75 Envision 87416WI0030021	$4,000	$8,000	$8,550	$17,100	25%	$50	$80	$100	D/C[3]	$20	$20	$75 after ded	D/C	30% after ded
Silver 3000/75/Copay 40 Envision 87416WI0030022	$3,000	$6,000	$8,550	$17,100	25%	$40	$80	$100	D/C	$20	$25	$75 after ded	D/C	30% after ded
Silver 7000/75 Envision 87416WI0030047 Rx Deductible Plan[4]	$7,000	$14,000	$8,550	$17,100	25%	$60	$120	D/C	D/C	$20	$10	$100	D/C	40% after ded
Bronze 8550/100 Envision 87416WI0030027	$8,550	$17,100	$8,550	$17,100	0%	$35	D/C	D/C	D/C	$20	D/C	D/C	D/C	D/C
Bronze 8150/100 Envision 87416WI0030028	$8,150	$16,300	$8,150	$16,300	0%	$30	D/C	D/C	D/C	$20	$25	D/C	D/C	D/C
HSA Bronze 7000/100 Envision 87416WI0030031	$7,000	$14,000	$7,000	$14,000	0%	D/C	D/C	D/C	D/C	D/C	D/C	D/C	D/C	D/C
Catastrophic 8550/100 Envision 87416WI0030026	$8,550	$17,100	$8,550	$17,100	0%	$0	D/C	D/C	D/C	$0	D/C	D/C	D/C	D/C

All plans offer preventive health benefits for $0. All Gold and Silver plans offer a $15 tier 2 insulin benefit. All plans offer 10 Virtuwell visits for $0 except the HSA Bronze plan which offers Virtuwell visits for a $49 copay.

[1]PCP = Primary Care Provider (includes general pediatrics, internal medicine, OB/GYN, family practice, general medicine, and geriatrics).
Urgent = Urgent Care services. **Emergency** (ER) = Emergency Room Care services.
[2]Services that meet the definition of Emergency Care are paid at the in-network rate even when care is delivered in a non-network ER. Because we do not have a contract with out-of-network ER facilities, we cannot prevent these facilities from billing our members for the balance of the charge. The copay applies to the facility care only. All other charges related to ER visits are subject to deductible/coinsurance.
[3]D/C refers to Deductible/Coinsurance.
[4]Rx Deductible Plan means that this plan has a separate prescription drug deductible for $5,000 (individual) and $10,000 (family).

Our Deductibles Explained: All plans have a 12 months deductible. All deductibles, coinsurance, and copayments accumulate toward the out-of-pocket maximum. All plans described on this page have embedded deductibles for family coverage. This means that if you are enrolled in 2-person or family coverage, an individual family member only has to satisfy the single person deductible before the plan begins to make payment for covered services for that family member.

Offer of Employer Coverage

- If a consumer has a health insurance coverage available through their employer that meets that minimum value standard they are not eligible for premium tax credits on the Marketplace.

- Coverage must meet minimum value standard
    - The plan must cover Essential Health Benefits and pay at least 60%
    - Must be affordable. Coverage is considered affordable if in 2023 if the employer's lowest self-only health plan premium does not exceed 9.12 percent of an employee’s household income.

Medical Loss Ratio

- The ACA changed to 80/20 insurer must spend at least 80% of collected premiums on medical care; 20% for overhead, administration, salaries, etc..
- If an insurer spends less than 80% of collected premiums on health care for its members, it must provide rebates to consumers.

Penalties for Violating Privacy Statutes

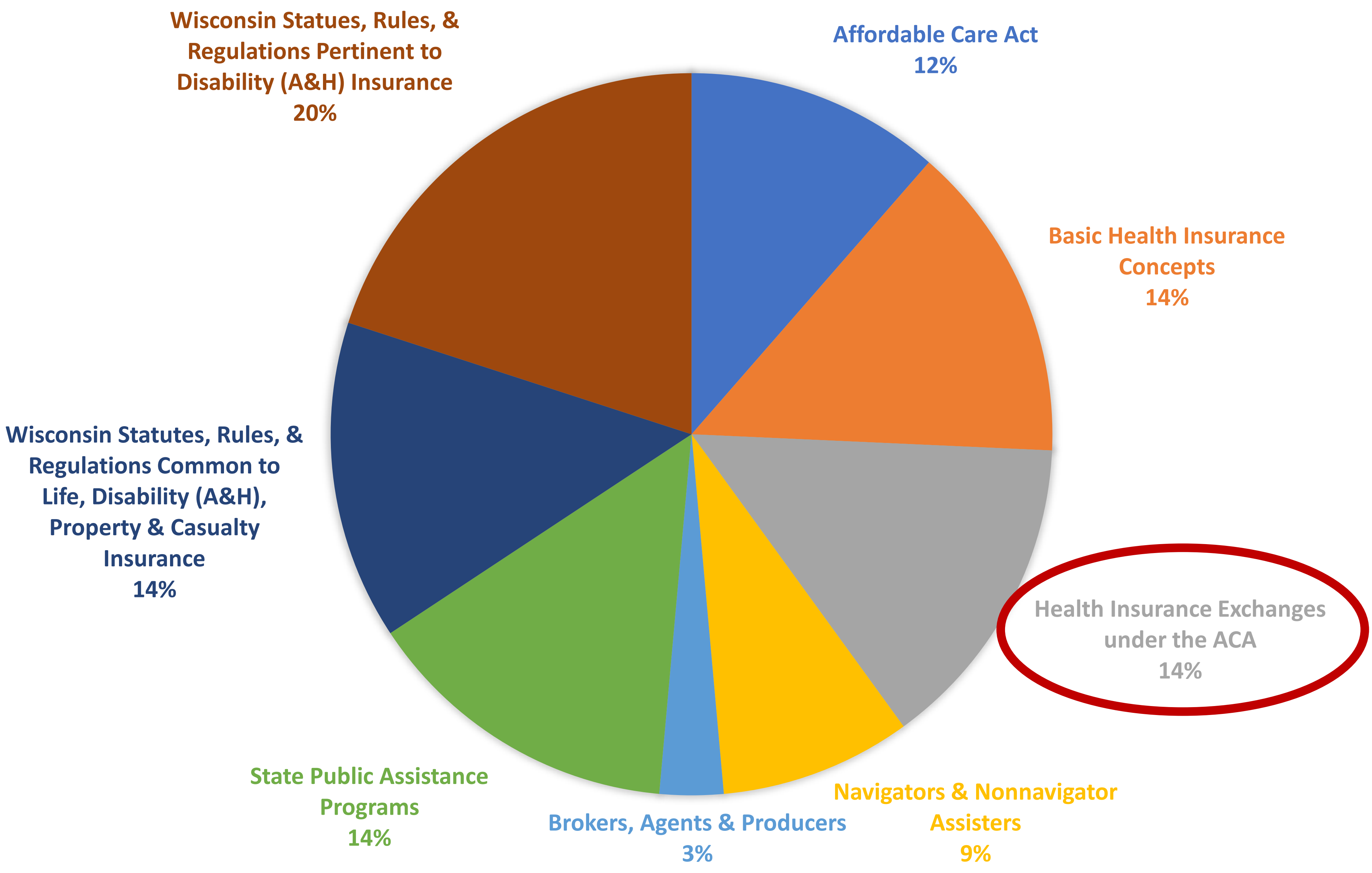
- The penalties for noncompliance are based on the level of negligence and can range from $100 to $50,000 per violation (or per record), with a maximum penalty of $1.5 million per year for violations of an identical provision. Violations can also carry criminal charges that can result in jail time.
- Navigator license revocation

Center for Consumer Information and Insurance Oversight (CCIIO)

- The Center for Consumer Information and Insurance Oversight (CCIIO) is charged with helping implement many reforms of the Affordable Care Act, the historic health reform bill that was signed into law March 23, 2010. CCIIO oversees the implementation of the provisions related to private health insurance. In particular, CCIIO is working with states to establish new Health Insurance Marketplaces.
- CCIIO works closely with state regulators, consumers, and other stakeholders to ensure the Affordable Care Act best serves the American people.

Continuation of Health Coverage (COBRA)

- The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals may be required to pay the entire premium for coverage up to 102% of the cost to the plan.
- Applies to most companies with 20 or more employees; can last up to 18 months, or 36 months with certain qualifying events.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Health Insurance Exchanges Under the ACA

Five (5) questions on the exam regarding the individual exchange, QHPs, tax credits, cost sharing, methods of enrollment and enrollment assistance, and the Small Business Health Options Program (SHOP) exchange.

Individual Exchange

Individual market means health insurance that people buy on their own, as opposed to coverage that's obtained through an employer or via a government-run program.

The **individual exchange** allows individuals shopping for coverage one place to go to consider coverage choices, determine eligibility for public programs or tax credits, use tools to compare plans and receive help through the website, call center or from navigators trained to assist individuals. The exchange offers qualified health plans, provides information on premiums, deductibles, out of pocket costs, and tools to compare plans. Consumers must purchase coverage through the individual exchange if they wish to receive the tax credits. Advance payments of the tax credit can be used to lower monthly premium costs.

Qualified Health Plans (QHPs)

- Under the Affordable Care Act (ACA), an insurance plan sold on the health insurance exchange/marketplace must be certified by the health insurance exchange/marketplace, and once certified it becomes a qualified health plan (QHP).

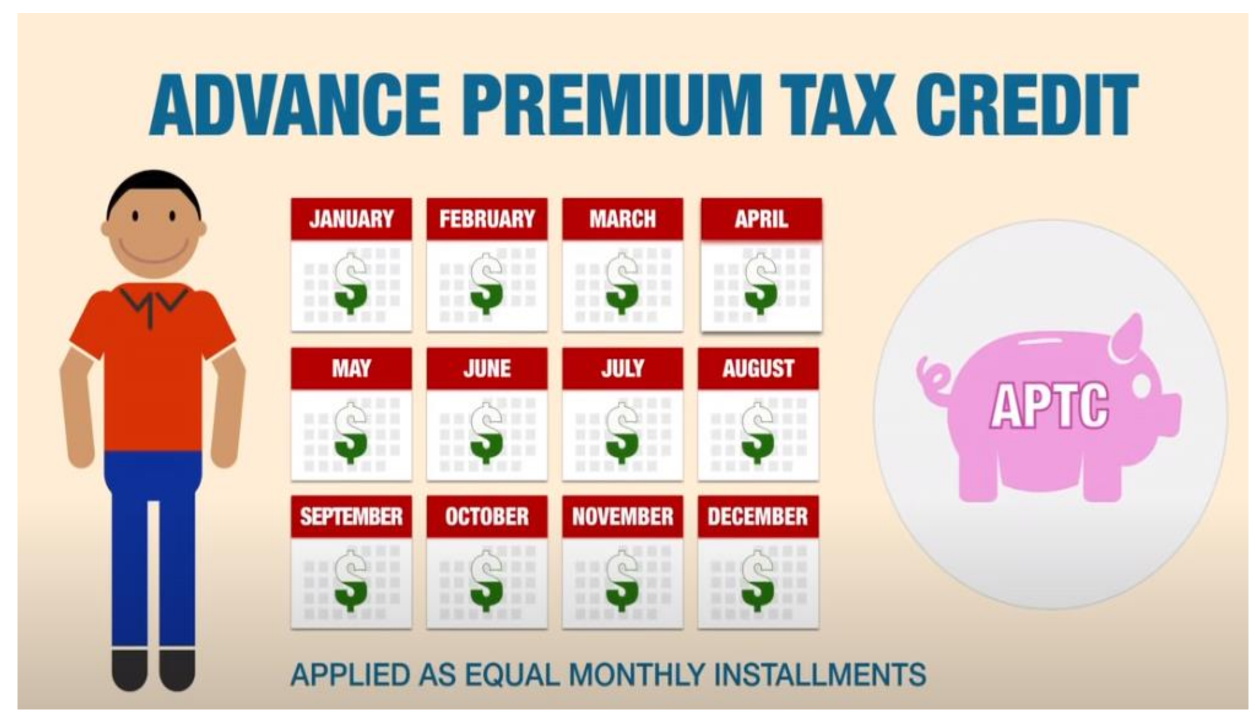
- Qualified health plans must provide essential health benefits and follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meet other requirements. QHPs are only available on the health insurance exchange/marketplace and are the only plans that provide premium tax credits and cost-sharing subsidies for eligible individuals.

Premium Tax Credits

- The ACA provides a federal tax credit to help individuals and families afford health coverage purchased through the health insurance exchange/marketplace.
- The premium tax credit can be taken in advance or in the form of a refund at the end of the year.
- People using the premium tax credit must file their taxes with the IRS.

Advance Premium Tax Credits (APTC)

The advanced premium tax credit, commonly referred to as APTC, will pay a reduced monthly premium. The tax credit amount that offsets the premium amount the consumer pays is sent directly from the federal government to the insurer.



Cost-Sharing Reductions

Cost-sharing reduction is a type of financial assistance available under the ACA. It is based on an individual's income and paid directly to the insurance company. It helps to lower the amount individuals will have to pay out-of-pocket for deductibles, coinsurance, and copayments.

Consumers must select a silver plan in order to be receive cost-sharing reductions.

Silver
70% approx. coverage
Low Monthly Premiums
High Deductibles
Cost Sharing Subsides

Deductible - The amount an enrollee pays for covered health care services before the insurance plan will pay.

Coinsurance - The percentage of allowed charges an enrollee pays for covered health care services after the enrollee pays the deductible.

Copayment - A fixed amount an enrollee pays to the doctor, hospital, pharmacy or other health care provider at the time of service for covered health care services.

Who is eligible for cost-sharing reductions?

- Individuals and families with incomes up to 250 percent of the poverty line are eligible for cost-sharing reductions if they are eligible for a premium tax credit and purchase a silver plan through the Health Insurance Marketplace in their state. People with lower incomes receive the most assistance.
- Unlike the premium subsidies, cost-sharing reductions are not provided as a tax credit and they do not have to be “reconciled” when people file their taxes for the year they received cost-sharing reductions.

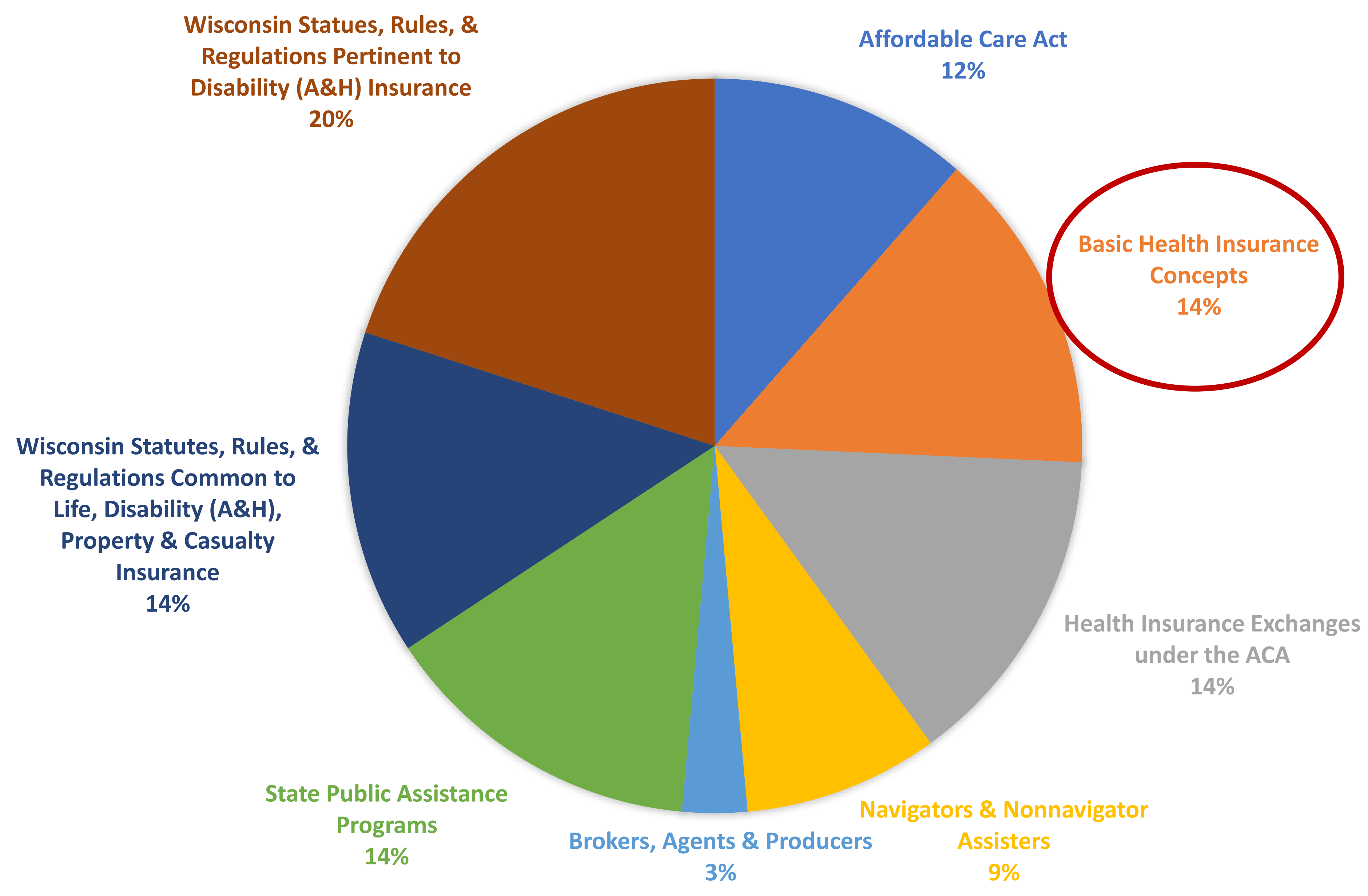
Navigators

An individual or organization that is trained and able to help consumers as they look for health coverage options through the Marketplace, including completing eligibility and enrollment forms. These individuals and organizations are required to be unbiased. Their services are free to consumers.

Navigators may not recommend that a consumer select a specific plan or set of plans—even if the consumer asks for a Navigator's recommendation.

Small Business Health Options Program (SHOP) Exchange

- The Small Business Health Options Program (SHOP) exchange changed in 2018. Consumers can no longer change or renew SHOP coverage through healthcare.gov. Small businesses should work directly with agents or insurers.
- Small businesses with fewer than 25 full-time employees with wages less than $50,000 a year may be eligible for a tax credit if the employer pays at least half of the employee’s premium and the employer purchases coverage through the SHOP exchange.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Basic Health Insurance Concepts

Four (4) questions on the exam regarding types of comprehensive health insurance plans, excepted benefits under the ACA and insurance terms.

Basic Elements in Any Contract

There are four basic elements in any contract:

- **Consideration** refers to what each party to a contract does in exchange for what the other party does. A consumer submits an application and pays and premium. The insurer promises to pay benefits as stated in the policy.
- **Meeting of the minds** means that both parties have the same understanding of the agreement and their respective obligations.
- **Capacity** to contract means that both parties have the ability to understand the terms of the contract.
- **Offer and acceptance** which means that one party makes the offer and the other party accepts it. The consumer submits the application and the insurer accepts it.

Definition of Risk

Individuals face the hazard of the high cost of an illness or injury. There are ways to cope with these risks: taking no action, trying to eliminate the risk, reducing the risk or transferring all or part of the risk to another party. Insurance is a mechanism that is used to transfer part or all of the risk.

The basic principles of insurance involve the:

- uncertainty of a loss;
- the measurability of loss;
- a large number of insureds;
- a significant size of a potential loss; and
- a method for sharing the risk.

Unique Aspects of the Health Insurance Contract

- **Conditional** – performance under the contract is conditional upon the event of a covered loss.
- **Unilateral** – A health insurance contract is unilateral because only one party makes a promise. The insurer promises to pay claims.
- **Adhesion** – The health insurer offers the coverage and the consumer can only choose to take the coverage or to reject it.

Pooling Concept - Law of Large Numbers

The law of large numbers means the larger the number of risks that an insurance company insures the closer they will be able to predict the actual results of the chance of a claim occurring. The insurer uses past experience to predict how many individuals are likely to file claims during a given period of time.

Insurance Advertising Limitations 1

The following words and phrases may not be used so as to exaggerate any benefit beyond the terms of the policy.

- all
- full
- complete
- comprehensive
- unlimited
- up to
- as high as
- this policy will pay your hospital and surgical bills
- this policy will fill the gaps under Medicare and your present insurance
- this policy will replace your income

These words may only be used to fairly and accurately describe a benefit.

Insurance Advertising Limitations 2

An insurance advertisement may not use the terms below unless the statement is literally true.

- pays hospital, surgical, medical bills
- pays dollars to offset the cost of medical care
- safeguards your standard of living
- pays full coverage
- pays complete coverage
- pays for financial needs
- provides for replacement of your lost paycheck
- guarantees your paycheck
- guarantees your income
- continues your income
- provides a guaranteed paycheck
- provides a guaranteed income
- fills the gaps in Medicare

Where appropriate, these or similar words or phrases may properly be used if preceded by the words “help,” “aid,” “assist,” or similar words.

Types of Insurance Companies

Insurance companies selling comprehensive health insurance in Wisconsin include stock companies, service insurance corporations, mutual companies and cooperatives.

- In a **stock company**, people purchase shares of the company's stock. The stockholders control the company and share in the earnings of the company through periodic dividend payments.
- **Mutual companies** have no stockholders and are owned by the policyholders.
- **Service insurance corporations** are nonprofit service plans set up by health care providers where policyholders have no control.
- **Cooperative health care plans** are nonprofits owned by the members of the cooperative.

Disability (A&H) Insurance

Disability (accident & health) insurance is generally defined as any type of insurance that covers policy claims involving:

(1) medical and surgical expenses;

(2) indemnities for loss of income due to accident or health;

(3) accidental death and disability;

(4) hospital care; and

(5) long-term care

When you see the statement, "every group disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy" think **health insurance policy**.

Types of Managed Care Health Insurance 1

Health Maintenance Organization (HMO)

A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO often requires that the enrollees live or work in its service area to be eligible for coverage. HMOs often require that an enrollee chooses a primary care physician (PCP) to manage patient care.

Point of Services Plan (POS)

Some HMOs offer point-of-service plans, which require that enrollees designate a network primary care physician. if you need to see other providers, except for OB-GYNS. In fact, "point of service" means that your PCP is your number one go-to for care—they are your initial point of service. If you need to see specialists or get any other care, your PCP will coordinate it.

Types of Managed Care Health Insurance 2

Preferred Provider Organization (PPO)

A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. Individuals pay less if they use providers that belong to the plan's network. Individuals can use doctors, hospitals, and providers outside of the network for an additional cost.

PPO plans do not require you to choose a PCP, but it's recommended. Referrals to specialists are also not required.

Exclusive Provider Organization (EPO)

A type of health plan that offers a **local** network of doctors and hospitals for you to choose from. An EPO is usually more pocket-friendly than a PPO plan. However, if you choose to get care outside of your plan's network, it usually will not be covered (except in an emergency).

If you're looking for lower monthly premiums and are willing to pay a higher deductible when you need health care, you may want to consider an EPO plan.

Characteristics of HMO vs PPO

HMO vs. PPO	HMO	PPO
Out-of-pocket costs, premiums, and deductibles	Lower	Higher
Primary Care Physician (PCP)	Required	Not Required
Coverage for out-of-network provider	Emergencies Only	Yes, but at higher cost than those in-network
Specialists	Must be referred by PCP	No referral needed
Network Size	Smaller	Larger

Essential Health Insurance Terms

Deductible - The amount an enrollee pays for covered health care services before the insurance plan will pay.

Coinsurance - The percentage of allowed charges an enrollee pays for covered health care services after the enrollee pays the deductible.

Copayment - A fixed amount an enrollee pays to the doctor, hospital, pharmacy or other health care provider at the time of service for covered health care services.

Coinsurance - The percentage of allowed charges an enrollee pays for covered health care services after the enrollee pays the deductible.

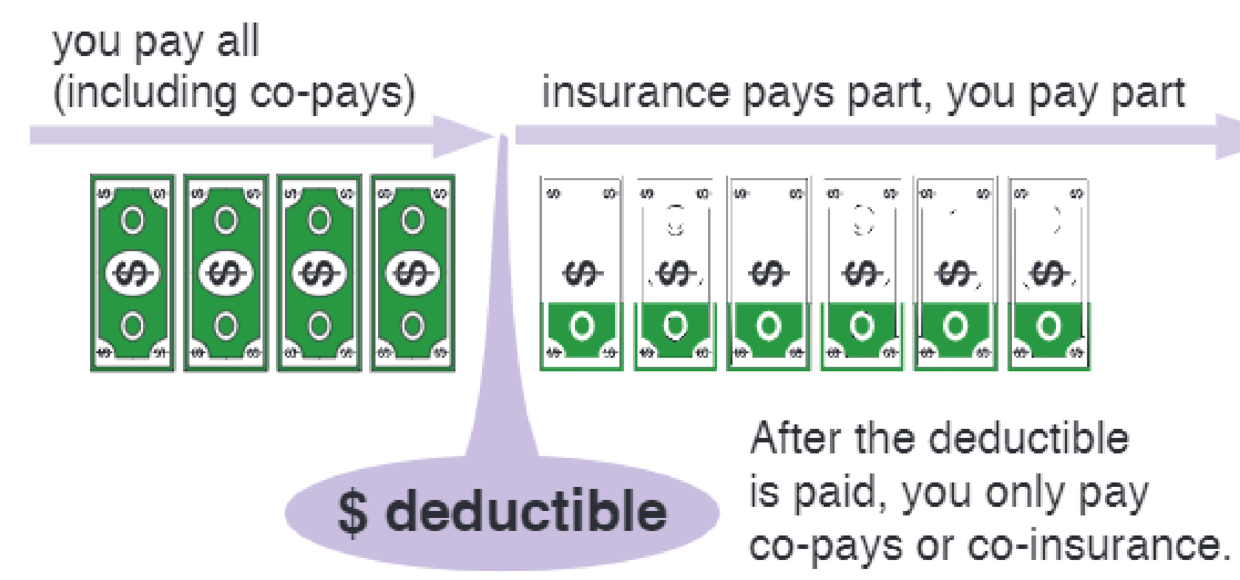
Co-insurance:

The percentage you pay for a service.

Example:

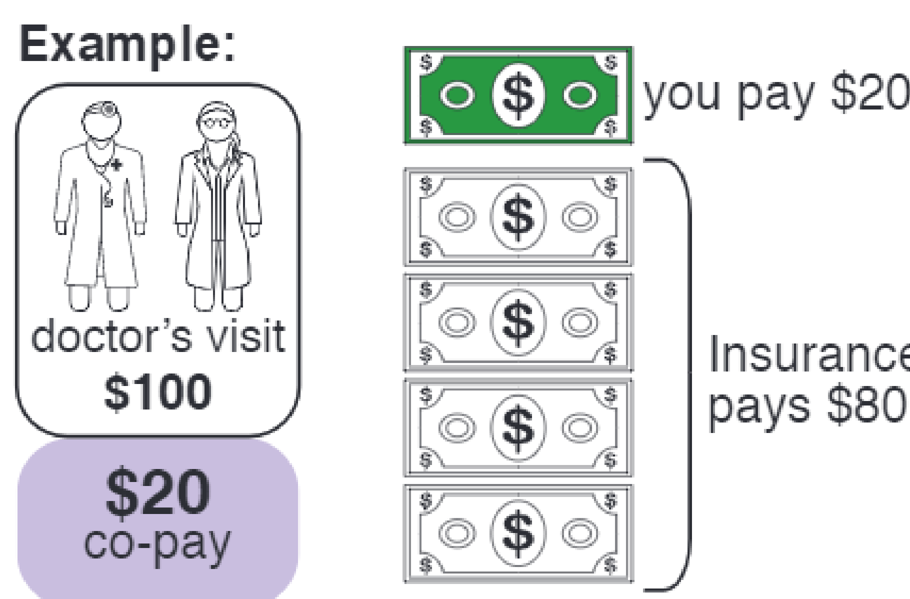
30%
co-insurance

Deductible - The amount an enrollee pays for covered health care services before the insurance plan will pay.



Note: A plan can have a **separate** deductible for medication.

Copayment - A fixed amount an enrollee pays to the doctor, hospital, pharmacy or other health care provider at the time of service for covered health care services.



Max Out-of-Pocket

The most you have to pay for **covered** services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance for in-network care and services, your health plan pays 100% of the costs of covered benefits.

The out-of-pocket limit doesn't include:

- Your monthly premiums
- Anything you spend for services your plan doesn't cover
- Out-of-network care and services
- Costs above the allowed amount for a service that a provider may charge

The out-of-pocket limit for Marketplace plans varies but can’t go over a set amount each year. For the 2021 plan year: The out-of-pocket limit for a Marketplace plan can’t be more than $8,550 for an individual and $17,100 for a family.

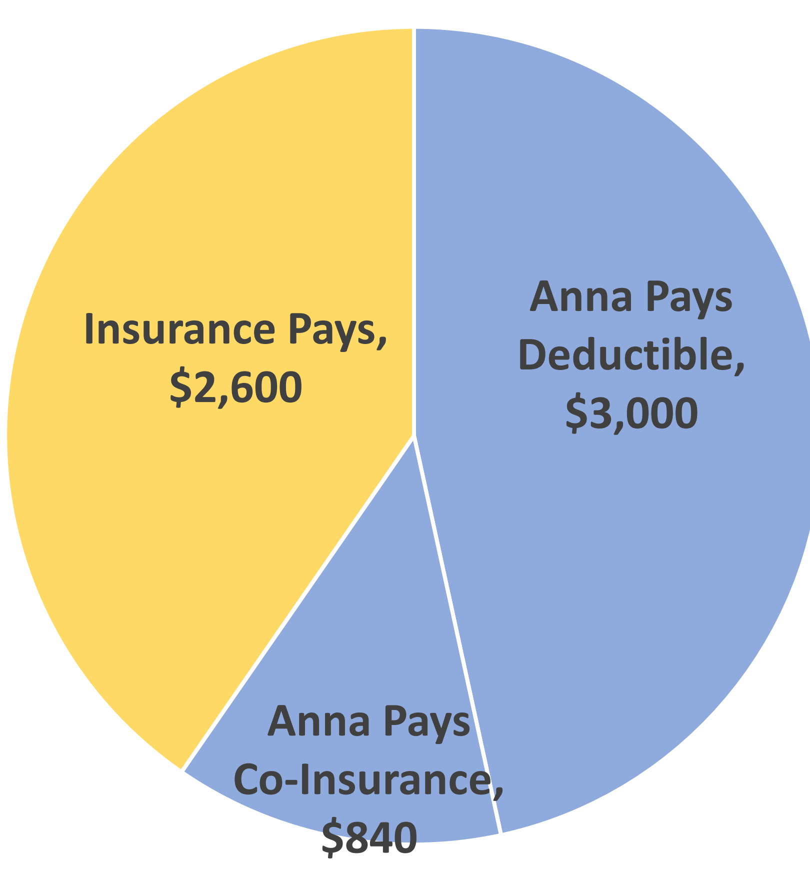
Quiz on Cost Sharing

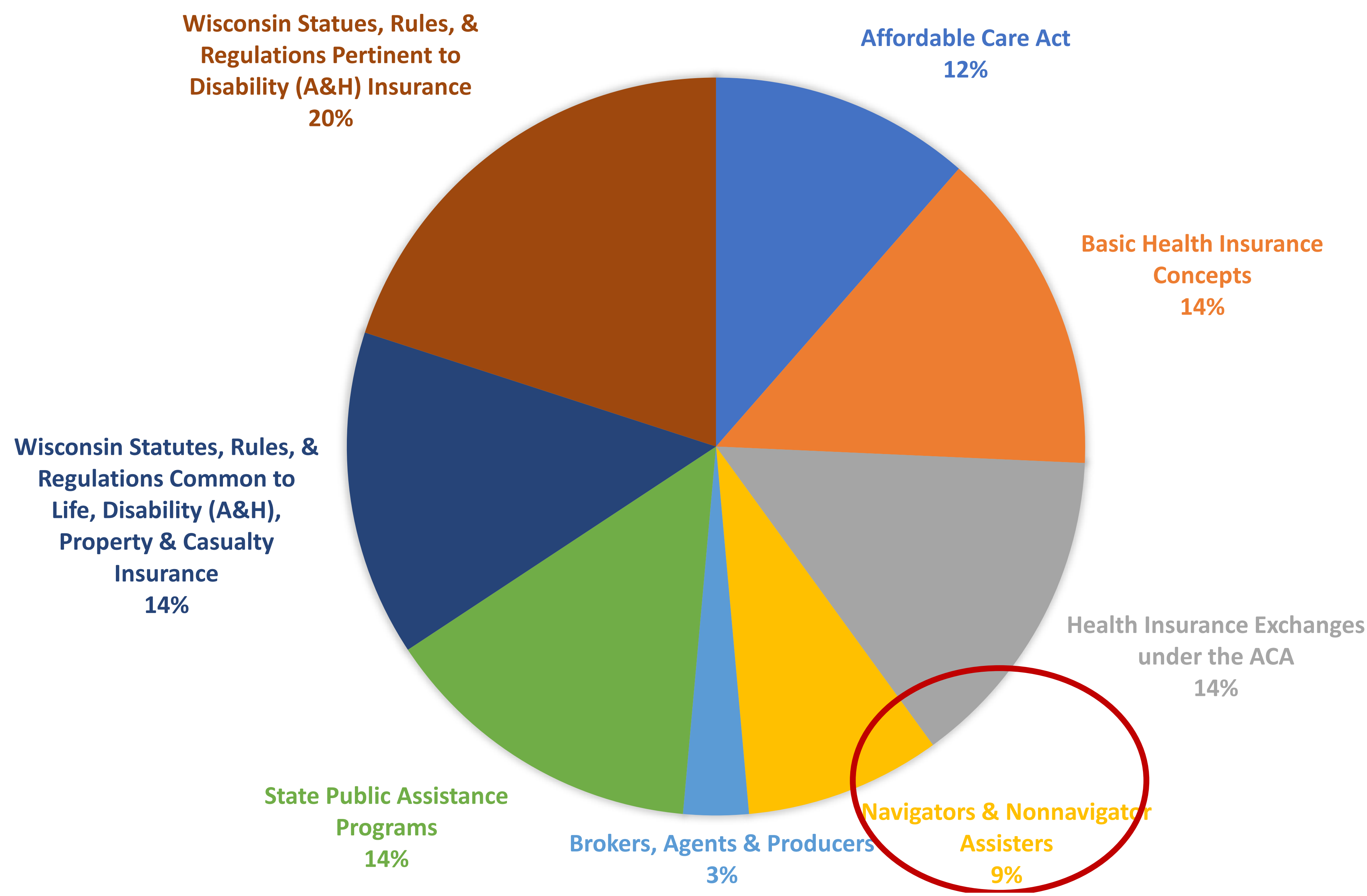
Anna has a procedure at an in-network hospital. Anna's plan has a $3,000 deductible, provides 80/20 coinsurance, and a max-out-of pocket limit of $6,000. The allowed charges for Anna's procedure totaled $7,200. Anna hasn't had any other health care expenses yet this year.

How much will Anna pay for the procedure out of pocket?

Answer How to Calculate Cost Sharing

1. Subtract the deductible from the total $7,200-$3,000 = $4,200
2. Calculate coinsurance $4,200x .20 = $840
3. Add deductible and coinsurance together. $3,000+ $840 = $3,840
4. Ask does this amount exceed her max-out-of-pocket limit?
   - No, Anna's max-out-of-pocket limit is $6,000, so she pays $3,840 for the procedure.
   - Remember Anna is responsible for the deductible and co-insurance until she reaches her max-out-of-pocket limit for the year.




EXAM SECTIONS
Wisconsin Statues, Rules, & Regulations Pertinent to Disability (A&H) Insurance
20%
Affordable Care Act
12%
Basic Health Insurance Concepts
14%
Wisconsin Statutes, Rules, & Regulations Common to Life, Disability (A&H), Property & Casualty Insurance
14%
Health Insurance Exchanges under the ACA
14%
State Public Assistance Programs
14%
Brokers, Agents & Producers
3%
Navigators & Nonnavigator Assisters
9%

Navigators and Nonnavigator Assisters

Three (3) questions on the exam regarding Navigators and Certified Application Counselors (aka Nonnavigator Assisters), permitted practices, prohibited practices, and confidential, integrity and availability of PHI.

Navigators

Navigators are funded by the federal government to help individuals determine their eligibility for public assistance programs using the health insurance exchange/marketplace website. Navigators cannot legally provide advice to consumers about which health insurance plan to choose and are not permitted to sell insurance.

Wisconsin Regulations Require Navigators to:

1. Be a resident of Wisconsin.
2. Complete 16 hours of accident and health pre-licensing training.
3. Complete initial and annual CMS training requirements.
4. Pass the Navigator Exam.
5. Submit fingerprinting and pass a background check.
6. Be affiliated with a navigator entity.
7. Complete 8 annual continuing education requirements.

Certified Application Counselors

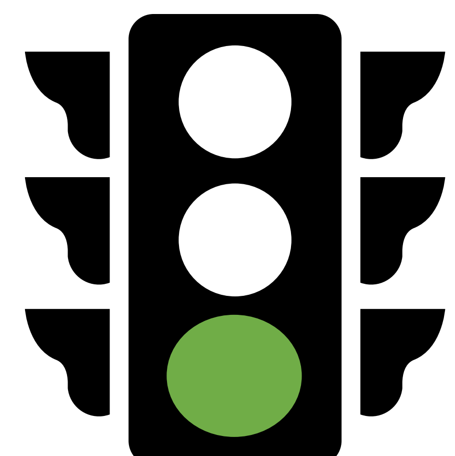
Certified Application Counselors (CACs) help individuals apply for public assistance programs and compare health insurance plans sold on the health insurance exchange/marketplace. CACs work in settings such as hospitals, local health departments, and health care provider offices.

Wisconsin Regulations Require that Certified Applications Counselors:

1. Complete 16 hours of accident and health pre-licensing training.
2. Complete initial and annual CMS training requirements.
3. Pass the Navigator Exam.
4. Be associated with a Certified Application Counselor Designated Organization.
5. Complete 8 annual continuing education requirements.

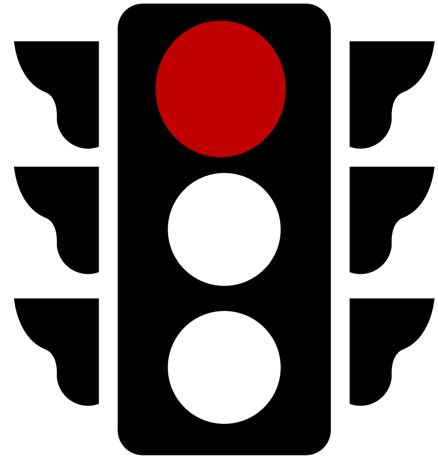
Navigator and CAC Permitted Practices

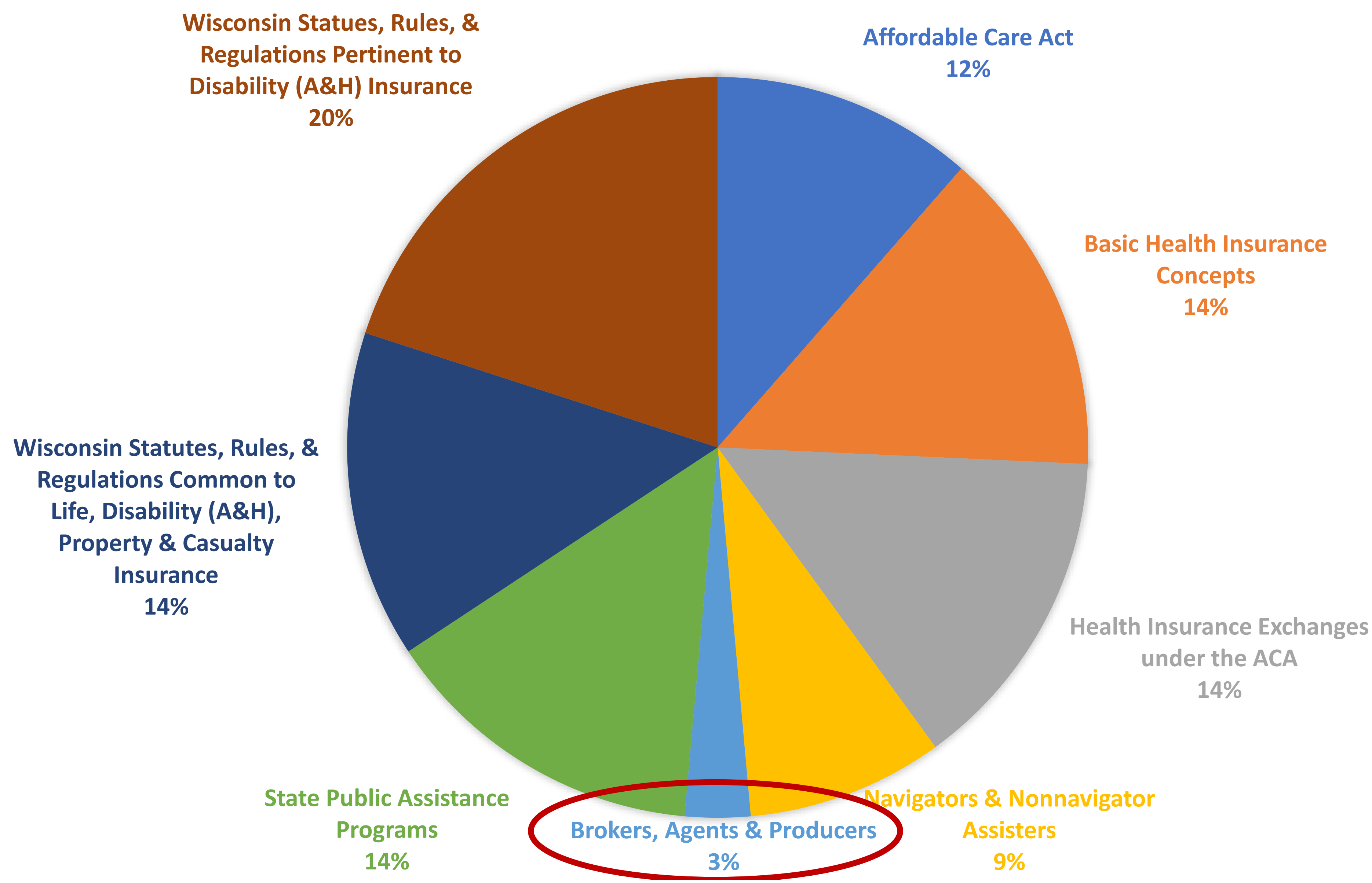
1. Provide public education on health insurance and enrollment options.
2. Distribute fair and impartial information.
3. Help consumers review plans available on and off the exchange.
4. Facilitate enrollment in a QHP on the exchange.
5. Describe the features and benefits of plans.
6. Provide information about provider networks and metal tiers.
7. Refer consumers to appropriate state/federal agencies for health coverage such as Medicaid and Medicare.



Navigator and CAC Prohibited Practices

1. Cannot receive compensation from an insurer.
2. Cannot provide information about plans off exchange.
3. Cannot recommend one plan over another.
4. Cannot engage in deceptive acts or unfair methods of competition.




EXAM SECTIONS
Affordable Care Act
12%
Basic Health Insurance
Concepts
14%
Health Insurance Exchanges
under the ACA
14%
Navigators & Nonnavigator
Assisters
9%
Brokers, Agents & Producers
3%
State Public Assistance
Programs
14%
Wisconsin Statutes, Rules, &
Regulations Common to
Life, Disability (A&H),
Property & Casualty
Insurance
14%
Wisconsin Statues, Rules, &
Regulations Pertinent to
Disability (A&H) Insurance
20%

Brokers, Agents/Producers

One (1) question on the roles and responsibilities of brokers, agents/producers and compensation regulation.

Roles

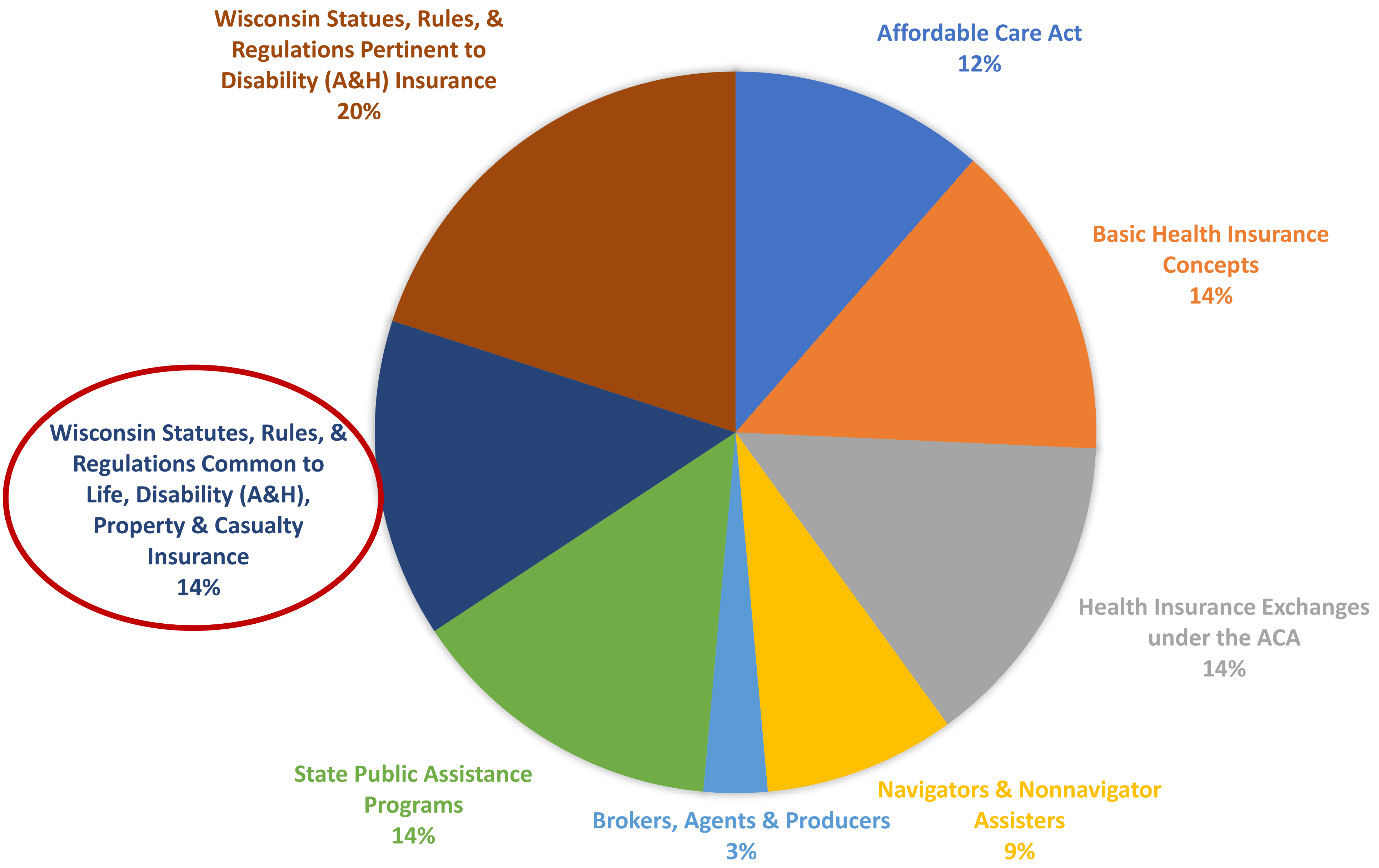
1. Insurance producers or agents represent insurance companies.
   - Producers or agents will look for clients who will buy insurance products.
2. Insurance brokers represent insurance buyers
   - Insurance brokers look for insurance products that will meet their clients' needs.
3. An insurance “intermediary” includes producers/agents and brokers and anyone who does any of the following things:
   - soliciting, negotiating, or placing insurance or annuities on behalf of an insurer or a person seeking insurance or annuities; or
   - advising persons about insurance needs and coverages.

Responsibilities

- Protect personal health Information
  - Agents that obtain information from an insured or an individual seeking coverage pertaining to the person's physical or mental health, medical history, or medical treatment, must take specific steps to ensure that personally identifiable information is shredded, erased, modified or otherwise handled so that no unauthorized person has access to the information
- Protect the consumers financial information according with Wisconsin law.
- Review with the applicant all questions contained in each application. The agent or representative must record on each application all material information disclosed by the applicant.

Compensation

1. Only brokers and agents/producers, licensed by the Office of the Commissioner of Insurance, may receive compensation for selling insurance.
2. A brokers and agents/producers may accept compensation under these circumstances. However, the agent must disclose to the applicant in writing:
   - the amount of compensation to be paid by the insured (other than a commission payment made by the insurer); and
   - the fact, if applicable, that compensation will be paid by another source
3. Brokers and agents/producers may be paid for referring business to another brokers or agent/producer but there are limitations.
4. A brokers or agents/producers may not be paid for procuring insurance upon their own property, life, or other risk unless during the prior year the intermediary sold other insurance with the same insurance company with total premiums exceeding the premiums on the intermediary's own risks.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Health Insurance Exchanges under the ACA 14%
State Public Assistance Programs 14%
Navigators & Nonnavigator Assisters 9%
Brokers, Agents & Producers 3%

Wisconsin Statutes, Rules, & Regulations Common to Life, Disability (A&H), Property & Casualty Insurance

Five (5) questions on the exam on responsibilities of the Commissioner of Insurance, licensing, marketing practices, general statutes, rules, and regulations affecting insurance contracts, and regulation of specific clauses in insurance contract.

Restraint of Competition

It is illegal for any of the following persons to commit or agree to take part in any act of boycott, **coercion**, or intimidation which tends to unreasonably restrain the business of insurance, or which tends to create a monopoly in the insurance business:

- a person who is or should be licensed in Wisconsin;
- a person who is an employee or agent of the person who is or should be licensed in Wisconsin;
- a person whose main interest is to compete in the same business as those persons who are or should be licensed in Wisconsin;
- a person who acts on behalf of those persons mentioned in the preceding sections.

Independent Review

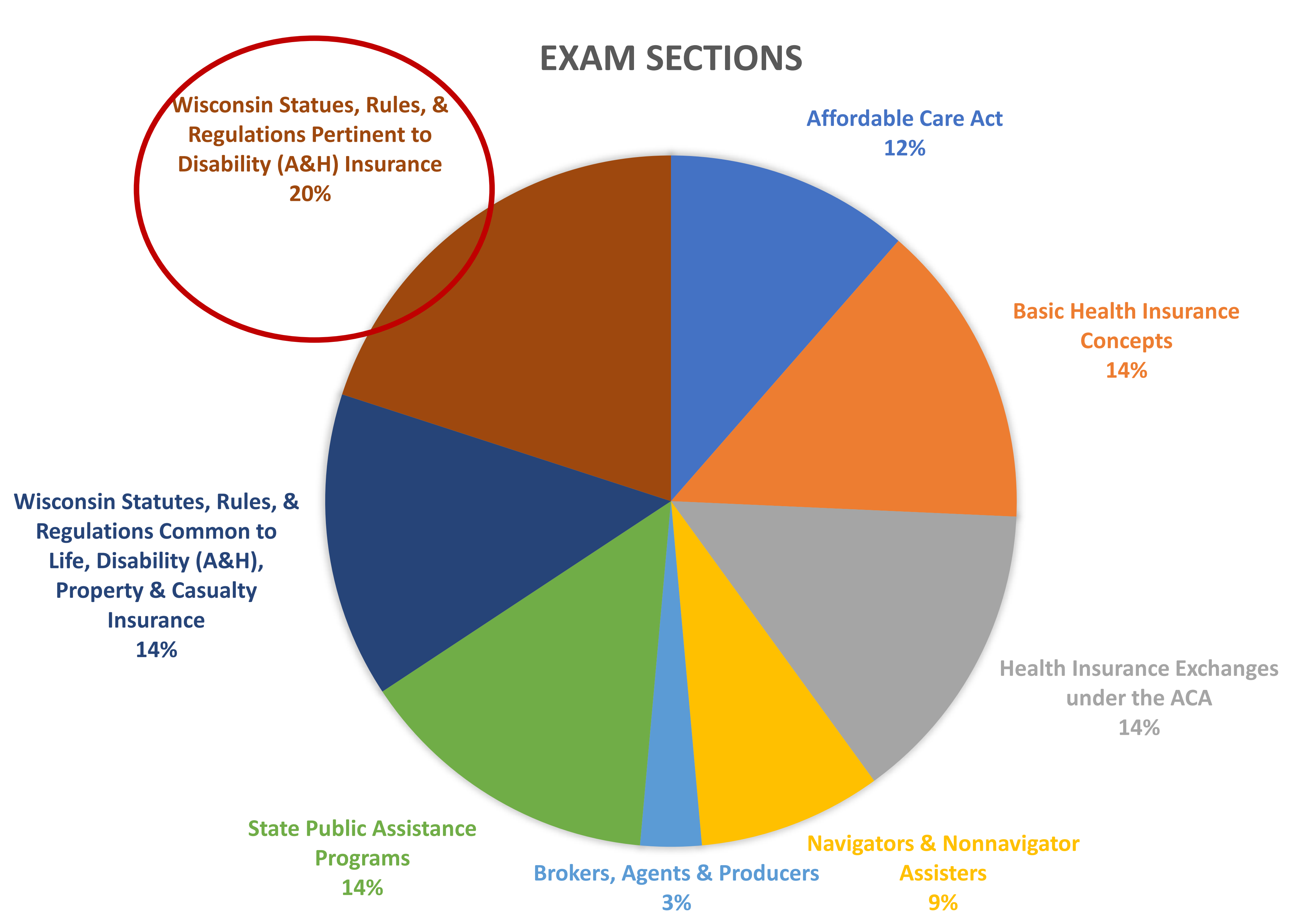
The independent review process provides an insured with an opportunity to have medical professionals who have no connection to their health plan review a dispute. The IRO assigns the dispute to a clinical peer reviewer who is an expert in the treatment of the disputed medical condition. The IRO has the authority to determine whether the treatment should be covered by the health plan.

- The dispute must involve a medical judgment. An insured can request an independent review whenever:
  - The health plan denies coverage for treatment because it maintains that the treatment is not medically necessary; or
  - That the treatment is experimental ; or
  - A denial of a request for out-of-network services when the insured believes that the clinical expertise of the out-of-network provider is medically necessary; or
  - The health plan’s denial based on a preexisting condition exclusion or the plan’s rescission of the policy.

Small Group Employer

In Wisconsin, a small employer is defined as one who employs at least two but not more than 50 employees.

Under the Affordable Care Act, every small group and comprehensive individual health insurance policy is required to include essential health benefits. These benefits serve as a minimum requirement of benefits that must be included in every small group and comprehensive individual health insurance policy.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Wisconsin Statutes, Rules, & Regulations Pertinent to Disability Insurance

Seven (7) questions on the exam on policy provisions, coverages, marketing methods and practice, requirements for group health policies, Medicare Supplements and short-term medical policies.

Policy Provisions

- Right to Return
- Grace Periods
- Disclosure Requirements
- Continuation and Conversation Privileges
- Independent Review
- Grievance

Coverages

Mandated Benefits in Health Insurance Policies

- Professional Health Care Service Providers
- Covered Persons
- Mandatory Benefits

Professional Health Care Service Providers

Chiropractors

Must cover services provided by a chiropractor if the policy would provide coverage for the same services if performed by a physician or osteopath. The insurer may not require the insured to be referred to a chiropractor by a physician to receive benefits.

Dentists

Must provide coverage for diagnosis or treatment of a condition or complaint performed by a licensed dentist if the policy covers diagnosis and treatment of the condition if performed by any other health care provider.

Nonphysician providers

Must cover services provided by a chiropractor if the policy would provide coverage for the same services if performed by a physician or osteopath. The insurer may not require the insured to be referred to a chiropractor by a physician to receive benefits.

Nurse Practitioners

Must cover services provided by a nurse practitioner if the policy would provide coverage for the same services if performed by a physician or osteopath. The insurer may not require the insured to be referred to a nurse practitioner by a physician to receive benefits.

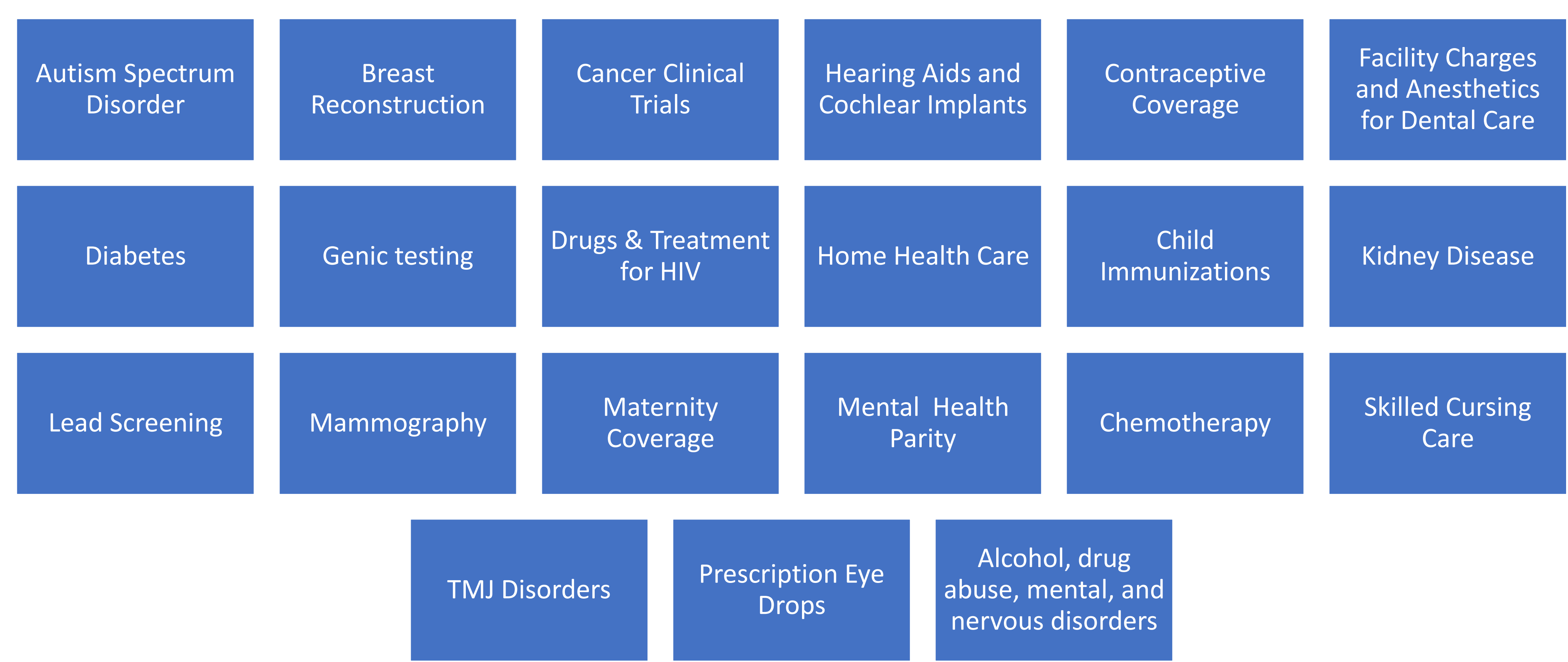
Optometrist

May not exclude coverage for services provided by an optometrist if the contract covers the same service when it is provided by another health care provider. Insurers may exclude all vision care services and procedures from coverage.

Covered Persons

- Adopted Children
- Dependents
- Grandchildren
- Handicapped Children
- Newborn Infants
- Students on Medical Leave

Mandatory Covered Benefits



Kidney Disease

Every disability (accident & health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy, that covers hospital expenses must provide coverage for hospital inpatient and outpatient treatment of kidney disease, which may be limited to dialysis, transplantation, and donor-related services.

The coverage is not required to duplicate Medicare benefits, and may be subject to the same limitations that apply to other covered health conditions.

Marketing Methods and Practices

Advertising

- Advertisements and representations must be truthful, and not misleading, and must accurately describe the policy to which they apply.
- The identity of the insurer must be made clear in all of its advertisements
- Advertisements for Medicare supplement policies must include specific disclosures, including prominently identifying the insurer and the fact that the document is an advertisement for insurance, and the fact that any information or materials offered may be delivered in person by a representative of the company.
- In addition, the content, form, and method of dissemination of all advertisements, regardless by whom designed, created, written, printed, or used, are the responsibility of the insurer whose policy is advertised. Insurers must require agents to submit all proposed disability advertising to them prior to use.
- An advertisement may not confuse or mislead prospective buyers into believing that the solicitation is in some manner connected with the government agency.

Marketing Methods and Practices

Suitability

- Before an agent or insurer can advise a prospective buyer to buy an individual policy, the agent or insurer must have reasonable grounds to believe that the recommendation is not unsuitable for the applicant.
- The agent or insurer must ask such questions as are necessary to determine that the purchase of such insurance is not unsuitable for the prospective buyer.
- This rule does not apply to an individual policy issued on a group basis.
- Special rules apply to long-term care insurance solicitations. Insurers are required to develop suitability standards for their long-term care insurance products.

Requirements for Group Health Policies

Special Provisions

- The law requires small employer insurers that offer group health benefit plans in the small group market to accept any small employer in the state that applies for such coverage, and to accept any eligible individual who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health benefit plan.
- Insurers must apply minimum participation requirements uniformly among all employers. They may vary minimum participation and contribution requirements only by the size of each employer group.
- Insurers may increase the minimum participation requirements once per calendar year only if the requirements are applied uniformly to all employers applying for coverage and to all renewing employers effective on the date of renewal.
- Insurers may establish separate participation requirements that uniformly apply to all employers that provide a choice of coverage to employees or their dependents.
- Insurers may also establish separate uniform requirements based on the number or type of choice of coverage provided by the employer.

Requirements for Group Health Policies

Disclosures Requirements

An agent is required to provide the small employer with a form providing the following information

- The insurer’s right to increase premium rates and the factors limiting the amount of the increase
- The extent to which benefit design characteristics affect premium rates
- The extent to which rating factors and changes in benefit design characteristics and case characteristics affect changes in premium rates
- The small employer’s renewability rights
- The small employer’s right to ask for information concerning the policy’s benefits and premiums under all other health insurance coverage

The agent is required to sign and date the form certifying that the above information was made available to the small employer prior to completing the application and obtain the signature of the small employer acknowledging receipt of the information. The agent must give one copy of the form to the small employer and the agent or the insurer must retain one copy of the completed form.

Requirements for Group Health Policies

Termination and Nonrenewal Regulations

An insurer may nonrenew or discontinue the individual health benefit plan coverage of an individual only for the following reasons:

- Nonpayment of premium
- Fraud
- The insurer ceases to offer individual health benefit plan coverage.
- In the case of network plans, the individual no longer resides, lives or works in service area. Coverage must be terminated uniformly without regard to any health status-related factor of any covered individual.
- The individual is eligible for Medicare and the commissioner by rule permits coverage to be terminated.

Medicare Supplements

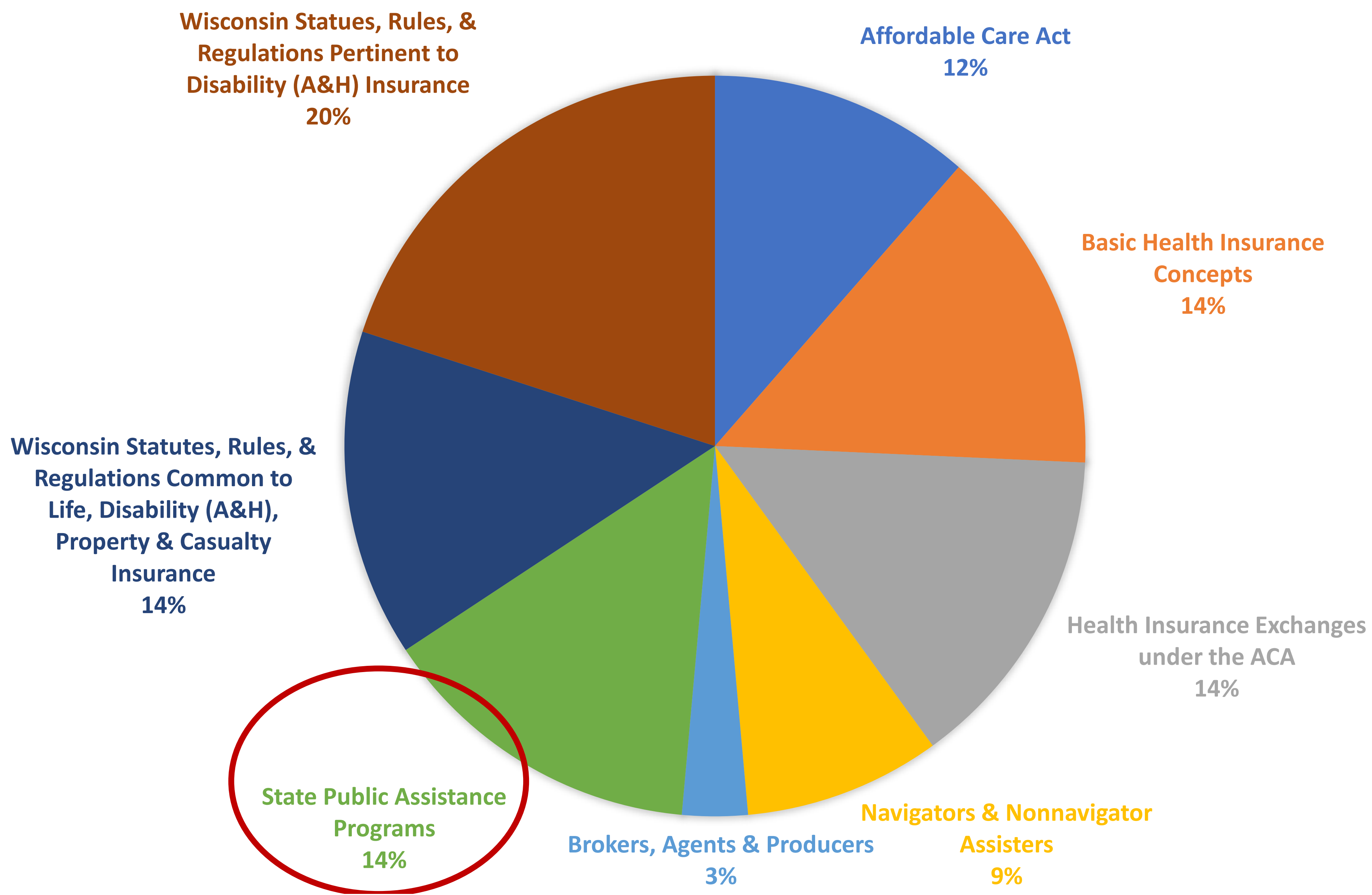
Medicare supplemental insurance, also known as Medigap, is designed to provide coverage for some of the "gaps" left by Medicare. Because Medicare may not cover all of the services needed and because Medicare requires recipients to pay deductibles, coinsurance, and copayments, many people purchase Medicare supplement policies to help pay for some of those extra services and costs. Medicare supplement policies are offered by private health insurance issuers.

- It is unlawful to claim that a Medicare supplement policy "fills the Medicare gap" or "pays everything Medicare does not" because none do so entirely.
- An agent may not describe themselves as connected in any way with the Medicare program.
- Insurers may sell only one individual Medicare supplement, one Medicare select (HMO), one Medicare replacement and one group Medicare supplement insurance policy form in Wisconsin.
- All Medicare supplement and Medicare select insurance policies must contain a provision allowing for midterm cancellation at the request of the insured, and providing for a prorated premium refund if the policyholder cancels a policy midterm. Insurers must also provide a prorated premium refund to the insured's estate if the insured dies during the term of the policy.
- Advertisements for Medicare supplement policies must include specific disclosures, including prominently identifying the insurer and the fact that the document is an advertisement for insurance, and the fact that any information or materials offered may be delivered in person by a representative of the company.

Short-term Medical Policies

- Short-term health policies, also called short-term, limited-duration insurance, are temporary solutions that can provide a low-cost safety net in case of illness or injury that might develop during the coverage period.
- Federal regulations limit the duration of short-term health insurance to an initial period of less than 12 months, and, taking into account any extensions, a maximum duration of no longer than 36 months in total. Short-term health insurance is typically bought in one-month increments that make it convenient to drop at the end of any month. Short-term health policies are not renewable. Insurers can refuse to issue a second policy. Others might offer the insured another policy, but they can treat any injuries or illnesses that occurred during the previous short-term policy as preexisting conditions and will not cover treatment related to such conditions.
- Most insurers only sell short-term health policies to people under the age of 65. Each short-term health policy has its own application that contains a number of questions. Additionally, applicants must meet acceptance guidelines, usually including acceptable height and weight.

EXAM SECTIONS



State Public Assistance Programs

Five (5) questions on the exam regarding BadgerCare Plus, EBD Medicaid, Long-Term Care Medicaid, and eligibility requirements.

Medicare

Medicare Program

Medicare is the federal health insurance program administered by the Centers for Medicare and Medicaid Services (CMS) for those who are:

- 65 years of age or over,
- some persons under 65 who are disabled,
- people with permanent kidney failure, also known as End-stage Renal disease (ESRD).

Medicare has two components: hospital insurance (Part A), and medical insurance (Part B).

Medicare Funding

- Funding for Medicare is done through **federal payroll taxes** and **premiums paid by recipients**.

Medicaid vs. Medicare

Medicaid

Medicaid is administered by states, according to federal requirements. The program is **funded jointly** by the state and the federal government.

Medicaid provides health coverage to millions of low-income Americans:

- Very low-income adults
- low-income children
- low-income pregnant people
- elderly adults
- people with disabilities

Medicare

Medicare administered by the federal government via the Centers for Medicare and Medicaid Services (CMS) and **funded by federal payroll taxes and premiums paid by recipients**.

Medicare provides health coverage to millions of Americans who are:

- 65 years of age or over,
- under 65 and are disabled,
- people with permanent kidney failure, also known as End-stage Renal disease (ESRD).

Medicare has four components:

A. Hospital coverage (enroll thru social security office)

B. Medical coverage (enroll thru social security office)

C. Medicare advantage (private plan)

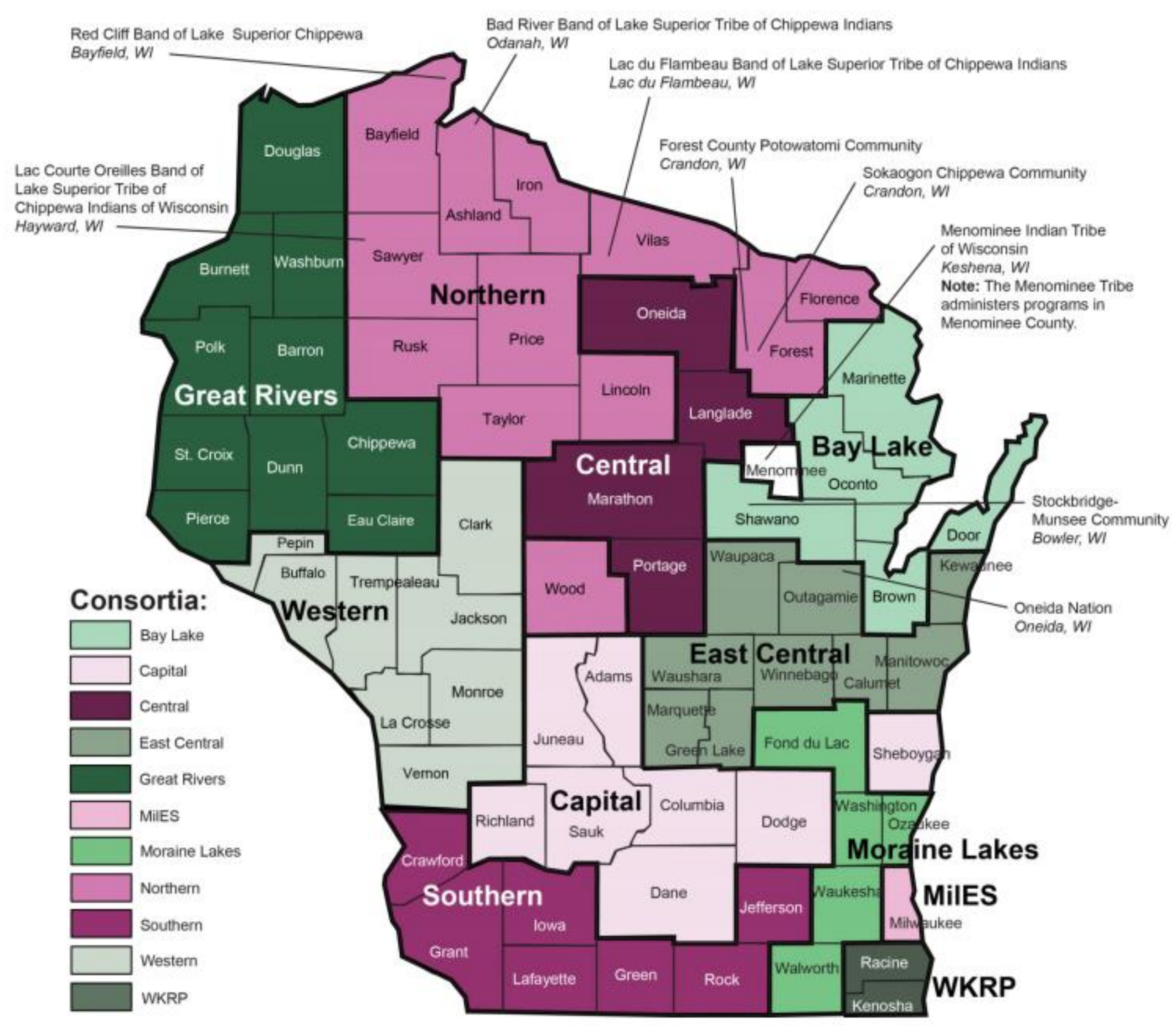
D. Prescription coverage (private plan)

About BadgerCare Plus (BC+)

BadgerCare Plus is a state and federal Medicaid program that provides health care coverage, including dental, for Wisconsinites.

- BC+ enrollment occurs by contacting the consumer's appropriate income maintenance (IM) agency (see next slide).
- Navigators and Certified Application Counselors screening consumers for BC+ eligibility and help them navigate the application process, advocate for their needs, and assist them in using their coverage to obtain health care services.

Map of Income Maintenance Consortiums and Tribal Agencies



How to Apply

Filing an Application

A person may use any of the following methods to complete and submit an application:

Online at ACCESS.wi.gov

In-person (face-to-face)

Phone

Paper application

Filing Date

- The filing date is the day a signed health care application is submitted to the IM agency.
- In most cases, eligibility starts as of the first day of the month in which the application was filed.
- Applicants can also request up to three months of backdating for most programs.
  - Note: Some pregnant women who are immigrants or inmates, as well as children with higher incomes, do not qualify for backdated coverage.
- IM agencies have 30 days from when they receive the application to determine eligibility.

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  - Note: Some pregnant women who are immigrants or inmates, as well as children with higher incomes, do not qualify for backdated coverage.
- IM agencies have 30 days from when they receive the application to determine eligibility.

Eligibility Determinations

- When someone applies for health care coverage, the IM agency considers:
- Whether the person meets all of the non-financial rules for health care programs.
  - For example, is the person a U.S. citizen or does the person have a qualifying immigration status?
- Whether the person meets all of the financial rules for health care programs.
  - For example, does a 67-year-old applicant have assets below the EBD Medicaid asset limit?

BadgerCare Plus (BC+) Eligibility

Eligible Categories	Residency Requirement	Citizen or Qualifying Immigrant	Income Limit	Asset Limit
Child	Wisconsin resident physically present with an intent to reside in Wisconsin	U.S. citizen	Child – 306% FPL	There is no asset limit for BC+
Parent or caretaker relative		Qualifying Immigrant	Parents – 100% FPL	
Pregnant person			Pregnant Person – 306% FPL	
Childless adults age 19 through 64 years old			Childless Adult – 100% FPL	
			No Limit for Former Foster Care Youth	

Counting Income for BadgerCare Plus

Most taxable income is counted for BadgerCare Plus. This includes (but is not limited to):

- Taxable gross earnings from a job,
- Taxable earnings from self-employment
- Unemployment compensation (but NOT FPUC)
- Financial aid, if used for living expenses
- Taxable retirement, pension, and annuities
- Interest and dividends

What Income Is Not Counted?

Examples of common types of income that are not counted for BadgerCare Plus include:

- Child support
- Supplemental Security Income (SSI)
    - SI - SSI/Supplemental Security Income
    - SISE - SSI-E/Supplemental Security Income - Expenditure
    - SISS - State Supplemental Security Income
- Gifts or other money from another person
- Worker's compensation
- Veteran's benefits

Federal Poverty Levels

2022 Federal Poverty Levels (monthly income)

Group Size	50%	100%	201%	250%*	306%	400%*
One	$566	$1,133	$2,276	$2,683	$3,465	$4,293
Two	763	1,526	3,067	3,629	4,669	5,807
Three	960	1,919	3,858	4,575	5,873	7,320
Four	1,156	2,313	4,648	5,521	7,076	8,833
Five	1,353	2,706	5,439	6,467	8,280	10,347
Six	1,550	3,099	6,229	7,413	9,483	11,860
Each additional	+197	+393	+791	+946	+1,204	+1,513

* Income levels marked with an asterisk relate to insurance coverage through the Marketplace. These 2021 FPLs remain in effect until Nov. 2022.

Updated Feb 2022

2022 Poverty Guidelines: 48 Contiguous States (all states except AK and HI)

Per Year

Household/ Family Size	25%	50%	75%	100%	125%	133%	135%	138%	150%	175%
1	$3,398	$6,795	$10,193	$13,590	$16,988	$18,075	$18,347	$18,754	$20,385	$23,783
2	$4,578	$9,155	$13,733	$18,310	$22,888	$24,352	$24,719	$25,268	$27,465	$32,043
3	$5,758	$11,515	$17,273	$23,030	$28,788	$30,630	$31,091	$31,781	$34,545	$40,303
4	$6,938	$13,875	$20,813	$27,750	$34,688	$36,908	$37,463	$38,295	$41,625	$48,563
5	$8,118	$16,235	$24,353	$32,470	$40,588	$43,185	$43,835	$44,809	$48,705	$56,823
6	$9,298	$18,595	$27,893	$37,190	$46,488	$49,463	$50,207	$51,322	$55,785	$65,083
7	$10,478	$20,955	$31,433	$41,910	$52,388	$55,740	$56,579	$57,836	$62,865	$73,343
8	$11,658	$23,315	$34,973	$46,630	$58,288	$62,018	$62,951	$64,349	$69,945	$81,603
9	$12,838	$25,675	$38,513	$51,350	$64,188	$68,296	$69,323	$70,863	$77,025	$89,863
10	$14,018	$28,035	$42,053	$56,070	$70,088	$74,573	$75,695	$77,377	$84,105	$98,123
11	$15,198	$30,395	$45,593	$60,790	$75,988	$80,851	$82,067	$83,890	$91,185	$106,383
12	$16,378	$32,755	$49,133	$65,510	$81,888	$87,128	$88,439	$90,404	$98,265	$114,643
13	$17,558	$35,115	$52,673	$70,230	$87,788	$93,406	$94,811	$96,917	$105,345	$122,903
14	$18,738	$37,475	$56,213	$74,950	$93,688	$99,684	$101,183	$103,431	$112,425	$131,163

Household/ Family Size	180%	185%	200%	225%	250%	275%	300%	325%	350%	375%	400%
1	$24,462	$25,142	$27,180	$30,578	$33,975	$37,373	$40,770	$44,168	$47,565	$50,963	$54,360
2	$32,958	$33,874	$36,620	$41,198	$45,775	$50,353	$54,930	$59,508	$64,085	$68,663	$73,240
3	$41,454	$42,606	$46,060	$51,818	$57,575	$63,333	$69,090	$74,848	$80,605	$86,363	$92,120
4	$49,950	$51,338	$55,500	$62,438	$69,375	$76,313	$83,250	$90,188	$97,125	$104,063	$111,000
5	$58,446	$60,070	$64,940	$73,058	$81,175	$89,293	$97,410	$105,528	$113,645	$121,763	$129,880
6	$66,942	$68,802	$74,380	$83,678	$92,975	$102,273	$111,570	$120,868	$130,165	$139,463	$148,760
7	$75,438	$77,534	$83,820	$94,298	$104,775	$115,253	$125,730	$136,208	$146,685	$157,163	$167,640
8	$83,934	$86,266	$93,260	$104,918	$116,575	$128,233	$139,890	$151,548	$163,205	$174,863	$186,520
9	$92,430	$94,998	$102,700	$115,538	$128,375	$141,213	$154,050	$166,888	$179,725	$192,563	$205,400
10	$100,926	$103,730	$112,140	$126,158	$140,175	$154,193	$168,210	$182,228	$196,245	$210,263	$224,280
11	$109,422	$112,462	$121,580	$136,778	$151,975	$167,173	$182,370	$197,568	$212,765	$227,963	$243,160
12	$117,918	$121,194	$131,020	$147,398	$163,775	$180,153	$196,530	$212,908	$229,285	$245,663	$262,040
13	$126,414	$129,926	$140,460	$158,018	$175,575	$193,133	$210,690	$228,248	$245,805	$263,363	$280,920
14	$134,910	$138,658	$149,900	$168,638	$187,375	$206,113	$224,850	$243,588	$262,325	$281,063	$299,800

Per Month

Household/ Family Size	25%	50%	75%	100%	125%	133%	135%	138%	150%	175%
1	$283	$566	$849	$1,133	$1,416	$1,506	$1,529	$1,563	$1,699	$1,982
2	$381	$763	$1,144	$1,526	$1,907	$2,029	$2,060	$2,106	$2,289	$2,670
3	$480	$960	$1,439	$1,919	$2,399	$2,552	$2,591	$2,648	$2,879	$3,359
4	$578	$1,156	$1,734	$2,313	$2,891	$3,076	$3,122	$3,191	$3,469	$4,047
5	$676	$1,353	$2,029	$2,706	$3,382	$3,599	$3,653	$3,734	$4,059	$4,735
6	$775	$1,550	$2,324	$3,099	$3,874	$4,122	$4,184	$4,277	$4,649	$5,424
7	$873	$1,746	$2,619	$3,493	$4,366	$4,645	$4,715	$4,820	$5,239	$6,112
8	$971	$1,943	$2,914	$3,886	$4,857	$5,168	$5,246	$5,362	$5,829	$6,800
9	$1,070	$2,140	$3,209	$4,279	$5,349	$5,691	$5,777	$5,905	$6,419	$7,489
10	$1,168	$2,336	$3,504	$4,673	$5,841	$6,214	$6,308	$6,448	$7,009	$8,177
11	$1,266	$2,533	$3,799	$5,066	$6,332	$6,738	$6,839	$6,991	$7,599	$8,865
12	$1,365	$2,730	$4,094	$5,459	$6,824	$7,261	$7,370	$7,534	$8,189	$9,554
13	$1,463	$2,926	$4,389	$5,853	$7,316	$7,784	$7,901	$8,076	$8,779	$10,242
14	$1,561	$3,123	$4,684	$6,246	$7,807	$8,307	$8,432	$8,619	$9,369	$10,930

Household/ Family Size	180%	185%	200%	225%	250%	275%	300%	325%	350%	375%	400%
1	$2,039	$2,095	$2,265	$2,548	$2,831	$3,114	$3,398	$3,681	$3,964	$4,247	$4,530
2	$2,747	$2,823	$3,052	$3,433	$3,815	$4,196	$4,578	$4,959	$5,340	$5,722	$6,103
3	$3,455	$3,550	$3,838	$4,318	$4,798	$5,278	$5,758	$6,237	$6,717	$7,197	$7,677
4	$4,163	$4,278	$4,625	$5,203	$5,781	$6,359	$6,938	$7,516	$8,094	$8,672	$9,250
5	$4,871	$5,006	$5,412	$6,088	$6,765	$7,441	$8,118	$8,794	$9,470	$10,147	$10,823
6	$5,579	$5,733	$6,198	$6,973	$7,748	$8,523	$9,298	$10,072	$10,847	$11,622	$12,397
7	$6,287	$6,461	$6,985	$7,858	$8,731	$9,604	$10,478	$11,351	$12,224	$13,097	$13,970
8	$6,995	$7,189	$7,772	$8,743	$9,715	$10,686	$11,658	$12,629	$13,600	$14,572	$15,543
9	$7,703	$7,916	$8,558	$9,628	$10,698	$11,768	$12,838	$13,907	$14,977	$16,047	$17,117
10	$8,411	$8,644	$9,345	$10,513	$11,681	$12,849	$14,018	$15,186	$16,354	$17,522	$18,690
11	$9,119	$9,372	$10,132	$11,398	$12,665	$13,931	$15,198	$16,464	$17,730	$18,997	$20,263
12	$9,827	$10,099	$10,918	$12,283	$13,648	$15,013	$16,378	$17,742	$19,107	$20,472	$21,837
13	$10,535	$10,827	$11,705	$13,168	$14,631	$16,094	$17,558	$19,021	$20,484	$21,947	$23,410
14	$11,243	$11,555	$12,492	$14,053	$15,615	$17,176	$18,738	$20,299	$21,860	$23,422	$24,983

The Health Insurance Landscape in Wisconsin

Income (% of Federal poverty level)	Pregnant Women	Children	Parents & Caretakers	Childless Adults	15 or older Family Planning Only Services	Elderly or Disabled
0-100% FPL	**BadgerCare** No premium			**BadgerCare** with premium (50-100% FPL)	Family Planning Waiver	Includes asset tests as well as income and other restrictions
100-201% FPL	**BadgerCare** No premium (up to 306%)	**BadgerCare** No premium	**Marketplace** with tax credit & cost-sharing subsidy (up to 250% FPL)			
201-250% FPL		**BadgerCare** With premium (up to 306%)				
250-306% FLP			**Marketplace** with tax credit			
306-400% FPL	**Marketplace** with tax credit					
400% + FPL	**Marketplace** with tax credit thru 2025					

The insurance options and income eligibility ranges for people who DO NOT have access to qualifying employer-sponsored insurance:

Note: regardless of income, Former Foster Care Youth are eligible for the BadgerCare Plus until age 26.

Elderly, Blind, or Disabled Medicaid

- SSI Medicaid – for people who are getting federal Supplement Security Income (SSI) payments
- EBD Medicaid - for people who are age 65 or older, blind, or disabled (but who are not getting SSI)
- Medicaid Deductible - allows people who are above the income limit for SSI related Medicaid to become eligible after they have met a deductible
- Special Status Medicaid – for people who once received SSI but no longer do and, with a special disregard, still meet the criteria for Wisconsin's SSI-Related Medicaid.

Elderly, Blind, or Disabled Medicaid Eligibility

Qualifying Age or Medical Condition(s)	Residency Requirement	Citizen or Qualifying Immigrant	Income Limit	Asset Limit
65 years or older Determined blind Determined disabled	Wisconsin resident physically present with an intent to reside in Wisconsin	U.S. citizen Qualifying Immigrant	Varies by Program	Varies by Program

Long-term Care Medicaid

- Institutional Medicaid – for elderly, blind, or disabled people who are living in a nursing home, hospital, or other institution.
- Home and Community-Based Waivers – helps elderly, blind, or disabled people live in their own homes or in the community, rather than an institution.

What Happens After You Apply

Before making a decision about eligibility, IM agencies must **verify** the information the applicant has reported.

In many cases, IM agencies can use **data exchanges** to verify the following information:

- Citizenship.
- Immigration status
- Earnings from a job
- Wisconsin unemployment benefits
- Social Security
- Supplemental Security Income
- Child support payments

Verification Checklist

- The agency will send a verification checklist (VCL), called a Notice of Proof Needed, listing the items that are needed.
- A VCL will also be sent if the agency is missing information needed to make a decision.
- If an applicant does not provide requested verification, the application will be denied.

The Verification Checklist contains all of the following:

- Lists verification requirements for BadgerCarePlus or Medicaid, as well as FoodShare if applicable.
- Provides the due date(s) for providing the information requested.
- Contains specific examples of documents that are needed.
- Includes a document tracking sheet, which can be used to submit documents.

Notices of Decision

After the IM agency has verified the information reported on the application, the agency will make a decision about eligibility. The applicant will receive a letter telling them if the benefits are approved or denied. This is called a Notice of Decision.

The Notice of Decision includes the following:

- summary,
- benefits details,
- household income and deductions,
- how income was calculated,
- reporting rules,
- key contacts, and
- information about how to request a fair hearing.

Fair Hearing

- If benefits are denied, reduced, or ended and the applicant or member believes the IM agency made a mistake, contact the IM agency. The applicant or member can ask the agency for help in requesting a fair hearing. The applicant or member can also directly contact the Division of Hearings and Appeals to request a fair hearing.
- At the hearing, a hearing officer will hear from the applicant or member and the agency to find out if the decision was right or wrong, and require the agency to take action as appropriate.
- After the hearing, the hearing officer will send a written decision to the individual and the agency.

Receiving Services

- Each eligible person will receive a ForwardHealth card, which should be shared with providers when services are requested.
- If someone has received a ForwardHealth card in the past, they will not get a new one unless they request it by calling Member Services at 1-800-362-3002.

Have Questions?

Reach out to Covering Wisconsin

https://coveringwi.org/contact

Have questions about our programs or want to partner with Covering Wisconsin?

Contact Courtney Harris, Covering Wisconsin's Outreach & Partner Relations Manager at charris2@wisc.edu or **(608) 262-1838**, or fill out our contact form below and a staff member will get back to you as soon as possible.

Name *

First Name

Last Name

Email *

Fair Hearing

Subject *

Message *

Phone *

(###) ### ####

Submit

Many people take this exam more than once.