Alaska health insurance exchange update - Producers

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A new year has arrived, and with it comes a new climate in health insurance and a new marketplace as required by the Patient Protection and Affordable Care Act (PPACA), the health insurance exchange.

Alaska leadership has made the decision not to develop a state-based exchange but instead to leave the development and implementation of the health insurance exchange to the federal government. Meaning Alaska will be one of approximately 25 states that have a Federally Facilitated Exchange (FFE).

While there are still many unknowns with the PPACA and we all eagerly await additional guidance from various federal agencies, one thing that is known is that the exchange will go live on October 1, 2013 as a marketplace for individuals and small employers (2-50). The website will provide information on eligibility for tax credits or other state and federal based programs, shop for insurance, compare policies from multiple carriers and ultimately purchase health insurance.

We have received many questions regarding the FFE for Alaska and ODS Alaska as they relate to the exchange. Below you will find a list of questions we have received, as well as our responses. Please be advised, our responses represent our current understandings and should in no way be interpreted as legal advice and are subject to change.

Q: Is ODS Alaska going to participate in the FFE for Alaska?
A: ODS Alaska intends to offer plans in both the Individual and Small Business Health Options Program (SHOP) markets.

Q: Will ODS Alaska continue to offer plans for individuals and small groups outside the exchange?
A: Yes, ODS Alaska will offer plans both inside and outside the exchange for both the individual and small employer markets.

Q: What role do producers play in the exchange?
A: While we do not currently have any guidance related to the producer's role in a FFE, we do believe that producers will play a critical role in enrolling members and small employers through the exchange.

Q: Will producers be compensated for policies purchased through the exchange? If yes, how much will producers be compensated?
A: ODS Alaska intends to compensate producers for policies written through the exchange at the same compensation levels as for policies written outside of the exchange.

Q: Do plans offered outside the exchange have to be the same plans offered inside the exchange?

A: Yes and no. A carrier can make the decision to offer the same plans both inside and outside the exchange. If a carrier chooses to offer the same plans inside and outside the exchange they must be identical both in benefits and rates. However, carriers may also offer additional plans outside of the exchange.

Q: What is the producer's role with the Summary of Benefits & Coverage (SBC)?
A: The responsibility for delivery of the SBC to employers and their members falls on carriers and Plan sponsors, for both fully insured and self-funded accounts. However, producers should be clear on the rules to help their clients remain compliant with the notice. Additional information can be found at the Healthcare.gov website.

Q: What do the required plans look like from ODS Alaska (gold, silver, etc.)?
A: ODS Alaska continues to refine the plan designs it will offer both inside and outside the exchange, as the rules around Actuarial Value (AV) and Essential Health Benefits (EHB) apply to plans offered both inside and outside the exchange.

Q: Are there limits to the annual out of pocket (OOP) and deductibles for plans offered in the exchange?
A: Yes, these limits apply to individual and SHOP plans offered inside and outside the exchange.

The PPACA limits the overall **OOP** for individual and SHOP plans to $6,500 for 2014. This amount will be indexed each subsequent year and will be increased based on the Consumer Price Index (CPI). For both SHOP and individual plans the OOP will include the plan deductible, coinsurance and copays for services covered by the plan including pharmacy copays.

For SHOP plans the PPACA limits the **annual deductible** to no more than $2,000 which again will be included in the annual OOP limit. The Center for Consumer Information and Insurance Oversight (CCIIO) has indicated that as a last resort to meet AV a carrier may increase a deductible above $2,000. However, this is only after changes in copays, coinsurance and OOP and as long as the overall OOP does not exceed $6,500.

For **individual plans**, the PPACA does not limit the annual deductible; however, any deductible amount will be included in the annual OOP limit.

Q: Who is eligible for tax credits starting in 2014?
A: Individuals earning between 133 percent and 400 percent of the Federal Poverty Level (FPL) may be eligible for tax credits when purchasing an individual policy. This may be applied as a pre-paid tax credit or taken as a credit on the individual's tax return.

Small employers who employ fewer than 25 full-time workers, pay average wages below $50,000 annually, provide health insurance to their employees and cover at least 50 percent of the cost of coverage may be eligible for tax credits. Employer tax credits will be filed and received as part of the employer's tax filings. For more information, please go to

HealthCare.gov Makes Care More Affordable or IRS.gov Small Business Health Care Tax Credit.

Q: Will employees of a small group being offered employer sponsored health coverage be allowed to opt-out of the employer coverage and purchase individual coverage and obtain tax credits through the exchange?
A: Individuals who are offered employer sponsored coverage can opt-out of the employer coverage to purchase individual coverage through the exchange; however, they cannot obtain tax credits unless the employee premium contribution is in excess of 9.5 percent of the employee's gross income. In the event that an employee's premium contribution does exceed 9.5 percent of the employee's income and the employee chooses to purchase individual health insurance through the exchange, the employer may be subject to penalties.

Q: Will the exchange be up and live October 1, 2013 as required?
A: Yes, at this time timelines remain as described in the PPACA. Only Congress can make a change to the current timelines. The exchange and carriers must focus on the timeline set forth.

Q: Individual Open Enrollment Period; is this the only time an individual can enroll through the exchange?
A: The initial individual open enrollment period will be from October 1, 2013 – March 31, 2014 allowing for a broader timeframe for year one enrollment through the exchange. Each subsequent year the individual open enrollment period will be October 1 – December 7 allowing for new enrollees to purchase through the exchange and for existing individuals and families to re-evaluate their plan selection and either renew with their current carrier and plan or make a change starting the first of the following year.

Individuals will also be allowed to purchase through the exchange if they experience a qualifying event such as death, divorce, loss of coverage, etc. Additionally, Alaska Natives and American Indians (AN/AI) have monthly open enrollment rights. The exchange will monitor and make eligibility determinations including the individual's eligibility to enroll outside of the standard open enrollment period.

Q: When can small employers purchase through the exchange?
A: Small employers will be allowed to retain their current renewal date and purchase through the exchange during their normal renewal timelines. A small employer may decide to move their renewal to begin purchasing through the exchange earlier than their renewal; that decision will be at the discretion of the small employer.

Q: Are employers required to provide employee and family coverage or can coverage be limited to employee only coverage?
A: Employers are required to contribute at least 50 percent of the employee only coverage and are not required to contribute towards dependent coverage. If an employer does not contribute towards the dependent coverage, the dependent may choose to purchase coverage through the exchange and this offering does not negatively impact the dependents ability to obtain tax credits or participate in other programs for which they may be eligible.

Q: If an employer employs less than 50 employees, can they continue to offer health benefits to management only, or are they required to offer health benefits to all employees?
A: The PPACA does not require businesses to provide health benefits to their workers, but large employers face penalties starting in 2014 if they don't make affordable coverage available. Employer Responsibility Under the Affordable Care Act - Kaiser Health Reform.

We continue to wait for additional guidance from HHS related to the non-discrimination provision in PPACA, at a high level, as it is written, this provision will not allow employers to favor highly compensated employees in eligibility and benefits; this provision will apply to all plans except grandfathered plans regardless of size.

Q: Will association plans survive past 2014?
A: PPACA states that all multiple employer plans must meet the ERISA definition of an association and that the Health & Human Services (HHS) Secretary shall require that multiple employer plans register with the Department of Labor (DOL). That being stated, some plans will retain or receive bona fide status and others may not. If an association loses bona fide status they will be subject to small employer rating requirements.

Q: What support is ODS Alaska providing to employers to meet the notice requirement of the exchange?
A: HHS is developing and will release a standardized notice for employers to provide to their employees related to the exchange.

Q: If an employer retains their employer sponsored health plan, are they now required to pay 100% of the premium? Does this also apply toward dependents?
A: The minimum employer contribution will remain at 50 percent of the employee only premium. There are no requirements for an employer to contribute towards dependent coverage.

Q: Can insured individuals still be double covered?
A: There are no regulations that prohibit an individual from being covered by more than one health plan. Each individual must make the decision on what is best for them and their family.

Q: Is there any additional guidance on the penalty if an individual does not purchase health insurance? If an individual does not have health insurance can a provider or hospital turn them away?
A: The penalty will vary by person based on income and household size. In 2014 the penalty is $95 per person and $47.50 per child up to $285 per family, or 1 percent of the family, whichever is greater. Penalties will increase each subsequent year. For more information please see KFF Requirement to buy Coverage Chart. There are no changes to the guidelines for providers related to patients that do not have coverage.

Q: Are the plans and rates offered between carriers going to be the same?

A: At this time we expect that issuers will be allowed to determine the plans they offer in the markets that they participate. We have not received any federal guidance regarding standardized plans under the FFE.

Q: What, if any changes should we expect related to provider networks?
A: Each carrier will be required to meet federal network adequacy standards. Each carrier will propose plan designs and network offerings, as they deem appropriate.

Q: Will individual policies offered outside the exchange be medically underwritten?
A: No, per the PPACA all individual plans regardless of age and if they are offered inside or outside the exchange will be guarantee issue. Carriers may still ask for health information from an enrollee to help place them in the most appropriate programs as they relate to their health needs or transition of care concerns.

Q: How will the Alaska FFE and issuers handle members with late premiums?
A: Until HHS releases additional guidance on the FFE's we will not know how this will be handled. However, we do know that for individual members who are receiving a tax credit that they have elected to take as a pre-paid subsidy, the PPACA and IRS have outlined a 90-day grace period must be applied to these members, and a members coverage cannot be canceled as long as the carrier has received the member portion of the premium. Lack of receipt of the pre-paid tax credit will not be applicable for purposes of determining delinquency.