ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

MANDATED CHANGES TO HEALTH INSURANCE PLANS
JANUARY 2014

One of the main components of the Patient Protection and Affordable Care Act (ACA) is that all health insurance plans offered to individuals and small groups must meet certain requirements starting in 2014. Late in 2013, President Obama decided health insurance plans that do not meet the requirements of the ACA may be continued for another year, until 2015, subject to state approval which was granted in Alaska. However, the insured individuals need to be informed that their plan does not meet the requirements, and offered plans that do. All new plans sold in 2014 must meet the ACA requirements.

What is a "grandfathered" plan?

"Grandfathered" plans are individual and group plans that were selected before the date of the implementation of the law, March 23, 2010, and that have not changed significantly since that time. Grandfathered plans are not required to meet the all requirements and consumer protections afforded by the ACA. All other Americans are required to have health insurance that meets the requirements, or to pay a penalty.

What are the key requirements and consumer protections mandated by the ACA?

These requirements and changes do not apply to grandfathered plans, but they do apply to all other health care plans. Most of these requirements begin effective 2014, although some were effective prior to 2014. These new requirements include the following:

- Allows young adults to stay on their parent's plans until age 26;
- Requires insurance companies to cover people with pre-existing health conditions;
- Requires insurance companies to give customers an easy-to-understand summary about a health plan's benefits and coverage;
- Requires insurance companies to publicly justify any rate increase of 10% or more before raising premiums;
- Requires insurance plans to offer "ten essential health benefits";
- Makes it illegal for health insurance companies to arbitrarily cancel health insurance just because a person gets sick;
- Makes it illegal for insurance companies to cancel coverage simply because of an honest mistake on an application or for leaving out information that has little bearing on a person's health;
- Provides for free preventive care;
- Ends lifetime and yearly dollar limits on coverage of essential health benefits;
- Insurance plans have to explain why a claim has been denied and they have to inform consumers about the process for disputing a decision. An external review from an independent organization can be part of the appeal process;
- Gives patients the right to choose the doctor they want from the health plan's provider network, and to use an out-of-network emergency room without penalty.

What are the Ten Essential Health Benefits?

The essential health benefits must be offered by every non-grandfathered health insurance plan, beginning in 2014. They include[1]:

1. ambulatory patient services;
2. emergency services;
3. hospitalization;
4. maternity and newborn care;
5. mental health and substance use disorder services including behavioral health treatment;
6. prescription drugs;
7. rehabilitative and habilitative services and devices;
8. laboratory services;
9. preventive and wellness services and chronic disease management; and
10. pediatric services, including oral and vision care.

The State of Alaska also requires specific benefits[2] including:

1. Additional preventative services including prostate cancer detection and infant hearing screening;
2. Reconstructive surgery following mastectomy;
3. Diabetes care management.

What are the Required Free Preventative Health Benefits?[3]

The following benefits must be provided without charging a co-pay or coinsurance for in-network providers, even if the yearly deductible has not yet been me. These services are based on the US Preventive Care Task Force.

1. Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked;
2. Alcohol misuse screening and counseling;
3. Aspirin use to prevent cardiovascular disease for men and women of certain ages (aspirin and other OTC recommended items and services must be covered without cost-sharing only when prescribed by a health care provider);
4. Blood Pressure screening for all adults;
5. Cholesterol screening for adults of certain ages or at higher risk;
6. Colorectal cancer screening for adults over 50;
7. Depression screening for adults;
8. Diabetes (Type 2) screening for adults with high blood pressure;
9. Diet counseling for adults at higher risk for chronic disease;
10. HIV screening for everyone ages 15 to 65, and other ages at increased risk;
11. Immunization vaccines for adults;
12. Obesity screening and counseling for all adults;
13. Sexually transmitted infection (STI) prevention counseling for adults at higher risk;
14. Syphilis screening for all adults at higher risk;
15. Tobacco use screening for all adults and cessation interventions for tobacco users.

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[1] http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html#Alaska
[2] http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/ak-state-required-benefits.pdf
[3] https://www.healthcare.gov/what-are-my-preventive-care-benefits/

What is a Qualified Health Plan?

Starting in 2014, a Qualified Health Plan is an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements[4].
Two companies are certified to offer Qualified Health Plans in 2014 via the federally-operated Health Insurance Marketplace for Alaska; Premera Blue Cross Blue Shield of Alaska, and Moda Health. These insurers agree to offer the same plans through the Marketplace and to the general public.

Although the term Qualified Health Plan is only applied to insurance plans certified by the Marketplace, all non-grandfathered insurance plans must provide "minimum essential coverage."

Minimum Essential Coverage[5]

Starting January 1, 2014, the individual shared responsibility provision calls for each individual to have minimum essential health coverage (known as "minimum essential coverage") for each month, qualify for an exemption, or make a payment when filing his or her federal income tax return.[6] This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. In 2014 only, individuals who enroll by March 31, 2014 for coverage that begins on or before May 1, 2014, will not have to pay the required fee.

Limits on Cost Sharing

Cost-sharing limitations under the Patient Protection and Affordable Care Act apply to deductibles, coinsurance and copayments for in-network essential health benefits and out-of-network emergency services. Plans offered on or off the Exchange/Marketplace must adhere to certain limits regardless of plan size or funding type[7].

In-network out-of-pocket (OOP) maximums are limited for all non-grandfathered plans:

- For 2014, the OOP maximum is:
  - -$6,350 for self-only coverage
  - -$12,700 for family coverage
- All in-network copays, deductibles and coinsurance for essential health benefits provided through the same carrier/vendor [e.g., medical, mental health/substance abuse, prescription drug, non-excepted dental and vision] combined must be less than the OOP maximum limit.

Limits on OOP maximum will be increased in 2015 and future years based on the cost of medical inflation.

If family income is between 100% and 250% of the federal poverty level, reductions in the deductibles, co-pays, coinsurance, and other cost sharing is available. The cost sharing reductions will be available through modified versions of Silver plans that are offered on the Marketplace. These plans will have lower deductibles, co-pays, coinsurance and out-of-pocket limits compared to regular Silver plans.[8]

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[4] https://www.healthcare.gov/glossary/qualified-health-plan
[5] https://www.healthcare.gov/glossary/minimum-essential-coverage/
[6] http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/minimum-essential-coverage.html
[7] http://www.cigna.com/assets/docs/about-cigna/informed-on-reform/cost-sharing-fact-sheet.pdf
[8] http://kff.org/health-reform/faq/health-reform-frequently-asked-questions/#section-cost-sharing-reductions

Safe Harbor for Separate Service Providers

For the first plan year beginning on or after January 1, 2014, where a group health plan or group health insurance issuer uses more than one service provider to administer benefits that must apply the yearly limit on out-of-pocket maximums, separate out-of-pocket limits can be used[9]. "More than one service provider" means any vendor or administrator responsible for the administration of a set of essential health benefits, including a pharmacy benefit manager. However, under the Mental Health Parity and Addiction Equity Act of 2008, plans and issuers are prohibited from imposing an annual out-of-pocket maximum on all medical/surgical benefits and a separate annual out-of-pocket maximum on all mental health and substance use disorder benefits.

[9] http://www.dol.gov/ebsa/faqs/faq-aca12.html