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Update on Federal Health Care Reform
October 2012

legal issues and status update

The Department of Health and Human Services ("HHS") has held regional stakeholder sessions in August and September to listen to stakeholder comments and questions. Although HHS continues to publish regulations on varying topics related to ACA, there are still many unanswered questions. The Republican Governors Association has resubmitted 30 detailed questions to HHS, requesting information needed by states to plan for implementation of the Affordable Care Act.

In September the requirement for the Summary of Benefits and Coverage went into effect. Stand-alone dental and visions plans are not required to issue this document. If it is required for the essential pediatric oral health services benefit, we are hopeful that an appropriate version will be created at that time.

essential benefits update

HHS has still not issued anything further on Essential Health Benefits other than the December 2011 Bulletin and the February 2012 Frequently Asked Questions document. Despite this absence of further regulatory guidance, October 1st was the "soft" deadline for states to advise HHS of the benchmarks selected for their state for their Essential Health Benefits. Many states have identified benchmarks but others are waiting for guidance or election results. For pediatric oral health services, many states have recommended their Children's Health Insurance Program ("CHIP") program, two have recommended the Federal Employees Dental and Vision Plan ("FEDVIP"), and a couple have recommended medical benchmarks that include minimal oral health procedures. For pediatric vision services, we have seen the FEDVIP plan recommended in a few states.

As states have solicited comments, we have provided input as to the need for affordability, simplicity, and transparency regarding the pediatric dental benefit, whether it is offered embedded in a medical policy or sold in a separate dental policy.

The National Association of Dental Plans ("NADP") has been communicating with HHS on options for the pediatric age, but this has not been finalized yet.

exchanges update

States continue progress in various stages of implementation of Exchanges. Some, such as CA and MD, are in advanced stages of implementation. CA has recently published an extensive draft application for carriers to submit for participation in their "active purchaser" model Exchange.

Other states continue to publicly oppose establishment of Exchanges but are preparing quietly for implementation. HHS in September announced additional grants to states. A total of 49 states, the District of Columbia, and four territories have received grants for exchange planning, and 34 states and the District of

Columbia have received grants for building exchanges.

In May HHS issued guidelines on the Federally Facilitated Exchange ("FFE"), which will serve for those states where an exchange is not ready or a partnership approach is desired. We understand that state variation in essential benefits will be accommodated in this federal exchange. U.S. Senator Orrin Hatch has been pressing HHS for further guidance as to what obligations and costs states will have to incur when utilizing the FFE. NADP has been working with representatives of FFE operations. Comments were provided on the Data Elements for employer and individual applications to Exchanges, and discussions are ongoing about many operational issues related to offering dental in Exchanges.

HHS also released a blueprint for states to follow if they are establishing either a State Exchange or a State Partnership Exchange through the FFE. States must submit a Declaration Letter and an Exchange Application by November 16th, 2012 for the plan year beginning January 1st, 2014.

States that are going to participate in the FFE without partnership are "invited" to submit a Declaration Letter but do not need to submit the Exchange Application.

ACA requires at least two multi-state plans to be offered nationwide in Exchanges. This may occur over time, as the draft application the Office of Personnel Management ("OPM") released for comment in September stated that carriers must be available in 60% of the states in the first year.

States are also considering the offer of stand-alone vision in Exchanges, even though that is not expressly authorized under ACA. The vision offer may include the pediatric vision services and potentially non-essential vision.

private market fix update

We are still seeking HHS regulation to allow medical plans in the private marketplace to be certified as Qualified Health Benefit Plans offering Essential Health Benefit Packages without providing the essential oral health benefits, since these are widely available through dental plan issuers. At this time, in the private marketplace outside Exchanges, Essential Health Benefit Packages for Individuals and Small Businesses can only be offered by carriers offering the full range of essential benefits. Dental plans can offer the benefits, but the purchase would be redundant to what consumers would buy from their medical carriers.

NADP met with White House staffers recently to advocate for equitable treatment of stand-alone dental both inside and outside Exchanges. The staffers were receptive to the issue and requested further information, so we are hopeful for progress in this area. Representative Sherrod Brown of Ohio wrote to the White House expressing support for our position. NADP is also seeking support on this issue from the National Association of Insurance Commissioners (NAIC), as the White House staffers indicated their receptivity to NAIC input.

Stand-alone vision plans are currently treated the same way both in and out of Exchanges, meaning that the pediatric vision benefit is included in the medical carriers' Essential Health Benefit Package offered in the Individual and Small Employer markets. Advocacy continues to promote the ability of stand-alone vision plans to fulfill the pediatric benefit.

annual fee on health insurance providers

We continue to monitor regulatory and industry activity related to the new fee to be charged to insurers, payable beginning in 2014. There is still not further guidance from the IRS and the Treasury Department n the ACA provisions related to the fee. However, the U.S. House of Representatives currently has about 221 co-sponsors on a bill (H.R. 1370) to repeal this fee.

It is currently understood that dental and vision carriers are included in this assessment. Self-insured plans and governmental entities are not, and not-for-profit plans may pay reduced amounts or not be subject to the fee depending on their business mix. The amount due will be based on an insurer's net premiums and market share in the industry so that the total collected will reach the amount specified for each year in the ACA. For 2014 the amount identified is $8 billion. It is expected to cost the industry about $87 billion over ten years.

IRS recently released proposed rules regarding a fee imposed on certain health insurance policy sponsors that will be used to fund medical outcome research. This $1 fee per participant, later to rise to $2 per participant, does not apply to dental and vision.

where can I get more information?

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