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Update on Federal Health Care Reform
November 2012

legal issues and status update

The Department of Health and Human Services ("HHS") continues to provide information to states through informal sessions, but most new regulations appear to be on hold until after the elections. Regardless of the election results, we anticipate a large number of regulations to be released very soon.

When the U.S. Supreme Court announced its ruling on the Affordable Care Act ("ACA") in June, pending appeals were rejected from further consideration. However, all legal actions are not over. It was recently announced that the Department of Justice does not object to a Virginia federal court of appeals considering an appeal by a religious college that ACA violates religious freedom.

Additionally, the Oklahoma Attorney General has filed a lawsuit charging that ACA only allows for premiums subsidies to be provided to eligible consumers in state Exchanges, not the Federally Facilitated Exchange ("FFE"). IRS has ruled that although ACA does not explicitly authorize such subsidies, it is clearly the intent of the law that subsidies be available regardless of a state's decision to develop an Exchange or rely on the FFE.

essential benefits update

HHS has still not issued anything further on Essential Health Benefits ("EHB") 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 EHB. Many states have identified benchmarks, but others are waiting for guidance or election results. For pediatric oral health services, about 18 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, about 4 states have recommended their CHIP plans, 8 the FEDVIP plan, and a few states have identified minor vision benefits in medical benchmark plans. HHS has said that if a state does not pick a medical benchmark, the largest small employer plan in that state will be deemed the benchmark. We have not seen any formal default benchmark for pediatric dental or vision but have heard that some states were told it would be FEDVIP. We have also heard that some states were told they could decide themselves whether or not to cover medically necessary orthodontia. We remain eager for HHS regulations and guidance on pediatric age.

exchanges update

States continue progress in various stages on implementation of Exchanges. Some, such as CA, MD, OR and WA, are in advanced stages of implementation. However, consideration of stand-alone dental policies has been inconsistent. CA is allowing stand-alone dental and vision policies to offer supplemental coverage in Individual and SHOP Exchanges, but as of now is requiring medical carriers to provide the pediatric coverage, separately priced. OR is also, at least initially, requiring medical carriers to provide the pediatric benefits. NADP and

individual plans are actively providing input on these issues. On the other hand, a few states such as MD and MA are allowing stand-alone vision to fulfill the pediatric vision benefit, even though that is not expressly authorized under current regulations.

At least half of the states are expected to participate in 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. Initially at least it will be an open contracting model, whereas several state Exchanges will use the "active purchaser" model, meaning the states will select only certain carriers to participate. Selection criteria and applications are being developed in these states

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 (said to be another "soft deadline"). 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.

Plan Management details are being worked out by states as well and a new filing platform is being developed by the National Association of Insurance Commissioners ("NAIC"). Some states are holding seminars on new policy and rate filing requirements and timetables. The timing for such filings will be very compressed, given the lack of EHB regulations, with plan certifications occurring in early and mid 2013 in preparation for October enrollments.

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 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 no further guidance from the IRS and the Treasury Department on the ACA provisions related to the fee.

It has been understood that dental and vision carriers are included in this assessment as they are not clearly excluded as they are in other sections of the law. NADP has recently written to IRS and the Treasury Department for confirmation of applicability or exception. We hope to have this answer even before regulations are issued.

Self-insured plans and governmental entities are not subject to the fee, 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.

what else is going on in the states?

Prohibiting insurers from requiring dentists to give discounts on services that are not covered under a plan has been a hot issue the past two years and 2012 is no exception. Nebraska and Illinois are among those states recently passing this legislation. Visit www.ameritasgroup.com/noncovered_procedures for more details about the laws that have now passed in more than 25 states.

Vermont has recently included dental policies in their claims assessment fee. Eight percent of claims paid for Vermont residents, whether insured or employer self-funded, must be paid to the state. The first payment is due January 2013 for the period July 1st, 2011 – June 30th, 2012.

The states continue to issue laws and regulations related to ACA implementation provisions, such as filing requirements, external review timeframes, and other grievance related matters.

where can I get more information?

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