

Update on Federal Health Care Reform June 2012

significant second quarter news

The Department of Health and Human Services continues to publish regulations on varying topics related to the Affordable Care Act (“ACA”). Over the past couple of months we have seen proposals on Health Plan Identifiers, the Federally Facilitated Exchange, Data Reporting Standards relating to issuers of potential benchmark plans for Essential Health Benefits, and accreditation entities for Qualified Health Plans.

The Department of Labor has begun audits of employers to review their implementation of ACA provisions. Penalties can be assessed for non-compliance.

legal issues update

All still eagerly await the United States Supreme Court ruling on the four separate issues the Justices are considering related to ACA. We hope that rulings will be issued this month prior to the end of the Court’s session. Additional law suits were filed in the past few months related to religious issues and certain coverage mandates.

essential benefits update

There has been recent talk that the Department of Health and Human Services (“HHS”) will issue regulations on Essential Benefits sooner than previously anticipated. The proposed Data Collection rules released last Friday affirm HHS’s approach to allow states to select a benchmark based on those identified in the December 16th, 2011 Bulletin. These regulations would require issuers of the largest three small group market products in each State to report certain information to HHS. The regulations would ask issuers of stand-alone dental policies to voluntarily report certain information to HHS, including where they propose to participate in Exchanges, so that Exchanges and medical carriers will know when Qualified Health Plans can be certified without covering pediatric oral services.

We continue to review the potential benchmark plans that HHS identified in their December 2011 bulletin, including the plans offered to federal employees and state CHIP programs, to prepare for the offer of Child-Only policies covering the essential oral health services.

Our trade association, The National Association of Dental Plans (“NADP”) is also consulting with Milliman on actuarial values of the potential plan designs

exchanges update

The final Exchange regulations are under careful review. A key area remaining is the certification requirements for dental plans. NADP requested a legal analysis on the applicability of provisions to issuers of the pediatric oral health services. An NADP Issues Brief was then prepared for submission to HHS and state regulators as to the appropriateness of each element for stand-alone dental policy issuers.

The National Association of Insurance Commissioners Exchange Sub-group has released draft White Papers related to Exchange Plan Management and some of the certification elements. As of now the drafts are either silent on stand-alone dental or acknowledge potential differentiation between medical Qualified Health Plans and dental Qualified Health Plans. Comments are being provided through NADP.

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 hybrid approach is desired. We understand that state variation in essential benefits will be accommodated in this federal exchange.

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 in Exchanges. NADP is meeting with the federal Office of Personnel and Management to advocate for multi-state dental plans to be offered as well.

In the meantime state progress is varied. California recently announced the IT vendor it will work with for administration of their Exchange. Massachusetts recently held a stakeholder session to discuss stand-alone dental plans in Exchanges. Maryland passed legislation that includes stand-alone vision plans as well as stand-alone dental plans. However, actual implementation of the vision offering may be dependent upon further guidance from HHS.

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. 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.

administrative simplification

On April 9th, 2012, HHS issued proposed regulations establishing a unique plan identifier for health plans. The proposal calls for a 10-digit, all numeric identifier with a Luhn check-digit as the tenth digit. Proposed effective dates are phased in, with registration beginning October 1st, 2012, and implementation October 1st, 2014 or 2015, depending on the size of health plan. Industry discussions indicate a lot more clarity is required as to what level of plan or product would require a unique identifier.

what else is going on in the states?

Maryland passed legislation prohibiting frequency limitations of greater than 120 days for preventive dental services such as exams, cleanings, and fluoride treatments. This does not mean that such benefits have to be provided more frequently than twice per year, just that the benefit for a second procedure cannot be deferred for a period longer than 120 days during the benefit year. Typically dental benefit plans require a six month interval.

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. Missouri's bill that included vision as well as dental did not pass. Some states that have passed legislation are going for another bite at the apple and proposing bills with more restrictions. Visit www.ameritasgroup.com/noncovered_procedures for more details about the laws that have now passed more than 25 states.

where can I get more information?

Visit the health care reform section of our website at ameritasgroup.com.