

Update on Federal Health Care Reform July 2012

legal issues and status update

The eagerly awaited rulings by the United State Supreme Court were issued June 28th, 2012. In essence, the Affordable Care Act (ACA) was upheld. The most controversial section of the law, the Individual Mandate, was upheld through recognition of the penalty for not having Minimum Essential Coverage as a tax, and thus valid under the taxing power of Congress. The requirement for states to accept Medicaid expansion or lose existing federal Medicaid funding was struck down. This adds another component of state variability to implementation of ACA. States can now decide:

- Whether to create a state Exchange, or participate in a regional or Federally Facilitated Exchange (FFE)
- The governance structure of a state Exchange, as well as funding mechanism, contracting model, and various administrative functions
- The state's benchmark plans for Essential Health Benefit Packages
- Whether to expand Medicaid eligibility

The Medicaid decision may have a significant impact on enrollment in Exchanges. If a state does not expand Medicaid eligibility to those earning between 100 and 133% of the Federal Poverty Level, those eligible may seek federally funded subsidies under ACA through Exchanges. For pediatric dental and vision the impact may not be as great, as those in the impacted poverty thresholds would already be eligible for coverage through the Children's Health Insurance Program (CHIP), but this will be reviewed further.

The debate over ACA is far from over, as it will remain an issue during the 2012 elections. Regardless of which party wins control of the Houses of Congress, it is expected that legislation will be proposed to improve or repeal the Act.

Implementation is expected to accelerate for now, as deadlines for state Exchange declaration and HHS review of readiness are looming over the next twelve months.

Although the following requirements do not apply to HIPAA excepted dental and vision benefits (those sold in stand-alone policies of insurance), expect to hear a lot in the marketplace about the following:

- Medical Loss Ratio – many insurers have been required to distribute rebates to customers because the premium dollars spent on health care claims and quality improvement did not rise to required thresholds (80 or 85% depending on group size). Employers may have to consider if part of this rebate must be refunded to employees, based on their plan and premium contributions.
- Health Insurer Assessment Fee – payable in 2014, as described later in this update

- Employer Mandate – set to begin in 2014; employers with 50 or more full time employees will be subject to penalties if they do not provide affordable health care coverage. The size of the penalty versus the cost of coverage has led to speculation as to the number of employers that could “send their employees to Exchanges” rather than provide coverage through typical employer sponsored insurance.
- Automatic Enrollment – Employer with more 200 employees are expected to automatically enroll them in health coverage, unless they specifically opt out. This is likely to begin in 2014.
- Employers and carriers may also be dealing with new uniform Summaries of Benefits and Coverage (SBC) requirements and reporting the cost of health care coverage on their employees’ W-2 forms.

essential benefits update

Although HHS has not yet issued regulations on Essential Benefits, states are reviewing benchmark plans for medical benefits based on those that HHS identified in their December 2011 bulletin. Most of these did not include pediatric dental or vision, and states were referred to the plans offered to federal employees and state CHIP programs.

The National Association of Dental Plans (NADP) consulted with Milliman and sent information to HHS comparing potential plan designs and associated costs and actuarial values. The big differences from typical commercial plans will likely be:

- Child-Only plans
- Lack of annual or lifetime limits
- Potential coverage for medically necessary orthodontics

exchanges update

The final Exchange regulations are under careful review. A key area remains 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 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.

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.

IRS and the Treasury Department are currently developing a request for comments on the ACA provisions related to the fee. This will be the first step in developing proposed and then final regulations. During this process we will seek clarification of several issues, including the accounting treatment of these fees, which would impact the timing of collection through premiums charged.

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.

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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