Patient Protection and Affordable Care Act Webinar

Hosted By:

Sponsored By:

May 14, 2013
Webinar Objectives

• Increase awareness regarding Health Care Reform (HCR)

• Expand understanding regarding impacts to dentists, small employers, consumers and insurers

• Provide a forum to answer your questions
Agenda

• Health Care Reform Basics
  ▪ Market reforms
  ▪ Exchanges
  ▪ Subsidies & penalties
• What can practicing dentists expect to see
  ▪ New market landscape
  ▪ Pediatric Oral Services
  ▪ The big picture for dentists
• Impacts to small employers
  ▪ Stuff for 2013 & 2014
  ▪ Rules & regulators
  ▪ Taxes & Fees
• Questions
Health Care Reform Basics

Kurtis Shook
Director, Health Care Reform
United Concordia Dental
What is health care reform?

- The Patient Protection and Affordable Care Act ("ACA")
- Passed into federal law in March of 2010
- Expands access to health care coverage
- Being phased in between 2010-2018
What are the Major Components?

- Individual mandate to buy health insurance (2014)
- Market reforms so that everyone can access coverage (2010+)
- New health insurance “exchanges” or “marketplaces” to help individuals & small businesses shop for and compare coverage (2014)
- Financial assistance for individuals to buy insurance (2014)
- Optional state expansion of Medicaid (2014)
- New taxes & cuts to pay for reform (2010+)
ACA Major Market Reforms

• No discrimination against children with pre-existing conditions (expands to adults after 2014)

• Bans on
  ▪ rescinding coverage
  ▪ lifetime coverage limits

• Elimination of annual limits (in 2014)

• 100% coverage of preventive care (no co-pays)

• Young adults covered on (up to 26) parent’s policies

• Medical Loss Ratio of 80% for individuals & small groups
ACA Major Market Reforms

• Not applicable to limited scope dental benefits where covered in a
  ▪ separate policy, certificate or contact or
  ▪ Not integral to health plan; participants:
    – can accept or reject and
    – make some payment for the coverage

• Actuarial Values
Market Reforms & Standalone Pediatric Dental Coverage

• Annual and lifetime limits: standalone dental plans that offer pediatric oral services as an EHB cannot place annual or lifetime maximums on kids <19

• Out-of-Pocket (OOP) maximums
  ▪ Estimated total for entire EHBP: $6,350
  ▪ **Standalone** pediatric dental must have a “reasonable” OOP maximum: $700 maximum per child, capped at $1,400 for 2+ children for most states
  ▪ Embedded **group** coverage has $700 OOP pediatric dental max (if health carrier so elects), reducing health OOP max to $5,650 for 2014 (in future years, pediatric dental is part of total health OOP max)
Dental Plan Market Practices Today

- No discrimination against children with pre-existing conditions
- No rescinding of coverage
- Lifetime limits only applied to orthodontia
- 100% coverage of preventive care
- Many dental insurers have voluntarily adjusted to coverage of young adults – up to 26 – on parent’s policies
Essential Health Benefits

- All Americans must have Minimum Essential Coverage (MEC)
- Individuals & Small Groups, MEC = the Essential Health Benefits Package (EHBP)

| 1. Ambulatory patient services | 6. Prescription drugs |
| 2. Emergency services | 7. Rehabilitative and habilitative services & devices |
| 3. Hospitalization | 8. Laboratory services |
| 5. Mental health & substance use disorder services | **10. Pediatric services, including oral & vision care** |
Exchanges/Marketplaces

• States – or HHS – must set up insurance exchanges (Health Insurance Marketplaces) where consumers and small groups (<50 employees in PA*) can purchase coverage

• Marketplaces “go live” October 1, 2013
  ▪ Individual coverage – on and off exchange – will have standardized open enrollment period, with calendar year policies
  ▪ Small group coverage – on and off exchange – will have rolling effective dates

• Exchange products will have member-level rates that build up into a family-like policy

* 2014-2015, in 2016 small group expands to 100 FTE employees
Impact to Dental Enrollment

• Pew Center on the States
  ▪ 5.3 million children (nationwide) will be added to dental coverage, primarily through public programs

• National Assn. of Dental Plan surveys
  ▪ Half of parents will drop dental coverage when their children are covered under medical policies (i.e., 10 to 11 million in the small group market nationwide)

• Potential net loss of dental enrollment: 7 to 9 million nationwide
Dental Benefits in the Affordable Care Act

Jeff Album, Vice President
Public and Government Affairs
Delta Dental of CA, NY, PA & Affiliates
New Market Landscape in 2014

- Everyone must enroll
- in one of these plans or programs

<table>
<thead>
<tr>
<th>Individual or Small Group Plans</th>
<th>Large Group Plans</th>
<th>Government Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offered in Exchange</td>
<td>Offered Outside Exchange</td>
<td>• Medicare</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medicaid</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• CHIP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Tricare</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Veterans</td>
</tr>
</tbody>
</table>

Grandfathered Plans*
(Individual, Small or Large Group)

* Existed 3/23/10, with no change in benefits or carrier. Added employees and dependents OK.
Defining Pediatric Oral Services

• How a dental benchmark gets chosen
  ▪ A state-driven process
  ▪ States that abdicate default to the FFM selection
  ▪ Options are CHIP, FEDVIP or the dental already in a state-selected medical benchmark

• How it went down
  ▪ States went with CHIP
  ▪ FFE went with FEDVIP
What a Benchmark is and isn’t

• Only a “Scope” of Benefits
  ▪ Does not define cost sharing (e.g. copays, deductibles, frequency and other limitations)

• Actuarial Value is Key
  ▪ Drives terms, limits and pricing
Three Ways Dental Can be Offered

• “True” Standalone
  ▪ One policy, can be coupled with any QHP/health plan.

• Bundled Standalone
  ▪ Two policies; one medical, one dental that is technically “standalone”
  ▪ Though standalone, bundled dental policy can be coupled only with medical partner
  ▪ OOP Max, AVs and deductibles are separately accumulated – not part of the QHP cost sharing limits
  ▪ FFE states won’t/can’t allow bundled inside

• Embedded in QHP
  ▪ One policy for medical and dental; variation possible on how they will treat OOP max, deductibles, AV etc...
AV Works Different for QHPs

• Four benefit tiers (based on actuarial values) that “embed” a pediatric dental requirement

- Platinum (90%)
- Gold (80%)
- Silver (70%)
- Bronze (60%)
Dental Handled Different when Standalone

- HHS approves high (85%) / low (70%)
  - with a separate “OOP max”
  - medically necessary ortho (when in the benchmark)
What Might these Dental Plans Look Like?

<table>
<thead>
<tr>
<th>Essential Pediatric Dental When Offered in a QHP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PPO/PPO</strong></td>
</tr>
<tr>
<td>Diagnostic &amp; Preventive (D&amp;P) - X-Rays, Exams, Cleanings, Sealants</td>
</tr>
<tr>
<td><strong>Basic Services</strong> - Basic Restorative</td>
</tr>
<tr>
<td><strong>Major Services</strong> - Crowns &amp; Casts, Prosthodontics, Endodontics, Periodontics, Oral Surgery</td>
</tr>
<tr>
<td><strong>Orthodontics (Medically Necessary)</strong></td>
</tr>
<tr>
<td><strong>Deductible:</strong></td>
</tr>
<tr>
<td><strong>Annual Maximum</strong></td>
</tr>
<tr>
<td><strong>Orthodontics Maximum</strong></td>
</tr>
<tr>
<td><strong>Waiting Periods</strong> (Major &amp; Ortho)</td>
</tr>
<tr>
<td><strong>Out of Pocket Maximum</strong> (PPO dentists only)</td>
</tr>
<tr>
<td>per child</td>
</tr>
<tr>
<td>per 2+ child</td>
</tr>
</tbody>
</table>
## What Might these Plans Look Like?

### Standalone PPO High and Low

<table>
<thead>
<tr>
<th>Procedure Categories</th>
<th>High Option</th>
<th>Low Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PPO High</td>
<td>PPO Low (70% AV)</td>
</tr>
<tr>
<td>Diagnostic &amp; Preventive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-Rays, Exams, Cleanings</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Sealants</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Basic Services - Basic Restorative</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Major Services - Crowns &amp; Casts, Prosthodontics, Endodontics, Periodontics, Implants, Oral Surgery</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontics (Medically necessary)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Deductible</td>
<td>$50 (not applied to D&amp;P)</td>
<td>$70 (applied to all services)</td>
</tr>
<tr>
<td>Annual Maximum</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Orthodontics Maximum (Lifetime)</td>
<td>No maximum</td>
<td>No maximum</td>
</tr>
<tr>
<td>OOP Maximum</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Waiting Periods (Major &amp; Ortho)</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Actuarial Value (AV)</td>
<td>86%</td>
<td>70%</td>
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## What Might these Plans Look Like?

### DHMO Standalone High and Low

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<td>DHMO 70%</td>
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<tr>
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<td></td>
<td></td>
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<tr>
<td>X-Rays, Exams, Cleanings</td>
<td>100%</td>
<td>$5 Copay</td>
</tr>
<tr>
<td>Sealants</td>
<td>100%</td>
<td>$5 Copay</td>
</tr>
<tr>
<td>OV Copay</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Basic Services</td>
<td>70%</td>
<td>50%</td>
</tr>
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<td>Basic Restorative</td>
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</tr>
<tr>
<td>Major Services</td>
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<tr>
<td>Orthodontics (Medically necessary)</td>
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<tr>
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<td>70%</td>
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</table>
Scenario Comparison

• Assumptions
  ▪ Child goes to dentist twice in a year.
  ▪ On 1\textsuperscript{st} visit, gets an exam, cleaning, x-ray, fluoride treatment, three sealants and a single, one-surface filling.
  ▪ On 2\textsuperscript{nd} visit, gets exam, cleaning, and fluoride treatment.

• Cost
  ▪ Under low AV standalone plan: child pays $130 OOP to receive $750 in total dental services charged to the plan.
  ▪ Under a high AV standalone, child pays $110.
  ▪ Under an embedded dental plan, unless deductible is waived, the OOP is entire $750. \textbf{There is no coverage from Plan}, until medical OOP expenses exceed the $2,000 deductible.
• Final point of comparison
  ▪ A child needing medically necessary ortho (typically costing $6000 to $12,000) spends just $1000 OOP in the standalone plan, versus $4,000 to $6,000 in the embedded dental, minus any medical OOP accrued to that point in time.
• Inside and outside are different
  ▪ ACA language defining issuer requirements outside the exchange “forgot” the Stabenow-Lincoln provision.
    – Inside, QHPs get waiver from offer of pediatric dental, when a standalone is offered.
    – Outside, all health plans must offer all 10, including pediatric dental, unless health plan is “reasonably assured” that an “exchange-certified” standalone pediatric dental plan has been obtained for children meeting the definition of essential pediatric oral services.
Transparency Concepts

• In FFM states, pediatric dental can vary based on when embedded, bundled or standalone
  ▪ The ACA is only partially prescriptive on how to incorporate standalone dental in the exchanges. States decide.
  ▪ FFM goes minimalist. QHPs with embedded dental have one deductible, one OOP max for all 10 EHBs. QHPs free to offer with or without dental when standalone is offered. No bundling on exchange.
  ▪ Standalone and their close cousins, bundled dental plans operate by different rules. How easy to compare?
  ▪ Final rule says exchange enrollees can purchase EHB without pediatric dental. Hence most QHPs will offer with AND without.
The Big Picture for Dentists

• **More business**, especially for offices affiliated with health/dental plans

• **Confused patients and dentists** owing to the embedded versus standalone handling of deductibles and OOP maximums

• **Standalone plan-affiliated dentists need to re-contract** if separate offer, reasonable assurance waiver and transparency provisions are not managed by states

• **Disruption** in the small group and individual markets likely.
  - Bifurcated families: Parents with one dentist, kids with another
Remaining Questions

• Clarity needed on the “reasonable assurance waiver” outside exchanges.

• Clarity on the embedded versus bundled versus standalone dental in and out of exchanges
  ▪ The AV and OOP “maximum conundrum.”
  ▪ State regulators need to recognize bundled outside.

• Establish “reasonable” out-of-pocket maximum and define medically-necessary ortho state by state

• Mandatory offer versus purchase of pediatric dental outside
  ▪ Must childless adults buy pediatric benefits they cannot use outside exchanges? Should parents be allowed to not purchase pediatric dental?
What Does This Mean to Small Employers?

David Vassilaros
Director, Health Care Reform
Capital Blue Cross
Miscellaneous stuff

• Pennsylvania & the exchange Marketplace (and the SHOP)

• Educational resources
  ▪ Kaiser Family Foundation at healthreform.kff.org
  ▪ America's Health Insurance Plan's (AHIP) at www.ahip.org/Issues/Affordable-Care-Act
  ▪ Heritage Foundation at www.heritage.org
  ▪ Center for American Progress at www.americanprogress.org
  ▪ National Association of Health Underwriters (NAHU) at nahu.org/legislative/index.cfm
  ▪ Health and Human Services at www.healthcare.gov
Stuff for 2013

• W-2 reporting

• Notice to employees of exchange Marketplace

• Slow down those annual salary reductions for Flexible Spending Accounts (FSA)

• Send out Summary of Benefits and Coverage (SBC)
Stuff for 2014

- New market rules
- Exchange marketplace may or may not work
- Taxes and fees
- New rating rules
Exchange Marketplace

rules & regulations
<table>
<thead>
<tr>
<th>Exchange Rules</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Certify &amp; decertify QHPs offered by carriers for subsidy eligibility</td>
<td>Utilize standardized appearance and format for QHP</td>
</tr>
<tr>
<td>Certify &amp; list web marketplaces to offer QHPs</td>
<td>Display standardized comparative plan information</td>
</tr>
<tr>
<td>Designate standard appearance and format of QHP</td>
<td>Utilize uniform enrollment form</td>
</tr>
<tr>
<td>Assign a quality rating for each QHP</td>
<td>Display QHP quality ratings</td>
</tr>
<tr>
<td>Oversee navigator grant program</td>
<td>Provide toll free hotline to assist in enrollment</td>
</tr>
<tr>
<td>Oversee state audit of marketplaces</td>
<td>Inform consumers of eligibility for &amp; connection to government programs</td>
</tr>
<tr>
<td>Collect and house QHP plan info and pricing</td>
<td>Provide a premium credit &amp; cost-sharing calculator tool</td>
</tr>
<tr>
<td>Distribute QHP plan data to approved marketplaces</td>
<td>Include a process for certification of exemption from individual mandate</td>
</tr>
<tr>
<td>Utilize industry standards for QHP plan data format</td>
<td>Be subject to state audit</td>
</tr>
<tr>
<td>Connect marketplaces &amp; carriers with HHS data services hub for eligibility &amp; subsidies</td>
<td>Conduct enrollee satisfaction survey and provide results at the portal</td>
</tr>
</tbody>
</table>
Application for Health Insurance
(and to find out if you can get help with costs)

Use this application to see what insurance choices you qualify for

- Free or low-cost insurance from Medicaid or the Children’s Health Insurance Program (CHIP)
- A new tax credit that can help pay your health insurance premiums
- Private health insurance plans
You may qualify for a free or low-cost program even if you earn as much as $82,000 a year (for a family of 4).

Who can use this application?
You can use this application to apply for anyone in your family, even if they already have insurance now.
You can still apply even if you don’t file a federal income tax return.

Apply faster online
Apply faster online at www.placeholder.gov.

What you may need to apply
- Social Security numbers (or document numbers for any legal immigrants who need insurance)
- Birth dates
- Employer & income information for everyone in your family (for example, from pay stubs or Forms W-2, Wage and Tax Statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Why do we ask for so much information?
We ask about income and other information to make sure you and your family get the most benefits possible. We’ll keep all the information you provide private, as required by law.

3 pages
15-30 minutes
20,000 “assistors” in California
Income & Subsidy Examples

The calculator assumes a 40 yr old adult would have an average monthly premium of $375.

Figures based on calculator from UC Berkeley Labor Center, Jan. 2013. www.laborcenter.berkeley.edu

The calculator assumes a 40 yr old adult would have an average monthly premium of $375.
<table>
<thead>
<tr>
<th>Tax</th>
<th>Description</th>
<th>Financial Impact</th>
<th>ASO</th>
<th>Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Insurer Tax (HIT)</td>
<td>$8B tax on insurers’ fully insured membership starting at $8B in 2014, growing to $14.3B in 2018. Thereafter increases by the rate of premium growth.</td>
<td>Equates to approximately 2% increase on premium in 2014, and growing each year. Bigger impact on insurers with larger books of fully insured business. Insurer to remit the tax to IRS.</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>PCORTF</td>
<td>Fee assessed to all plans and plan sponsors for the development and funding for the Patient Centered Outcomes Research Institute.</td>
<td>$2 assess per average number of covered lives effective 2013. It is indexed to national health expenditures thereafter until it ends in 2019.</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Reinsurance fund</td>
<td>The reinsurance fee is a transitional fee to stabilize the individual market. The fee will be assessed on a per capita basis for both fully insured and self-funded members.</td>
<td>Approximately $5.25 pmpm on all covered lives, equating to around a 2% increase on premium in future rates. Fee steps down over 3 years, ending after 2016. HHS to control use of $20 billion fund.</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Risk adjustment</td>
<td>There will be a federal fee for administering the risk adjustment program. Risk adjustment will apply to individual and small group markets, state-wide, regardless of channel.</td>
<td>Proposed $.96 per risk-adjustment eligible member for 2014. Fee will change over time to support a “robust Federal risk adjustment program…[but] we intend to keep the user fee amount as low as possible.” (Final Rule, CMS-9964-F, 31)</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Exchange fee</td>
<td>Administrative fee charged per billable member to plans selling QHPs, payable upon use of services or monthly to FFE.</td>
<td>Approximately 3.5% in 2014 per billable member, up to three under age 21. This fee in addition to broker commissions. Proposed to include this fee across all administrative expenses.</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Pharmaceutical</td>
<td>Sliding scale tax on the pharmaceutical industry for brand name medications.</td>
<td>Equates to approximately $2.5 billion annually, and will be reflected in future rates as costs rise.</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>DME</td>
<td>Sales tax on most durable medical equipment. “Retail exemption” for items meant for individual use.</td>
<td>2.3% additional cost that will be reflected in future rates as costs rise.</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>
Excise Tax Calculator from Capital BlueCross

Find this and other great tools on capbluecross.com

What is the cost of individual coverage under your plan?

$ 6500 .00 □ Monthly

How many employees are enrolled in this plan?

15

What is the cost of family coverage under your plan?

$ 15000 .00 □ Monthly

How many employees are enrolled in this plan?

15

By what percentage do you expect your organization's medical costs will increase on a yearly basis?

11 □ %

Note: Roll your mouse over any point in the charts for specific dollar amounts.

Plan Year Ending | Single Plan | Family Plan | Annual Tax Liability
--- | --- | --- | ---
2018 | $10,953 | $25,276 | $4,517
2019 | $12,158 | $28,056 | $15,083
2020 | $13,495 | $31,142 | $41,625
2021 | $14,979 | $34,568 | $71,085
2022 | $16,627 | $38,371 | $103,787
2023 | $18,456 | $42,591 | $140,085
2024 | $20,486 | $47,276 | $180,377
2025 | $22,740 | $52,477 | $225,100
2026 | $25,241 | $58,249 | $274,743
2027 | $28,018 | $64,657 | $329,847
2028 | $31,100 | $71,769 | $391,012

Please note: Only individual and family tier plans are subject to the 'Cadillac' tax. Other tiers you may offer, such as employee + dependents, are exempt.
Rating Factors

- Geography
- Age
- Tobacco Use
Stuff you want to ask
Employer Penalty

Does the employer have at least 50 full-time (FT) equivalent employees? **NO**

Penalties do not apply to small employers.

Does the employer offer coverage to its workers? **NO**

Did at least one FT employee receive subsidized coverage in an exchange? **YES**

The employer must pay a penalty for each month it did not offer adequate or affordable coverage. The maximum penalty is $2,000 times the number of FT employees, minus 30 employees. The penalty is increased each year by the growth in insurance premiums.

Does the insurance pay for at least 60% of covered health care expenses for a typical population? **NO**

Did at least one FT employee receive subsidized coverage in an exchange? **YES**

The employer must pay a penalty for each month it did not offer adequate or affordable coverage. The maximum penalty is $3,000 for each FT employee receiving subsidies on the exchange up to a maximum of $2,000 times the number of FT employees minus 30 employees. The penalty is increased each year by the growth in insurance premiums.

Do any FT employees have to pay >9.5% of their household income for the employer coverage? **NO**

There is no penalty on the employer. Because the employer offers adequate & affordable coverage, employees are not eligible to receive subsidies on an exchange.

Please note that the information in this chart is based on an interpretation of the Patient Protection and Affordable Care Act. This chart is for general information purposes only and is not intended to constitute legal advice or a recommended course of action in any given situation and should not be relied upon in making decisions of a legal nature.
Subsidies, Tax Credits, Penalties

• Individuals may be eligible for premium assistance – 133% to 400% FPL if employer:
  ▪ Doesn’t offer minimum essential coverage or
  ▪ Offers coverage, but premium isn’t affordable
  ▪ However, if employer does offer affordable MEC and the employee purchases on HIX, not eligible for subsidy

• Cost sharing assistance
  ▪ Individuals 133%-250% of FPL
  ▪ Must purchase silver plan

• Small employer tax credits
  ▪ Employers < 25
  ▪ Must purchase on SHOP, other requirements apply

• Penalties for not having/offering health insurance