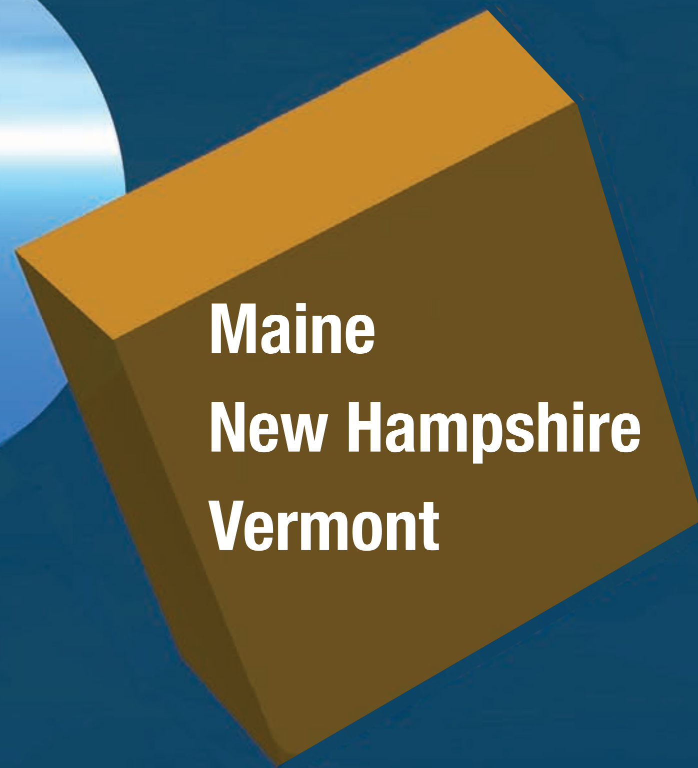
Some think that the Affordable Care Act is like placing a square peg into a round hole



DELTA DENTAL®

Northeast Delta Dental

We think it is more like ...

... Putting together puzzle pieces

Northeast Delta Dental

Northeast Delta Dental

On March 23, 2010 the Patient Protection and Affordable Care Act (ACA) was signed into law.

As regional leaders in oral health care, we have been working to determine exactly how the ACA will affect dental insurance coverage, and the best means to integrate dental and medical care in order to help our clients derive maximal value for employees in benefit design.

To this end, we have been partnering with outside consultants, and with their insight have been able to begin the process of putting the puzzle pieces together. The response from the state governments of Maine, New Hampshire, and Vermont, when considering the implementation of the Affordable Care Act, has been diverse. Our challenge is to incorporate each state's platform into our vision.

In the following pages, you will find a wealth of information detailing the ACA, the possible outcomes of upcoming United States Supreme Court rulings and possible effects of the election this November.

You may visit my blog at *http://tomraffio.wordpress.com* for any updates and how we plan to integrate them into our company.

Tom Raffio

Thomas Raffio
President and CEO of Northeast Delta Dental

April, 2012

The ACA – An Overview

The ACA is principally designed:

i) to achieve near universal health insurance coverage, with substantial reduction in the number of uninsured in the U.S., and
ii) to increase the affordability of health insurance in the individual and small group markets.

The coverage expansion is achieved through a series of mandates, tax penalties and affordability measures, and further aided through subsidies (described below) to make coverage affordable. The theory is that coverage expansion will broaden the health insurance risk pool by requiring good risks (i.e., healthier people) to purchase insurance, thereby lowering the cost of health insurance for the average purchaser in the individual and small group market.

The following is a brief description of key ACA features designed to expand coverage:

The Mandates. The ACA has two key mandates:

Individual Mandate. Individuals are required to secure health insurance, either through their employer or individually, with imposition of a tax penalty for non-coverage. The validity of the Individual Mandate will be decided by the Supreme Court in June, 2012.

Large Employer Mandate. Large employers (>50 employees) must offer health insurance that is affordable, or pay a tax penalty.

The Subsidies. There are two subsidized programs in the ACA – Medicaid expansion and Exchange-based Premium Tax Credits (PTCs) and Cost Sharing Reductions (CSRs).

Medicaid Expansion. Where Medicaid has focused on coverage for low-income pregnant mothers and families, Medicaid will be expanded to include all individuals and families with annual household income below 138% of the Federal Poverty Level (FPL). An estimated 16-18M individuals will gain coverage through Medicaid expansion.

Exchange PTCs and CSRs. To make coverage affordable, the ACA offers PTCs and CSRs on a sliding scale that reduces out-of-pocket cost for those with income from 138% - 400% of the FPL. An estimated 22M will gain coverage through Exchange PTCs and CSRs.

The Future. In March, 2012, the Congressional Budget Office (CBO) issued updated guidance on the coverage and cost effects of the ACA, with several key findings:

Higher Premium Costs. Average premiums will be higher than originally projected because required Essential Health Benefits (EHBs) are expected to be more generous.

Lower Employer Sponsored Insurance (ESI). Because small employers (≤50 employees) will not face a tax penalty, and with higher premium costs, more employers are expected to drop coverage, resulting in a 4M person decline in ESI.

Higher Medicaid Expansion. Because of the slow economy, more individuals will enroll in Medicaid than originally projected.

Fewer Individuals Purchasing Coverage. With higher premium costs, fewer individuals are expected to take advantage of Exchange PTCs and CSRs and will go without coverage.

More Uninsured. Given all of the coverage effects above, the ACA will be less successful in achieving coverage, with 2M more uninsured than originally projected.

Overall Cost. The ACA will reduce the deficit by $50B more than originally projected because although per person premium costs will go up, fewer individuals will purchase insurance through Exchanges with federal subsidies (lowering federal cost) and will be subject to higher aggregate penalties (resulting in greater federal revenue).

Future actions, including the Supreme Court decision and the 2012 elections, may dramatically affect the future shape of the ACA. Northeast Delta Dental is pleased to answer any questions you may have about how the ACA affects the dental coverage you purchase. (See page 14 for contact information.)

Key Features of the Affordable Care Act

2010

NEW CONSUMER PROTECTIONS

- Putting Information for Consumers Online.
- Prohibiting Denying Coverage of Children Based on Pre-Existing Conditions.
- Prohibiting Insurance Companies from Rescinding Coverage.
- Eliminating Lifetime Limits on Insurance Coverage.
- Regulating Annual Limits on Insurance Coverage.
- Appealing Insurance Company Decisions.
- Establishing Consumer Assistance Programs in the States.

IMPROVING QUALITY AND LOWERING COSTS

- Providing Small Business Health Insurance Tax Credits.
- Offering Relief for 4 Million Seniors Who Hit the Medicare Prescription Drug "Donut Hole."
- Providing Free Preventive Care.
- Preventing Disease and Illness.
- Cracking Down on Health Care Fraud.

INCREASING ACCESS TO AFFORDABLE CARE

- Providing Access to Insurance for Uninsured Americans with Pre-Existing Conditions.
- Extending Coverage for Young Adults.
- Expanding Coverage for Early Retirees.
- Rebuilding the Primary Care Workforce.
- Holding Insurance Companies Accountable for Unreasonable Rate Hikes.
- Allowing States to Cover More People on Medicaid.
- Increasing Payments for Rural Health Care Providers.
- Strengthening Community Health Centers.

2011

IMPROVING QUALITY AND LOWERING COSTS

- Offering Prescription Drug Discounts.
- Providing Free Preventive Care for Seniors.
- Improving Health Care Quality and Efficiency.
- Improving Care for Seniors After They Leave the Hospital.
- Introducing New Innovations to Bring Down Costs.

INCREASING ACCESS TO AFFORDABLE CARE

- Increasing Access to Services at Home and in the Community.

HOLDING INSURANCE COMPANIES ACCOUNTABLE

- Bringing Down Health Care Premiums.
- Addressing Overpayments to Big Insurance Companies and Strengthening Medicare Advantage.

2012

IMPROVING QUALITY AND LOWERING COSTS

- Linking Payment to Quality Outcomes.
- Encouraging Integrated Health Systems.
- Reducing Paperwork and Administrative Costs.
- Understanding and Fighting Health Disparities.

INCREASING ACCESS TO AFFORDABLE CARE

- Providing New, Voluntary Options for Long-Term Care Insurance.

2013

IMPROVING QUALITY AND LOWERING COSTS

- Improving Preventive Health Coverage.
- Expanding Authority to Bundle Payments.

INCREASING ACCESS TO AFFORDABLE CARE

- Increasing Medicaid Payments for Primary Care Doctors.
- Providing Additional Funding for the Children's Health Insurance Program.

2014

NEW CONSUMER PROTECTIONS

- Prohibiting Discrimination Due to Pre-Existing Conditions or Gender.
- Eliminating Annual Limits on Insurance Coverage.
- Ensuring Coverage for Individuals Participating in Clinical Trials.

IMPROVING QUALITY AND LOWERING COSTS

- Making Care More Affordable.
- Establishing Affordable Insurance Exchanges.
- Increasing the Small Business Tax Credit.

INCREASING ACCESS TO AFFORDABLE CARE

- Increasing Access to Medicaid.
- Promoting Individual Responsibility.
- Ensuring Free Choice.

2015

IMPROVING QUALITY AND LOWERING COSTS

- Paying Physicians Based on Value Not Volume.

HHS will not enforce these rules against issuers of stand-alone retiree-only plans in the private health insurance market.

Excerpted from: http://www.healthcare.gov/law/timeline/full.html

Key Provisions of the Affordable Care Act

Insurance Reforms

For health plans, the ACA includes market reforms for: lifetime or annual limits; prohibition on rescissions; preventive health services; dependent coverage; uniform explanation of coverage and standard definitions; discrimination based on salary; quality of care; medical loss ratios; appeals; prohibitions on preexisting condition exclusions; premium rating; guaranteed availability; guaranteed renewability; health status nondiscrimination; comprehensive essential health benefits; and waiting period requirements. Other requirements may be applicable to pediatric dental coverage offered in an Exchange. Stand-alone dental plans are generally exempt from the insurance market reforms because they are considered "excepted benefits."

Exchanges

The ACA establishes state-based Exchanges that facilitate the purchase of health insurance coverage and related insurance products at an affordable price by qualified individuals and qualified employer groups. The ACA also allows for regional exchanges operating in a defined geographic area. Exchanges will be administered by a governmental agency or a not previously established non-profit organization. Initially, coverage through Exchanges will be offered only to individuals and small-group health plans. Stand-alone dental plans can be sold in Exchanges in order to meet the pediatric dental requirement of any coverage offered in the Exchange. Subsidies may be available to be used for coverage purchased through the Exchange, including the pediatric dental plan.

Individuals may continue to purchase insurance outside the Exchange structure, but will not be eligible for subsidies. Exchanges will impose a surcharge on all participating plans. While state-based Exchanges are enabled by the bill, the exact nature and operation of the various state Exchanges, including the benefits to be offered through the Exchanges, will depend in large measure upon decisions made by the individual states.

Benefit Tiers in Exchanges

The law creates four benefit tiers of health coverage listed as bronze, silver, gold and platinum. All tiers include a pediatric dental benefit requirement for all levels of coverage.

Essential Health Benefits

In order to be offered in the Exchange, a Qualified Health Plan (QHP) must offer a package of essential health benefits. One of these specified benefits is a pediatric dental benefit. States have been given the authority to define the essential benefits, controlling the specific plan scope of the pediatric dental benefit. In 2014, when the Exchanges are operational, all coverage offered in the Exchange must meet the essential benefit requirements. Essential health benefit (EHB) requirements extend outside the Exchanges to individuals and small groups at the same time (2014), meaning all health plans must offer at least the EHB.

Stand-Alone Dental Benefits

Stand-alone dental benefits can be offered in the Exchanges in order to satisfy the requirements of an essential health benefits package for providing a pediatric dental benefit. However, further work is needed to clarify the treatment of stand-alone dental outside the Exchange, beginning in 2014.

Grandfathered Plans

Any group health plan or health insurance coverage in which an individual was enrolled when the ACA was signed into law is considered "grandfathered," and this status exempts the plan from a number of provisions contained in the bill including: annual/lifetime caps, meeting essential benefit requirements, premium ratings, preventive services, cost-sharing and rescissions. An individual can renew this coverage and add dependents after enactment without changing the status of their grandfathered coverage. Grandfathered plans are subject to some of the reforms: uniform explanation and definitions; medical loss ratios; waiting periods; lifetime limits (annual limits for group); extension of dependent coverage; and preexisting conditions (group only). But as an excepted benefit, stand-alone dental is not subject to these requirements.

Dependent Coverage

Plans offering individual or group coverage to a beneficiary's dependent children must make the coverage available until the child turns 26. This provision has applied to all health plans since 2010. As an excepted benefit, stand-alone dental is not subject to this requirement.

Premium Ratings

Insurers offering individual or small group plans can base premium rates only on: whether such plan or coverage is for an individual or family, age (3:1), tobacco use (1.5:1) and geographic area based on rating areas as defined by the state insurance commissioner. As an excepted benefit, stand-alone dental is not subject to this requirement.

Excise Tax on High Cost Employer Group Health Insurance Policies

Beginning in 2018, high cost, employer-provided "Cadillac plans" will be taxed. Any amount of a plan value that exceeds $10,200 for single coverage and $27,500 for family coverage will be taxed at 40 percent. Those thresholds are indexed to inflation and are higher for retirees and employees in high risk occupations. Stand-alone dental and vision plans are excluded from the tax calculation in the reconciliation language.

CHIP

States are required to maintain current income eligibility levels for children in Medicaid and CHIP until 2019; benefit packages and cost-sharing rules will continue as under current law. Beginning in 2015, states will receive a 23 percent increase in the CHIP match rate, up to a cap of 100 percent. CHIP eligible children who are unable to enroll in the program due to enrollment caps will be eligible for tax credits on the state Exchanges. Children's parents may be eligible for tax credits to purchase coverage which would include a pediatric dental benefit.

FSAs

The Act limits the amount of contributions to a flexible spending account for medical expenses (including dental) to $2,500 per year, effective in 2013.

No Lifetime or Annual Limits

The Act eliminated lifetime limits for individual and group plans in 2010. It eliminates annual limits for individual and group plans in 2014. As an excepted benefit, stand-alone dental is not subject to this requirement. As part of the Essential Health Benefits, Pediatric Dental Benefits will be subject to this requirement.

Annual Fee on Health Insurance Providers (*Including Delta Dental Member Companies*)

The ACA will raise $70 billion over ten years, assessed by market share. Dental is not excepted from this annual fee. Here is a breakdown of how the fee will ramp up in the next ten years:

Year	Level
2014	$8 billion
2015	$11.3 billion
2016	$11.3 billion
2017	$13.9 billion
2018	$14.3 billion

Subsequent years — Previous year plus rate of premium growth.

The ACA provides a partial exclusion for tax exempt activities. Eligible non-profit organizations will pay a tax on 50 percent of net premiums.

Additional Oral Health or Dental Specific Provisions

- Oral Health Prevention Campaign – The ACA established a five-year oral health campaign targeted at children, pregnant women and minorities.
- Grants for Caries Research – HHS will be empowered to award grants to demonstrate the effectiveness of research-based dental caries disease management activities.
- School-based Sealant Grants – Grants will be made available in all 50 states.
- Cooperative Agreements – HHS will partner with state, local and tribal governments to establish "oral health leadership."
- Surveillance Activities – HHS will update and improve Pregnancy Risk Assessment Monitoring System with a specific focus on improving oral health.
- Workforce – Oral health was called out as a special area of need in the bill, and HHS will be empowered to extend grants to dental schools.
- Alternative Dental Health Providers – The bill calls for a two-year demonstration project that will look into the efficacy of mid-level providers.

Source: Delta Dental Plans Association.

Northeast Delta Dental and the Affordable Care Act

Exchanges, Premium Tax Credits and All that Jazz

State Exchanges must be operational on October 1, 2013 to accept applications for coverage effective January 1, 2014. With the deadline looming, the federal government is issuing a plethora of regulations that govern the operation of Exchanges and the integration of Exchanges into the entire health insurance coverage scheme.

Premium Tax Credits and Cost Sharing Reductions. So that low income Americans can afford to purchase health insurance under the Individual Mandate, individuals and families with income between 138% - 400% of the FPL and who do not qualify for Employer Sponsored Insurance (ESI) will be eligible for Premium Tax Credits (PTCs) to help pay premiums, and Cost Sharing Reductions (CSRs) to help pay deductibles, co-insurance and co-payments.

PTCs and CSRs are available only when a policy is purchased through an Exchange. To receive PTCs or CSRs, people must file estimated income to determine if they qualify and are eligible. If eligible, the Tax Credit is paid in advance directly to your insurer – you don't have to wait until year end for the PTC or the CSR. At the end of the year, there is a "true-up;" people must file a tax return and there is the prospect of retrospective tax liability or a tax refund, depending on whether the taxpayer over or under estimated income. An important note for married couples – you must file jointly (and not separately) to qualify for the credit.

Essential Health Benefits / Qualified Plans. Once you qualify for a PTC, the question is "What type of health plan can I buy?" Under the ACA, each plan offered in the individual and small group market, whether inside or outside the Exchange, must cover "Essential Health Benefits" (EHBs), a state-specific baseline of covered health services. Each state has the flexibility, during 2014-2015, to adjust EHBs for state mandates, and can base EHBs on the historic small group coverage in the state (termed "benchmark" plans). Each state must finalize its EHBs in the fall, 2012.

EHBs must include pediatric dental benefits, and state Exchanges may permit pediatric and adult dental benefits to be coupled in family plans so that all family members can receive dental services from the same provider.

Once a state defines its EHBs, the next step is developing four different plan types, called the "metal" plans – bronze (60% Actuarial Value), silver (70%), gold (80%) and platinum (90%). "Actuarial Value" is the total cost, including enrollee out of pocket expenses, of providing EHBs to an average enrollee per year. Plans with lower actuarial value have lower premiums and higher enrollee cost sharing; plans with higher actuarial value have higher premiums and lower out of pocket costs. Each metal plan design must fall within a +/- 2% corridor around actuarial value (e.g., silver plan benefits can have actuarial value ranging from 68%-72% and qualify) - if your existing health plan has actuarial value at 75%, it must be modified to comply with the new actuarial value requirements.

Operation of the Exchanges. A state must demonstrate by December 31, 2012, that it will have an Exchange operational by October 1, 2013; otherwise the federal government will operate a "Federally Facilitated Exchange."

Exchanges have a number of requirements, but one of the most important is determination of eligibility for PTCs and CSRs. Individuals can seek an eligibility determination through either the Exchange, Medicaid Agency, or even private exchanges, which must coordinate activity. If an individual requests an eligibility determination through an Exchange but qualifies for Medicaid, or vice versa, each must transmit the eligibility determination to the appropriate agency and the federal government.

As noted in the section describing the Exchange formation activity in Maine, New Hampshire and Vermont, states must now act quickly to meet deadlines. Northeast Delta Dental will be monitoring future developments, so feel free to contact us for additional information (see p. 14).

Maine, New Hampshire and Vermont Update

Despite legal and legislative challenges, the federal health care reform statute, the ACA, continues to be the law. Federal regulations further defining the details of the law and state laws designed to address implementation of the law continue to develop. Northeast Delta Dental is actively engaged in efforts to help shape both the federal regulations and state statutes as they relate to dental benefits to be included in the Exchanges as they are established. To assist in this effort, a special attorney has been hired by Northeast Delta Dental.

Northeast Delta Dental has been actively involved in Maine's, New Hampshire's and Vermont's deliberations regarding the development of state Exchanges, particularly regarding the manner in which dental benefits will be handled on those Exchanges. Exchanges are need-based markets where health and dental coverage will be offered for purchase. Under the ACA, Exchanges are to become fully implemented by January 1, 2014. Northeast Delta Dental representatives are working with legislators, regulators and others in all three states to clarify and secure the role of dental benefits both within and outside the Exchanges.

One of the primary objectives of Northeast Delta Dental's activities has been to make certain that state legislators and regulators understand the provisions of the ACA as those provisions relate to dental benefits. Pediatric dental benefits is one of ten categories of benefits included as "essential health benefits" under the ACA. However, as of yet, the precise definition of the pediatric dental benefit has not been set. The role of adult dental benefits within the Exchange also has not been defined. Many other related questions remain unanswered at this point in time.

A second primary objective is to try to make certain that any Exchange adopted by a state is designed to make it easy for persons using the Exchange to find information about available dental coverages and to select an appropriate dental plan. Small employers (employers having 50 or 100 employees or fewer, as a state may elect) will also be able to go through the Small Business Health Options Program (SHOP) under the ACA. The SHOP Exchange may either be separate from the Exchange or combined into a single Exchange, at the option of the state.

The ACA requires individual states to set up its own Exchange(s), to be operational by January 1, 2014, or have the federal government become involved in setting up the Exchange(s). By the end of 2012, states must be progressing sufficiently toward implementation, in the judgment of federal officials, to avoid having the federal government become involved.

In all three states, we remain active in the legislative process. We are using the opportunities presented to inform our lawmakers of how critical oral health is to overall good health, and, therefore, why it's in the public's interest to make dental insurance as available as health insurance on the state Exchanges.

The United States Supreme Court will hear oral arguments on the lawsuits that were brought by states challenging the constitutionality of the ACA. The highest court in the country will decide whether Congress assumed more power than the Constitution gives it when it voted to make it mandatory for every person in the United States to maintain health insurance (the so called "individual mandate"). Reasonable people can disagree on which way they think the United States Supreme Court will rule on the cases, but nothing will be certain until the nine Supreme Court justices release their decision, which will likely be in June, 2012.

Northeast Delta Dental believes implementation of the Exchanges by the states is preferable to having them set up by federal regulators. Federal intervention would reduce (or possibly eliminate) the ability of a state to design an Exchange that would best serve the state's needs. We believe the state and its citizens and employers will be best served by a state-designed and run Exchange, and Northeast Delta Dental is continuing to work toward that end.

In the meantime, Maine, New Hampshire and Vermont remain on very different paths.

Maine

In mid-March of 2012, the Maine legislative committee considered the bills to create a state Exchange and voted two Exchange related bills out of committee. The bill that would authorize Maine to create an Exchange did not receive majority support. The other bill, which did receive majority support, would simply require all Exchange navigators to be licensed brokers when an Exchange is established in Maine. The Maine House and Senate are expected to vote on both bills this session.

New Hampshire

New Hampshire, as widely reported in local press, has sidestepped the bill that would have created its state Exchange, tabling the bill in a manner that effectively killed it, at least for this year. Another bill is being considered that would actually prohibit the state from creating an Exchange. However, under the ACA, if a state fails to pass a law to create an Exchange by January, 2013, the federal government will set one up for the state. Even if the United States Supreme Court rules the individual mandate requirement unconstitutional, the rest of the ACA is likely to survive, and that includes the part about states having to establish Exchanges. Much remains to be seen how that will play out in New Hampshire. Northeast Delta Dental is preparing for both state run Exchanges and the possibility of a federally facilitated one, at least in New Hampshire.

Vermont

Vermont is continuing to forge ahead to set up its Exchange to be up and running for January 1, 2014, as required by the ACA. Vermont's legislature and state agencies are working on many fronts hammering out how best to implement its Exchange. The Exchange will be a site that compares options (now common on the Internet).

How the United States Supreme Court ruling will affect the ACA

The United States Supreme Court has scheduled oral arguments for the two cases it accepted for hearing on the constitutionality of the ACA over three days, March 26-28, 2012.

What's it all about?
The Court will decide whether the so-called "Individual Mandate" - which requires that almost all Americans acquire health insurance or pay a tax penalty - is constitutional. If the Court determines that it is not constitutional, the court must also decide the remedy – to strike down the mandate and immediately related provisions (e.g., guaranteed issue with no pre-existing condition limitations, and community rating of policies), or to invalidate the entire ACA.

What's the Basis for Support of the ACA?
The argument will likely turn on two key constitutional standards – the Commerce Clause, and the Necessary and Proper Clause.

The Commerce Clause generally gives the federal government sweeping power to regulate interstate commerce, but its application has usually been limited to regulating "action" (i.e., engaging in commerce), rather than "inaction" (i.e., compelling specific commerce like the purchasing of health insurance merely by reason of residence in the U.S.). Constitutional scholars are concerned that if the Individual Mandate is upheld, then the federal government could compel almost any interstate commerce (e.g., requiring Americans to purchase a GM or Chrysler automobile to minimize federal government risk of the auto bailout).

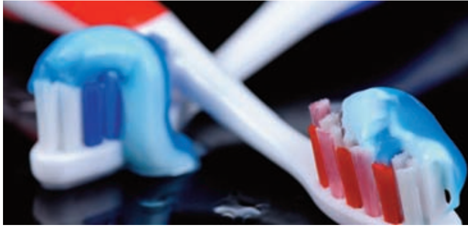
The Necessary and Proper Clause has been used to authorize federal regulation where the underlying objective is permissible (here federal action regulating the health and welfare of the population), and the approach taken (the Individual Mandate) is a necessary and proper means of achieving the goal.

In both cases, the ACA is challenging the fundamental constitutional premise that the federal government was intended by the founding fathers to have limited power, and that any power not expressly granted to the federal government is reserved to the states.

What's the likely outcome?
Nobody knows. Even the parties have modified their arguments during the submission of multiple briefs. Where the federal government initially focused on justifying action under the Commerce Clause, the most recently submitted briefs have placed more emphasis on the Necessary and Proper Clause, as several of the more conservative judges on the Court have supported its application.

In June, 2012, we will have the decision and can begin assessing the impact.

Exploring the possible outcomes regarding the ACA



There will be two major influences on the Affordable Care Act:

- The Supreme Court ruling, expected sometime this summer 2012
- The November 2012 election: President, All 435 Representatives, 33 Senators.

Following are the most likely political situations based on the assumption that the Individual Mandate is deemed unconstitutional:

Scenario one:
The re-election of President Obama with Congress maintaining current Republican/Democratic numbers.
The President would use the powers of the executive branch to continue many of the mandates of the ACA, with Congress trying to defund as much of the law as possible. Under these conditions most of the ACA will be implemented.

Scenario two:
The re-election of the President with both houses in Congress comprising a Republican majority.
In this case most of the ACA will stay intact, however the opposition party will force the President to cut in other areas to pay for the parts of the ACA that are agreed upon by both parties.

Scenario three:
A Republican is elected President with a majority support of Republicans in Congress.
Under this scenario the ACA would be repealed and replaced with a new plan, including many aspects of the ACA upon which both parties agree and about which the public is favorable.

Under any scenario we believe the ACA will continue in some form in the future regardless of the political outcome this November. Vermont will continue to move in the direction of a single payer system, implemented by the Green Mountain Care Board, and utilize the Exchange already in place. Maine will wait to see the United States Supreme Court decision and if the ACA is upheld as constitutional, Maine will pass Exchange legislation later this year in order to have more control over its Exchange. New Hampshire will meet statute requirements.

From its inception the insurance reform legislation has enjoyed broad support for a majority of its parts and will certainly be replaced if repealed. Repealing the ACA without regard to the agreed upon aspects would be like trying to push toothpaste back into its tube.

Thomas Raffio
President and CEO of Northeast Delta Dental

Please visit my blog at *http://tomraffio.wordpress.com* for future updates.

Northeast Delta Dental is Here to Help Navigate the ACA

The ACA is incredibly complex, and even Congress didn't know all of the details or fully understand how the ACA would affect private markets.

And because so much of the ACA is ultimately defined by evolving federal and state regulations, and private market response, the ACA implementation will be dynamic for years to come.

Given all of the complexity, what can you do?

Please call us.

Northeast Delta Dental has personnel devoted to understanding how the ACA affects your health and dental insurance benefits. And we have also engaged renowned experts to help us understand the many possible future permutations of the ACA so we can be prepared with fast response in this dynamic market. So, our expertise is yours – for free! And if you have any questions where we don't know the answer, we'll do the research to find it for you.

If you would like to schedule a personal consultation on how the ACA affects purchasing of dental benefits or integration of dental benefits with your medical plan, just give us a call.

To answer inquiries or schedule a personal consultation, please contact:

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Patient Protection and Affordable Care Act

Timeline for Health Care Reform

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April, 2012