Compliance Corner

Update on Federal Health Care Reform and State Issues

June 2015

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Strategy Update

As of June, Ameritas and our strategic partners have 667 clients that selected plans with our new pediatric dental benefits. One of these clients is comprised of 825 small employers. The total number of small groups that have pediatric dental coverage included in their group policy is almost 1,500. The number of lives covered through all these groups is over 23,000. Additionally, group terminations due to health care reform have been extremely low.

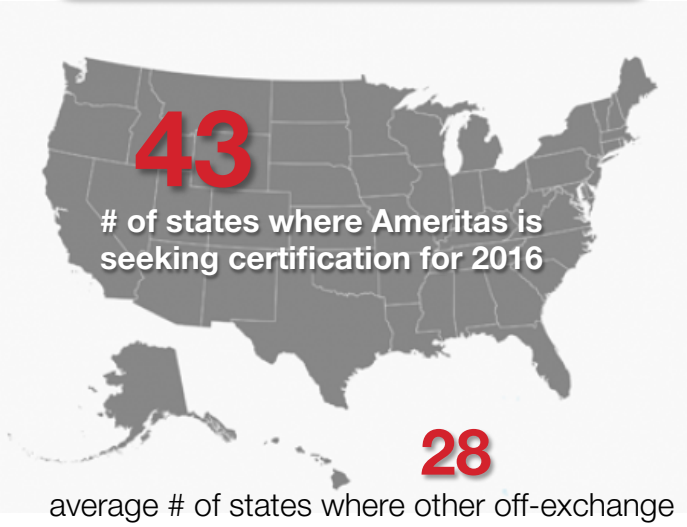
We continue to pursue regulatory approvals for our 2016 pediatric plans. States are applying more scrutiny to the covered procedure frequency this year than for the 2015 plan year. Some states also continue to challenge variability in policies or features previously approved, but we are working together to meet deadlines and influence approvals.

We are seeking certification for Ameritas and two strategic partners in 43 states for the 2016 small employer marketplace. The number of states we hope to be exchange-certified in well exceeds other off-exchange carriers in the marketplace, who are averaging around 28 states for certification. In addition, we are seeking recertification in the individual marketplace in one state where we have a medical partnership.

We have completed the certification filings, which is challenging as the submission process varies between the Federally-Facilitated Marketplace (FFM) and partnership or state-based exchanges. We have submitted 127 electronic "binders" with network, rate, plan, and organization information in accordance with state and/or federal timelines and requirements. We have a handful of form and/or rate submissions remaining, based on state filing deadlines.

23,000

# of lives covered under Ameritas plans that include pediatric dental benefits



average # of states where other off-exchange carriers are seeking certification

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Regulatory Matters and Affordable Care Act Status Update

Political Landscape

Political posturing and debate continues as the country anticipates the ruling on the legal challenge of the exchange subsidies in the Federally Facilitated Marketplaces under the King vs. Burwell challenge. A decision is expected any day, but no later than June 26. Both the House and Senate have already or are anticipated to introduce bills to modify or nullify the Affordable Care Act in its entirety.

Exchange Enrollment

Exchange enrollment in both the state-based and Federally Facilitated Marketplaces (exchanges) for medical has grown from 8 million in 2014 to the estimated 11.7 million during the 2015 open enrollment. This figure includes 4.5 million who re-enrolled from 2014. Dental enrollment has increased as well from roughly 1 million to 1.4 million. The growth rate of dental can be attributed to the growth in individual medical coverage overall on the exchanges, and to the small employer marketplace (SHOP) being available as of the 2015 enrollment period.

Federal Regulations/Guidance

Regulations or guidance have been proposed for the following, which are not applicable to stand-alone dental or vision coverage outside of the exchanges, but are closely monitored for any future implications: Summary of Benefits and Coverage and Uniform Glossary, Proposed Out-of-Pocket (OOP) Cost Comparison Tool for the Federally-Facilitated Marketplaces, Distribution of Information Regarding Advance Payments of the Premium Tax Credit (APTC) and Cost-Sharing Reductions (CSR) in Federal Standard Notices for Coverage Offered through the Federally-Facilitated Marketplaces (FFMs), Essential Health Benefits: List of the Largest Three Small Group (medical) Products by State, and Questions and Answers Regarding the Medical Loss Ratio Reporting and Rebate Requirements.

Health Plan Identification Number (HPID)

As part of the Administrative Simplification requirements under the Affordable Care Act, Controlling Health Plans (CHPs) are required to obtain a Health Plan Identification Number (HPID). The HPID is a standardized 10-digit number assigned to health plans, which is designed to increase standardization and help covered entities verify information from other covered entities. A covered entity is required to use an HPID when it identifies a health plan in a standard transaction.

Late last year, the Federal government postponed until further notice the requirement for Controlling Health Plans to obtain a Health Plan Identifier (HPID). The Centers for Medicare and Medicaid Services (CMS) is revitalizing this requirement, and has requested stakeholder comments in the next few weeks. Ameritas and its strategic partners have already secured a Health Plan Identification Number (HPID) last year before CMS postponed its implementation. We are reviewing internally to determine if comments are warranted.

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Administrative Simplification

The Administrative Simplification provisions of the Affordable Care Act adopt new standards and "operating rules" for how electronic transactions are conducted between HIPAA "covered entities" (health plans, clearinghouses and health care providers who conduct electronic health care transactions).

These new operating rules supplement existing HIPAA transactions and guidelines (ANSI X12 version 5010), and will require health plans to certify their compliance with the new rules. Controlling health plans (CHPs) must submit documentation that demonstrates compliance with the adopted standards and operating rules for three electronic transactions: 1) Eligibility for a health plan, 2) Health care claim status, and 3) Health care electronic funds transfers (EFT) and remittance advice.

The rule proposes that controlling health plans submit their certification on or before December 31, 2015 for large CHPs, and December 31, 2016 for small or new CHPs. This proposed rule would also establish penalty fees for a CHP that fails to comply with the certification of compliance requirements. The rule was proposed in December 2013, and as of yet has not been finalized by CMS.

The second certification of compliance is applicable to health claims or equivalent encounter information, enrollment or disenrollment in a health plan, health plan premium payments, health claims attachments, and referral certification and authorization transactions. It is also due on December 31, 2015 according to the statute; however there are currently no standards or operating rules for these transactions.

While much detail regarding this certification remains to be developed, Ameritas has begun discussions so that we can complete the certification's required testing process when final regulations are issued.

Equitable Treatment 2.0

Among the proposed changes pending the outcome of the King vs. Burwell legal challenge, the dental benefits industry is continuing the pursuit of equitable treatment of stand-alone dental plans between off and on exchanges. The National Association of Dental Plans (NADP) continues work on a draft amendment for a legislative fix, which would also seek to obsolete the separate exchange certification process for products containing pediatric dental benefits and leave approval of compliant products to the states, as done today.

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Network Adequacy/Provider Directories

State and Federal requirements surrounding network plans for both medical and dental continue to grow. The National Association of Insurance Commissioners (NAIC) is currently working on a network adequacy model act for state use, which would include medical, dental and vision. The National Association of Dental Plans (NADP) has created a work group to review the model language and determine which sections should be applicable and which should not. The medical, dental, and vision trade associations are collaborating in advocacy efforts for either a separate dental model, or at minimum alignment on applicability. The NADP work group has advised roughly 1/3 of the model act is applicable, 1/3 is applicable but consideration for non-applicability should be given, and 1/3 should not be applicable.

As previously reported, the final instructions for Qualified Health Plans (QHPs) and Stand-Alone Dental Plans (SADPs) both on and off the public exchanges were released under the federal 2016 Letter to Issuers and Benefit and Payment Parameters. A new requirement will apply in 2016 for carriers to list their provider directories in machine-readable format on their websites. This would apply to us as part of our Essential Health Benefit (EHB) certification. We are required to follow the QHP requirements under Network Adequacy, which includes providing our provider directory link. Carriers are concerned with data protection and integrity issues since this would allow anyone access to and the ability to manipulate carrier provider data. It could also have a potential liability risk for carriers if members receive and rely on outdated information created by third parties. Both Ameritas and our dental trade association, the National Association of Dental Plans (NADP), have submitted comments to address these concerns to the Centers for Medicare and Medicaid Services (CMS).

Private Market

We continue our strategies to provide education and communications to brokers and small employers who are still confused about ACA impacts on the dental benefits. As the small group market is still on track to change from 50 to 100 beginning in January of 2016, we may see a repeat of the 2013 trend - groups may renew early in late 2015 to avoid making the required change to the Essential Health Benefit package as of their 2016 renewal. This may trigger questions about their dental coverage in this market segment. We are ready to help them with traditional and pediatric essential dental benefit plan designs.

Ameritas Readiness

We have submitted most of the 2016 exchange certification filings. We are efficiently using this filing window to add additional product enhancements and technical language fixes for approval in all states. We are also employing creative filing strategies to mitigate disruption to our current product offerings. We continue to advocate for exchange-certified status in the remainder of states without actual participation on those exchanges.

We continue to monitor and advocate through various trade associations against laws and regulations that increasingly expand medical carrier requirements to dental carriers on an issue by issue, state by state basis. Issues such as dental loss ratios, provider directories, state insurer fees, and network adequacy requirements continue to be of concern. The outcome of the King vs. Burwell legal challenge will dictate any changing of the tides in this trend. We continue to advocate for retention of our excepted benefit status for dental and vision products.

What else is going on in the states this month?

Provider Directories: In Illinois, amendments have deleted provisions to require dental plans to remove providers from directories if they have not filed a claim within a prior 3-month period. The version being considered by the Assembly would require dental plans to note whether a provider is accepting new patients at each of the specific locations listed in the directory. Providers are instructed to notify plans of any changes to their information, and plans are then required to update directories within 10 business days.

Ohio has published another version of its Provider Network Disclosures rule for public comment. The rule would require carriers to maintain an accurate provider directory (reviewed quarterly, updated within 15 business days of effective date of change), provide notice to enrollees on network changes and also includes standards for the timing of updating network information with hold harmless provisions.

Dental Loss Ratio (DLR): The DLR bill in Washington passed, effective 1/1/2017, and was reduced to a study. California DLR reporting is due September 30, 2015. A similar bill was introduced in Rhode Island this year, but was held for further study. The latest state to introduce a DLR bill is Massachusetts, which is proposing a set DLR for dental carriers to adhere to of 90% the first year, and 95% in years thereafter. We continue to work through our trade association to mitigate the impact of these bills and reporting requirements.

Cost-Sharing: New Mexico has released a bulletin advising carriers that all insured/policyholder or potential insured/policyholder documents need to reflect cost-sharing requirements from the perspective of the insured/policyholder. We are assessing the bulletin for implications accordingly and recommending an implementation plan.

Marketing Materials: New requirements necessitate us to file our marketing materials in Arizona and New Mexico. We are working with the state and other stakeholders to mitigate business impacts.

Exchange Fees: Colorado is recommending an increase to medical carrier assessments at 4.5% for calendar year 2016, which is an increase from the current 1.4%. Connecticut increased their fee as well. The Federal exchange fee will increase from 3.5% to 4% in 2016.

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For more information:
- visit **ameritas.com** and check out Affordable Care Act under Businesses and Groups
- visit the Affordable Care Act section of **ameritasinsight.com**
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