compliance corner

Update on Federal Health Care Reform and State Issues

July 2015

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Strategy Update

We continue to pursue regulatory approvals for our 2016 pediatric plans. We have received preliminary approval of form and rate filings in roughly 15 states, and continue to respond to state and federal objections on our forms, rates, certification binders, and network adequacy filings. States are applying more scrutiny this year to the covered procedure frequency than for the 2015 plan year. Some states also continue to challenge variability in policies or features previously approved. We are working diligently to meet deadlines and influence approvals, while leveraging internal resources to comply with new unique requirements.

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. The number of actual state certifications that we will achieve may vary based on our ability to comply with complex requirements in a few states.

Regulatory Matters and Affordable Care Act Status Update

Political Landscape

In a 6-3 decision, the Supreme Court upheld the insurance subsidies created by the Affordable Care Act can be offered in both state and federal exchanges. This has been the second ruling that has been favorable in maintaining the Affordable Care Act. This does not change the House and Senate from posturing to introduce bills to modify or nullify the Affordable Care Act in its entirety. As the subsidies will continue and Congress will not need to divert attention to providing an alternative solution to insureds currently in the federal exchange, we anticipate more attention will be given to fixing other unfavorable provisions of the law, such as the Employer Mandate and the Health Insurer Assessment Fee (HIAF).

Medical Early Renewals

Small group is redefined in 2016 as 100 and fewer eligible employees (up from 50) for purposes of complying with the Affordable Care Act and the Essential Health Benefits package. The small group definition can be delayed under the President's Transitional Period policy, which allowed groups to keep their current non-ACA complaint medical plans until as late as October 1, 2016.

Although the state can make the decision to delay the extension until the transitional period expires, it is then up to each individual medical carrier in the state to allow non-compliant plans to continue to be offered.

Same Sex Marriage

In another major Supreme Court decision in June, states are now prohibited from refusing licenses to same-sex marriage couples. Fourteen states that did not recognize same-sex marriage will now be required to: Alabama, Arkansas, Georgia, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Tennessee, and Texas. As we do not define "spouse" in our fully-insured dental, vision and hearing documents today, they already support same-sex marriage and will not need to be amended/filed.

The ruling does not require employers to cover spouses for health/welfare benefits; however, employers with fully insured plans that cover spouses are required to extend those benefits to same-sex spouses. Employers with ASO plans are able to define "spouse," and administer to limit to opposite-sex spouses, but could be subject to EEOC discrimination claims accordingly.

The ruling is already being implemented in certain states, but some states are resisting. As we receive eligibility information from the employer, the effective date does not have an impact.

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

- 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 had 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.

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. The dental industry is also working closely with America's Health Insurance Plans (AHIP) on their own version of the same fix, which is not as detailed as the NADP version, but aims to achieve the same outcome.

Private Market

We continue our strategies to provide education and communications to brokers and small employers who are still confused about ACA impacts on dental benefits. As the small group market is still on track to change from 50 to 100 beginning in January of 2016, we are seeing a repeat of the 2013 trend - groups are renewing their medical 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 dental plan designs.

Ameritas Readiness

We have submitted most of the 2016 exchange certification filings. We are efficiently using this filing window to add 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 United States this month:

Dental Loss Ratio (DLR)

The DLR bill in Washington passed, effective January 1, 2017, and was reduced to a study. California DLR reporting is due September 30, 2015. Washington has passed a bill as well, requiring reporting of carrier DLR next year. 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% 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 have filed revised policy language, and are working on implementation accordingly on various member documents.

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.

Look for the Compliance Corner, visit ameritasinsight.com, or contact your sales representative with questions. Contact Kate McCown, our Group Compliance Officer, at kmccown@ameritas.com or any member of our Compliance Team. Let us know if you would like copies of any materials mentioned.

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