compliance corner

Update on Federal Health Care Reform and State Issues

September 2015

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Strategy Update

We are wrapping up regulatory approvals for our 2016 pediatric plans. We have received preliminary approval of form and rate filings in 37 states, and continue to wrap up responses to state and federal objections on our forms, rates, and network adequacy filings. States continue to apply more scrutiny to dental carrier filings this year than in years past. We are working diligently to meet deadlines and influence approvals, while leveraging internal resources to comply with new unique requirements.

The Federally Facilitated Exchange certification notices are expected September 18. State-Based Exchange certification timing varies by state, but we expect it to be shortly after the federal certification notices. We did have to withdraw our certification submissions in Maryland and Tennessee. In Maryland this was due to unclear guidance on policy structure and provisions that has been on-going for over two years and restricting our ability to receive approval of other products in the state. In Tennessee, the state required carriers to have an open list for procedures for the Essential Health Benefits, which is unsustainable within our current product structure.

Regulatory Matters and Affordable Care Act Status Update

Political Landscape

Legislation to fix various elements of the Affordable Care Act continues to be introduced. As anticipated, lawmakers are giving more attention to correcting other unfavorable provisions of the law, such as the Employer Mandate, Cadillac Tax, Small Employer Definition, and the Health Insurer Assessment Fee (HIAF). A bill to allow states the decision to leave the small employer definition at 50, rather than expanding to 100 as of January 1 2016, is gaining momentum and support. However by the time the bill passes it may be too late for practical application, as most carriers have created and issued renewals for January plans. We will see proposed changes introduced in the next month on other unfavorable elements of the law as lawmakers also solution for funding the federal government before the funds expires at the end of the month.

Medical Maximum Out-of-Pocket Limits

The Centers for Medicare and Medicaid Services (CMS) announced this week that they will not change rules surrounding the maximum yearly medical out-of-pocket limit currently set at $6,850 for individuals, and $13,700 for families. They have clarified that no individual, regardless of whether he or she is in a family or individual health plan, will have to pay more than the individual maximum for cost-sharing. Those limitations apply to individual, small-group, large-group, and self-insured plans.

The intent of this policy is to protect families from racking up burdensome medical debts. Large employers however are not in favor of the rule, especially self-funded companies, as it increases costs for employers or the insurer. Employers also said the timetable for the change was impractical since most large group plans have already been set for the 2016 calendar year.

2016 Small Group Definition

A bill to allow states the decision to leave the small employer definition at 50 employees, rather than expanding to 100 employees as of January 1, is gaining momentum and support. If successful, the bill will delay moving businesses with 51 to 99 employees from the large group market to the small group market effective January 1, 2016. However by the time the bill passes it may be too late for practical application, as most carriers have created and issued renewals for January 1 plan years.

States are reviewing the expansion as well, and several states have released guidance that the small group definition can be delayed in their state 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.

Network Adequacy/Provider Directories

We continue to monitor State and Federal requirements surrounding network plans for both medical and dental networks. The National Association of Insurance Commissioners (NAIC) is close to finalizing their Network Adequacy Model Act for state use, which applies to medical, dental and vision networks. Provider directory requirements include posting information in a searchable electronic format, updating the directory at least monthly, periodic audits of the directory, provision of a hard copy upon request, and specific provider information for each plan.

As a result of dental and vision carrier advocacy, a definition for limited scope dental and vision benefits was added to the model law, along with drafting notes directing state regulators to look to their state laws and definitions to determine how to apply network adequacy standards to limited scope plans. Due to this drafting discretion for limited scope benefits given to states, not every state may have consistent requirements. As states look to adopt the model during the 2016 legislative session, we will monitor proposed legislation and advocate for simplistic approaches for limited scope dental and vision plans.

Related, the Centers for Medicare and Medicaid Services (CMS) has clarified that stand-alone dental carriers that are exchange-certified outside of the public exchanges are no longer required to create provider directories in machine-readable format and make available on their websites. While we are now exempt from this for 2016, CMS could reverse this position in future years.

Equitable Treatment 2.0

Both the dental and medical benefits industries continue to pursue equitable treatment of dental benefit offering off and on the exchanges. America's Health Insurance Plans (AHIP) has been successful in achieving sponsorship and introduction of a bill, H.R. 3463 "Aligning Children's Dental Coverage Act," to alleviate the disparity of pediatric dental benefit offerings inside and outside of the exchanges. The National Association of Dental Plans (NADP) is reviewing the Act to ensure alignment with the provisions of this bill.

2017 Essential Health Benefit Benchmarks

The Center for Consumer Information and Insurance Oversight (CCIIO) released new guidance related to coverage of essential health benefit (EHB) requirements for the 2017 plan year. The new guidance included a list of proposed 2017 EHB benchmark plans for all 50 states DC, a summary of benchmark plan coverage and supporting plan documents; and a list of the number of prescription drugs that are covered in each category and class in the benchmark plans.

As it relates to dental coverage, roughly half of the states have selected a medical plan that contains a pediatric dental benefit for the new 2017 benchmark plan. However, as the medical plans were required to include either the Federal Employees Dental and Vision Insurance Plan (FEDVIP) or Children's Health Insurance Plan (CHIP) procedures as the benchmark in 2014, we do not anticipate this having a major impact on our 2017 plan designs, other than the concern of transparency in the medical carrier coverage documents. Comments on the EHB benchmarks and related guidance are due by September 30.

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 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 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 the majority 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, while 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. We continue to advocate for retention of our excepted benefit status for dental and vision products.

Look for the Compliance Corner communications, visit our website, or ask your sales contacts any questions. Or 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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