DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA
HEALTH BENEFIT EXCHANGE AUTHORITY

To establish a reasonable out-of-pocket maximum for Qualified Dental Plans.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, § 1311(d)(2)(B)(ii) of the Affordable Care Act of 2010 (P.L. 111-148 & P.L. 111-152) ("ACA"), 45 CFR § 155.1065, and § 5(b) of the Act (D.C. Official Code § 31-3171.04(b)) permit a health carrier to offer a limited scope dental benefit either separately or in conjunction with a Qualified Health Plan, if the plan provides essential pediatric dental benefits meeting the requirements of §1302(b)(1)(J) of the ACA;

WHEREAS, § 10(e) of the Act (D.C. Official Code § 31-3171.09(e)) applies the certification requirements of the Act to Qualified Dental Plans to the extent relevant and permits health carriers to jointly offer a comprehensive plan through the exchanges in which the dental benefits are provided by a health carrier through a Qualified Dental Plan and the other benefits are provided by a health carrier through a Qualified Health Plan; provided, that the plans are priced separately and are also made available for purchase separately at the same price;

WHEREAS, the Dental Plan Working Group, which included ten dental and health carriers, consumer groups, and a DC resident, met on April 2, 2013and reached consensus on three recommendations and did not reach consensus on one recommendation;

WHEREAS, on April 15, 2013, the Insurance Market Working Committee deliberated on the non-consensus recommendation regarding an out of pocket maximum for the pediatric dental essential health benefit in a stand-alone dental plan;

WHEREAS, 45 C.F.R. §156.150 requires a stand-alone dental plan covering the pediatric dental essential health benefit to demonstrate that it has a reasonable annual limitation on cost-sharing as determined by the Exchange;

WHEREAS, on April 5, 2013, the Centers for Medicare & Medicaid Services within the U.S. Department of Health and Human Services, issued a letter of guidance for federally facilitated and partnership exchanges defining a reasonable out-of-pocket maximum for the pediatric dental essential health benefit from 45 C.F.R. §156.150 as at or below $700 for a plan with one child enrollee or $1,400 for a plan with two or more child enrollees; and

WHEREAS, the Insurance Market Working Committee in a 3-0 vote recommends an out-of-pocket maximum that is not greater than $1000 for one child, increasing to $2000 for two or more children for the pediatric dental essential health benefit in Qualified Dental Plans.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves an out-of-pocket maximum for Qualified Dental Plans that is not greater than $1000 for one child, increasing to $2000 for two or more children for the pediatric dental essential health benefit.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this **___18th___** day of **_April____**, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

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Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority