DC Health Benefit Exchange Dental Working Group Report

April 13, 2013

This report is submitted to the Health Benefit Exchange Authority by the Dental Plan Advisory Working Group Chair (Leighton Ku) and Co-Vice Chairs (Katherine Stocks and Anupama Rao Tate). The purpose of this report is to outline the recommendations of the Dental Plan Advisory Working Group regarding what stand-alone dental plan issuers will be required to submit the DC Health Benefit Exchange Authority (HBX) with respect to becoming certified to sell stand-alone dental plans covering the Essential Health Benefit pediatric dental benefits, and non-pediatric dental benefits if chosen by the issuer, through the HBX.

Background

For dental coverage beginning in 2014, individuals and small groups will be able to purchase coverage through exchanges, the purpose of which is to provide a competitive marketplace and facilitate comparison of dental plans based on price, coverage and other factors. Dental plan issuers must be certified as meeting minimum standards in order to participate in the exchange and issue qualified dental plans. In March of 2012, the U.S. Department of Health and Human Services issued a final (some parts interim final) rule on "Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers." (45 CFR Parts 155, 156 and 157). The preamble to the rule and the rule itself provide detailed guidance to exchange operators on the federal standards with which the exchange and the issuers must comply, such as state licensure; benefit and product standards; rating, rate filing and rating disclosures; marketing; quality, network adequacy and accreditation; and other required processes, procedures and disclosures.

Dental Issuer Certification Process

Discussion

The working group was charged with coming to consensus on the process by which dental carriers become certified to offer dental plans in the DC HBX. To assist in its discussions and deliberations, the working group used a checklist approved by the Board for use with QHP issuer certification, modified as appropriate for stand-alone dental plans. That document is attached. (Attachment A)

Additional information provided to the Working Group was the narrative regarding Departments of Insurance (DOIs) across the states, including DC's Department of Insurance Securities and Banking (DISB), use of attestations of compliance with required standards, as recited in the QHP Issuer Certification Process Working Group report:

One of the ways departments of insurance (DOIs) across the nation operate is to use attestations (also known as certifications) of issuers that they are in compliance with the law. For example, company actuaries routinely certify that their rates are reasonable in relation to the premium charged and that they are not unfairly discriminatory. State DOIs, including DC's Department of Insurance Securities and Banking (DISB), accept these actuarial certifications. Similarly, issuers file annual financial statements and certify that they are correct. Again, state DOIs, including DISB, routinely accept these certifications.

DISB retains regulatory authority by acceptance of attestations, since it has full authority to enforce correction of an issuer error and impose any sanction, such as a fine, commensurate with the gravity of the error.

A significant portion of the working group's discussion recognized the fact that the DC HBX is in start-up mode, and time is of the essence in getting processes underway in order for plans to have qualified products and the HBX to be ready for the initial open enrollment period, which starts on October 1, 2013. Due to this very real time crunch, the bulk of the working group's recommendations are to accept issuer certifications of compliance with the various standards for first plan year. However, the working group also recognizes that operation of the HBX will be an evolving experience and in fact the HBX will have more data as the HBX grows and adds more enrollees. The working group recommends that the HBX Board revisit these standards prior to QHP recertification in the second plan year, since the HBX will have additional data and experience to evaluate whether regulator verifications based on prospective evidence or means of accreditation other than issuer certifications should be required for certain standards.

It is also important to note that under the federal regulation, exchanges have an obligation to monitor compliance with federal standards for QHP and issuer certification. As HBX gains experience, becomes fully staffed and gains enrollees, actions such as spot checks of issuer websites and other monitoring activities should increase.

Consensus Recommendation

The Working Group reached a consensus recommendation to follow the general certification process adopted by the Board for QHP issuers, with certain categories modified or deleted as appropriate to dental plans.

I – Licensed and in good standing

- The regulator will verify that the issuer has a certificate of authority to conduct insurance business in DC for health (or dental) insurance
- Attestations for the following will be accepted:
  - Service area
  - General attestation that QDP issuer has appropriate structure, staffing, management, etc. to administer QDP effectively and in conformance with federal requirements now and in the future

II – Benefit Standards and Product Offerings
III – Rate Filings, Standards and Disclosure Requirement
IV – Marketing

Attestations for all the standards in II, III and IV will be accepted.

V – Network Adequacy Requirements

Attestations for all the standards in V will be accepted.

VI– Applications and Notices
VII – Transparency Requirements
VIII– Enrollment Periods
IX– Enrollment Process for Qualified Individuals
X- Termination of Coverage of Qualified Individuals.
XI – Other Substantive Requirements

Attestations for all the standards in VI, VII, VIII, IX, X and XI will be accepted.

Non-Pediatric Dental Benefits

Discussion
The working group was charged with coming to consensus on the offering of non-pediatric dental benefits in QHPs and stand-alone plans.

The following are allowed EHB dental plans under DC law:

a. QHP that includes pediatric dental EHB (called "embedded")
b. Standalone dental plan that includes pediatric dental EHB (QDP)
c. QHP in conjunction with a QDP. In this case:
   i. The plans are priced separately
   ii. The plans are made available for purchase separately at the same price.

A QHP is not required to provide pediatric dental benefits if:

i. There is at least one QDP available and
ii. The carrier discloses there are no pediatric dental benefits in the plan and those benefits are available on the HBX.

The Secretary has expressly stated that stand-alone dental plans can offer additional benefits, including non-pediatric coverage. (Federal Register, Vol. 78, No. 37, Feb. 15, 2013, p. 12853). However, DC law does not require it.

Consensus Recommendation
The working group reached consensus recommendation that licensed District of Columbia issuers offering stand-alone pediatric dental plans may also offer non-pediatric dental benefits.

Reasonable Out-of-Pocket Maximums

Discussion
The Working Group was charged with coming to consensus on what a reasonable out-of-pocket maximum (OOP) (dollar amount) would be for a stand-alone pediatric dental plan. According to 45 CFR 156.150, the HBX must establish such a reasonable OOP. In a draft March 1 letter, the Center for Consumer Information and Insurance Oversight (CCIIO) stated that a $1,000 OOP would be considered reasonable (i.e. a safe harbor). However, it was not clear in the letter if that was per plan, or whether it could be applied to each child covered in the plan. Our neighbor jurisdiction, Maryland, has set the OOP at $1,000 if there is one child in the plan, and $2,000 if there are two or more children in the plan.

The dental issuers strongly support a $1,000 per child OOP and maintain that if it is less, premiums, deductibles and other cost-sharing will be higher. They maintain that at $1,000 per child, about 2% of children would reach the OOP. If the OOP were dropped to $500, then about 4% reach the OOP. One reason for the low percentages is that only medically necessary orthodontia is covered as an EHB, and according to the experts, the handicapping criteria to reach that threshold are extremely difficult. A pediatric dentist reported that children who reach the threshold have significant deformities.

Generally speaking, consumer advocates think a $1,000 per child OOP is too high, and even more so if there are several children in the plan. This creates a barrier to purchasing a plan because the pediatric dental benefit, although a required offer, is not a mandated purchase for childless adults and may result in less coverage. An actuarial study circulated by Milliman[1] that indicated the premium rise for a lower

[1] *Out of Pocket Maximum for Pediatric Dental and Orthodontia Benefit Plan to Prevent Catastrophic Dental Cost*. Milliman, November 5, 2012.

OOP was not significant (about $2-$3 to go from $1,000 to $270), but various parties disputed the age of the report and the assumptions used.

A working group member thought that CCIIO was going to revisit the $1,000 safe harbor, and a few working group members wanted to follow the federal safe harbor, whatever it turned out to be.

Non-Consensus Recommendation
The issue of the out-of-pocket maximum was discussed at both working group meetings, and the working group was unable to reach consensus on the OOP issue.

Subsequent to the working group meetings, on April 5, 2013, CCIIO released a revised letter that set the stand-alone dental OOP safe harbor at $700 per child, and $1,400 if there are two or more children covered by the plan.

Separate Pricing of Pediatric Dental Benefit Embedded in QHP

Discussion
The Working Group was charged with coming to consensus on whether an issuer offering QHP with the EHB pediatric dental benefit embedded in the plan should be required to display the cost of the pediatric dental benefit portion separately from the cost of the rest of the plan. The discussion of this issue showed that stand-alone dental plans and QHPs with an embedded have polar opposite views. Stand-alone dental plans insist they will be at a competitive disadvantage if the QHP is not required to separate out and display the pediatric EHB portion. QHP issuers are equally adamant that it is impossible to do since the pricing of the plan covers so many benefits and is spread among people who will never use the pediatric dental benefit. The Department of Insurance, Securities, and Banking also confirmed that separating the cost of dental benefits in these plans would not be feasible for comparison purposes.

Consensus Recommendation
In what can be considered a compromise, the working group reached consensus that a QHP should clearly label whether it does, or does not, include the pediatric dental EHB.

<u>Working Group Members</u>

The Dental Plan Advisory Working Group is comprised of representatives from dental plans, health plans and consumer advocates. Two meetings were held, on March 26 and April 2, 2013, both with in-person and conference call participation.

Leighton Ku	The George Washington University Center for Health Policy Research (DC HBX Board)
Katherine Stocks	The Goldblatt Group

Anupama Rao Tate	Children's National Medical Center
Mark Haraway	DentaQuest
Guy Rohling	UHC Dental
Jim Mullen, Kevin Wrege	Delta Dental
Louisa Tavakoli	Care First
Colin Reusch	Children's Dental Health Project
Amy Hall	DC resident
Tiffany	Kaiser Permanente
Jim Sefcik	Consultant
Mike Hickey	MetLife
Dean Rodgers	Dominion Dental
Jonathan Zuck	United Concordia
Meg Booth	CDHP
Claire McAndrew	Families USA

Company Name (Name in DC Company is Licensed under):	
NAIC Company Number:	
Company Address:	
Contact Person for Filing:	
Contact Person for filing address:	
Contact Person for filing telephone number:	
Contact Person for filing email:	
☐Individual ☐SHOP ☐Dental only	

		Requirements	**Federal Source**	**SERFF-supported function***	**SERFF could be used for data collection****	**Notes**
☐	I	Licensed and in good standing	45 CFR § 156.200(b)(4)		X	1. Regulator verifies directly through evidence that requirement is met. 2. Regulator will accept verification by company officer that requirement has been met. 3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	1.2	☐ Authorized by DISB to offer **dental** insurance			X	
	1.3	☐ Is in good standing			X	
	1.4	☐ Service area- entire District				
	1.5	☐ General attestation regarding ability to participate in and abide by requirements of HBX, comply with the risk adjustment program, and that the products are in the interest of qualified individuals	45 CFR § 156.200(b); 45 CFR § 155.1000(c)(2)			

☐	II	Benefit Standards and Product Offerings				1. Regulator verifies directly through evidence that requirement is met. 2. Regulator will accept verification by company officer that requirement has been met. 3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	2.1	☐ Covers the Essential Health Benefit Package for Pediatric Dental	42 USC §18022	X		
	2.2	☐ Complies with Reasonable Annual Limitation on Cost Sharing.	45 CFR §156.150 (a)	X		
	2.3	☐ Offers through the Exchange: ☐ one low level plan (AV 70%), **AND/OR** ☐ one high level plan (AV 85%) ☐ certified by a member of the American Academy of Actuaries	45 CFR §156.200 (b)(2)(3)	X		
	2.4	☐ Offers a child-only plan at the same level of coverage—low or high level—o individuals who, as of the beginning of the plan year, have not attained age 21.	45 CFR §156.200(c)	X		
	2.5	☐ Does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.	45 CFR §156.200(e)		X	
	2.6	☐ Does not have benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs.	45 CFR §156.225(b)	X		

	2.7	☐ Submits a description of covered benefits and cost-sharing provisions to the Exchange at least annually.	45 CFR §156.210(b)		X	
☐	III	Rate Filings, Standards and Disclosure Requirements				1. Regulator verifies directly through evidence that requirement is met. 2. Regulator will accept verification by company officer that requirement has been met. 3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	3.1	☐ Files rates for prior approval.	{State law cite}	X		
	3.2	☐ Submits rate information to the Exchange at least annually.	45 CFR §155.1020 45 CFR §156.210(b)	X		
	3.3	☐ Submits to the Exchange a justification for a rate increase prior to the implementation of the increase.	45 CFR §155.1020; 45 CFR §156.210(c)	X		
	3.4	☐ Prominently posts the rate increase justification on issuer Web site prior to the implementation of the increase.	45 CFR §155.1020; 45 CFR §156.210(c)		X	
	3.5	☐ Sets rates for an entire benefit year, or for the SHOP, plan year.	45 CFR §156.210(a)	X		
	3.6	☐ Rates must be the same for products inside and outside Exchange.	45 CFR §156.255(b)	X		
☐	IV	Marketing				1. Regulator verifies directly through

						evidence that requirement is met. 2. Regulator will accept verification by company officer that requirement has been met. 3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	4.1	☐ Marketing practices do not discourage the enrollment of individuals with significant health needs.	45 CFR §156.225(b)	X		
☐	V	Network Adequacy Requirements	45 CFR §155.1050; 45 CFR §156.230			1. Regulator verifies directly through evidence that requirement is met. 2. Regulator will accept verification by company officer that requirement has been met. 3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	5.1	☐ Has a network for each plan with sufficient number and types of providers, including essential community providers as available, to ensure that all services are accessible without unreasonable delay. ☐ Network must include providers that specialize in mental health and substance abuse services.	45 CFR §156.230(a)(2)		X	
	5.2	☐ Has a network with sufficient geographic distribution of providers for each plan.	45 CFR §156.230(a)(2)		X	
☐	5.3	☐ Makes its provider directory available: ☐ to the Exchange for publication online in	45 CFR §156.230(b)		X	

		accordance with guidance from the Exchange; and ☐ to potential enrollees in hard copy upon request. ☐ Provider directory identifies providers that are not accepting new patients.				
☐	VI	Applications and Notices				1. Regulator verifies directly through evidence that requirement is met. 2. Regulator will accept verification by company officer that requirement has been met. 3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	6.1	☐ Provides to applicants and enrollees all applications and other material: ☐ in plain language; and ☐ in a manner that is accessible and timely to: ☐ individuals living with disabilities, and ☐ to individuals with limited English proficiency through the provision of language services at no cost to the individual.	45 CFR §155.230(b)		X	
	6.2	☐ Complies with DC minimum language simplification standards.	{State law cite}		X	.
☐	VII	Transparency Requirements	45 CFR §155.1040; 45 CFR §156.220			1. Regulator verifies directly through evidence that requirement is met. 2. Regulator will accept verification by company officer that requirement has

						been met. 3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	7.1	☐ Makes available to the public in an accurate and timely manner, and in plain language: ☐ Claims payment policies and practices; ☐ Periodic financial disclosures; ☐ Data on enrollment; ☐ Data on disenrollment; ☐ Data on the number of claims that are denied; ☐ Data on rating practices; ☐ Information on cost-sharing and payments for out-of network coverage; ☐ Information on enrollee rights under title I of the Affordable Care Act (includes insurance market reforms and Patient's Bill of Rights).	45 CFR §156.220		X	
	7.2	☐ Makes available to the Exchange in an accurate and timely manner, and in plain language: ☐ Claims payment policies and practices; ☐ Periodic financial disclosures; ☐ Data on enrollment; ☐ Data on disenrollment; ☐ Data on the number of claims that are denied; ☐ Data on rating practices; ☐ Information on cost-sharing and payments for out-of network coverage; ☐ Information on enrollee rights under Title I of the Affordable Care Act (includes insurance	45 CFR §156.220		X	

		market reforms and Patient's Bill of Rights).				
	7.3	☐ Makes available to Commissioner of Insurance in an accurate and timely manner, and in plain language: ☐ Claims payment policies and practices; ☐ Periodic financial disclosures; ☐ Data on enrollment; ☐ Data on disenrollment; ☐ Data on the number of claims that are denied; ☐ Data on rating practices; ☐ Information on cost-sharing and payments for out-of network coverage; ☐ Information on enrollee rights under title I of the Affordable Care Act (includes insurance market reforms and Patient's Bill of Rights).	45 CFR §156.220		X	
	7.4	☐ Makes available to the U.S. DHHS in an accurate and timely manner, and in plain language: ☐ Claims payment policies and practices; ☐ Periodic financial disclosures; ☐ Data on enrollment; ☐ Data on disenrollment; ☐ Data on the number of claims that are denied; ☐ Data on rating practices; ☐ Information on cost-sharing and payments for out-of network coverage; ☐ Information on enrollee rights under title I of the Affordable Care Act (includes insurance market reforms and Patient's Bill of Rights).	45 CFR §156.220		X	

	7.5	☐ Makes available the amount of enrollee cost sharing for a specific item or service by a participating provider in a timely manner upon the request of the individual. ☐ Makes available such information through: ☐ Internet Web site; and ☐ Other means for individuals without access to the Internet.	45 CFR § 156.220(d)		X	
	7.6	☐ Provides required notices on internal and external appeals in a culturally and linguistically appropriate manner.	45 CFR §147.136(e)		X	
☐	VIII	Enrollment Periods				1. Regulator verifies directly through evidence that requirement is met. 2. Regulator will accept verification by company officer that requirement has been met. 3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	8.1	☐ Provides an **initial open enrollment** period October 1, 2013 to March 31, 2014.	45 CFR §155.410(b)		X	
	8.2	☐ Provides an **annual open enrollment** period October 15 to December 7.	45 CFR §155.410(e)		X	
	8.3	☐ Enrolls qualified individuals under 10.1 and 10.2 with the proper effective coverage date	45 CFR §155.410(c		X	
	8.4	☐ Provides **special enrollment** periods for qualified enrollees with proper effective coverage date	45 CFR §155.420		X	

☐	IX	Enrollment Process for Qualified Individuals				1. Regulator verifies directly through evidence that requirement is met. 2. Regulator will accept verification by company officer that requirement has been met. 3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	9.1	☐ Enrolls a qualified individual when Exchange notifies the issuer that the individual is a qualified individual and transmits information to the issuer.	45 CFR §156.265 (b)(1)		X	
	9.2	☐ If an applicant initiates enrollment directly with the issuer for enrollment through the Exchange, the issuer either: ☐ Directs the individual to file an application with the Exchange; or ☐ Ensures that the individual received an eligibility determination for coverage through the Exchange through the Exchange Internet Web site.	45 CFR §156.265 (b)(2)		X	
	9.3	☐ Accepts enrollment information consistent with the privacy and security requirements established by the Exchange.	45 CFR §156.265 (c)		X	
	9.4	☐ Uses the premium payment process established by the Exchange.	45 CFR §156.265 (d)		X	
	9.5	☐ Provides new enrollees an enrollment information package that is compliant with accessibility and readability standards.	45 CFR §156.265 (e)		X	

	9.6	☐ Reconciles enrollment files with HHS and the Exchange no less than once a month.	45 CFR §156.265 (f); 45 CFR §156.400 (d)		X	
	9.7	☐ Acknowledges receipt of enrollment information transmitted from the Exchange in accordance with Exchange standards.	45 CFR §156.265 (g)		X	
☐	X	Termination of Coverage of Qualified Individuals	45 CFR §155.430; 45 CFR §156.270			1. Regulator verifies directly through evidence that requirement is met. 2. Regulator will accept verification by company officer that requirement has been met. 3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	10.1	☐Terminates coverage only if: ☐ Enrollee is no longer eligible for coverage through the Exchange; ☐ Enrollee's coverage is rescinded; ☐ QHP terminates or is decertified; ☐ Enrollee switch coverage: ☐ during an annual open enrollment period; ☐ special enrollment period; or ☐ obtains other minimum essential coverage. ☐ For non-payment of premium only if: ☐ Applies termination policy for non-payment of premium uniformly to enrollees in similar circumstances; ☐ Enrollee is delinquent on premium payment; ☐ Provides the enrollee with notice of such	45 CFR §155.430(b); 45 CFR §156.270		**X**	

		payment delinquency; and ☐ Provides a grace period of at least 3 consecutive months if an enrollee is receiving advance payments of the premium tax credit and has previously paid at least one month's premium.				
	10.2	☐ Provides reasonable notice of termination of coverage to the Exchange and enrollee (this includes effective date of termination).	45 CFR §155.430 (d); 45 CFR §156.270 (b)		X	
	10.3	☐ Maintains records of terminations of coverage for auditing.	45 CFR §155.430(c); 45 CFR §156.270(h)		X	
☐	XI	Other Substantive Requirements				
	11.1	☐ Complies with internal claims and appeals processes.	45 CFR §147.136		X	

**SERFF is expected to collect data for analysis of the requirements in this column.*
***SERFF may be used to collect state-specific, document-based information to suppo*