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Memo

To: Patty Fontneau
From: Peg Brown
Cc: Doug Dean
Date: August 2, 2013
Re: Off-Exchange Stand-alone Dental Plans and Exchange Certification

Issue

What does it mean for an off-Exchange stand-alone dental plan to be Exchange-certified? What are the requirements, constraints and limitations for the designation of "Exchange-certified"?

Background

Stand-Alone Dental Plans on the Exchange

Pediatric oral (and vision) benefits are one of the required categories of coverage as an Essential Health Benefit (EHB) under the Affordable Care Act. ACA §1302(b). Health plans offering coverage through an Exchange are "qualified health plans" (QHPs) if they have a certification from an Exchange, provide the EHBs required under §1302, and agree to charge the same premium rate for a QHP inside and outside a state's Exchange. ACA §1301(a). The ACA permits an Exchange to allow "stand-alone dental benefits" (including pediatric dental benefits) to be offered through an Exchange. ACA §1311(d)(2)(B)(ii). Under ACA §1302(b)(4)(f), if stand-alone dental benefits are offered through an Exchange, a qualified (medical) health plan does not have to include the pediatric dental benefit as one of the mandated EHBs. Moreover, the federal government also opined that, inside an Exchange, "someone (with a child or without) can purchase a QHP that does not cover the pediatric dental EHB without purchasing a stand-alone dental plan." 78 Fed. Reg. 12834, 12853.

Stand-Alone Dental Plans Off the Exchange

This sets up a dichotomous situation with QHPs outside the Exchange. In the final rule on Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834, the federal government discussed the difference of treatment inside and outside of an Exchange as follows:

The Affordable Care Act does not provide for the exclusion of a pediatric dental EHB outside of the Exchange as it does in section 1302(b)(4)(F) of the Affordable Care Act for QHPs. Therefore, individuals enrolling in health insurance coverage not offered on an Exchange must be offered the full ten EHB categories, including the pediatric dental benefit. However, in cases in which an individual has purchased stand-alone pediatric dental coverage offered by an

Exchange-certified stand-alone dental plan off the Exchange, that individual would already be covered by the same pediatric dental benefit that is part of EHB. When an issuer is reasonably assured that an individual has obtained such coverage through an Exchange-certified stand-alone dental plan offered outside an Exchange, the issuer would not be found non-compliant with EHB requirements if the issuer offers that individual a policy that, when combined with the Exchange-certified stand-alone dental plan, ensures full coverage of EHB. We note that the stand-alone dental plan would have to be an Exchange-certified stand-alone dental plan to ensure that it covered the pediatric dental EHB, as required for Exchange certification under section 1311(d)(2)(B)(ii) of the Affordable Care Act. However, the Exchange-certified stand-alone dental plan would not need to be purchased through an Exchange. 78 Fed. Reg. at 12853. [Emphasis added].

Following these federal pronouncements, the Division issued Bulletin No. B-4.57 – Pediatric Dental Benefits – Limitations on Cost-sharing for Stand-Alone Pediatric Dental Plans and Required Notice to Consumers by Carriers of Non-coverage of Pediatric Dental Benefits, on May 2, 2013. The bulletin suggests a notice be provided to consumers by (medical) QHPs, both on the Exchange or off the Exchange, which do not include the pediatric dental benefits as follows:

This policy does not include coverage of pediatric dental services [as required under the ACA . . .]. Coverage of pediatric dental services is available for purchase in the State of Colorado and can be purchased as a stand-alone plan. Please contact your insurance carrier, agent, or Connect for Health Colorado if you wish to purchase either a plan that includes pediatric dental coverage, or an Exchange-certified stand-alone dental plan that includes pediatric dental coverage.

The foregoing raises the question of what it means for a stand-alone dental plan to be Exchange-certified.

What are the requirements for a Stand-Alone Dental Plan to be Exchange-certified?

The primary statement by the federal government concerning Exchange certification of stand-alone dental plans was contained in the March 27, 2012 Final and Interim Final Rule on the Establishment of Exchanges and Qualified Health Plans, 77 Fed. Reg. 18310.

We are persuaded by comments suggesting that stand-alone dental plans comply with QHP certification standards, as such standards will help ensure a consistent level of consumer protections as QHPs. Accordingly, we have added a new provision to §155.1065(a)(3) establishing that stand-alone dental plans must comply with QHP certification standards, except for those certification standards that cannot be met because the stand-alone dental plans [sic] covers only pediatric dental benefits. For example, to the extent that accreditation standards specific to stand-alone dental plans do not exist, such plans would not have to meet §155.1045. *We also note that the Exchange may establish certification standards that are specific to the unique nature of stand-alone dental plans. For example, an Exchange can set a different network adequacy standard for stand-alone dental plans than for medical plans. For the purposes of this provision, any application of QHP standards to stand-alone dental plans by the Exchange would only apply to stand-alone dental plans offered through the Exchange.* 77 Fed. Reg. at 18412. [Emphasis added].

The federal government recognizes that stand-alone dental plans are “excepted benefits” and subject to different rating standards. In the March 11, 2013 final rule on HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15410, they stated:

We agree that stand-alone dental plans, as defined at §155,1065, are “excepted benefits” under section 2791(c) of the PHS Act, and clarify that issuers of stand-alone dental plans are not

required to follow the rating standards set forth in the final Market Reform Rule for purposes of pricing stand-alone dental coverage. 78 Fed. Reg. at 15479.

Further, in their May 10, 2013 “QHP Dental Frequently Asked Questions,” the federal government said:

Q1: Can an issuer be certified to offer stand-alone dental plans only off the Exchange?

A1: If an issuer would like to offer a stand-alone dental plan only off of the Exchange in a state with a Federally-facilitated Exchange but receive Exchange certification that it meets standards related to the pediatric dental essential health benefits, then the issuer must select the “off Exchange” option in the dental-specific plan and benefits template. To be considered “Exchange-certified,” the issuer of the stand-alone dental plan must complete the certification process up [sic] the point of signing the agreement. This process would provide a stand-alone dental plan with the “Exchange certified” status outlined in the EHB final rule where a health insurance issuer could offer a health plan without the pediatric dental EHB to an individual if the issuer is reasonably assured that the individual has obtained pediatric dental EHB coverage through an Exchange-certified stand-alone dental plan.

Q2: What benefits are required to be included in stand-alone dental plans?

A2: In order to be certified, all stand-alone dental plans must cover the pediatric dental essential health benefits, as required in the Affordable Care Act. As outlined in section 156.150 of the EHB final rule, a stand-alone dental plan must offer the pediatric dental EHB but may offer additional benefits, which could include non-pediatric coverage. We note that only the pediatric dental benefit, and not any non-pediatric coverage, would be subject to EHB standards, including complying with the requirement to offer benefits that are substantially equal to the benchmark and meeting AV [actuarial value] and out-of-pocket limit requirements for stand-alone dental plans. Stand-alone dental plans that are submitted without coverage of the pediatric dental EHB will not be certified. . . .

Q5: How do rating tables and rating business rules apply to stand-alone dental plans?

A5: For the purposes of completing the application for certification of stand-alone dental plans in the FFE [federally facilitated Exchange], stand-alone dental plans must complete the rates table and associated business rules table according to the rating rules. Stand-alone dental plans, as excepted benefits, have additional flexibility to adjust premiums based on other rating factors. The modified dental plan and benefits template will have a data field in which dental issuers will indicate whether they are committing to the rates in the template, and thereby voluntarily complying with the rating rules, or whether the issuer reserves the right to make further premium adjustments. The plan display will indicate to consumers whether the premium displayed for stand-alone dental plans is a guaranteed rate or an estimated rate. . . .

The discussion and guidance issued by the federal government leads to the conclusion that the primary consideration in whether an off-Exchange stand-alone dental plan is Exchange-certified is ensuring it covers the pediatric dental EHB. Further, the federal guidance also provides that the application of QHP requirements to stand-alone dental plans by the Exchange would only apply to stand-alone dental plans offered through the Exchange. For submission of the rate templates to the Division, the federal guidance provides flexibility to stand-alone dental plans to designate whether they are committing to the rates (guaranteed rates) which meet the QHP standards, or filing estimated rates. Thus, stand-alone dental plans offered off the Exchange must provide the pediatric dental EHB to be “Exchange-certified,” but the Exchange’s QHP requirements cannot be imposed on such plans.

Operational Considerations

Stand-alone dental plans had to file their rates with the Division as of June 14, 2013. On June 12, 2013, the Division issued informal guidance on filing requirements for Stand-Alone Dental Plans which stated: "In order to be "Exchange-certified," carriers must complete the entire dental plan certification process, and must offer the plan: 1) inside of C4HCO; or 2) both inside and outside of C4HCO." The guidance further noted that:

Rate Filings:

- Rate table/manual

There is no specific format for that document – it should contain basic information about the rates – including the base rate, rating factors, etc. – for the policies and riders that are included in the filing

- Geographic Rating Areas

When you complete the Rate Data Template and the Rating Business Rules template in the binder, you will need to "temporarily" abide by the rating rules for medical plan [sic], including geographic rating areas, due to the way the templates are designed. However, there is a data field on the template, where you can indicate if the rates are "guaranteed" or "estimated." If you check guaranteed, that means you are affirming that the information in the template is final, and that you are essentially voluntarily abiding by the rating rules for medical plans. If you check "estimated," it means you are reserving the right to make further premium adjustments, using factors not allowed for medical plans.

Note: * FOR THE EXCHANGE (CONNECT FOR HEALTH COLORADO) CARRIERS HAVE TO USE GUARANTEED RATES.**

***** FOR OFF THE EXCHANGE:** Dental plans can use guaranteed rates, as entered into the template using the factors required of health benefit plans, or they can use estimated rates, and apply different rating factors allowed for dental plans by the Affordable Care Act.

On June 13, 2013, after further consideration, the Division issued further guidance about dental filings, noting that "Carriers offering stand-alone dental plans **will be allowed to offer "Exchange-certified" plans outside of the Exchange only.** To be considered "Exchange-certified," a plan must still go through the same certification process required of on Exchange plans – **you must complete and submit and [sic] binder, and meet the filing deadlines** (June 14 for rates, and June 30 for form, network adequacy, and marketing)."

In similar guidance issued by the federal government issued on April 5, 2013 Letter to Issuers on Federally-facilitated and State Partnership Exchanges, it is clear that stand-alone dental plans are treated differently under the ACA, and are not subject to the same requirements as QHPs, both in and out of an Exchange. In the guidance, Chapter 4 addresses Stand-alone Dental Plans, and Table 4.1: Certification Standards Applicable to Stand-alone Dental Plans summarizes and designates which of the standards apply for certification. It shows the certification standard applies (with a * for a modified standard) for: essential health benefits*, actuarial value*, maximum out-of-pocket limits*, licensure, network adequacy, inclusion of ECPs [essential community providers], marketing, service area, and non-discrimination. The chart lists the certification standard as not applying to accreditation, cost-sharing reduction plan variations, and unified rate review template.

Conclusion

Under the federal guidance reviewed above, the “Exchange-certified” designation for stand-alone off-Exchange dental plans is to ensure that the pediatric EHB is covered by the plan. The Division of Insurance can provide C4HCO with information about which off-Exchange stand-alone dental plans meet the pediatric dental EHBs and who have been reviewed for rating, actuarial value, maximum out-of-pocket limits for pediatric dental coverage, licensure, network adequacy, marketing, service area and non-discrimination compliance. The federal guidance specifically recognizes that stand-alone dental plans have, and can utilize, separate non-ACA rating methodologies and that QHP requirements cannot be imposed on off-Exchange stand-alone dental plans.