

**Recommendations for
Certification Criteria for Stand-Alone Dental Plans
And Other Exchange Dental Coverage Issues
November 6, 2012**

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) directs the U.S. Department of Health and Human Services (HHS) to issue certification criteria for Qualified Health Plans (QHPs) sold in American Health Benefit Exchanges. In March 2012, HHS issued final rules governing the Exchanges, including requirements for issuers and QHPs¹ offered through the Exchange. State-based Exchanges must ensure their standards for QHPs and issuers meet federal requirements and may also choose to create additional certification standards.

Federal rules require Exchanges to allow stand-alone dental plans to be offered on the Exchange. Federal rules also stipulate that such plans must be offered if “the plan and issuer of such plan meets QHP certification standards...except for any certification requirement that cannot be met because the plan covers only the [pediatric dental essential health benefit].” Finally, federal Exchange rules allow QHPs to be sold on the Exchange even if they do not include the pediatric dental essential health benefit provided stand-alone pediatric dental plans are available on the Exchange.

The Plan Certification Subgroup held three meetings between August and October 2012 to discuss proposed certification standards for stand-alone dental plans to be sold in the Exchange (referred to as qualified dental plans or QDPs) and the carriers who wish to offer them. The Plan Certification Subgroup began its work by gaining familiarity with federal standards and related existing state laws and regulations applicable to stand-alone dental plans to the extent they exist.

The Plan Certification Subgroup had two charges:

- 1) to develop understanding of the feasibility of applying certification criteria for QHPs to stand-alone dental plans; and
- 2) to recommend how what the specific certification criteria for QDPs should be, with the understanding that it is useful to draw upon existing provisions of state laws and rules as the basis for these criteria.

The Plan Certification Subgroup’s recommendations, therefore, include both a recommendation about whether a specific criterion should be applied to QDPs based on the feasibility of the requirement as well as a recommendation for what specifically the certification criterion should be. As the only Exchange technical work group to examine dental issues to date, the Plan Certification Subgroup’s

¹ The term “issuer” and “carrier” are used in this document to describe the company issuing a health benefit or stand-alone dental plan, while the term “qualified health plan” (QHP) and “qualified dental plan” (QDP) refers to a specific policy to be sold to a consumer. The term “qualified dental plan” (QDP) is used to describe a stand-alone dental plan to be sold on the Exchange.

recommendations also include other topics related to dental coverage in the Exchange. It should be noted that critical federal regulations are pending on key topics related to the offering of stand-alone dental plans that must offer a pediatric dental EHB, such as who is required to purchase pediatric dental EHB, what the age range for “pediatric” will include, and the scope of market reforms that will apply to pediatric oral health services offered through a stand-alone dental plan.

As we look ahead to numerous activities required of carriers to develop proposed qualified dental plans, of regulators to evaluate various components of QDP certification, and of the Exchange to ensure its on-line web portal is available for open enrollment as required by federal rules on October 1, 2013, it will likely be necessary to apply current state laws and rules where they can reasonably be applied as the initial basis for issuer and QDP certification standards. Adoption of other standards would require modifications to existing state laws and rules. Carriers will need to begin to submit proposed QDPs through the certification process during the first quarter of 2013 and it will likely not be possible for carriers to incorporate other standards that may emerge during the 2013 legislative session into QDPs that need to be certified and available on the Exchange by October 1, 2013. Insurers would subsequently need adequate lead time to develop and seek certification for new QDPs meeting different standards.

BENEFIT DESIGN REQUIREMENTS

Federal Requirements

Coverage requirements within the Affordable Care Act include the essential health benefits described in 1302(b) of the ACA, cost sharing limits as described in 1302 [c], and the metal levels in 1302 (d). Broadly speaking, the essential health benefit package includes ambulatory and emergency services, hospitalization, maternity and newborn care, mental health and substance abuse, prescription drugs, rehabilitative services and devices, laboratory services, preventive services, and pediatrics. The essential health benefits package and cost sharing limits are market wide reforms applying to all non-grandfathered health plans.

Qualified health plans must offer pediatric oral health services unless a stand-alone dental plan offers such coverage on the Exchange.

State Requirements Applicable to Stand Alone Dental Plans

Current state law has no coverage mandates related to basic dental care.

Recommendation:

- Most EHB services would not be offered by stand-alone dental plans because stand-alone dental plans by definition cover a limited benefit; however, pediatric oral health services are part of essential health benefits and must be offered by stand-alone dental plans. A certification standard related to inclusion of pediatric oral health EHB services must apply to QDPs.

LICENSURE CERTIFICATION STANDARDS

Federal Requirements

Federal rules require that all QHP issuers be licensed and in good standing to offer health insurance in each state in which it provides coverage.

Existing State Requirements Applicable to Stand Alone Dental Plans

Minnesota Statutes 60A.07 and 62C.08 respectively require insurers and service plan corporations to obtain a certificate of authority from the Minnesota Department of Commerce, while similar provisions in Minnesota Statutes 62D.03 requires health maintenance organizations to receive a certificate of authority from the Minnesota Department of Health to conduct business in the state.

Recommendations:

- Licensure requirements are already included in state law and should be part of certification criteria for QDPs.
- Minnesota Statutes 60A.07, 62C.08, and 62D.03 should respectively serve as the licensure certification standard for insurers, service plan corporations, and HMOs offering QDPs.

QUALITY IMPROVEMENT REPORTING AND STRATEGIES

Federal Requirements

Federal rules require Exchanges to develop and implement quality rating and enrollee satisfaction survey systems by 2016. Issuers are also required to implement and report on a quality improvement strategy or strategies consistent with the standards of the ACA, disclose and report information on health care quality and outcomes, and implement appropriate enrollee satisfaction surveys by 2016.

Existing State Requirements Applicable to Stand-Alone Dental Plans

None.

Discussion:

- The dental industry lacks standardized, nationally-recognized diagnostic codes that could serve as the infrastructure on which to build quality measurement. There are multiple initiatives underway to create a unified, standard set of dental diagnostic codes to be implemented across the country. Lacking such a standardized code set, the only existing quality measures for dental care relate to utilization of certain services. These measures are based on claims data.
- Several Subgroup members advocated not waiting for the development of a standardized code set in order to measure any aspects of quality related to dental coverage. For example, a member proposed measuring some aspects of care that don't require a national code set, such as utilization and/or overutilization of services by various population groups. Another member suggested it would be possible for stand-alone dental plans to measure enrollee satisfaction.

Recommendations:

- Subgroup members have a strong interest in supporting the development of quality measurement related to dental care, but recognize there are few quality measures available related to dental care or dental plans today. The Subgroup recommends the Exchange and/or the Measurement and Reporting Work Group consider options related to measuring stand-alone dental plan quality prior to January 1, 2016.

RISK ADJUSTMENT REQUIREMENTS

Federal Requirements

QHP issuers must comply with the standards related to the risk adjustment program developed or certified by the United States Department of Health and Human Services.

Existing State Requirements Applicable to Stand Alone Dental Plans

None.

Recommendations:

- It is the Subgroup's understanding that risk adjustment cannot reasonably be applied to stand-alone dental plans because there is no diagnostic coding system used by dentists to indicate risk factors.
- The risk adjustment requirement should not be part of certification criteria for QDPs.

NON-DISCRIMINATION REQUIREMENTS

Federal Requirements

The issuer, with respect to its QHP may not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

Existing State Requirements Applicable to Stand Alone Dental Plans

Minnesota Statutes 72A.20 prohibits issuers from unfair discrimination between individuals between the same rating class in the amount of premium, policy fees, or rates charged and may not permit the rejection of an individual's coverage based on a disability. Minnesota Statutes 62D.12 prohibits HMOs from discrimination in rate variation except in accordance with accepted actuarial principles.

Recommendations:

- Non-discrimination requirements should be part of certification criteria for stand-alone dental plans. The Subgroup recognizes that pediatric dental essential health benefits are a targeted benefit required by federal law to be offered for a yet-to-be defined pediatric population.
- Minnesota Statutes 72A.20 and 62D.12 should serve as the non-discrimination certification standard for QDPs.

RATING VARIATION

Federal Requirements

Issuers may vary premiums for a QHP in accordance with permitted geographic rating areas, age (3-1 ratio), tobacco use (1.5-1 ratio), and whether the coverage is for individuals or families. Issuers may not vary premiums for the same plans offered both inside and outside of the Exchange.

State Requirements Applicable to Stand Alone Dental Plans

Minnesota Statutes 62A.02 permits rating variation in the individual and small group markets by limited rating bands between two policies with the same or similar coverage. Issuers may vary premiums by health status including tobacco use (1.67 to 1 ratio), and age (3 to 1 ratio). Issuers may also vary premium between approved geographic rating areas. Annual premium changes based on health status in the small group market may not exceed 15 percent.

Discussion

- Subgroup members discussed the extent to which market reforms, such as guarantee issue, apply to stand-alone pediatric dental plans. Current provisions of Minnesota law do not prohibit rating variation for general dental coverage based on claims experience or other factors. Current interpretation of the ACA suggests that market reforms do not apply to stand-alone pediatric dental plans. Subgroup members noted there is an apparent contradiction to having pediatric dental EHB services offered through stand-alone dental plans not be covered by market reforms given that pediatric dental is part of the essential health benefit set framework.
- Subgroup members believe that HHS may address this issue in a set of pending regulations. One Subgroup member advocated for including a requirement that market reforms apply to pediatric stand-alone dental plans if pending federal regulations do not require market reforms to apply. The Subgroup hopes this issue will be resolved in forthcoming rules, but may need to revisit this issue depending on the outcome of the federal rule-making process.

Recommendation:

- State law already requires issuers to obtain prior approval for rates for stand-alone dental plans. This certification criterion should apply to QDPs.
- Minnesota Statutes 62A.02 should serve as the certification standard for rating variation for stand-alone dental plans.
- If future federal rule-making does not require market reforms to apply to pediatric essential health benefits offered through QDPs, the Plan Certification Subgroup should revisit this issue.

MARKETING

Federal Requirements

A QHP issuer and its officials, employees, agents, and representatives must comply with applicable state laws regarding marketing and may not employ marketing practices that discourage enrollment of people with significant health needs.

Existing State Requirements Applicable to Stand Alone Dental Plans

A dental organization shall make available to an enrollee, upon request, a clear and concise description of the following terms of coverage: 1) the dental care services and other benefits to which the enrollee is entitled under the dental plan; 2) any exclusions or limitation on the services, kind of services, benefits, or kind of benefits to be provided, including any deductible or co-payment features and any requirements for referrals to specialists; 3) a description as to how services, including emergency dental care and out-of-area service, may be obtained; 4) a general description of payment and co-payment amounts, if any, for dental care services, which the enrollee is obligated to pay; and 5) a telephone number by which the enrollee may obtain additional information regarding coverage. [MN Statutes 62Q.77] The provisions contained in section 62Q.77 shall not require a dental organization to disclose information which the dental organization is already obligated to disclose under applicable Minnesota law governing the operation of the dental organization. Any information a dental organization is required to disclose or communicate under section 62Q.77 to its subscribers, enrollee, participating providers, contracting groups, or dentists may be accomplished by electronic communication including, but not limited to, e-mail, the Internet, Web sites, and employer electronic bulletin boards. [MN Statutes 62Q.79] Marketing materials that misrepresent the terms of any policy or make any misrepresentation to a policyholder with the purpose of inducing them to drop coverage shall constitute an unfair and deceptive act or practice. No insurer may design a network of providers, policies on access to providers, or marketing strategy in such a way as to discourage enrollment by individuals or groups whose health care needs are perceived as likely to be more expensive than average. [MN Statutes 72A.20]

Recommendations:

- Marketing requirements are already included in state law for stand-alone dental plans and should be part of certification criteria for stand-alone dental plans.
- Minnesota Statutes 62Q.77, 62Q.79, and 72A.20 should serve as the certification criteria for marketing for QDPs.

NETWORK ADEQUACY

Federal Requirements

Federal rules governing Exchanges include network adequacy standards requiring Exchanges to ensure that QHP provider networks are sufficient in number and types of providers, including mental health and substance abuse providers, to assure that all services are accessible without unreasonable delay.

Existing State Requirements Applicable to Stand Alone Dental Plans

Minnesota does not currently have a network adequacy standard for stand-alone dental plans in the private market. Minnesota's Medicaid program does have a network adequacy standard of a maximum of 60 miles/60 minutes transport time for dental care. The Medicaid network adequacy standard also includes requirements related to appointment wait times and a 48-hour requirement for provision of urgent dental care for children.

Discussion:

- Subgroup members expressed support for using the Medicaid 60 miles/60 minutes transport time program standard for general dentistry in order to establish basic network adequacy standards. Dentistry specialists would not be included in these network adequacy requirements.
- A substantial majority of members did not support use of either the appointment wait time or 48-hour urgent dental care for children requirements. Members noted it is difficult to accurately measure appointment wait times. Members discussed the 48-hour urgent dental care standard at length. While most members believe this is a laudable goal, they also recognized that few urgent dental care clinics exist and this requirement is not viable in today's dental care delivery system.
- Members also raised concerns about the extent to which increased access to dental care will strain availability of dental care. The state currently faces shortages of dentists and other dental care providers and members expressed concern this capacity will become even more limited with greater numbers of consumers seeking dental care.

Recommendations:

- Although a standard for network adequacy does not exist for stand-alone dental plans today in the private market, it is important for issuers to meet a network adequacy standard. The certification requirements should include Medicaid's standard of 60 miles/60 minutes transport time.

Advantages:

- This recommendation provides a practical basis for measuring network adequacy for stand-alone dental plans. Given that no network adequacy requirements currently exist for private stand-alone dental plans in the state, this moves the market in the direction of ensuring access to dental care.

Disadvantages:

- This recommendation would not require a stand-alone dental plan to ensure urgent dental care is available to children within 48 hours. This urgent care requirement was not included in the Subgroup's recommendations because there are few urgent care dental clinics and this is not viewed as a viable standard in the current dental care delivery system.

ESSENTIAL COMMUNITY PROVIDERS

Federal Requirements

Federal Exchange rules require a QHP to include within its network a sufficient number and geographic distribution of essential community providers, where available, that serve predominantly low income, medically underserved individuals. Providers meeting this definition deliver significant care to the

uninsured and enrollees in public programs. A staff model health plan or integrated delivery system plan that contracts with a single medical group must have a sufficient distribution of providers to ensure reasonable and timely access for low-income, medically underserved individuals in its service area.

Existing State Requirements Applicable to Stand Alone Dental Plans

Minnesota Statutes 62Q.19 requires all health plans to offer contracts to state designated essential community providers within their service areas. The Minnesota Department of Health designates essential community providers pursuant to statutory requirements. Once providers receive this designation, the designation remains in effect for five years. In practice, the vast majority of essential community providers designated by the Minnesota Department of Health also meet the similar federal definition of essential community provider. The state requirement to offer contracts to essential community providers is more expansive than the federal certifications standards for qualified health plans.

Recommendations:

- The essential community provider standard should apply to stand-alone dental plans.
- Minnesota Statutes 62Q.19 should serve as the essential community provider certification standard for QDPs.

RATING INFORMATION REQUIREMENTS

Federal Requirements

Rates must be set for the entire benefit year (or plan year for the SHOP). QHP issuers must submit required justification for rate increases in advance and post justifications on their website. The Exchange must consider rate increases in its QHP determination. In doing so, the Exchange may consider the recommendations of state insurance regulators and the rate of premium growth both inside and outside of the Exchange. The Exchange must receive annual updates from issuers regarding rates, covered benefits, and cost sharing requirements of each QHP.

Existing State Requirements Applicable to Stand Alone Dental Plans

Minnesota Statutes 62A.02 requires prior approval for rate filings in the small group and individual markets. Rate filings may be disapproved for the following reasons: (1) the benefits provided are not reasonable in relation to the premium charged; (2) (filings) contain a rate or provision which is unjust, unfair, inequitable, misleading, deceptive, or encourages misrepresentation of the form; (3) if the proposed rate is excessive or not adequate; (4) the actuarial reasons and data submitted do not justify the rate.

Recommendations:

- State law already requires issuers to obtain prior approval for rates for stand-alone dental plans. This should be included in certification criteria for stand-alone dental plans.

- Minnesota Statutes 62A.02 should serve as the certification criterion for rating information for QDPs.

SERVICE AREAS (MINIMUM GEOGRAPHICAL AREAS)

Federal Requirements

A QHP service area must cover a minimum geographical area that is at least an entire county or group of counties unless the Exchange determines that serving a smaller area is necessary, nondiscriminatory, and in the best interest of enrollees. The QHP service area must be established without regard to racial, ethnic, language, health status related factors, or other factors that exclude specific high utilizing, high cost, or medically underserved populations. As noted in the preamble to the final rules, this service area standard mirrors the “county integrity rule” for Medicare Advantage plans.

Existing State Requirements Applicable to Stand Alone Dental Plans

Health Maintenance Organizations seeking a certificate of authority from the Minnesota Department of Health provide regulators a statement describing the geographic service area where they plan to market and sell health plans. This service area relates to Minnesota’s network adequacy requirements. HMOs may enroll people residing outside the service area, but they must notify those individuals of the potential consequences of enrollment. HMOs wishing to expand their service area must file a request with the Minnesota Department of Health including a detailed map of the proposed area containing network provider locations, evidence of provider contracts, and other supporting documentation.

Recommendations:

- This certification criterion is relevant to stand-alone dental plans and should be included as part of certification criteria.
- A service area should include at least an entire county unless an issuer demonstrates that serving a smaller area is necessary, non-discriminatory, and in the best interest of enrollees.

ACCREDITATION REQUIREMENTS

Federal Standards

State-based Exchanges must establish a timeframe in which QHP issuers must be accredited. A QHP issuer must maintain accreditation on the basis of the local performance of its QHPs within its accredited product type in the following categories by an accrediting agency recognized by HHS: (1) Clinical quality measures; (2) CAHPS patient experience ratings; (3) Consumer access; (4) Utilization management; (5) Quality assurance; (6) Provider credentialing; (7) Complaints and appeals; (8) Network Adequacy and Access; and (9) Patient information programs.

Existing State Requirements Applicable to Stand Alone Dental Plans

There are no existing state laws or regulations requiring carriers to be accredited in either the private insurance market or for purposes of serving as a Managed Care Organization for Minnesota Health Care Program enrollees.

More significantly, there are currently no accreditation programs for stand-alone dental plans.

Recommendation:

- Because no accreditation programs for stand-alone dental plans currently exist, this certification standard should not apply to QDPs at this time. The potential for such a certification standard should be revisited at a point in time that an accreditation program is developed.

ENROLLMENT AND TERMINATION REQUIREMENTS

Federal Requirements

Federal regulations require issuers to enroll qualified individuals during designated periods, observe all standards for the collection and transmission of enrollment and premium payment information, and conduct monthly reconciliation of enrollment files with the Exchange. All issuers and brokers providing assistance during enrollment must first verify that the enrollee received an eligibility determination from the Exchange. The federal rules also include QHP termination requirements including enrollee notification and grace periods. QHPs participating in the Exchange may only terminate enrollees for non-payment of premium, enrollee fraud or misrepresentation, enrollee relocation outside of the QHP service area, or transition to another qualified health plan during designated enrollment periods. Issuers terminating coverage in a QHP for any reason must provide enrollees with a notice of termination of coverage at least 30 days prior to the last day of coverage during which the policy remains in effect. Issuers must provide a grace period of three consecutive months for enrollees receiving advance payment of the premium tax credit.

Existing State Requirements Applicable to Stand Alone Dental Plans

Various provisions of Minnesota state laws provide a grace period after the premium due date during which policies must remain in force. For individual HMO contracts, the grace period is 31 days. For all other commercial health plans in the individual and small group markets, the grace period is 7 days for premiums paid weekly, 10 days for those paid monthly, and 31 days for all other payment installment periods. Plan issuers in the individual market must provide enrollees with 30 days written notice prior to cancellation due to non-payment of premium.

Recommendations:

- The federal enrollment and termination requirements should apply to QDPs.
- The Subgroup made no recommendations beyond existing federal requirements.

Other Issues Related to Dental Coverage

- The Subgroup explored the issue of how consumers will be able to compare options for dental coverage when some coverage may be bundled as part of a qualified health plan and other

coverage may be offered through a stand-alone qualified dental plan. Subgroup members recognized that consumers would not be able to compare options for dental coverage unless the pricing information for dental coverage embedded in qualified health plans is broken out so that consumers can compare the costs and scope of coverage offered as part of QHPs and separately through QDPs. In addition, the Internal Revenue Service's final rules on premium tax credits require carriers to report the portion of the cost of a premium attributable to pediatric dental EHB to Exchanges for purposes of administering the tax credits. Carriers should be prepared to break out the cost of dental coverage embedded as part of a QHP.

- The Subgroup also discussed whether the Exchange should offer opportunities to purchase adult dental coverage. In order to facilitate the ability of consumers to purchase dental coverage for all family members, it is recommended the Exchange offer consumers the opportunity to buy dental coverage beyond the pediatric dental EHB if they so choose.