

ISSUE BRIEF: Certification of Dental Plans Offering Pediatric Dental Through an Exchange



BACKGROUND

On March 13, 2012, the Department of Health and Human Services (HHS) released its final rule regarding the establishment of Exchanges and Qualified Health Plans (hereinafter the “Final Rule”).ⁱ The purpose of this rule is to implement the requirements regarding the key functions of Exchanges with respect to eligibility, enrollment, as well as plan participation and management. This rule addresses only those health insurance plans offered through Exchanges and not the entire individual and small group market.ⁱⁱ

In order to be offered through an Exchange, a plan must have in effect a certification issued or recognized by the Exchange as a Qualified Health Plan (QHP).ⁱⁱⁱ § 155.1000. To be certified as a QHP, the Final Rule requires that a plan provide evidence that it complies with the minimum certification requirements. § 155.1000(c)(1). As noted below, a limited scope dental plan is not a QHP; but because the pediatric dental benefit is an essential benefit, dental plans must comply with relevant QHP certification requirements. The certification requirements set forth under the Final Rule require that an issuer of QHPs must, with respect to each of the QHPs it offers through the Exchange, also be certified by the Exchange.

According to the Final Rule, a “limited scope dental benefits plan” may be offered through an Exchange if, among other things, the plan and issuer of such plan meets qualified health plan (QHP) certification standards, with the exception of any certification requirement that cannot be met because the plan covers only the pediatric dental essential health benefit. 45 C.F.R. § 155.1065.

As representatives of the dental benefits industry, the National Association of Dental Plans (NADP) and Delta Dental Plans Association have reviewed the QHP certification requirements to provide guidance to state and federal Exchange officials in applying the requirements to separate dental policies and dental plans, i.e. issuers of dental policies.

SUMMARY & GUIDE

As the essential health benefits (EHB) package includes “pediatric services, including oral and vision services” (pediatric dental), the QHP requirements are applied to the pediatric dental portion of the EHB and on the issuer, when appropriate, not on the non-essential dental benefits that may be offered in a separate dental policy.^{iv} Therefore certification requirements are restricted to pediatric dental, unless the requirement is structured so that the full plan or issuer must comply.

For easier review, the comments are color coded:

- **Green:** Dental plans meet this requirement today and thus, can be compliant in an Exchange;
- **Blue:** Dental plans can meet all or part of the requirements if the requirement is customized for dental;
- **Red:** Dental plans cannot meet the QHP certification requirement.

The quick summary below is organized in the three groups of certification requirements. However, the overall comments are structured to follow in order of the Affordable Care Act and Final Rule with a restatement of the requirement followed by an explanation by NADP and DDPA. In brief, the overall comments conclude that the QHP certification requirements fall into these groups:

Dental Plans Can Meet the Requirements: Licensing, Payments & Fees, Child-Only Plans, Non-Discrimination, Plan Rates, Provider Costs, Marketing, Community Providers, Geographic Coverage, Broker & Plan Offerings, Enrollment Periods, Payment Processes, Enrollee Termination, SHOP Requirements, Enrollee Non-Recertification, and QHP Decertification.

Dental Plans Will Need the Requirements Customized: Benefit Design, Quality Improvements, Rate Information & Justification, Policy & Enrollee Information, Network Adequacy, Provider Information, Enrollee Notifications, and Enrollee Information.

Dental Plans Can Not Meet the Requirements: Benefit Design, Quality Improvements, Risk Adjustment, Actuarial Value, Premium Rates, Accreditation, Abortion Coverage, and Prescription Coverage.

Certification Requirements:

Benefit Design

1) *Comply with benefit design standards requiring:*

(1.1) coverage of the essential health benefits described in section 1302(b) of the Patient Protection and Affordable Care Act (the “ACA”);

(1.2) cost-sharing limits described in section 1302(c) of the ACA; and

(1.3) a bronze, silver, gold, or platinum level of coverage described in section 1302(d) of the ACA (or catastrophic coverage described in section 1302(e) of the ACA). § 156.200(b); see also § 156.20 (definition of “benefit design standards”).

NADP: Benefit design standards are also incorporated through the QHP certifications, but we will address these specific requirements separately:

1.1 NADP & DDPA: No, this requirement is not applicable to dental plans. The requirement to cover all essential health benefits clearly does not apply to a limited scope dental plan because, by definition, it covers only dental benefits. ACA Sec 1311 (d)(2)(B)(ii) specifically allows for dental plans not to meet the full EHB, or QHPs not to include dental if one stand-alone dental plan is present in the Exchanges.

1.2 NADP & DDPA: Yes, dental plans can comply with the various elements of cost sharing limits (deductibles, out-of-pocket costs and elimination of annual/lifetime limits) for the pediatric dental portion of EHB with guidance on appropriate methods of meeting this provisions under a separate policy. The NADP/DDPA Exchange White Paper includes several recommendations for the addressing cost-sharing limits that are applicable to subsidized consumers when purchasing EHB through both medical and dental policies through Exchanges. These include

1. Designing “pediatric oral services” in a way that requires no cost-sharing;
2. Apportioning the total OOP maximum between medical and dental;
3. Developing individual carrier systems to administer a shared OOP maximum;
4. Setting up the Exchange to serve the function of claims aggregator

Under the current regulations, Option 2 is the simplest for consumers and Exchanges and the most cost effective alternative for issuers of Exchange policies. Dependent on benchmarks chosen by states, Option 1 could be too costly if the dental policy reflects the dental benchmark options of the FEDVIP or CHIP benefit. Option 3 would include extensive administrative costs, increasing premiums without increasing benefits or

lowering costs for the consumer. Additional advantages and disadvantages of the above options are laid out in the NADP/DDPA Exchange White Paper Issue Brief 5 with regard to out-of-pocket costs.

How the deductible limit is administered must also be considered. The deductible can have a significant impact on claims utilization and costs. For dental benefit plans, the overall ACA deductible amount would be inappropriate. Typical dental benefit deductibles are \$50 per person which is most often waived for preventive care. If the pediatric dental benefits and traditional medical plan benefits each are set with a proportionate deductible which together does not exceed the maximum, then this issue is fully addressed in a manner consistent with how medical and dental coverage works in today's marketplace, as well as being the most expedient and consumer friendly option.

1.3 NADP & DDPA: No, this requirement should not be applied to dental plans (for details see #6.)

Licensing

2) *Be licensed and in good standing to offer insurance coverage in the state (i.e., have no outstanding sanctions by the department of insurance).*^v § 156.200(b)(4).

NADP & DDPA: Yes, dental plans comply with proper DOI licensing in their state(s).

Quality Improvements

3) *Implement and report on a quality improvement strategy (or strategies), disclose and report information on health care quality and outcomes, and implement appropriate enrollee satisfaction surveys in accordance with the applicable provisions of the ACA.* § 156.200(b)(5).

NADP & DDPA: No, dental plans cannot currently meet this requirement with regard to quality and outcome measures. Currently, the lack of use of diagnostic codes in the dental profession impedes the types of quality improvement strategies or health care quality outcomes envisioned under ACA. In the future, measurements on pediatric dental may be available as the Dental Quality Alliance, initiated by HHS through the ACA and CHIP Reauthorization, is currently reviewing potential quality measures for the dental industry.

NADP & DDPA: However, reporting requirements could be introduced that assist in demonstrating the care provided by dental plans (to parallel QHP^{vi} policies) for Exchange consumers. Utilization reporting could be submitted by dental plans. For example, in HEDIS there are measures on dental office visits and sealant applications for children which would be reflected in utilization data. In addition, enrollee satisfaction surveys can be incorporated if they are dental specific. Both NADP & DDPA can work with stakeholders to develop these surveys.

Payments & Fees

4) *Remit user fee payments, or any other payments, charges or fees assessed by the Exchange.* § 156.200(b)(6); see also § 156.50(b).

NADP & DDPA: Yes, dental plans can pay appropriate Exchange fees. Exchange fees applied to dental plans should be structured to recognize the wide variances among medical and dental premiums^{vii}. We recommend they be assessed proportionately.

Risk Adjustment

5) *Comply with standards related to the risk-adjustment program under 45 C.F.R. Part 153.* § 156.200(b)(7).

NADP & DDPA: No, risk adjustment and its' related components are not applicable to dental plans as acknowledged in the preamble of HHS regulations on these topics^{viii}.

Actuarial Value

- 6) *Offer at least one QHP in the silver coverage level of actuarial equivalence and at least one QHP in the gold coverage level of actuarial equivalence described in section 1302(d)(1) of the ACA. § 156.200(c)(1). All QHPs must provide at least the bronze level of actuarial equivalence.*^{ix}

NADP & DDPA: No, an Exchange should not require pediatric dental to be offered at the silver and gold actuarial value (AV). Pediatric dental is only part of one category of the ten overall benefit categories included as part of the EHB package. As outlined by Milliman for the NADP/DDPA White Paper on Exchanges, the metal level applies to the EHBP as a whole; not to each service within the EHB Package. They found the typical DPPO in today's market has an 86% AV level and that significant cost sharing would need to be applied to meet lower AV levels. While this could be done, it would not reflect current dental benefit design. As well, the AV calculators that have been developed for medical are not able to separate the pediatric dental from the remaining medical categories.

NADP has contracted with Milliman, to provide information on the actuarial values (AV) of the EHB benchmark plans for dental. The information will include their value as structured today; as they will be structured in 2014 (without annual or lifetime limits); and with the addition of a "medically necessary" orthodontic benefit. NADP will forward the information when completed as further background material on this issue.

Child-Only Plans

- 7) *Offer a child-only plan at the same level of coverage as any QHP offered through the Exchange to individuals who have not obtained age 21 by the beginning of the plan year. § 156.200(c)(2).*

NADP & DDPA: Yes, dental plans are developing child-only policies to offer on the Exchange. NADP and DDPA have compiled information on the number of dental issuers that is provided in a separate report.

Dental issuers still need a clarification if child-only policies for pediatric dental will cover children up to age 21. Currently, the dental profession identifies age 13 (the clinical age of getting permanent teeth) as the age applicable to pediatric care. Age 13 is also the age utilized in the embedded dental portion of the FEHBP BCBS medical plan – one of the four EHB benchmarks as outlined by HHS. However, since state CHIP programs use age 19 for their policies, and Medicaid utilizes age 21, it is unclear which age should be applied to these policies.

Discrimination

- 8) *Not discriminate, with respect to its QHP, on the basis of race, color, national origin, disability, sex, gender identity or sexual orientation. § 156.200(e).*

NADP & DDPA: Yes, dental plans do not utilize these criteria today and can comply with non-discrimination.

Plan Rates

- 9) *Set plan rates for an entire benefit year. § 156.210(a).*

NADP & DDPA: Yes, dental plans can adhere to Exchange rules related to plan rates within specific calendar timelines.

Rate Information & Justification

- 10) *Submit rate and benefit information to the Exchange, § 156.210(b), and provide a justification for rate increases prior to the implementation thereof (and post such justifications prominently on its website). § 156.210(c); see also § 155.1020(a) & (c).*

NADP & DDPA: Yes, all issuers, including dental plans, will need to submit rate and benefit information to the Exchanges. However, as issuers of HIPAA excepted benefits^x dental policies would not be subject to the justification of rate increases based on current HHS regulations^{xi}. Dental plans comply with states that include rate review as part of their product filing requirements.

Policy & Enrollee Information

11) *Submit the following information to the Exchange, HHS, and the state insurance commissioner: (1) claims payment policies and practices; (2) periodic financial disclosures; (3) data on enrollment; (4) data on disenrollment; (5) data on the number of claims that are denied; (6) data on rating practices; (7) information on cost-sharing and payments with respect to any out-of-network coverage; and (8) information on enrollee rights under Title I of the ACA. This information must be submitted in plain language and must also be made available to the public. § 156.220(a)-(c).*

NADP & DDPA: Yes, dental plans can comply with financial and data disclosures in sections 1-7 above for the pediatric dental benefit, and provide information on enrollee rights. However, in section (8) there is a reference to Title 1 that is unclear. Title 1 contains no section on enrollee rights but does include market reforms that are not applicable to HIPAA excepted benefits including dental plans sold as separate policies of insurance. More specificity is needed to respond as to appropriateness for dental plans. For instance, if "enrollee rights" includes the Patient Protections named in Section 2719A for emergency treatment, it must be recognized that although dental plans provide emergency benefits at the network level, dental plans do not cover hospitalization or treatment rendered in hospital emergency rooms. Additionally, typical dental PPO plans do not require a designation of a primary care provider, whereas dental HMO plans may require such selection. Applying this requirement to issuers of dental plans overall is not practical given the small number of pediatric dentists nationally^{xii}, and the ability of general dentists to deliver pediatric dental care.

Provider Costs

12) *Make available, upon request by an individual, the amount of enrollee cost-sharing under the individual's plan or coverage with respect to the furnishing of a specific item or service by a participating provider. § 156.220(d).*

NADP & DDPA: Yes, dental plans can provide cost-sharing information to consumers regarding services provided by an in-network dentist on the predetermination process for the pediatric dental benefit.

Marketing

13) *Comply with applicable state laws and regulations regarding marketing by insurance issuers and refrain from using marketing practices that have the effect of discouraging enrollment by individuals with significant health needs. § 156.225.*

NADP & DDPA: Yes, dental plans already meet marketing regulations per their state's insurance requirements.

Network Adequacy

14) *Comply with the applicable network adequacy requirements, which require QHPs to maintain a network of a sufficient type and number of providers to assure that all covered services will be available without undue delay. § 156.230(a)(2); see also § 155.1050(a).*

NADP & DDPA: Yes, dental plans comply with "dental specific" network adequacy requirements, in the few states that have these standards specific to dental. These requirements are not specific to a children's benefit, and they are most often applied to dental HMOs where consumers must use an in-network provider.

Dental HMOs networks are also smaller than dental PPOs which are the predominant dental product. Nationwide, dental HMOS have one fifth the number of participating dentists as dental PPOs.

HHS recognized the need for dental specific requirements in the preamble of the Final Rule, noting adequacy requirements may need to be specific to the unique nature of limited scope dental plans. In general, states that have network adequacy requirements allow dental plans to set their own targets based on communities to be served (urban, suburban, rural) and monitor compliance with established targets. This is the approach that should be considered if network adequacy standards are added by Exchanges. Additionally, choice of a pediatric dentist as a primary care provider is not practical given the small number of pediatric dentists available and the ability of general dentists to provide needed care^{xiii}.

Community Providers

15) *Include in its network a sufficient number and geographic distribution of essential community providers who provide care to predominately low-income and medically-underserved populations in order to ensure reasonable and timely access to a broad range of such providers for the medically underserved in the QHP's service area. § 156.230(a)(1); see also §§ 155.1050 & 156.235.*

NADP & DDPA: Yes, dental plans can comply if requirements are dental specific. Employers, who hire minimum wage employees, sometimes request their dental carrier contract with providers who work in community health centers, or provide similar services for a low income population. Carriers will contract with these providers and centers if they meet a carrier's credentialing standards. However, due to the severe maldistribution of dentists and extremely low number of dentists who work within public programs, targets for dental community providers need to be flexible and likely set by the state when appropriate.

Geographic Coverage

16) *Consistent with section 2702(c) of the Public Health Service Act ("PHSA"), not deny coverage to employers or individuals within a service area based on a lack of capacity unless it does so uniformly and without regard to claims experience. § 156.230(a)(3).*

NADP & DDPA: Yes, dental plans can comply with this prohibition.

Provider Information

17) *Make its provider directory for a QHP available to the Exchange electronically and to potential enrollees in hard copy upon request. § 156.230(b); see also § 155.206(b)(1)(viii). This information should identify those providers who are no longer accepting new patients, § 156.230(b), as well as information on provider credentials, specialty, and contact information, which could include institutional affiliation.^{xiv}*

NADP & DDPA: Yes, dental plans can comply with most of this requirement. However, the information on institutional affiliation should not be applied to dental plans as very little dental care is provided outside the dental office environment. In general dental plans do not request nor do dental providers indicate their institutional affiliation on applications. Deleting this portion of the certification would recognize the difference between medical and dental delivery without harm to the consumer. In addition, information on provider credentials should take into account the variation between state requirements as well as product types, i.e. dental HMO provider credentialing includes additional information not collected for providers within dental PPO networks.

Enrollee Notifications

18) *Provide all applications and notices to enrollees in accordance with standards established by the Exchange. § 156.250; see also § 155.230(b).*

NADP & DDPA: Yes, dental plans can provide applications and notices to Exchange enrollees as required by Exchanges; however, NADP & DDPA urge creation of different formats or content as appropriate for pediatric dental.

Premium Rates

19) *Charge the same premium rate with respect to a plan that is offered through an Exchange as the issuer would charge with respect to a plan offered directly by issuer or through an agent or broker. § 156.255(b). A QHP issuer is permitted, however, to vary premiums by the rating areas established under section 2701(a)(2) of the PHSA. § 156.255(a).*

NADP & DDPA: Dental plans can offer similar plans at the same premiums as described above. However, this is a complex issue as medical carriers may be required to include pediatric dental in the medical policies offered outside the Exchange. Inside the Exchange, medical carriers can exclude pediatric dental if at least one dental plan has been certified to offer a separate pediatric dental policy which meets the EHB. The policy costs therefore would be different for both medical and dental plans inside and outside Exchanges as plan offerings can differ inside and outside Exchanges. For example, dental plans may not issue child-only policies outside the Exchange because currently the coverage must be included in all medical policies offered in the small group and individual market, making dental plan child-only policies a duplicative purchase by consumers.

NADP & DDPA have continuously requested that HHS clarify this issue through regulations. Such regulations should clearly reflect the intent of the Stabenow-Lincoln dental amendment that was unanimously approved by the Senate Finance Committee.

Broker & Plan Offerings

20) *In order to be eligible for premium tax credits and cost-sharing assistance, individuals must enroll through Exchanges. Thus, a QHP issuer may not enroll an individual directly. Similarly, the issuer may not enroll individuals through an agent or broker, as this would not be “enrollment through the exchange.” Instead, the issuer may only enroll an individual if the Exchange notifies the issuer that the individual is eligible to enroll in the plan. § 156.265(b)(1). If the individual seeks to enroll directly with a QHP, the QHP issuer must either direct the individual to file an application with the Exchange, or ensure the applicant received an eligibility determination for coverage through the Exchange. § 156.265(b)(2). Eligibility determinations must then be made by the Exchange and transmitted to the QHP issuer. § 156.265(c). The issuer must acknowledge receipt of enrollment information transmitted from the Exchange. § 156.265(g). The QHP issuer must reconcile enrollment files with the Exchange at least once a month. § 156.265(f).*

NADP & DDPA: Yes, dental plans can comply for pediatric dental. Individual adults will be able to go directly to a dental plan or through an agent/broker to purchase adult dental coverage or wrap-around family dental coverage as those benefits are not EHB requirements.

NADP & DDPA recommend the development of dental specific application templates and enrollment forms for ease of use and transparency for both consumers and Exchanges.

Enrollment Periods

21) *Enroll individuals during the initial and annual open enrollment periods established by the Final Rule, make available special enrollment periods for individuals who have experienced a “triggering event,” and abide by the effective dates of coverage established by the Exchange. § 156.260(a).*

NADP & DDPA: Yes, dental plans will comply with initial and annual enrollment periods.

Enrollee Information

22) *Notify the individual of the effective date of his or her coverage, § 156.260(b), and provide new enrollees with an information package, including a summary of benefits and a coverage document. § 156.265(e).*

NADP & DDPA: Yes, dental plans will be in compliance; however, the summary of benefits and coverage documents should be modified to be dental specific. NADP & DDPA are willing to work with HHS to develop templates (parallel to the medical templates already designed by the NAIC) and suggest the utilization of the outlines of coverage typically used in the individual dental market today (which may vary by state).

Payment Processes

23) *Adhere to the premium payment process established by the Exchange. § 156.265(d); see also § 155.240.*

NADP & DDPA: Yes, dental plans can comply.

Enrollee Termination

24) *Only terminate coverage under certain, specified circumstances, including: (1) the enrollee is no longer eligible for coverage in a QHP through the Exchange; (2) non-payment of premiums by the enrollee; (3) the enrollee's coverage is rescinded; (4) the QHP terminates or is decertified; (5) the enrollee changes from one QHP to another during an annual open enrollment period or special enrollment period. § 156.270(a); see also § 155.430(b). The plan must establish a standard policy for the coverage of enrollees due to non-payment of premiums that allows for a three-month "grace period" for non-payment of premiums with respect to individuals who are receiving premium subsidies. §§ 156.270(c)-(g).*

NADP & DDPA: Yes, dental plans can comply. When individuals are not receiving subsidies, however, state regulations related to non-payment premiums (typically 30 days) should be applied.

Enrollee Termination

25) *Provide enrollees with notice at least 30 days prior to terminating coverage if their coverage in a QHP is terminated for any reason. § 156.270(b)(1). The QHP issuer must also notify the Exchange together with the reason for the termination, § 156.270(b)(2), and keep a record of termination of coverage in accordance with standards established by the Exchange under § 155.430(c), 156.270(h). (Section 155.430(c)(3) also requires a QHP issuer to make reasonable accommodations for all individuals with disabilities before terminating their coverage, although this particular requirement is not cross-referenced in § 156.270(h).)*

NADP & DDPA: Yes, dental plans can comply.

Accreditation

26) *Be accredited within the timeframe established by the Exchange and maintain such accreditation for as long as the issuer offers QHPs. § 156.275(b); see also § 155.1045.*

NADP & DDPA: No, dental plans cannot comply as accreditation programs specific to dental plans do not exist. HHS recognized this fact in the Final Rule.

Abortion Coverage

27) *Comply with certain requirements relating to abortion coverage. § 156.280.*

NADP & DDPA: No, dental plans cannot comply as this procedure is never covered by a dental plan.

SHOP Requirements

28) Comply with certain additional provisions if the QHP is offered to small employers through a Small Business Health Options Program or “SHOP” Exchange. § 156.285. These provisions require that an issuer of QHPs must, with respect to each of the QHPs it offers through the SHOP Exchange:

1. Accept premium payments from the SHOP Exchange rather than directly from the employer. § 156.285(a)(1).
2. Change rates at a uniform time that is either quarterly, monthly, or annually, and not change rates for an employer during the employer’s plan year. § 156.285(a)(2) & (3).
3. Enroll eligible employees and dependents during the employer’s annual open enrollment period (established pursuant to the SHOP Exchange’s rules) consistent with the plan year of the employer, and as of the date an employee first becomes eligible for the employer’s plan if that occurs outside the employer’s annual open enrollment period. § 156.285(b)(1), (b)(3) & (c)(6).
4. Make available special enrollment periods similar to those otherwise available on the Exchange, except that they do not have to include changes in immigration status or changes in eligibility for advance payments of the premium tax credit or for cost-sharing reductions. § 156.285(b)(2).
5. Abide by the effective dates of coverage specific to the SHOP Exchange, which require, among other things, first determining whether the employer is qualified to participate in the SHOP Exchange. § 156.285(b)(4) & (c)(1).
6. Safeguard the privacy of enrollment information received in an electronic format in accordance with §§ 155.260 and 155.270. § 156.285(c)(2).
7. Follow the same rules regarding termination of coverage that otherwise apply on the Exchange, except that if an employer withdraws from the SHOP Exchange the QHP issuer must terminate coverage for all employees and other enrollees of the employer. § 156.285(d).
8. Impose group participation rules only if and to the extent authorized by the SHOP Exchange. A SHOP Exchange may authorize only uniform group participation rules and, if it authorizes a minimum employee participation rate, the rate must be based on the rate of employee participation in the SHOP Exchange, not on the rate of employee participation in a particular QHP or the QHPs of a particular QHP issuer. § 156.285(e).

NADP & DDPA: Yes, dental plans can comply.

Enrollee Non-Recertification

29) If a QHP issuer elects not to seek recertification with the Exchange, the QHP issuer must notify the Exchange of its decision prior to the beginning of the recertification process, cover benefits for each enrollee through the end of the current plan or benefit year of the certification, fulfill data reporting obligations from the last plan or benefit year of the certification, provide a written notice to each enrollee, and comply with the applicable requirements regarding the termination of enrollees (described above). § 156.290(a). The issuer must also provide a written notice to each enrollee. § 156.290(b).

NADP & DDPA: Yes, dental plans can comply.

QHP Decertification

30) If a QHP is decertified by the Exchange, the QHP issuer may terminate coverage for enrollees only after the Exchange has provided a notice of decertification to the QHP and enrollees have had an opportunity to enroll in other coverage. § 156.290(c).

NADP & DDPA: Yes, dental plans can comply.

Prescription Coverage

31) *If the plan covers prescription drugs, provide to HHS the information regarding prescription drug distribution and cost reporting required under section 6005 of the ACA.^{xv} § 156.295.*

NADP & DDPA: No, dental plans cannot comply as they do not typically cover prescription drugs.

Other Requirements

Geographic Coverage

32) *The Final Rule also requires that the service area of the QHP cover a minimum geographical area that is at least the entire geographic area of a county (unless the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers). § 155.1055(a). The Final Rule further requires that the service area must have been 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. § 155.1055(b).*

NADP & DDPA: Yes, dental plans can comply.

The **National Association of Dental Plans (NADP)** is the largest non-profit trade association focused exclusively on the dental benefits industry, i.e. dental PPOs, dental HMOs, discount dental plans and dental indemnity products. NADP's members provide dental benefits to over 90% of the 176 million Americans with dental benefits. Our members include major commercial carriers, regional and single state companies, as well as companies organized as non-profit plans.

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Based in Oak Brook, IL, **Delta Dental Plans Association (DDPA)** is a national network of 39 independently operated not-for-profit dental service corporations specializing in providing dental benefits in all 50 states, the District of Columbia and Puerto Rico. Collectively, Delta Dental is the largest provider of dental benefits in the country, covering more than 56 million people in over 95,700 groups across the country.

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WORKING DOCUMENT: RELEASED MAY 2012 v1.0

ⁱ 77 Fed. Reg. 18,310; CMS-9989-F "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers", March 27, 2012

ⁱⁱ 77 Fed. Reg. 18,312; CMS-9989-F "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers", March 27, 2012

ⁱⁱⁱ Once certified, the plan will be subject to ongoing monitoring to ensure compliance with the certification standards by the Exchange, § 155.1010(a)(2), and will be required to undergo recertification at intervals to be established by the Exchange, § 155.1075.

^{iv} In the Final Rule's Summary of Regulatory Changes for Stand Alone Dental Plans, HHS notes in the response related to cost-sharing that, *"...for any benefit offered by a stand-alone dental plan beyond those established under section 1302(b)(1)(J) of the Affordable Care Act, standards specific to the essential health benefits would not apply."*

^v 77 Fed. Reg. 18,415; CMS-9989-F "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers", March 27, 2012

^{vi} ACA Sec 1311(g)(1) requires QHPs to implement health care quality improvement strategies which include activities such as prevention of hospital readmissions, reduction of medical errors, etc. These are examples of specific activities dental plans cannot meet.

^{vii} Dental premiums today are about 1/12th that of medical premiums. Pediatric premiums would be an even smaller portion of medical premium.

^{viii} 77 Fed. Reg. 17220; CMS-9938-AR07 "Standards Related to Reinsurance, Risk Corridors and Risk Adjustment; Final Rule", March 23, 2012

^{ix} 77 Fed. Reg. 18,415; CMS-9989-F "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers", March 27, 2012

^x 2794 PHSA

^{xi} 77 Fed Reg. 18,411, Section h. Stand-alone Dental Plans; CMS-9989-F "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers", March 27, 2012

^{xii} There are 5,800 Pediatric Dentists practicing in the U.S. according to the American Dental Association's Distribution of Dentists in the United States by Region and State, 2008, August 2010.

^{xiii} Ibid

^{xiv} 77 Fed. Reg. 18,420; CMS-9989-F "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers", March 27, 2012

^{xv} This information includes data regarding: (1) the percentage of all prescriptions that were provided under the QHP through retail pharmacies compared to mail order pharmacies, and the percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type, that is paid by the QHP issuer or the QHP issuer's contracted PBM; (2) the aggregate amount, the type of rebates, discounts, or price concessions (excluding bona fide service fees) that the QHP issuer or its contracted PBM negotiates that are attributable to patient utilization under the QHP, and the aggregate amount of rebates, discounts, or price concessions that are passed through to the QHP issuer, and the total number of prescriptions that were dispensed; and (3) the aggregate amount of difference between the amount the QHP issuer pays its contracted PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies, and the total number of prescriptions that were dispensed.