



June 29, 2016

Louis Gutierrez, Executive Director
Commonwealth Health Insurance Connector Authority
100 City Hall Plaza, 6th Floor
Boston, MA 02108
Sent via email

Dear Mr. Gutierrez:

The National Association of Dental Plans (NADP) is commenting in response to the Health Connector Seal of Approval (SOA) and Request for Responses (RFR) requiring medical plans to include coverage for dental benefits. As this policy goes directly against the letter and intent of the Affordable Care Act (ACA), we are dismayed by the utter lack of any public discussion with stakeholders where the Connector could better understand the complex issues surrounding dental benefits on the Marketplaces. We are also deeply concerned by reports from carriers that the Connector may not certify plans for offer outside of the Exchange.

These issues are critical for Massachusetts residents to have choice and access to quality, affordable oral health care on and off the Marketplace. We urge the Connector to reconsider these policies as part of a transparent public discussion with stakeholders. Background and our specific recommendations are included below.

BACKGROUND

The U.S. Congress was very clear on the importance and role of oral health and dental benefits when the ACA identified pediatric dental as one of the 10 essential health benefits (EHB). Recognizing that 99% of Americans with dental coverage obtain that coverage separate from their medical policy on a standalone basis, Congress directed the ACA to allow separate dental policies to provide the essential pediatric dental EHB. Furthermore, the ACA requires Exchanges to allow medical carriers to offer Qualified Health Plans (QHPs) without dental, as long as there are separate dental policies available on the same Exchange.

The Connector's SOA and RFR advance a policy in which the Marketplace would only offer medical policies with embedded pediatric dental and separate stand-alone dental policies. This would mean policies offered by stand-alone dental plans would be duplicative of what is offered by the medical carrier and that medical plans do not have the option of offering a medical policy without dental – today, most medical policies do not include dental.

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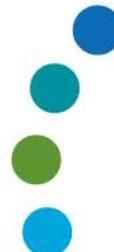
National Association of Dental Plans

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To allow only embedded pediatric dental directly conflicts with the ACA law and federal Exchange rules as illustrated by the following excerpts:

ACA 1302(b)(4)(F):

(F) provide that if a plan described in section 1311(b)(2)(B)(ii) (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the standalone plan that are otherwise required under paragraph (1)(J);

Federal Exchange Rules § 155.1065(d) repeats this standard:

(d) QHP Certification standards. If a plan described in paragraph (a)1 of this section is offered through an Exchange, another health plan offered through such Exchange must not fail to be treated as a QHP solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under section 1302(b)(1)(J) of the Affordable Care Act.

NADP Recommendation: For Massachusetts to be in compliance with the ACAⁱ and HHS Guidanceⁱⁱ, the Connector must continue to allow medical carriers the opportunity to offer Qualified Health Plans (QHPs) without embedded pediatric dental benefits when standalone dental plans (SADPs) are certified to offer on the Exchange.

NADP Recommendation: A public discussion with stakeholders and review of this policy is necessary to understand the complex offer and selection of dental benefits on Exchanges. Several issues, which have not been explored, but should be included:

- *Disruption of Current Coverage:* An offer of only medical policies with embedded dental and standalone dental policies requires a change and disruption to 2016 policy holders and severely limits enrollee choice. Understandably, enrollees will choose their medical policy first and thus by default will have to use the dental benefit that is included in that policy. They will not have the option to shop for a dental plan which includes their dentist or has the best selection of benefits for them. To further suggest the purchase of an additional standalone policy in order to keep their dentist is burdensome, costly and not in the best interest of the consumer.
- *Separation of Family Coverage & Duplicative Coverage:* In most cases, medical policies with embedded dental are only offering pediatric coverage. If an adult wants to purchase coverage for themselves or their family, they will only have the option to purchase coverage from a standalone plan. Most likely the providers offered in the standalone dental plan will not be in the same network included in the medical policy, forcing the parents and children to find separate dentists through two different policies unless the adult purchases a family policy - again, making the benefits duplicative and more costly to the consumer.
- *Adverse Selection & Differing Consumer Protections:* Standalone dental and medical carriers with embedded dental have different maximum out-of-pocket limits (MOOP). Medical policies are \$6,850 per individual or \$13,700 for a family. In 2015, HHS regulations require a standalone child-only dental policy MOOP limit of \$350 and for additional children a total of \$700. Milliman has done a significant amount of work for NADP on the impact of MOOP on children with

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varying dental needs. That work indicates that most children (94-95%) have less than \$900 in annual dental costs. If a child has medically necessary orthodontia which costs thousands of dollars a year or other high cost services, the standalone dental carrier payment would be much higher than the medical plan. The higher payment by the dental plan creates an incentive for individuals with greater dental needs to select the dental plan while the lower premium creates incentives for children with low to moderate needs to select the medical plan.

EXCHANGE CERTIFICATION OF STANDALONE DENTAL FOR OFFER OUTSIDE OF THE EXCHANGE

Today, there are almost 44 million individuals insured under dental coverage in the small group and individual market—22.9 million of whom are children. Less than 1% of consumers have dental benefits as part of their medical policies. These children and their parents should be able to keep their dental coverage and the providers they see under that coverage, as long as the pediatric dental portion of that coverage is brought into compliance with the Connector's rules for coverage.

The process referenced in the final Essential Health Benefit rulesⁱⁱⁱ by HHS was Exchange certification of SADP for offer in the small group and individual market outside of the Marketplaces. There was no detail provided as to what "Exchange certified" meant but the federal Marketplace has interpreted^{iv} it to mean that SADP coverage is vetted through the same process as SADP coverage offered on the Exchange. State-based marketplaces, including Colorado, Connecticut, Minnesota and New York have developed similar policies and processes, recognizing how critically important the availability of certified plans are for continuation of coverage and choice for families and individuals in the small group market.

Other states including those on the federal Marketplace have used various methods such as insurance department regulations or state legislation providing their clarification on this guidance; a summary of these methods is attached for your review.

- **NADP Recommendation:** To stay legally compliant with the ACA's intention, the Connector must confirm the continued path for SADPs to become 'exchange certified' in the private market.

Again, we strongly recommend open and public discussion of these issues. Throughout ACA implementation, NADP has supported consumer choice of dental plan options, both embedded and standalone, and has provided industry input on the variety of issues arising from the offer of pediatric dental benefits as part of the Essential Health Benefits package in state Marketplaces. We look forward to participating in future discussions and providing resources and our expertise.

We also have attached our member list as well as a Massachusetts dental fact sheet. Please contact myself, or NADP's Associate Director of Government Relations, Eme Augustini, with any questions regarding our concerns at eaugustini@nadp.org or 972 458-6998x112. Thank you for your time and consideration.

Sincerely,



Kris Hathaway
Director of Government Relations

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NADP DESCRIPTION

NADP is the largest non-profit trade association focused exclusively on the dental benefits industry, i.e. dental PPOs, dental HMOs, discount saving plans and dental indemnity products. NADP's members provide dental benefits to more than 92 percent of the 205 million Americans with dental benefits. Our members include the entire spectrum of dental carriers: companies that provide both medical and dental coverage, companies that provide only dental coverage, major national carriers, regional, and single state companies, as well as companies organized as non-profit plans.

ⁱ Marketplaces to allow a QHP without pediatric dental coverage when a separate dental policy meeting EHB requirements is offered (42 U.S.C. sec. 18022(b)(4)(F) / ACA Sec 1302(b)(4)(F).

ⁱⁱ Marketplaces to allow stand-alone dental plans to offer pediatric dental EHB products either independently from a QHP or in conjunction with a QHP issuer, but cannot limit participation of stand-alone dental plans to only one of those options (77 Fed Reg. 18411, March 27, 2012).

ⁱⁱⁱ 78 Fed Reg. 12853, Feb 25, 2013

^{iv} Q1: Can an issuer be certified to offer stand-alone dental plans only off of 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 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. (CMS "QHP Dental Frequently Asked Questions," May 10, 2013)



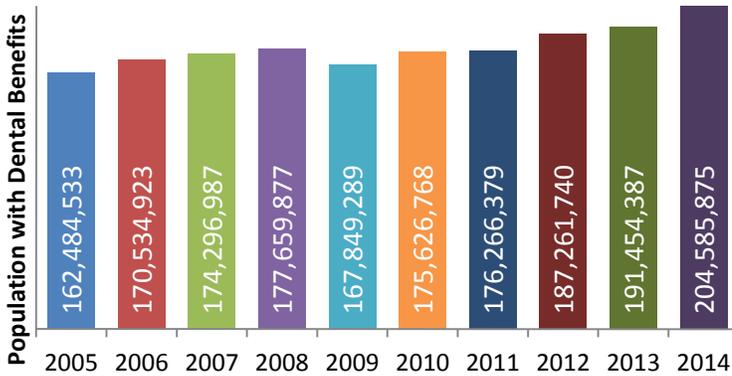
Massachusetts

Dental Benefits Fact Sheet



National Enrollment Trends

An estimated 204,585,875 Americans, 64% of the population, have dental benefits.



Source: 2015 NADP Dental Benefits Report on Enrollment

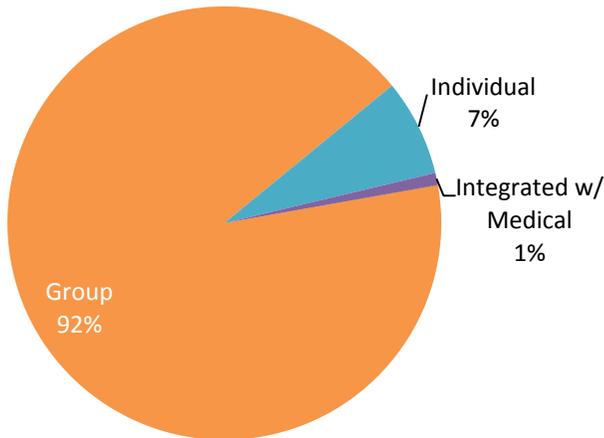
Dental Enrollment

An estimated 4,077,335 or 60% of the population have dental benefits in Massachusetts.

Plan Type	Enrollment
Private Plans	
DHMO	44,617
DPPO	2,838,537
Indemnity	815,196
Other Private	46,997
Public Plans	
Medicaid/CHIP ³⁹	330,906

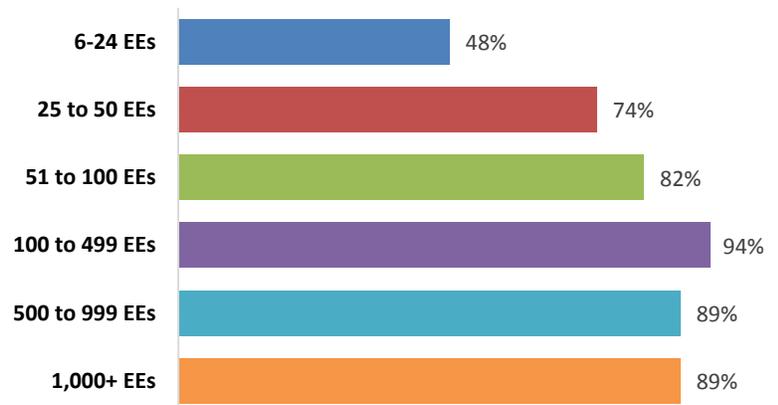
Source: Data from the Centers for Medicare and Medicaid Services and 2015 NADP Dental Benefits Report on Enrollment

Sources of Private Dental Coverage



Source: 2015 NADP Dental Benefits Report on Enrollment

Employers Offering Dental Benefits by Employer Size



Source: 2015 NADP Survey of Employers

Premium Facts

Massachusetts	DPPO	Indemnity
DHMO		
Small Group	--	\$39.86
Large Group	--	\$34.88
Individual	--	--
Nat'l All Group Avg	\$17.01	\$36.13

Source: NADP 2015 Dental Benefits Report: Premium and Benefit Utilization Trends

Distribution of Commercial Benefits: State vs National

	DHMO	DPPO	Indemnity	Other
Massachusetts	1.1%	69.6%	20.0%	1.2%
National	7.9%	78.9%	6.8%	6.4%

Source: 2015 NADP Dental Benefits Report on Enrollment

Massachusetts Dental Benefits Fact Sheet

Workforce NADP Members

The federal standard for an adequate supply of dentists is 3.33 practicing dentists per 10,000 population.⁴⁰

The table presents the number of dentists participating on provider networks including the number of network dentists per 10,000 population

Network Type	Total Dentist	General Dentists	Pediatric Dentists	Specialists	Per 10,000
DHMO	634	371	29	234	0.94
DPPO	5,779	4,349	272	1,158	8.57
Discount	3,361	2,619	155	587	4.98

Source: 2015 NADP/DDPA Joint Dental Benefits Report on Network Statistics and U.S. Department of Health and Human Services

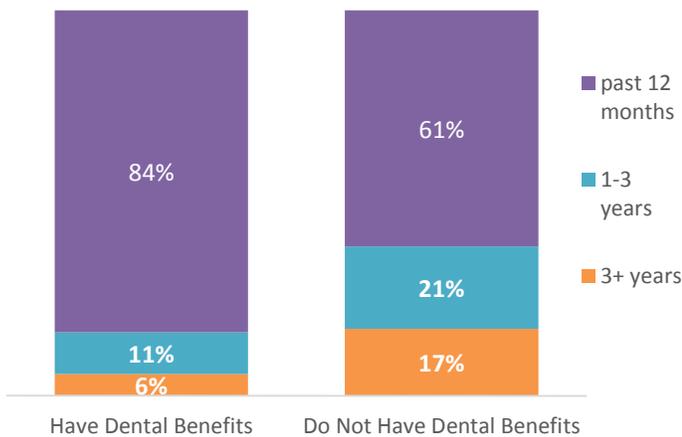
Plan Types Offered by NADP Members



Source: 2015 NADP Membership Directory

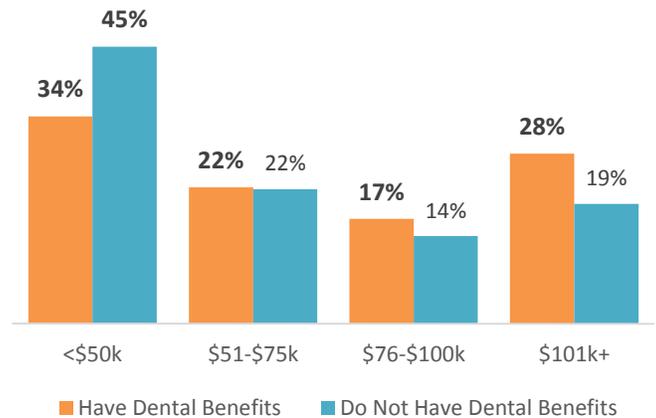
Dental Benefits Impact Consumer Behavior Who Has Dental Benefits

When was your last visit to the dentist?



Source: 2015 NADP Survey of Consumers

Consumers with and without Dental Benefits by Household Income



Source: 2015 NADP Survey of Consumers

About



The National Association of Dental Plans (NADP), a nonprofit corporation with headquarters in Dallas, Texas, is the “representative and recognized resource of the dental benefits industry.” NADP is the only national trade organization that includes the full spectrum of dental benefits companies operating in the United States. NADP’s members provide dental benefits to about 90 percent of 205 million Americans with dental benefits.



DATE: MAY 2015

RE: STATE INTERPRETATIONS OF REASONABLE ASSURANCE

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BACKGROUND

The ACA includes coverage for pediatric oral health services as part of the Essential Health Benefits (EHB) package which will be included in health policies offered to the small group and individual market. The ACA specifically allows for separate dental policies to provide coverage for the pediatric dental offering within a Marketplace, (when chosen with a medical plan offering all other EHB requirements). However, the ACA obliges Qualified Health Plans to include all 10 categories of the EHB, including dental, in their policies offered off the Exchange in the private market. Therefore, any dental policies sold by stand-alone dental plans outside the Exchange in the small group/individual market could be duplicative to what a full service health plan must offer. Considering 99% of dental policies are sold separately from medical (from both medical and dental carriers), this issue would have caused great disruption to consumers and was specifically addressed by the U.S. Department of Health and Human Services (HHS).

CURRENT FEDERAL REGULATIONS

Within the latitude provided by the ACA, HHS addressed the choice of consumer dental options in regulations. HHS noted the ACA does not provide for the exclusion of pediatric dental benefits by QHPs outside of the Exchange in the manner it does inside of Exchanges in section 1302(b)(4)(F). Therefore, HHS outlined an alternative for health insurance carriers to meet their responsibility under the statute by allowing medical and dental carriers to provide separate dental policies to consumers in a manner parallel to today's dental marketplace.

The HHS Final Rule¹ on Essential Health Benefits states that health plans offered outside of Exchanges will now be considered compliant with ACA if they do not cover pediatric dental services so long as the health plan is reasonably assured that an individual has obtained such coverage through an Exchange-certified stand-alone dental plan (SADP). [See Endnote #1 for the specific regulation wording.] The regulation utilizes terminology that is not otherwise defined in the ACA or other federal guidance.

The information outlined below specifically addresses the phrase, "reasonably assured" and outlines how states are implementing and addressing HHS regulations.

IMPLEMENTING "REASONABLY ASSURED" & "EXCHANGE CERTIFIED"

Several states are concerned with the ambiguity of the federal guidance and have taken steps to define "reasonably assured" for medical carriers offering medical policies within their state. As addressed in memorandums and insurance bulletins, state leaders are concerned about disrupting dental coverage within their state and want to support a competitive dental marketplace.

States have taken a variety of approaches clarifying federal reasonable assurance guidance. Four general approaches have been taken in the states that have provided guidance:

Notification: Many states which have taken action are requesting medical issuers provide notification to enrollees that their policy (if appropriate) does not include an approved pediatric dental benefit. The consumer is free to make their own choice for dental or medical carrier for the purchase of dental benefits.

Attestation: Another approach allows for the medical issuer not to embed pediatric dental as long as the consumer attests they have such coverage. Questions from the medical carrier will need to be added during the enrollment process to determine whether or not the consumer has obtained separate coverage for pediatric dental benefits. If the enrollee had not obtained such coverage, the medical issuer could offer a medical policy that covers the pediatric dental benefits and/or direct the enrollee to the state Health Insurance Marketplace to find an Exchange-Certified stand alone dental plan. The medical carrier would need to maintain medical policies with and without dental and be ready to address consumer inquiries on their current dental coverage status.

Proof of Coverage: Two states require medical carriers obtain from the consumer or his/her dental carrier some proof that the consumer has obtained the pediatric dental coverage at the time of applying for medical coverage.

Issuer Determination: The remaining states have either declined to clarify the federal standard or have restated the federal standard without interpretive guidance. In these cases, the method of obtaining assurance is at the discretion of the issuer, who could employ any or all of the approaches listed here.

Some states have also taken steps to clarify the process through which a dental plan may become “Exchange certified” for purposes of this policy. In the 37 or so Federally-facilitated Marketplaces, a standalone dental plan must complete the certification process of the Exchange up until the point of signing an agreement to become “exchange certified” for sale off the Exchange. To become certified, dental policies must meet the same criteria as SADPs offered on a Marketplace, including being approved by the state’s department of insurance (DOI). Exceptions to this general rule are noted within the listing below.

STATE’S GUIDANCE ON “REASONABLY ASSURED” AND “EXCHANGE CERTIFIED”

Following are summaries of states which have implemented guidance on clarifying “reasonable assurance” and/or “exchange certification”:

Arkansas:

2015: SB 927, which became law April 7, 2015, clarifies that a healthcare insurer is considered to have reasonable assurance if (1) at least one qualified dental plan offers the minimum essential pediatric oral health benefits that are available to the purchaser of the health benefit plan; and (2) a qualified health plan prominently discloses at the time of purchase on a form approved by the Insurance Commissioner that the qualified health plan does not provide the minimum essential pediatric oral health benefits. The notification requirement is applicable to health plans offered on and off the Exchange in the small group and individual market.

AR SB 927 to regulate pediatric dental benefits and clarify reasonable assurance for off-exchange pediatric dental-essential health benefits: <http://bit.ly/1CUYCP9>

To become “exchange certified,” SADP issuers must follow the Marketplace certification filing process. Requirements for Exchange Certification: <http://1.usa.gov/1OwfaoS>

2014: Issuers on and off the Exchange will be required to notify potential policyholders, prior to sale, if a plan does not cover the required pediatric dental benefit. The DOI has provided suggested language for the

disclosure.

AR DOI Bulletin 12-2013: <http://1.usa.gov/1EzpFF7>

Colorado:

Issuers on and off the Exchange will be required to notify potential policyholders prior to sale if a plan does not cover the required pediatric dental benefit. The DOI has provided recommended language for carriers to utilize within notifications to enrollees. In a memo, the state DOI recommended notification language for issuers on and off Exchanges. The sample notice for on and off Exchange are slightly different; notifications provided to issuers on Exchanges inform enrollees who “wish” to purchase dental, versus the notification for enrollees off the Exchange asks enrollees “to please contact” a variety of resources to purchase dental coverage.

DORA Bulletin B-4.57: <http://1.usa.gov/1kjHFdw>

In its “Uniform Individual and Small Group Health Benefit Plan Applications,” the CO DORA included a section that allows an applicant to certify pediatric dental coverage has been obtained under another plan. The section also indicates that the applicant may be required to provide proof of that coverage prior to policy approval.

DORA Insurance Regulation 4-2-45 (sample application): <http://1.usa.gov/1dU3I26>

In a separate bulletin, the CO DORA noted its work with dental carriers to allow the sale of Exchange-certified “child only” pediatric dental policies at low/no cost to individuals and families without children. According to the Bulletin, “such products allow purchasers to obtain the required pediatric dental coverage, in full knowledge that such a benefit will never be needed or used.” The proof of purchase of such plan could help meet the “reasonable assurance” requirement.

DORA Bulletin B-4.69: <http://1.usa.gov/1pAQVvX>

In addition to these bulletins, the Division of Insurance has finalized regulation 4-2-50 “Concerning Pediatric Dental Coverage Requirements,” which includes provisions outlined by the bulletins linked here.

Reasonable assurance may be obtained by one or more of the following:

1. Obtaining a certification from the consumer that they have purchased pediatric dental EHB coverage;
2. Obtaining proof of purchase from the consumer who is a childless adult that they possess low-cost/no-cost child-only pediatric dental EHB coverage; or
3. Obtaining an attestation as supplied on the individual application that the consumer has or will purchase pediatric dental EHB coverage.

DOI Regulation 4-2-50, effective 7/15/14: <http://bit.ly/T8g4R9>

Connecticut:

The Connecticut Exchange, access health CT, will perform the function of certifying standalone dental plans for off-Exchange offer. The Connecticut Insurance Department (CID) performs rate and form filing reviews.

AHCT 5/28/2014 Board Meeting Presentation: <http://1.usa.gov/1DJqf2C>

Hawaii:

No formal guidance has been provided; however, instructions from the Department directed the following language be included in major medical applications: “The undersigned attests that they have purchased an Exchange-certified stand-alone pediatric dental coverage plan from any insurer whether purchased ‘on’ or ‘off’ the Exchange, and therefore are eligible to purchase a medical plan that excludes pediatric dental coverage. The undersigned acknowledges that the Patient Protection and Affordable Care Act requires that pediatric dental be included as an essential health benefit for customers of small group and individual health insurance policies.”

Idaho:

In Bulletin 14-02, the Idaho DOI outlines standards regarding reasonable assurance for Qualified Health Plans (QHPs) when sold through the Exchange, for QHPs when sold outside of the Exchange, and to non-QHPs (a health plan sold only outside of the Exchange).

- For QHPs sold through the Exchange, there is no additional reasonable assurance requirement as the ACA provides that QHPs are not required to include pediatric dental care EHB as long as an SADP is available.
- For QHPs offered off the Exchange, the DOI will consider the inclusion of disclosure language on enrollment documents and applications as *prima facie* evidence that the carrier is reasonably assured of other exchange-certified SADP coverage. The bulletin includes specific recommended notification language.
- The Idaho Bulletin also identifies health plans that are sold exclusively outside of the Exchange as "Non-QHPs," a distinction that is not employed by other states or the federal marketplace. For these plans, the Bulletin notes, "Non-QHPs must provide coverage of all 10 EHB categories, and non-QHPs are not eligible for the 'reasonable assurance' allowance."

According to DOI guidance to carriers, exchange certification will not be available for Plan Year 2016. As noted above, the DOI is differentiating between medical plans offered solely off the Exchange ("non-QHPs") and QHPs purchased off the Exchange. The former will have dental benefits embedded. The latter would result when a medical carrier sells off the Exchange the exact certified QHP that it offers on the Exchange, which was not required to have dental embedded. The DOI contends that individuals and employers will be able to purchase these non-embedded certified QHPs off the Exchange. Because there is no requirement that individuals or employers purchase dental products, they will be able to purchase non-embedded QHPs off the Exchange and be free to purchase any dental plan of their choosing. Thus, standalone dental carriers can continue to offer plans with pediatric dental benefits with no need to be certified unless offering on the Exchange. The DOI offered that dental carriers could educate small groups that there is no reason to prefer certified over non-certified dental plans in order to be compliant.

According to an issuer FAQ for Plan Year 2015 released prior to Bulletin 14-02, an off-exchange only, stand-alone dental plan can be "Exchange certified" by submitting through SERFF all the requirements for on-exchange QHPs, while indicating that the plan is off-exchange only. It will go through the same process as an on-exchange product, and it has the same filing deadlines as on-exchange products.

ID Bulletin 14-02: http://www.doi.idaho.gov/laws/14_02.pdf

ID DOI FAQ, Part 2: <http://bit.ly/1FDSocx>

Illinois:

Issuers offering plans that do not include the essential pediatric oral benefits outside the Exchange will be deemed to have reasonable assurance if: (a) at least one Exchange certified stand-alone dental plan is available for purchase by the small group or individual; (b) the issuer prominently discloses to the purchaser or enrollee at the time of offer that the plan does not provide the benefits; and (c) the issuer has received and kept records of written, verbal or electronic confirmation from the purchaser, or enrollee in the case of a group plan, that he or she has obtained or is obtaining, other coverage that includes the benefits.

IL Administrative Code Title 50, Section 2001.11(a)(2): <http://bit.ly/1EoHYws>

Iowa:

Issuers on and off the Exchange will be required to notify potential policyholders, prior to sale, if a plan does not cover the required pediatric dental benefit. A memo to issuers describes "reasonable assurance" as the act of notifying the consumer of this fact. The memo also includes specific notification language carriers may utilize: "This policy does not include pediatric dental services as required under the federal Patient

Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your carrier, your insurance agent, or Iowa's Partnership Marketplace Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product."

IA DOI Memo: <http://bit.ly/1I3X65f>

Kentucky:

Insurers are allowed to propose the method they intend to use to meet "reasonably assured" standard. An FAQ from the DOI states: The final federal regulation on essential health benefits includes guidance in the preamble that clarifies an insurer may offer plans outside of the Exchange that exclude pediatric dental benefits if the insurer is "reasonably assured" that the individual has obtained pediatric dental coverage through an Exchange certified stand-alone dental plan. Because the responsibility to determine reasonable assurance rests with the insurer, we will allow insurers to propose to DOI the method they will use to meet the "reasonably assured" requirement.

With regard to the requirement that the stand-alone dental plan be "Exchange certified," the DOI will consider that this requirement is met if: (1) the forms and rates are approved for sale in the Exchange by the DOI and the product has been certified by the Exchange; or (2) if the plan is not intended for sale in the Exchange, the plan includes, at a minimum, the KCHIP pediatric dental benefits.

Information forwarded within an FAQ e-mail sent to carriers.

Maryland:

House Bill 693, which had passed both chambers of the Maryland legislature as of April 2, 2014 and was approved by the Governor on May 15, 2015, would require health plans to disclose to potential purchasers outside the Exchange that a plan does not include pediatric dental benefits and to include on applications the following questions:

Have you obtained stand-alone dental coverage that provides pediatric dental essential health benefits through a Maryland Health Benefit Exchange certified stand-alone dental plan offered outside the Maryland Health Benefit Exchange? Yes No

- If you answered "yes," please provide the name of the company issuing the stand-alone dental coverage.
- If you answered "no," you will be issued a health benefit plan that includes the pediatric dental essential health benefits.

With regard to the requirement that the stand-alone dental plan be "Exchange certified," the bill notes that a stand-alone dental plan must be reviewed and approved by the Administration as meeting appropriate requirements including covering the state benchmark, complying with annual and lifetime limits, complying with annual limits on cost sharing applicable to SADPs and meeting AV requirements. The Administration will place on its website a list of the Exchange certified SADPs in the state.

MD HB 693 to repeal and reenact with amendments 31-115(a) and (k)(1) and 31-116(a):

<http://1.usa.gov/1m2NtZr>

Massachusetts:

According to a DOI bulletin, the Department will only approve QHP form filings that either include the pediatric dental benefits or include materials that describe the Exchange-certified stand-alone dental plan (SADP) that will be required to be purchased.

The bulletin goes on to specify that in order for a health carrier to be "reasonably assured:"

"a Carrier must obtain documentation with respect to each potentially covered person that demonstrates that, as of the date of the enrollment in the Carrier's health plan, each person being considered for the health plan without pediatric dental benefits is, in fact, already covered by or has coverage pending for a dental plan that is on the Dental Plan List with the same or a different Carrier. If the Carrier does not receive appropriate documentation with respect to each potentially covered person, then the Carrier may not issue or renew health coverage unless it includes pediatric dental EHB features."

Massachusetts will also require a notice with medical plans in and outside the Exchange to indicate whether the plan covers pediatric dental benefits and provides sample language for the disclosures.

MA DOI Bulletin: <http://1.usa.gov/1y6YG0t>

Michigan:

An online set of Question and Answers for carriers includes a non-specific policy approach that mentions attestation: "plans in the individual and small group market may exclude dental coverage from the plan if they are 'reasonably sure' the consumer has purchased a stand-alone dental plan with pediatric dental coverage. Outside the Exchange, the issuer still has to offer the coverage, but can carve out the pediatric dental coverage for a consumer that attests that he/she has purchased the stand-alone from elsewhere."

Examples of reasonable assurance off the Marketplace are provided and include:

- requiring a copy of the dental certificate;
- an attestation of pediatric dental coverage from the consumer;
- enter into issuer partnership agreements that allow for simultaneous issuance of coverage (when the QHP is issued, the dental carrier will be notified and, at that time, the dental certificate will be issued); or,
- marketing agreements between QHP issuers and stand-alone dental carriers.

DIFS Pediatric Dental FAQ, updated 3/25/15: <http://1.usa.gov/1zAA7vQ>

Minnesota:

State has advised carriers they will allow for exchange certification via guidance issued in February 2013 ("Minnesota Health Insurance Exchange Plan Certification Guidance For Qualified Dental Plans February 4, 2013"). The guidance is unclear if the certification process is meant for off-exchange stand-alone dental plans as well.

MN DOI Discussion and guidance above.

According to Department of Commerce instructions to carriers, dental carriers may offer off-Exchange only pediatric dental policies that are exchange certified. All limited scope pediatric dental plans seeking certification (including off-exchange only) must use the QDP on-Exchange instructions, including compliance with rate and benefit parameters.

Montana:

Health insurers in the individual and small employer group market selling products off the Exchange that do not have "embedded" pediatric dental benefits must disclose to all applicants and consumers shopping for coverage that pediatric dental services are a required benefit not included in the health plan being offered by that insurer.

Montana bulletin, "CLARIFICATION REGARDING WHAT CONSTITUTES "REASONABLE ASSURANCE" AS IT RELATES TO PEDIATRIC DENTAL BENEFITS AND PROHIBITING "FORCED" OR "AUTOMATIC ENROLLMENT" November 13, 2013: <http://1.usa.gov/1EoIAIH>

New Hampshire:

After outlining federal regulation on this topic, an Insurance Department bulletin clarifies the Department will consider a carrier to have received “reasonable assurance” if certain disclosure is provided and the consumer has indicated understanding of several points regarding health coverage, including: (1) the coverage being purchased, without purchase of an additional exchange-certified stand-alone dental plan, does not include all of the Essential Health Benefits; (2) failure to purchase coverage that includes all Essential Health Benefits may have tax consequences for the consumer; and (3) exchange-certified, stand-alone dental plans are available for sale either on or off the Exchange. Additionally, the bulletin states that automatic enrollment by a carrier into a pediatric dental plan is not required in order to obtain reasonable assurance and that such action may constitute a violation of the state’s Unfair Insurance Trade Practices.

NH DOI Bulletin No. 13-039-AB: <http://1.usa.gov/1nmF0Od>

Nevada:

The Division of Insurance will only accept product filings for health plans that meet the requirements for EHB in accordance with guidance from CCIIO. Insurers have the option of meeting the pediatric dental EHB by embedding the benefit, by not embedding the benefit, or by offering the health benefit plan with embedded and not embedded plan variations.

NV DOI Bulletin 13-003: <http://1.usa.gov/1PNmY7m>

In guidance to issuers, the DOI has clarified that pediatric dental is not required to be embedded in a medical plan outside the Exchange if the issuer is reasonably assured certified stand-alone coverage has been obtained. Nevada will consider self-attestation by an applicant to be “reasonable assurance.” The issuer must obtain “reasonable assurance” that the consumer has certified stand-alone coverage every year at renewal.

NV Exchange 2016 QHP Certification, slide 45: <http://1.usa.gov/1bQdrMC>

New Mexico:

Issuers on and off the Exchange will be required to notify potential policyholders, prior to sale, if a plan does not cover the required pediatric dental benefit. A memo to issuers describes “reasonable assurance” as the act of notifying the consumer of this fact.

OSI-suggested language for the notification: “This policy does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent or the New Mexico Health Insurance Exchange (www.mnhix.com) if you wish to purchase pediatric dental coverage or a stand-alone dental insurance product.”

7/7/13 NM OSI Memo: <http://bit.ly/QIAww9>

10/16/14 NM OSI Bulletin No. 2014-017: <http://bit.ly/1r2nBv4>

For PY 2016, carriers can sell pediatric dental plans outside of the Exchange. The plan must comply with the same requirements as a plan offered on the Exchange and receive the same approval status as other health plans. To differentiate between an Off-Exchange and On-Exchange pediatric dental plans, the On-Exchange plan receives the disposition (through SERFF) of “Approved-Certified” opposed to an “Approved” disposition for Off-Exchange plans.

OSI FAQs for PY 2016 QDP Submission: <http://bit.ly/1EldjuB>

For PY 2014, the NM Office of Superintendent of Insurance (OSI) recommended the following process for the creation of “exchange certified” SADPs:

- A. SADP Issuers should submit a pediatric-only stand-alone dental plan as part of exchange submissions, so that, once approved, it will be “exchange certified.”

- B. Then, SADP issuers should file amendments on existing stand-alone dental plans that are outside the exchange, substituting the exchange-certified pediatric dental module for the pediatric dental module in the existing plan. If the plan has no existing pediatric dental, it must be added to comply with the 2014 rules. When the amendment is approved, the entire plan will be considered “exchange certified.”

OSI FAQs for QDP Submission: <http://bit.ly/1qW0sbx>

New York:

An FAQ from the Department of Financial Services indicates issuers may ask questions on enrollment forms regarding pediatric dental benefits. The FAQ does not confirm by including any such questions, the issuer can be “reasonably assured.”

Question: For individual and small group comprehensive health insurance offered outside the Health Benefit Exchange, an issuer must be reasonably assured that an individual has obtained stand-alone dental coverage through an Exchange-certified stand-alone dental plan offered outside the Exchange in order for the issuer to provide coverage without the pediatric dental essential health benefit. May an issuer ask questions on the application to determine whether an individual has such coverage?

Answer: Yes. Issuers may place questions on the application/enrollment form in order to verify whether an individual has obtained stand-alone dental coverage through an Exchange-certified stand-alone dental plan offered outside the Exchange. Issuers should use the following language on their application/enrollment form:

A. Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified standalone dental plan offered outside the New York Health Benefit Exchange? Yes No

B. If you answered “yes”, please provide the name of the company issuing the standalone dental coverage. _____

If you answered “no”, we will provide you coverage of the pediatric dental essential health benefit.

NY DFS Dental Q&A: <http://on.ny.gov/1QVgRaU>

The New York Department of Financial Services (DFS) authorizes the issuance of Exchange-certified stand-alone dental plans off the Exchange. Carriers are instructed to file with the DFS policy forms that contain full model language and compliance with Exchange parameters.

Ohio:

According to an online Plan Management Toolkit from the ODI, “reasonable assurance could be obtained by requiring proof of coverage from the individual or establishing a method of confirming coverage directly with the dental issuer that is offering an Exchange certified Stand-Alone Dental Plan. The issuer is responsible for the method of obtaining assurance and demonstrating compliance.”

If an issuer would like to offer an “exchange certified” SADP off the Exchange, then the issuer must select the “off-Exchange” option in the dental-specific plan and benefits template.

ODI Plan Management Toolkit: <http://1.usa.gov/1m2NYCP>

Oregon:

In a memo to issuers, the Insurance Division reiterates “reasonable” assurance language used in the HHS Final EHB Rule and also notes that “an absence of reasonable assurance is not an exception to the ACA’s guaranteed issue requirements.”

OR Insurance Division memo: <http://bit.ly/1kXNvOh>

The OR Insurance Division noted in discussions that if a dental plan was not certified and offered on the Exchange, the plan cannot use the words “pediatric essential benefit” in its description. It is unclear if a disclosure (as seen in Colorado and other states) is required.

Rhode Island:

If the enrollee has already obtained the pediatric dental EHB, the health plan issuer must offer a medical policy without the pediatric dental EHB. This policy was determined prior to CMS guidance.

Small group policy check list: <http://1.usa.gov/1m2ffmx>

South Carolina:

Carriers offering comprehensive individual or small group health insurance plans outside of the Exchange may satisfy the reasonable assurance requirement by disclosing, in advance of the policy’s effective date, that the plan does not include the pediatric dental services. The disclosure will serve as reasonable assurance and should be conspicuous and note that such coverage is available through Exchange-certified coverage on or off the Exchange.

SC DOI guidance to carriers, May 2014

South Dakota:

Outside the exchange, medical carriers must have a "reasonable assurance" that dental is being provided by a qualified dental plan. The rule around reasonable assurance is "any reasonable method for obtaining reasonable assurance including an attestation on an insurance application or other documentation from the applicant or the applicant’s dental insurer."

39 SDR 203, 20:06:56:06. Pediatric dental, effective June 10, 2013.

Virginia:

Senate Bill 484, which was approved by the Governor and Chaptered on March 27, 2014, clarified that a health carrier will have obtained reasonable assurance if it prominently discloses the plan does not provide the pediatric dental benefits and if at least one qualified dental plan offers the benefits and is available for purchase by the small group or individual purchaser.

VA SB 484, an act to amend and reenact §38.2-3451: <http://bit.ly/1gwCwIA>

Washington:

In 2014, all health plans offered outside the Washington Health Benefit Exchange in the small group and individual markets were required to embed the pediatric dental benefits. For 2015 and future plan years, the Office of the Insurance Commissioner (OIC) approved new regulation to allow health carriers to offer non-embedded plans off the Exchange if there is reasonable assurance of other coverage, which is defined as “receipt of proof of coverage from the stand-alone dental plan and a signed attestation of coverage from the applicant.” Health carriers may issue coverage prior to receiving reasonable assurance if the issuer receives the assurance within sixty days of the effective date of the health benefit plan.

WAC 284-170-810: <http://1.usa.gov/1kjFTZW>

Wisconsin:

Issuers on and off the Exchange will be required to notify potential policyholders, prior to sale, if a plan does not cover the required pediatric dental benefit. A memo to issuers describes "reasonable assurance" as the act of notifying the consumer of this fact.

WI DOI Bulletin: <http://1.usa.gov/1lwT6Jn>

¹ From HHS Final Regulations on Essential Health Benefits (EHB): FR, Vol. 78, No. 37, Monday, February 25, 2013, Section k., 156.150, Pg 12853. "Comment: The statute and regulations provide that if an Exchange offers a stand-alone dental plan offering a pediatric dental EHB benefit, medical plans are not required to offer a pediatric dental plan benefit on that Exchange. Several commenters encouraged HHS to extend the ability of a medical insurance plan to not offer the pediatric dental EHB into the non- Exchange market, in cases where a stand-alone dental plan that meet the standards to cover the pediatric dental EHB is offered. Response: 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 a 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. This alternate method of compliance is at the option of the medical plan issuer, and would only apply with respect to individuals for whom the medical plan issuer is reasonably assured have obtained pediatric dental coverage through an Exchange-certified stand- alone dental plan. In addition, this option is only available for the pediatric dental EHB, and not for any other EHB, because of the unique treatment of stand-alone dental plans inside the Exchanges. With respect to other individuals seeking to enroll in the same plan, the issuer would be required to offer the same coverage generally (there would be no exception to guaranteed availability that would apply), but would have to make pediatric dental benefits available to such individuals." <http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf>