National Association of Dental Plans

April 17, 2014

Ms. Mary Ellen Breault, Life and Health Filings
Connecticut Department of Insurance
PO Box 816
Hartford, **CT** 06142-0816
Sent Via Email

Re: *Approval of Dental and Medical (Without Dental) Filings*

Dear Director Breault;

Thank you for your email on April 8 with regard to the Connecticut Insurance Department's (CID) policy with regard to approval of medical plans without pediatric dental (9.5 medical benefit plan) in Connecticut. You stated the CID would approve a 9.5 medical benefit plan on two conditions: Access Health CT (AHCT) certify a standalone dental plan (SADP) for offer on AHCT, and that a mechanism for compliance is in place. You further qualified the mechanism for compliance as ensuring enrollees purchase and maintain both benefits, i.e. 9.5 medical and a SADP.

NADP appreciates your clarification and believes AHCT has the capability of meeting both of your conditions. We wanted to provide you and AHCT some background on those capabilities from our perspective which we outline below.

CERTIFICATION OF SADP: As you know, AHCT has solicited letters of intent from dental carriers for certification to offer coverage on both the individual and SHOP marketplace for 2015. Last week, ACHT began weekly meetings with SADPs to work out the details of these offerings. Thus, it appears that your requirement for approval of SADPs is in process. However, the CID's policy review and approval of both SADPs and 9.5 medical benefit plans will need to take place before final AHCT certification of SADPs to allow appropriate filing of both SADPs and 9.5 medical products under the AHCT timeline for certification.

It is our understanding that the benefit structures for standard policies are to be presented to the ACHT Board for approval on April 30. To abide by the ACA and the AHCT authorizing statute, NADP is requesting ACHT staff develop a standard benefit structure for medical plans at each metal level without pediatric dental benefits, i.e. a 9.5 medical benefit plan. This action would meet the requirements of law and allow consumers freedom of choice

for the types of dental coverage they may prefer. This action will likely offer more provider options as well. Without allowing for a 9.5 plan design and certification of those plans, AHCT and CID would be violating the provisions of the ACA and implementing regulations.

As the AHCT requires a highly prescriptive dental plan design, only high (85%) AV dental policies are likely to be available in 2015, and those policies are expected to be chosen only by consumers whose children have higher cost dental needs such as medically necessary orthodontia. Those purchases would be made to take advantage of the low maximum consumer out-of-pocket limits and zero deductibles under the SADP coverage. As an insurance regulator you recognize that under these circumstances, SADPs would be subject to adverse selection.

- **NADP POSITION:** For Connecticut to be in compliance with the ACA[i], HHS Guidance[ii], and its own state Marketplace law[iii], CID and AHCT must allow medical carriers the opportunity to offer Qualified Health Plans (QHPs) without embedded pediatric dental benefits on Connecticut's Marketplace when SADP are certified to offer on the Exchange beginning in 2015.

AHCT MECHANISM FOR COMPLIANCE WITH EHB: NADP understands and appreciates your interest in assuring children have pediatric dental coverage. The HHS/CCIIO interpretation that SADPs were only an offer on exchanges, not a required purchase, surprised our industry as much as it did consumers and regulators. We appreciate Marketplaces, such as Kentucky, Nevada, and Washington that have stepped forward and acted affirmatively to assure that there is not adverse selection between the on and off exchange markets by requiring the purchase of pediatric dental for children on Exchanges.

REQUIRED PURCHASE: Kentucky, Nevada and Washington have not reported any significant issues with requiring purchase of pediatric dental coverage. Each Marketplace has applied their requirement only when children 0-18 are being covered. While enrollment has not been released from all of these states, what has been released indicates success in covering children.

- Kynect, Kentucky's Exchange, has made a decision to require the purchase of pediatric dental for children. Like AHCT, the state also utilizes Deloitte as a vendor. Currently, Kynect has QHP enrollment of 77k which is similar to Connecticut's 76k, but Kentucky also has an additional dental enrollment of 20k. They allow both dental benefit offerings, i.e. embedded in a medical plan or purchased via a standalone dental policy.
- While Nevada Health Link has experienced some technical issues during open enrollment, the Exchange has achieved 40k for QHP enrollment and an additional 20k for dental enrollment. This impressive dental statistic has been credited to a requirement that children enrolling in health coverage also have pediatric dental benefits, but also to the allowance of purchasing dental without the purchase of medical, similar to what is proposed by AHCT.

The percentage of children to overall enrollment in Nevada is significant as the data released for SBMs and FFMS at the end of February showed that only 6% of all consumers selecting policies in these marketplaces are in the age group 0-17 (251,156 of 4.2 million overall), and only 20% of individuals selecting coverage in FFM states purchased SADPs (544,075 of 2.6 million). The low percentage of children being covered in state and federal Marketplaces likely reflects referrals of

children to either Medicaid or CHIP where eligible. Given the fact that Connecticut's threshold for CHIP extends to 318% of poverty, only those children above that level would be selecting commercial coverage through AHCT. We would anticipate that the percentage of children doing so in AHCT would be lower than other states with thresholds around 250% of poverty.

- **NADP POSITION:** States cannot bar SADPs from offering compliant dental policies on their Marketplaces or require QHPs to embed pediatric dental when SADPs are offered. States can act under specific state authority or interpretations of the ACA to require purchase of the full essential health benefit package set by the ACA, either as a single medical plan offering all benefits or as a 9.5 medical plan in combination with a separate dental policy. When states take this action, NADP recommends requiring purchase in instances where the individuals being covered are in the 0 to 18 age group as other states have done.

MONITORING OF MAINTENANCE OF COVERAGE: While most states are requiring both medical and dental carriers to submit reports on coverage (both finalized with payment of premium, and coverage that has lapsed), NADP is not aware of any other mechanism states have in place for monitoring coverage. The requirement to keep coverage in place under the ACA as Minimum Essential Coverage, is enforced through the IRS.
We could find no authority in the AHCT authorizing statute and are not aware of any provision in the federal rules or guidelines that suggest states have this responsibility.

- **NADP POSITION:** Monitoring the maintenance of coverage is the responsibility of the IRS under the ACA, not that of individual states unless additional statutory authority has been enacted.

REASONABLE ASSURANCE IN THE SMALL GROUP AND INDIVIDUAL MARKET OUTSIDE AHCT: 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. 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 your state's exchange rules for coverage.

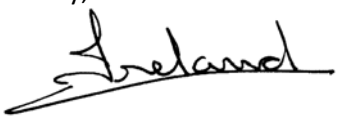
Ameritas and perhaps other carriers have contacted you to determine if Connecticut will offer any guidance on what medical carriers can accept as "reasonable assurance" in the small group and individual market outside of AHCT. Attached is a summary of other states' guidance. Where a state has not acted, individual medical carriers must set a guideline for themselves. Such a carrier by carrier approach can be confusing for consumers and small employers that encounter a variety of interpretations of this standard.

- **NADP POSITION:** Whatever form of "reasonable assurance" Connecticut accepts, NADP interprets the final Essential Health Benefit rules as requiring the approval of 9.5 medical plans without pediatric dental for sale in the small group and individual market *outside* of the Exchanges in the states. Without such approval, a medical carrier could not act within the authority granted by the rule to accept "reasonable assurance" with regard to the purchase of pediatric dental. Under federal rules, the responsibility for assurance that

consumers purchase pediatric dental where such a policy is offered is on the medical carrier[iv].

NADP looks forward to future discussions on the critical issues we addressed above. Please contact me with any questions regarding these comments at eireland@nadp.org or 972 458-6998x101. Thank you for your time and consideration.

Sincerely,



Evelyn F. Ireland, CAE
Executive Director, National Association of Dental Plans

cc: Kevin Counihan, Chief Executive Officer, AHCT
Virginia Lamb, Legal Counsel, AHCT
The Honorable Nancy Wyman, Chair, Board of Directors, AHCT
Anne Melissa Dowling, Board of Directors, AHCT

[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] Qualified dental plans shall be limited to dental and oral health benefits, without substantial duplication of the benefits typically offered by health benefit plans without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary pursuant to Section 1302(b)(1)(J) of the Affordable Care Act, and such other dental benefits as the exchange may specify or the Secretary may specify by regulation. (Public Act 11-53, Sec.8(e)(3))

(4) Health carriers may jointly offer a comprehensive plan through the exchange in which dental benefits are provided by a health carrier through a qualified dental plan and health benefits are provided by another health carrier through a qualified health plan, provided the plans are priced separately and are also made available for purchase separately at the same such prices.

[iv] 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

DATE: **APRIL 17, 2014**

TO: **ACCESS HEALTH CT (AHCT)**
CONNECTICUT INSURANCE DEPARTMENT (CID)

RE: **STATE INTERPRETATIONS OF REASONABLE ASSURANCE**

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, the 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 Rule[i] 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 onus of assuring the purchase of all ten Essential Health Benefits (EHB) is placed on the health plan issuer by the statute and this provision in the final rule.

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 equitable treatment guidance. Three general approaches have been taken in the states that have provided guidance:

Notification: The majority of 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 as to where and which dental and/or medical carrier they want to purchase their dental benefits through.

Attestation: Another approach allows for the medical issuer not to embed the dental as long as the consumer attests they have dental 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.

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 33 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:

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://www.insurance.arkansas.gov/Legal/Bulletins/12-2013.pdf

To become "exchange certified," SADP issuers must follow the Marketplace certification filing process. Requirements for Exchange Certification: http://bit.ly/1eF58Ph

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/11Cq02C

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/Mm7Fqi

***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 an issuer FAQ, the DOI noted it is the responsibility of issuers to be "reasonably assured" that an individual has obtained pediatric dental coverage through an Exchange-certified stand-alone dental plan. Issuers "will need to decide how they fulfill that responsibility in order to be found compliant with EHB requirements." The FAQ also notes that the DOI would accept disclosure language similar to that listed in Iowa and Wisconsin bulletins.

According to the same DOI FAQs, 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 DOI FAQ, Part 2: http://www.doi.idaho.gov/press/Idaho%20Exchange%20QandA%20Part%202.pdf

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://www.nadp.org/Libraries/GR_Documents/IA_Memo_re_SADP_4-26-13.sflb.ashx

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, 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/1p3pOtY

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."

http://www.michigan.gov/difs/0,5269,7-303-13648-293672--,00.html

***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.

Montana:

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.

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

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.

NM OSI Memo: http://bit.ly/QlAww9

The NM Office of Superintendent of Insurance (OSI) has 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/1qWOsbx

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://www.dfs.ny.gov/insurance/health/dent-file-g.pdf

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 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

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://oci.wi.gov/bulletin/0413peddental.htm

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[i] 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