Qualified Health Plan (QHP) Dental Frequently Asked Questions

QHP Dental Frequently Asked Questions (FAQs) # 1
Release Date: May 31, 2013

Stand-alone Dental Plans (SADPs)

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.

Q2: What parts of the Federally-facilitated Exchange certification application do stand-alone dental plan issuers complete?

A2: Issuers of stand-alone dental plans must complete all sections of the QHP application for stand-alone dental plans in the FFE, except for the pharmacy template, the accreditation template, and the unified rate review template. Issuers should use the dental plan and benefits template 1.32 or later in order to activate the modifications that are specific to stand-alone dental plans. More information on what parts of the application apply to stand-alone dental plans can be found in three documents: 1) a chart titled "Application requirements related to stand-alone dental plans" posted on Regtap on April 18, 2013; 2) the presentation "Stand-alone Dental Plans Applying for Certification in the FFE" posted on 05/02/13; and, 3) Chapter 4 of the Letter to Issuers (http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf).

Q3: What benefits are required to be included in stand-alone dental plans?

A3: In order to be certified, all stand-alone dental plans must cover the pediatric dental essential health benefits, as required in the Affordable Care Act. As outlined in section 156.150 of the EHB final rule, a stand-alone dental plan must offer the pediatric dental EHB but may offer additional benefits, which could include non-pediatric coverage. We note that only the pediatric dental benefit, and not any non-pediatric coverage, would be subject to EHB standards, including complying with the requirement to offer benefits that are substantially equal to the benchmark and meeting AV and out-of-pocket limit requirements for stand-alone dental plans. Stand-alone dental plans that are submitted without coverage of the pediatric dental EHB will not be certified. State-specific benchmarks for the pediatric dental benefit are listed in the EHB final rule.

We note that a stand-alone dental plan could enroll adults only in a family plan.

All of the templates for the certification application are the same for stand-alone dental plans as for QHPs, except for the modified plan and benefits template. These templates, including the dental plan and benefits template, are available on zONE and SERFF (http://www.serff.com/plan_management_data_templates.htm

Q4: How do rating tables and rating business rules apply to stand-alone dental plans?

A4: For the purposes of completing the application for certification of stand-alone dental plans in the FFE, stand-alone dental plans must complete the rates table and associated business rules table according to the rating rules. Stand-alone dental plans, as excepted benefits, have additional flexibility to adjust premiums based on other rating factors. The modified dental plan and benefits template will have a data field in which dental issuers will indicate whether they are committing to the rates in the template, and thereby voluntarily complying with the rating rules, or whether the issuer reserves the right to make further premium adjustments. The plan display will indicate to consumers whether the premium displayed for stand-alone dental plans is a guaranteed rate or an estimated rate. Please see pages 31-32 of the letter to issuers for additional information (http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf).

Q5: Do health plans outside of the Exchange need to cover the pediatric dental EHB? How would that work with stand-alone dental plans outside of the Exchange?

A5: The EHB final rule (78 FR 12834) stated the following with respect to coverage of pediatric dental EHB in the outside market: "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 noncompliant 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. HHS notes 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."

Q6: What if a stand-alone dental plan does not contract with any of the essential community providers listed on the dental ECP list, or contracts with the dentists at those facilities directly but not with the facility itself?

A6: Only facilities should be listed on the ECP template, not individual providers. If an issuer of a stand-alone dental plan does not believe the ECP standard can be met due to the limited number of dental-specific ECP providers, then the issuer should submit a narrative justification using the ECP Supplemental Response Form to describe why the standard cannot be met and how the existing network would provide access for low-income and medically underserved populations. If an issuer of a stand-alone dental plan contracts with ECP-like providers, but not the facilities listed on the list, then this should also be described in the ECP Supplemental Response Form. For the submission of the ECP template, please follow the instructions for entering "dummy data" on page 9 of the Chapter 7 Instructions for the Essential Community Providers Application section if you do not have any dental ECPs to submit. The Chapter 15 SADP Application Instructions also contains additional information.

Q7: If an issuer has not submitted a medical QHP application yet, can the issuer submit medical and stand-alone dental plan applications during the dental plan window?

A7: Applications for medical QHP were due to the FFM on May 3, 2013. The stand-alone dental submission window is available only for the submission of stand-alone dental plans. Issuers of QHPs who have already submitted QHP applications can use the stand-alone dental submission window to add information related to dental to their existing QHP applications where appropriate, but the addition of QHPs is not allowed. The document titled "Application requirements related to stand-alone dental plans" that was posted to Regtap on April 18, 2013 outlines how stand-alone dental plan information should be added to QHP applications that have already been submitted.

Q8: Because the windows overlap, what should issuers do if they are submitting changes for the Limited Correction Window but also want to add information to the existing QHP applications for stand-alone dental plans?

A8: Issuers that have received notification from CMS that they should make certain data corrections during the Limited Correction Window should make the changes and resubmit the complete QHP applications between May 20 – 22nd. After the QHP submissions are processed, the issuer should then proceed with the process of re-opening the applications to start adding information related to stand-alone dental plans. The application must then be resubmitted with all information for stand-alone dental plans by June 5th.

Q9: What are the constraints on stand-alone dental plans when filling out the rating tables?

A9: The rating tables should be filled out according to federal requirements and any applicable state law. As described in the FAQ released on May 10, 2013, because dental is an excepted benefit, issuers then have the option to indicate whether the release is "guaranteed" or "estimated" in the plan and benefits template. Please see page 31 of the Letter to Issuers for more detail on the estimated/guaranteed rate distinction.

Q10: Is the dental application window the same for issuers seeking certification for off-Exchange stand-alone dental plan products only?

A10: All applications for certification of stand-alone dental plans in states with a Federally-facilitated Marketplace must be submitted between May 20 and June 5, 2013.

Q11: Does a stand-alone dental plan have to use the Chapter 13m SADP Actuarial Value form?

A11: Issuers of stand-alone dental plans must provide documentation that the actuarial values submitted in the plan and benefits template were based on analyses conducted by a member of the American Academy of Actuaries and were performed in accordance with generally accepted actuarial principles and methodologies. The Chapter 13m contains the minimum information needed for certification and serves as a template for the actuarial value documentation, but issuers could provide alternate documentation that provides the same information.

Q12: To what extent should issuers of stand-alone dental plans enter information for adult dental benefits?

A12: For purposes of filling out the rating tables and plan and benefit template for off-Exchange plans, we recommend entering the rates and benefits as you intend to offer the plan, which could be as a child-only plan or as a family plan that includes adult coverage. The FFM will certify submitted plans based on whether they meet the minimum standards for certification for stand-alone dental plans, particularly the pediatric dental EHB. Because adult benefits are not considered EHB, there are no specific federal benefit and rate requirements. The amount of plan-level information included for such benefits is at the discretion of the issuer.

Q13: With respect to the Rates Template for QHP Application submission, how should stand-alone dental plans complete the tables for the pediatric under 19 rates? There appears to only be an option of 0-20 in the drop-down column for "Age".

A13: Stand-alone dental plans should enter their 0-18 rate in the 0-20 column of the rating tables. If the issuer chooses to indicate a guaranteed rate, the 0-18 rate will be the rate charged for 19 and 20-year olds as well. Note that the rates for 19 and 20 year olds can be averaged into the overall rate for that age band. In addition, there is no requirement to offer EHB coverage to individuals over 18 or the pediatric age set by your state, so while the rate will be encompassed in the age band the benefits can be different. Dental issuers may also identify the rates as 'estimated' and charge a different premium before the consumer effectuates enrollment. Please see page 31 of the Letter to Issuers for more detail on the estimated/guaranteed rate distinction.

Q14: The dental benefits in the Plan & Benefits template seem very general compared to the benchmark plan. How do I indicate that I cover other benefits or have more specific limits and do I need to enter these at a diagnostic code level?

A14: The pediatric dental EHB is determined by the benchmark plan selected by the state, not by the categories of benefits in the Plan & Benefits template. For the purposes of meeting EHB requirements, pursuant to 45 CFR 156.115(a)(1), the plan must offer benefits and limits that are substantially equal to the state's EHB benchmark plan. Although the categories of benefits may be broader than what is included in the benchmark plan, issuers should fill out the template in a manner that best represents the EHB covered by the plan. This does not need to be at a diagnostic code level. An issuer may add additional or more granular benefits and limits using the "Other" tab in the plan and benefits template.

Q15: What information needs to be provided for the EHB Apportionment field in the plan and benefits template for stand-alone dental plans?

A15: Issuers of stand-alone dental plans in the individual market should enter into the EHB Apportionment field the dollar amount that reflects the portion of the premium allocable to the pediatric dental essential health benefit. The dollar amount should reflect the statewide average amount for that plan. This number will be used to determine the amount of the advance payment of the premium tax credit under 45 CFR 155.340(e)(2). The issuer of the stand-alone dental plan also needs to submit the Chapter 13n Description of EHB Allocation form as a supporting document.

Q16: In the plan and benefits template, how should the maximums and deductibles be entered if they are different from adults and children as there is only one data field?

A16: Issuers should enter maximums and deductibles in the plan and benefits template that are specific to the pediatric dental EHB. There are no regulatory requirements related to the non-EHB adult dental benefits, and therefore, the information necessary for certification that the stand-alone dental plan meets the pediatric dental EHB standards is the information specific to the pediatric dental benefit. For purposes of plan compare, consumers can access additional information about adult benefits through the link to the plan brochure.