MEMORANDUM

To: Stand-Alone Dental Plans
From: Maryland Health Benefit Exchange
Date: March 14, 2013
Subject: Questions on Stand-Alone Dental Plans for Maryland Health Connection

Thank you for continuing to be engaged as the Maryland Health Benefit Exchange (MHBE) works with our partners to build Maryland Health Connection. As product filing deadlines approach, we would like to provide answers to questions that have been submitted about stand-alone dental plans. For questions not addressed in this memorandum, the MHBE will release additional information as it becomes available.

Product Filing Requirements

1. What stand-alone dental plans may be sold on Maryland Health Connection?
   • Carriers will be permitted to offer two types of stand-alone dental plans on Maryland Health Connection: (1) pediatric-only plans; and (2) family plans that include the pediatric essential health benefits.

2. What are the deadlines for filing rates and forms for approval to be used on Maryland Health Connection?
   • For stand-alone pediatric dental plans, both forms and premium rates are required to be filed for approval with the Maryland Insurance Administration on or before March 22, 2013.
   • For family stand-alone dental plans, both forms and premium rates are required to be filed for approval with the Maryland Insurance Administration on or before April 1, 2013.

3. Is there a requirement that a carrier offer a stand-alone dental plan on Maryland Health Connection if it offers a stand-alone dental plan on the commercial market?
   • No.

4. If a carrier offers a stand-alone dental plan on Maryland Health Connection, is there a requirement that the same plan be offered on the commercial market?
   • No.
5. Are stand-alone dental plan designs required to meet one of the metal levels (i.e. bronze, silver, gold, platinum) as described in the Affordable Care Act?

- No, but each plan design that is filed for approval for sale on Maryland Health Connection is required to be identified as "high" or "low." The "high" plans are required to meet an actuarial value of 85% and the "low" plans are required to meet an actuarial value of 70%. Federal regulations permit a de minimus variation of plus or minus 2%. The AV requirements apply only to the portion of the plan that covers pediatric dental benefits.

Maximum Number of Plans

6. How many stand-alone dental plan designs are allowed for each carrier?

- A maximum of 4 benefit designs per carrier will be allowed on the Individual Exchange.

- A maximum of 4 benefit designs per carrier will be allowed on the SHOP Exchange.

Filing Exemption

7. If a carrier plans to sell a stand-alone dental plan on the commercial market, but is not planning on selling on Maryland Health Connection, does the carrier need to apply for an exemption with the Maryland Insurance Administration, as described in § 15-1303 of the Insurance Article?

- No. Because a stand-alone dental plan does not meet the definition of "health benefit plan" in § 15-1301 of the Insurance Article, an exemption request is not required. The only carriers that are required to file an exemption request are those that intend to sell health benefit plans on the commercial market to individuals or small employers and who do not plan to sell on Maryland Health Connection.

Cost Sharing

8. Are there any benefits in the pediatric dental plans that are required to be covered with no cost-sharing requirements?

- Yes. All non-grandfathered health benefit plans are required to cover preventive health services with no cost-sharing on the part of the covered person. One covered preventive service for children that would appear to fall under the benefits covered by pediatric dental plans is the oral health risk assessment for young children as supported by the Health Resources and Services Administration. Therefore, to the extent the oral health risk assessment for children from birth to 10 years is covered, the contracts may not contain a cost-sharing amount for these services. See 45 CFR 147.130(a)(1)(iii), 75 FR 41740 and 75 FR 41753.
9. What are the out of pocket maximums for stand-alone dental plans offered in the exchange?

- For stand-alone pediatric dental plans, the out of pocket maximum for one covered child is $1,000 per year. For two or more covered children, the out of pocket maximum is $2,000 in aggregate per year. No lifetime limits are allowable for stand-alone pediatric dental plans.

- For stand-alone family dental plans, the adult portion of the dental plan is not considered an Essential Health Benefit therefore the requirements for out of pocket maximums or prohibition of lifetime limits will not apply.

Provider Networks

10. Do dental plans need to have Essential Community Providers (ECP) in networks?

- Yes. Dental plans offered on Maryland Health Connection need to demonstrate that they have an adequate number of ECPs in their network in order to be certified to sell products on Maryland Health Connection.

- Stand-alone dental carriers will be required to complete an Access Plan Template detailing standards used to ensure network adequacy and the inclusion of Essential Community Providers. Additionally, stand-alone dental carriers will also be required to submit provider directory data to CRISP and provide quarterly data on contracted providers as defined by the MHBE.

11. Must provider contracts be in place to illustrate network capacity or will “letters of intent” be sufficient?

- Only contracted providers will be considered for network adequacy requirements. Letters of intent will not be accepted.

12. Do stand-alone dental carriers need to provide a final Provider Directory report by the March 22, 2013 product filing deadline?

- No. The Access Plan Template must be completed and sent to the MHBE by April 1, 2013. The first provider directory data file will be required to be submitted to CRISP in the July timeframe. Carriers that have agreed to assist with the testing process will submit test provider data before July.