**State of New Hampshire Insurance Department**

**Dental Issuer Questions & Answers #2**

**June 13, 2014**

*This Q&A document contains information from the New Hampshire Insurance Department relating to the processes and policies for applying to offer dental coverage on the State Health Insurance Marketplace during the 2015 plan year.*

*Any additional questions should be directed to Michael Wilkey, Director of Compliance and Consumer Services, at* *Michael.Wilkey@ins.nh.gov**.*

**Q1. Stand-Alone Dental Plan Network Data Template**

**Must issuers of Stand-Alone Dental Plans (SADPs) submit the Network Data Template as part of the Qualified Dental Plan application?**

Answer: Yes, issuers of Stand-Alone Dental plans must include their Network Data Template in as part of the application.

**Q2. PPO and Premier Dentists**

**If an SADP issuer is filing tiered PPO plans, must these issuers list providers from both tiers in their Network Data Template?**

Answer: Yes, issuers need to list providers in all tiers in the Network Data Template.

**Q3. Accepting New Patients**

**Can issuers fill in the “Accepting New Patients” column in the Network Data Template with a “yes” until they are specifically instructed to the contrary from dentists?**

Answer: All information provided in the Network Data Template, including the “Accepting New Patients” column, must be current and accurate to the best knowledge of the issuers at the time of filing.

**Q4. SADPs and Essential Community Providers (ECPs)**

**If a SADP does not contract with ECPs directly, but may have participating agreements with individual dentists who perform services at ECPs, should the issuers identify participating dentists who perform services at ECPs under the ECP column? If so, which category do we use in the ECP category column?**

Answer: Yes, issuers should identify those dentists who perform services at Essential Community Provider (ECP) locations and may designate those providers as ECPs. When selecting the specific ECP category for these dental providers, select from the drop-down in the ECP column to select the category of ECP in which the services are provided.

**Q5. CMS Network Adequacy Template**

**When will CMS be updating and issuing their instructions for the Network Adequacy Template?**

Answer: The Network Adequacy Templates have been released by CMS; updated versions and instructions for using these templates may be found at the following link: <http://www.serff.com/plan_management_data_templates_2015.htm>

**Q6. “Same plan”**

**Does the New Hampshire Insurance Department know when the final regulations will be issued to address the "same plan" issues?**

Answer: The final regulations were released on May 16, 2014, and can be accessed at the following link: <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/508-CMS-9949-F-OFR-Version-5-16-14.pdf>.

**Q7. Pediatric Only Plans**

**Does the Small Business Health Options Program (SHOP) support pediatric only plans? If not, should issuers be filing pediatric high and low plans for SHOP? Will this have an impact on individual plans?**

Answer: Federally-Facilitated Small Business Health Options Program (FF-SHOP) and State Partnership Small Business Health Options Program (SP-SHOP) will not support child-only SADPs. SADP enrollment groups must match corresponding SHOP QHP enrollment groups, which must include an employee; thus only plans which include an adult (employee) will display.

**Q8. Pediatric Employee**

**Can an 18 year old (pediatric) employee purchase and be covered by a family plan with the pediatric benefits?**

Answer: For SHOP, 18 year old employees will be able to purchase plans available to employer groups the same as all other employees in the employer group. Age of employee does not change the plans available for employees.

**Q9. Pediatric Employee – Individual Market**

**Can an 18 year old (pediatric) employee purchase and be covered by a family plan with the pediatric benefits? If so, would an issuer eliminate pediatric only for the individual market, or can an issuer eliminate pediatric only from the individual market, if an 18 year old (pediatric) consumer can purchase a family plan?**

Answer: In the individual market, there are no employees. An 18 year old single subscriber in the individual market has available plans designated “Allows Child-Only” or “Allows Adult and Child-Only” on the Plan and Benefits template. Married couples under age 21, or an individual under age 21 and enrolling with their own child will see only plans designated “Allows Adult and Child-Only” on the Plans and Benefits template.

**Q10. Pediatric Employee – Small Group Market**

**Can an 18 year old (pediatric) employee purchase and be covered by a family plan with the pediatric benefits? If so, does this impair an issuers ability to file pediatric only plans for small groups off the exchange that are submitted with binders for "exchange certification"?**

Answer: See response to Question 9 above—same response applies.

**Q11. Family Rating for SHOP**

**Is there no family rating for SHOP, or simply age banding and per member build-up rate (except no more than 3 in the 0-20 age band)? Does this have any impact on the family rating for individuals (family and pediatric only)?**

Answer: For SHOP, only age-banded rates are accommodated. No tiered rates can be accommodated. Rates must be guaranteed (including rates through age 20) and no more than 3 under-age 21 dependents will be included in the family rate.

**Q12. Business Rules Template**

**Is the Business Rules template expected to be used for both SHOP and individual? If so, is it not the case that the business rules are different for both?**

Answer: The Rating Business Rules template must be submitted for both individual and SHOP plans. The Rating Business Rules template allows issuers to describe the rating business rules for each plan submitted in an application. Please review instructions for this template at the following link: <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Chapter-13-Business-Rules-Template-Instructions-05192014.pdf>

**Q13. Template Updates for Future Changes**

**If an issuer completes the template based upon the present network as of a current date, is the template to be updated in the future for changes?**

Answer: The Insurance Department recognizes that issuer networks continually evolve, and thus issuers will not be required to provide an updated Network Data template each time a provider contract changes. The department will, however, continue to monitor the market conduct of issuers throughout each plan year, including any concerns about the adequacy of issuer networks, and may request an updated network access template during the course of the plan year.

**Q14. Providers from Contiguous States**

**Is it mandated that SADPs include the providers from contiguous states from which an issuer may draw enrollees?**

Answer: All providers available to enrollees in the issuer’s service area must be listed in the Network Data Template. These include providers within New Hampshire as well as providers with locations in contiguous states if available. The Network Data template allows issuers to enter the state in which a provider is located.

**Q15. Providers with Multiple Locations**

**The instructions relative to providers with multiple locations states: "If a provider has multiple locations with the same name, each unique provider address should be added to the template as a separate record by appending the provider name with a unique three-digit number for each location, such as Provider-001."   This being the case, should an issuer add the three-digit number to the last name of the individual provider, or is that only necessary for facilities, not individual providers?**

Answer: If an individual provider offers services in multiple locations, that provider name should include an appended with a unique three-digit number for each location at which the provider delivers services.

**Q16. Pediatric Only on FFM-SHOP Exchange**

**Since the limitation for pediatric only plans on the Federally-Facilitated Marketplace Small Business Health Options Program (FFM-SHOP) exchange appears to be a functionality issue, should issuers expect to file pediatric only (exchange certified) for Off the exchange?**

Answer: See response to Question 7 above-same response applies.

**Q17. Networks within Networks**

**Can an issuer construct a two tier network dental product? Can an issuer advertise and sell a “network within a network”?**

Answer: In order for the Department to accept a dual network plan, three criteria must be met:

1) Fixed Maximum Allowable Amount: The differences in reimbursement between the two networks in a dual network plan are to be a function of a fixed, maximum allowable amount. This would create transparency to the consumer as the amount of cost share may be determined, at the network level, in advance of services being rendered.  A consumer could call an issuer and get the rate of reimbursement for the service as a fixed amount.  The difference cannot be based on the provider's charge, unless the provider's charge is less than the fixed, maximum allowable amount.

2)   Covered Services after maximum is met: Covered Services performed after an individual or family maximum under a benefits plan has been met must follow the same maximum allowable charge negotiated between an issuer and the provider.  Meeting a plan maximum does not cause the member to lose his or her rights under a network arrangement.  A provider can bill the patient for the maximum allowable amount for a covered service less any amount payable by the issuer.

3)   Provider Agreements: Provider charges for services provided under a network arrangement will be limited to the maximum allowable amount for members as set forth for services agreed to under the provider agreement between the issuer and the participating provider. For non-covered services for which an issuer has not established a maximum allowable amount (an example of such a service may be a cosmetic procedure that is not considered necessary treatment), a provider may bill at the provider’s standard rate provided there is full disclosure by the provider to the consumer with agreement that the individual is responsible for the cost of those non-covered services.   The consumer is to be held harmless for the cost of non-covered services in the absence of the appropriate disclosure.

**Q18. SADP ECP Tool and User Guides**

**Will CMS be releasing an Essential Community Provider (ECP) tool for Stand-alone Dental Plans (SADPs) with a step-by-step user guide for the review tools?**

Answer: Yes, the Centers for Medicare & Medicaid Services (CMS) has released an updated version of the Qualified Health Plan (QHP) Application Review Tools for the 2015 plan year. The latest version includes a new ECP Tool for SADPs. CMS has also released a step-by-step user guide with screen shots to assist with the 2015 QHP Application Review Tools.

The tool and user guide will be posted on the National Association of Insurance Commissioners (NAIC) SERFF website soon.