VENDOR INQUIRY RESPONSES: DENTAL v2.0

Note: Version 2.0 includes responses to questions received by Covered California by or before 3/18/2013.

#	Inquiry Category	Bidder Inquiry	Exchange Response to Inquiry
D026	Benefits & Plan Design	For the Child-only policy, who will be the policyholder?	The policy holder is the individual who bares financial responsibility for the plan. Therefore, the policy holder would be the parent or legal guardian of the child who has purchased the insurance on behalf the child.
D036	Benefits & Plan Design	We recommend a leaner DHMO plan design that is more affordable, less prone to adverse selection, yet still a substantive benefit more likely to find a following with adults in Covered California. This plan is also a group based plan, so it covers more procedures than many individual plans out in the market today and still represents an improvement over many current options. • This plan has a $5 office visit and higher copayments. • It is priced around $10 to $19 less per month than the current proposed plan. The estimated group-based totally voluntary 1-party rate for this leaner plan ranges from about $12/month in metro regions to a high of about $41/month in the rural regions. (For the individual market, additional cost factors will increase the rates further, including risk will need to be factored, taxes, and user fees, and etc.) • It covers more procedure codes than the current proposed plan, and topical application of fluoride codes are covered for all ages. • The plans codes are current CDT-13 codes • This plan encourages network stability because providers like the higher copayment plans for obvious reasons.	Please see the updated Attachment 16 - Supplemental Benefit Plan Design.
D045	Benefits & Plan Design	Does the EHB plan include all of the procedure codes that are covered on the Healthy Families plan? Will Cover California be providing the ADA procedure codes for each covered procedure under the plan?	The Pediatric Dental EHB Plan is based on the structure and procedure codes covered by the California Healthy Families plan. The California Healthy Families Dental Scope of Benefits for Subscriber Children is in the California Code of Regulations (CCR) Title 10, Chapter 5.6, Article 3, Section 2699.6709 and the Share of Cost for Dental Benefits for Subscriber Children is in CCR Title 10, Chapter 5.8, Article 3, Section 2699.6715.
D050	Benefits & Plan Design	Should implants be covered under the PPO, but not the DMO as the plans states on the supplemental plan?	Please see the updated Attachment 16 - Supplemental Benefit Plan Design.
D051	Benefits & Plan Design	Can you please confirm the A/V levels for the Pediatric dental benefit also apply to the Supplemental dental benefit offerings? Are carriers required to offer both AV levels or can they submit one or the other AV level?	The Actuarial Value levels for the Pediatric Dental EHB Plan do not apply to the Supplemental Dental Benefit Plan Design. For Pediatric EHB, carriers are required to propose plans that meet both A/V levels. For Supplemental Dental benefits, please see the updated Attachment 16 - Supplemental Benefit Plan Design.

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D054	Employer	We request clarification about the degree of plan standardization proposed for Supplemental Benefits within Attachment 16 For the supplemental benefit specifically, we believe flexibility is critical, as the adult supplemental dental market is quite unproven, and highly vulnerable to adverse selection. Bear in mind, these supplemental benefits fall outside the scope of Affordable Care Act (ACA) requirements (e.g., the AV levels of 85%/75% do not apply), giving the Exchange an opportunity to allow dental carriers to innovate, test and provide competitive options. Consumers should be allowed to compare and choose based on their interests, needs and cost tolerance.	Please see the updated Attachment 16 - Supplemental Benefit Plan Design.
D055	Employer	Even if Covered California is wedded to standardization for supplemental benefits, our recommendation is that the Exchange look towards a less expensive plan design more typical of what is found today in the current marketplace, and without the suggested AV levels of 85%/75%. Affordability is our biggest concern. The following points regarding Attachment 16 summarizes why we view that this proposed DHMO plan is not the plan of choice: • This plan is a rich “no copayment” plan developed for group business. It has low cost sharing and rich benefits, meaning it will be prohibitively expensive for the individual, totally voluntary market. With the higher cost comes higher risk of adverse selection, which in turn fuels a higher cost; • The estimated group-based totally voluntary 1-party rate for this plan ranges from $22/month in metro regions to a high of about $60/month in the rural regions. (For the individual market, additional cost factors will increase the rates further, including risk factors, taxes, user fees, and etc.) • The plan codes are not current CDT-2013 codes • We fear that providers will resist this plan design, leading fewer to participate. Many codes are covered at “no cost”, so the more patients on this plan, the less compensation for dentists.	Please see the updated Attachment 16 - Supplemental Benefit Plan Design.

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D056	Employer	Delta Dental recommends that Covered California allow flexibility and competition between certified dental plans for the supplemental adult dental product, but at the very least, consider a more modest, more affordable plan design should the decision to standardize adult supplemental stand.	Please see the updated Attachment 16 - Supplemental Benefit Plan Design.
D064	Benefits & Plan Design	Page 12 (also applies to Attachments 9 and 10): Under Plan Network Design Issues and on the noted Attachments, it appears the required actuarial values must be met for supplemental plans. Actuarial value is a requirement of essential health benefits. Supplemental benefits are not essential health benefits. It is suggested that issuers be permitted greater flexibility on actuarial value when designing non-essential benefits. Further, because Adult or Supplemental benefits are not a part of the EHBs, the prohibition on annual and lifetime maximums and imposition of cost-sharing limits (such as out-of-pocket accumulators) should not apply to that coverage.	Please see the updated Attachment 16 - Supplemental Benefit Plan Design.
D073	Benefits & Plan Design	Would the optional adult benefits include Orthodontic benefits as well? If so, what type and with what deductibles or co-payments at various metal levels of benefits?	Please see the updated Attachment 16 - Supplemental Benefit Plan Design. Carriers are to provide rates for plans with and without Orthodontia (optional) benefits.
D076	Benefits & Plan Design	Attachment 16 – Proposed Supplemental Benefit Plan Design Please confirm the dependent age limit for both individual and small group. Specific to orthodontic coverage: Please clarify that orthodontics coverage applies to child only. Please confirm that the dependent age is equal to the pediatric age limit.	Dependent age is not equal to the pediatric age limit. The Exchange defines dependent children up to age 26. Pediatric dental coverage, including medically-necessary orthodontia, is defined for individuals up to age 19. Supplemental Dental Benefit Plans that include Orthodontia provide coverage for dependents up to age 26.
D077	Employer	The solicitation indicates credit cards being accepted and displayed in carrier's provider agreements. This is not commonly collected by dental plans. Is there a regulatory basis for this request?	The Exchange requests carriers to indicate if the providers in their network accept credit cards. This indicator is aligned with the Exchange's goal to gather information about the quality, accessibility, and affordability of care.
D082	Employer	Attachment 10 – Premiums SHOP What is the definition for child in this rating method? Is a child over age 19 defined as a child? If so, would a subscriber, spouse and an adult child age 24, be rated as 2 adults+ 1 child?	Please see the answer to Question D076.
D098	Benefits & Plan Design	We request additional clarification section D on the procedures by class. Specifically, we would like to know which ADA codes are part of Class I, II, III, IV, etc.	Please see the updated Attachment 16 - Supplemental Benefit Plan Design.

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D120	Exchange Admin	Page 11: What are the "uniform disclosure (summary of benefits and coverage)", "basic health services" and "independent medical review" referenced in the Definition of Good Standing Checklist as it would relate to issuers that are licensed under the CA Insurance Code (i.e. disability insurers that are not licensed under the Knox-Keene Health Care Service Plan Act of 1975).	The Exchange uses definition of good standing specifications form the California Department of Managed Care (http://www.dmhc.ca.gov/) and the California Department of Insurance (http://www.insurance.ca.gov/).
D131	Employer	Attachment 14 – Additional Questions and Requirements #10: Please clarify the last sentence, "In addition the Exchange will retain the right to communicate with Exchange customers and members." Does this mean that issuers will not be able to reach out to prospects or customers/members directly, but only in conjunction or coordinated with HBEX marketing and outreach efforts?	Both the Exchange and Issuers may coordinate outreach and communication activities to customers and members independently. Communication with members is not exclusive to the Exchange.
D138	Employer	Attachment 11 – Technical Specifications # 20: How is "clean eligibility data" defined and at what point are ID cards considered "distributed"? For example, when they are batched for mailing; when they are postmarked; when they are actually in the mail? What if the 48 hours falls during a holiday, weekend or non-business hours when mail services are not available?	The Exchange considers "clean eligibility data" to be information that is complete (not missing required data fields), able to processed (indicates for what coverage patient is eligible), and does not yield duplicate values or results. ID cards are considered "distributed" when they are postmarked. 48 hours is considered two business days.
D156	Benefits & Plan Design	On page 17 of the Attachment 16 guidance, it lists "There is a 6-month waiting period for services for which there is no member copayment (some fillings)." Is that accurate? Typically there are no waiting periods for DHMO plans. This would require a plan that typically offers $0 copayment exams and cleanings, to put a 6 month wait on those services. We can quote this, but it could end up being detrimental to people getting preventive and diagnostic services that typically have no waiting periods. On the document it lists two columns for the Individual benefits that state: Employer-Sponsored and Voluntary. I am assuming you just want one column for the individual exchange since essentially, it is all voluntary.	Attachment 16 has been updated and the referenced line has been removed as there are no waiting periods for DHMO. Additionally, there should only be one column and one list of co-payments for Individual DHMO Benefits. Please refer to the latest version of Attachment 16 - Supplemental Benefit Plan Design.