

New York State Department of Financial Services

Instructions for the Submission of New York State of Health (NYSOH)- Certified Individual and Small Business Stand-alone Dental Plans offered Inside and Outside of NYSOH

These instructions are to be used for the submission of the 2017 premium rates for stand-alone dental plans to be sold through the NYSOH as well as NYSOH-Certified plans to be sold outside the NYSOH. This applies to stand-alone dental which may be pediatric dental only or a family dental plan covering both pediatric dental and adult dental.

The filing type codes “Exchange Forms & Rates” and “Off Exchange NG Forms & Rates” must be used with new form and rate filings for stand-alone dental products to be sold on or off the Health Plan Marketplace. A Type of Insurance code of Dental should be used.

Items changed for 2017:

- **Enrollment Data required for 2015 and first quarter 2016**
- **2017 PPACA Health Insurer Fee moratorium**
- **Pediatric Dental Essential Health Benefits updated (aligned with model language; Oral Surgery added)**

Filing Instructions:

1. Issuers must offer a Standard Pediatric Dental Plan inside NYSOH. This product must be offered in the issuer's entire service area and must include the benefits outlined in Attachment A.
2. Issuers may offer at most two optional non-standard dental products inside NYSOH. The non-standard products may, for example, be a family dental and a second pediatric dental product. The pediatric component of a family dental benefit must include at least the same pediatric benefits as outlined in Attachment A.
3. The standard pediatric dental product may be offered at either a high level (85% actuarial value) or a low level (70% actuarial value), but not both. Actuarial value compares the cost of a plan after cost-sharing is taken into account against the same plan assuming 100% payment for all covered dental services.

Please note that the HHS AV Calculator cannot be used to determine the dental actuarial value. The actuary will need to develop a dental model to determine the actuarial value of the proposed pediatric dental plans. The dental model must use the same standard population to evaluate all the pediatric dental plans. For a network dental plan only in-network charges are counted toward the development of the actuarial value.

4. For stand-alone dental plans offered inside NYSOH that provide coverage for adult benefits, the issuer must cover children to age 26 or age 30. The pediatric only dental plan must provide coverage through the end of the month in which the member turns 19.
5. Stand-alone dental issuers must use the standardized rating regions (those specified in the “Invitation to Participate in the NY State of Health, The Official Health Plan

Marketplace”)

6. Under 45 CFR 155.1065 (a)(2), the pediatric dental EHB offered by stand-alone dental plans must be offered without annual and lifetime limits. Annual and lifetime limits may be used for benefits in addition to the pediatric dental essential health benefits and for adult dental benefits.

Under 45 CFR 156.150(a), stand-alone dental plans offered inside an Exchange will be required to have a reasonable annual limit on pediatric dental EHB cost sharing. A pediatric dental EHB cost sharing annual limit at or below \$350 for a plan with one child enrollee or \$700 for a plan with two or more child enrollees is considered reasonable and no higher limit will be approved.

7. The standard rating tier and child-only factors applicable to the medical QHP do not apply to stand-alone dental plans. However, any stand-alone dental plan that offers adult coverage must offer a four tier rating structure of Individual, Individual and Spouse, Parent + Children and Family.
8. Rolling rates may not be used for Individual NYSOH-Certified plans but quarterly rolling rates may be used for Small Business NYSOH-Certified plans.
9. **The ACA Health Insurer Fee has been suspended for 2017. As such, this fee must not be reflected in 2017 Individual rates. With regard to Small Group, this fee may be reflected to the extent that policies written or renewed in 2017 roll into 2018 and to the extent that such amounts have not already been collected on the similar portion of business associated with policies written or renewed in 2016 that rolled into 2017.**
10. Attachment B, General Rate Filing Guidelines, lists the information to be included in the actuarial memorandum such as description and justification for the derivation of rates, the methods and the assumptions used, and the underlying experience data (including the source of that data).

In addition, the following is to be included in the actuarial memorandum:

- A discussion of the model used to develop the actuarial value and documentation showing the development of the actuarial value for the pediatric EHB part of any stand-alone dental plan. In the derivation of the AV, show the claim cost used for each service classification such as basic services, prevention and diagnostic, etc.
 - Supporting justification for the proposed area factors;
 - Actuarial justification for the proposed rating tier structure.
 - In a separate exhibit provided by DFS, submit enrollment data for the 2015 NYSOH-Certified plans including
 - Incurred claims paid through 3/31/16
 - Earned premium
 - Member months
 - This data should be provided separately by HIOS Standard Component ID sold inside or outside NYSOH
 - In a second separate exhibit provided by DFS, give the same (estimated) enrollment data for 2016 NYSOH-Certified plans for the First Quarter of 2016.
11. The completion of HHS’s Unified Rate Review Template is not required for stand-alone dental.

12. The stand-alone dental plan must be submitted as a separate policy, certificate or contract of insurance plan from the medical plans.
13. All filings must include an Actuarial Memorandum, an Actuarial Certification, and the Rate Manual. The information to be included in the Actuarial Memorandum, Actuarial Certification, and the Rate Manual are listed in Attachment B.

Appendix A – Pediatric Dental Essential Health Benefits

SERVICE	LIMIT
Emergency Dental Care	Includes emergency dental treatment required to alleviate pain and suffering caused by dental disease and trauma.
Preventive Dental Care	Includes procedures which help prevent oral disease from occurring, including: Prophylaxis: scaling and polishing teeth at 6 month intervals. Topical fluoride application at 6 month intervals where local water supply is not fluoridated. Sealants on unrestored permanent molar teeth. Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.
Routine Dental Care	Dental examinations, visits and consultations covered once within 6 month consecutive period (when primary teeth erupt). X-ray, full mouth or panoramic x-rays at 36 month intervals, bitewing x-rays at 6 month intervals, and other x-rays if Medically Necessary (once primary teeth erupt). Procedures for simple extractions and other routine dental surgery not requiring hospitalization including preoperative care and postoperative care. In office conscious sedation. Amalgam, composite restorations and stainless steel crowns. Other restorative materials appropriate for children.
Endodontics	Routine endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where hospitalization is not required.
Periodontics	Limited periodontic services. Non-surgical periodontic services. Periodontic surgical services necessary for treatment related to hormonal disturbances, drug therapy, or congenital defects. Periodontic services, including periodontic services in anticipation of, or leading to covered orthodontics.
Prosthodontics	Removable complete or partial dentures for Members 15 years of age and above, including six months follow-up care. Additional services include insertion of identification slips, repairs, relines and rebases and treatment of cleft palate. Interim prosthesis for Members 5 to 15 years of age. Fixed bridges are not covered unless: (1) Required for replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth; (2) Required for cleft-palate stabilization; (3) Required, as demonstrated by medical documentation, due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis.
Oral Surgery	Non-routine oral surgery, such as partial and complete bony extractions, tooth re-implantation, tooth transplantation, surgical access of an unerupted tooth, mobilization of erupted or malpositioned tooth to aid eruption, and placement of device to facilitate eruption of an impacted tooth.
Orthodontics	Includes procedures which help to restore oral structures to health and function and to treat serious medical conditions such as cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias Procedures include but are not limited to: Rapid Palatal Expansion (RPE) Placement of component parts (e.g. brackets, bands) Interceptive orthodontic treatment Comprehensive orthodontic treatment (during which orthodontic appliances have been placed for active treatment and periodically adjusted) Removable appliance therapy Orthodontic retention (removal of appliances, construction and placement of retainers)

Appendix B – General Rate Filing Guidelines

- A. General Information (to be included in the rate manual)
- a. Table of contents;
 - b. The name of the insurer and the policy form number on each rate manual page, or endorsement to which the rates apply;
 - c. An outline of the essential benefits, coverages, limitations and exclusions to which the rates apply;
 - d. A schedule of premium rates or formulas;
 - e. A description of the counties included in each region, in which the company plans to market the Marketplace products;
 - f. A schedule of commissions and fees, if payable;
 - g. A sample premium calculation;
 - h. The expected loss ratio and the breakdown of the non-claim expenses.
- B. Actuarial Memorandum
- a. The scope and purpose of the filing;
 - b. A brief description of benefits and cost sharing;
 - c. Detailed description and justification of the derivation of rates, including reference to relevant information used in the development of such justification, the methods and assumptions used, the underlying experience data and modifications made thereto. **The data should include the net claim cost for each type of service and the total net claim cost for all services combined;**
 - d. The trend factor and actuarial justification of the trend factor;
 - e. The breakdown of the non-claims expense component into administrative expenses, premium tax, commissions, profit and risk margin, etc.
 - f. The expected loss ratio and a demonstration that the applicable minimum loss ratio (11 NYCRR 52.45) will be met.
- C. Actuarial Certification
- a. The filing is in compliance with all applicable laws and regulations of the State of New York;
 - b. The filing is in compliance with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans” as adopted by the Actuarial Standards Board;
 - c. The expected loss ratio meets the minimum requirements of the State of New York;
 - d. The benefits are reasonable in relation to the premiums charged;
 - e. The rates are not unfairly discriminatory.
 - f. Actuarial qualifications:
 - (i) Member of Society of Actuaries or member of the American Academy of Actuaries; and
 - (ii) Meets the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries