Small Group Standalone Dental

Disability Carriers Workshop

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OFFICE of the
INSURANCE
COMMISSIONER
WASHINGTON STATE

Workshop Objectives

- Provide a brief overview of requirements applied to small group stand-alone dental plans.
- Provide direction regarding implementation plan.
- The information in this presentation also applies small group stand-alone vision plans.

Overview

1. Background information
2. Changes for Disability carriers
3. Rate filing requirements
4. Rate filing examples
5. Forms
6. Network
7. Implementation

Background Information

How did disability small group stand-alone dental or vision plans get here?

- RCW 48.43.733 required OIC to amend existing rules so filing processes and review standards for Disability carriers are identical to existing Health Care Service Contractor (HCSC).
  - This means Disability carriers must now follow the same standards that HCSCs have been required to follow, which includes some changes in how and when to file rates and forms.

Disability Carrier Changes

Before and After RCW 48.43.733

"Prior approval" or "File-and-use"

	Before	After
Form Filings	***"Prior approval"*** per RCW 48.18.100	***"File-and-use"*** per RCW 48.43.733(1), which states "contract form or rate must be filed before the contract form is offered for sale to the public and before the rate schedule is used."
Rate Filings	***"File-and-use"*** per RCW 48.19.010(2).	

Rating Requirements

	Before	After
Rate Filings	*Rates subject to* ***WAC 284-60***	*Rates subject to* ***WAC 284-43 Subchapters I and J*** *(same as HCSCs)*

Small and Large Group Requirements

	Before	After
Rate Filings	• WAC 284-60 does not define "small group." • Issuers could file **combined** small and large group dental plans in one pooled rate filing under WAC 284-60.	• RCW 48.43.733(1), WAC 284-43-6100 and WAC 284-43-6520(8) prohibit issuers from negotiating small group dental rates and forms. • Must file small group stand-alone dental plan rates **separate** from large group.

What does “prohibit negotiation” mean?

Do’s	• When rates are filed before use via small group rate filing, every variation of premium is documented in that filing. • The exact premium amount for every small group stand-alone dental plan is determined by the small group rate filing (to the penny). • All small group stand-alone dental plans must be filed with OIC prior to being offered for sale.
Don’ts	• Actual company rating practice cannot deviate from the filed small group rate filing. • Carriers, regardless of licensure, cannot negotiate small group stand-alone dental or vision plans.

Small Group Standalone Dental

Rating Details

Important Citations and Definitions

- WAC 284-43 Subchapters I and J.
- Definitions
  - ***Small Group***
    - The definition of “small group” in WAC 284-43-6020(40) refers to the definition in RCW 48.43.005(33) and it states “small groups” are groups “that employed an average of at least one but no more than fifty employees during the previous calendar year.”
  - ***Plan***
    - A “plan” means a “contract” [WAC 284-43-6020 (11) and (29)]
  - ***Base Rate***
    - "Base rate" means the "premium" for a specific "plan," expressed as a monthly amount per "covered person or subscriber," prior to any adjustments for geographic area, age, family size, wellness activities, tenure, or any other factors as may be allowed. [WAC 284-43-6020(4)]

Important Rating Requirements

- WAC 284-43-6100: The experience of all small group plans must be pooled. Filings for small group plans must include ***base rates*** and annual base rate changes in dollar and percentage amounts for **each** small group ***plan***.
- WAC 284-43-6100 (1) through (6) require detailed documentation and justification for small group stand-alone dental pool rate filing.

Base Rate Adjustments

What are the allowable factors for adjustment of base rates?

- WAC 284-43-6100(5), issuers must provide experience data, assumptions, justifications, and methodology of descriptions.
    - Description of the methodology used to adjust the base rate to obtain the premium rate for a specific individual or group must be detailed enough to allow the commissioner to replicate the calculation of premium rates if given the necessary data.
- WAC 284-43-6100(5)(a): Allowable factors include geographic region, age, family size, tenure discounts, and wellness activities.
- WAC 284-43-6100(5)(b): Any other factors that are justified.

Base Rate Adjustments

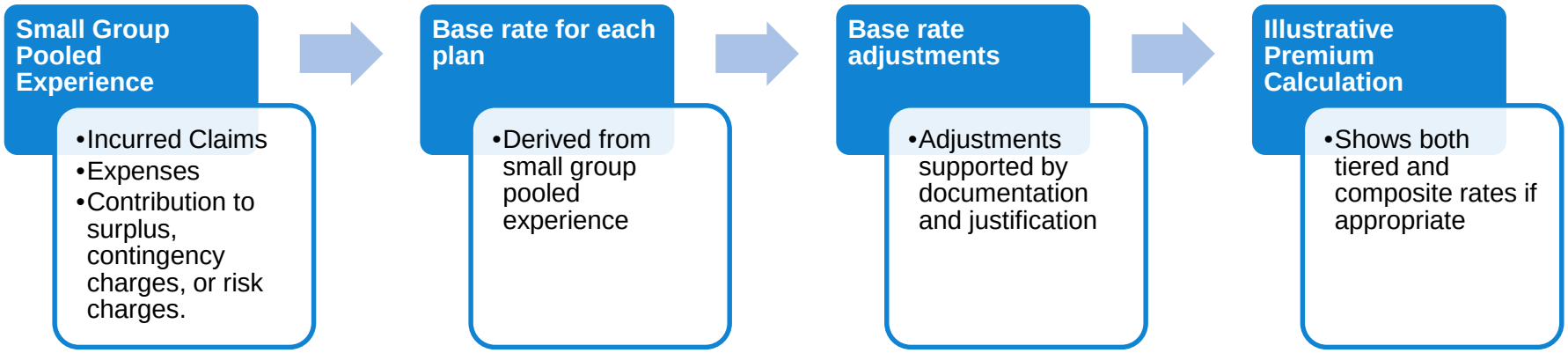
Commonly asked questions:

- Can small group dental rates vary by Industry factors?
  - Yes, provided that the factors are justified.
- Can small group dental rates vary by the size of the group?
  - Maybe.
- Can small group dental rates vary by the commissions?
  - No.

Small Group Stand-Alone Dental

Illustrative Rating Exhibits

High Level Rate Exhibit Flowchart Example



Base Rates Exhibit Example

Dental Plan	Base Rate
Excellent Dental Care Plan A	$40.34
Excellent Dental Care Plan B	$61.08
Excellent Dental Care Plan C	$48.46
Excellent Dental Care Plan D	$38.19
Excellent Dental Care Plan E	$43.05
Excellent Dental Care Plan F	$45.88
Excellent Dental Care Plan G	$50.63
Excellent Dental Care Plan H	$43.89

Premium Calculation Illustrative Example

Policy Inputs

Dental Plan:	Excellent Dental Care Plan B
Effective Date:	2/1/2018

Policyholder Information

Group County:	King
Group Size (Members):	11
Group Size (Subscribers):	4
SIC code:	327212

Rate Development

	Dental
Base Rate	$61.08
Trend Factor	1.004
Area Factor	1
Duration Factor	1
Industry Factor	0.95
PMPM Rate	$58.26

Composite Rate

	Age 21+	**Age Under 21**	**Total**
Count	6	5	11
Composite Rate	$58.26	$58.26	$58.26
Total Monthly Premium	$349.55	$291.29	$640.84

Small Group Stand-Alone Dental

Forms

Forms May Not Have Variability

Why not?

- WAC 284-43-6100: "Filings for small group plans must include base rates and annual base rate changes in dollar and percentage amounts for **each** small group **plan**."
  - "Plan" means a "contract" [WAC 284-43-6020(29)]
  - Contract includes each specific set of benefits and cost sharing the carrier agrees to provide

- Must be able to identify each specific plan, so that it can be matched with its filed rate and network
  - Plans must have identifiers in both rates and forms so each plan can be matched to its rate and network
  - Variability does not allow this identification and matching

Forms May Not Have Variability

- Variability results in uncountable numbers of plans and inability to identify each to match it with rates

- Necessary for compliance
  - Forms must be filed before being offered for sale, rates before they are used – negotiation of Small Groups prohibited
  - Carriers and OIC unable to tell whether a particular combination of provisions, or a rate for that plan, has been filed (use of unfiled rates and forms)

Forms May Not Have Variability

Administrative Variability is Allowed

- What's Administrative Variability?
  - Includes things like specific group name and policy number, effective dates, eligibility requirements, premium due dates and grace periods
  - Does not include variable benefits (including those available by rider) or cost sharing

- If you have questions about whether a variable is "administrative" vs. "non-administrative", work with your Analyst

Forms May Not Have Variability

How to file without non-administrative variability

- It is possible to file many plans in one filing without non-administrative variability

- Work with us if you have questions

Forms May Not Have Variability

Filing non-administrative variability

Example 1

Filing ABCD-123456789

- Policy (with administrative variability)
- Benefit Booklet/Certificate of Coverage (with administrative variability)
- Cost Schedule 1
- Cost Schedule 2
- Cost Schedule 3
- Cost Schedule 4
- Cost Schedule 5
- Group Application
- Enrollment form

Forms May Not Have Variability

Filing non-administrative variability

Example 2

Filing EFGH-101112131

- Policy (with administrative variability)
- Benefit Booklet/Certificate of Coverage1
- Benefit Booklet/Certificate of Coverage 2
- Benefit Booklet/Certificate of Coverage 3
- Benefit Booklet/Certificate of Coverage 4
- Benefit Booklet/Certificate of Coverage 5
- Group Application
- Enrollment form

Forms May Not Have Variability

Filing non-administrative variability

Example 3

Filing EFGH-141516171

- Policy (with administrative variability)
- Benefit Booklet/Certificate of Coverage1
  - Cost Schedule 1-A
  - Cost Schedule 1-B
  - Cost Schedule 1-C
- Benefit Booklet/Certificate of Coverage 2
  - Cost Schedule 2-A
  - Cost Schedule 2-B
  - Cost Schedule 2-C
- Group Application
- Enrollment form

Forms May Not Have Variability

Contact us if you have questions or want assistance structuring filings for your Small Group portfolios

Provider Contracting and Network Access Reports

RCW 48.43.730 and Chapter 284-170 WAC

Provider Contract Filings

RCW 48.43.730 (enacted July 2013)– requires all carriers that deliver services through a network to file all provider contracts and compensation agreements with the commissioner for approval or disapproval.

What is a "Provider contract"?

- A provider contract is a written contract between a **carrier** and a **provider** for any **health care services** rendered to an enrollee.
- Key Terms in the law:
  - *What is a carrier?*
  - *Who is a provider?*
  - *What are health care services?*

Provider Contracting continued

Definitions

- "Carrier" means a disability insurer, a health care service contractor (HCSC), limited-HCSC, or a health maintenance organization.
- "Provider" means:
  - A person regulated under Title 18 or Chapter 70.127 to practice health or health-related services or an employee or agent of such person.
    - For example: Dental hygienist, Denturist, Dentist, Optometrist, Ophthalmologist, etc.
  - Facility
  - *Intermediaries* that have agreed in writing with a carrier to provide access to "providers" who render covered services to enrollees of a carrier.
- "Health care service" means services offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

Provider Contracting continued

Option 1- Carriers may directly contract with a provider or facility:

- Carriers may use a standard or "sample" template contract. The contract may use either a standard or negotiated compensation exhibit; or
- Carriers may negotiate a unique contract with compensation exhibit.

Option 2 - Carriers may lease a network to access downstream contracts between the intermediary and provider or facility.

Option 1 – Direct Contracting

Must be filed for prior approval by the health carrier.

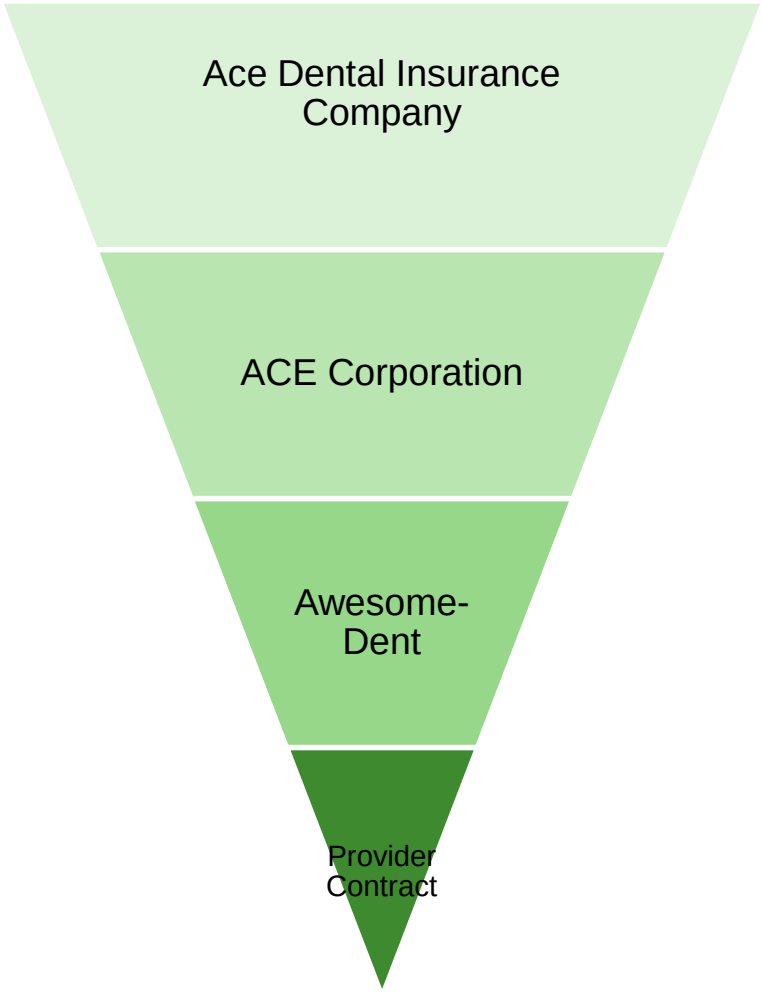
Option 2 – Intermediary Contracting

What gets filed for approval?

1. Ace Dental Insurance Company (carrier) intercompany agreement with ACE Corporation (intermediary)
2. ACE Corporation intermediary agreement with Awesome-Dent (intermediary)
3. Awesome-Dent downstream direct and negotiated provider contracts with dentist, facility, etc.

- Who is responsible for provider contract language?

  <u>Ace Dental Insurance Company</u>



Network Access Reports

Network access requirements apply to:

1. Health benefit plans:
   - Large group market
   - Small group market
   - Individual market (including Student Health Plans for higher education)
2. Stand-alone dental plans offered through the exchange or where a stand-alone dental plan is offered outside of the exchange for the purpose of providing the essential health benefit category of pediatric oral benefits. [WAC 284-170-200(14)]

Network Access Reports

When are reports required to be filed?

- For individual and small groups, submission must occur when the issuer submits its plan under WAC 284-43-0200. [WAC 284-170-280(1)]

What reports must be filed?

- Provider Network Form A report
- Provider Directory Certification
- Network Enrollment Form B report
- Access Plan
- Geographic Network report
- Alternative Access Delivery Request – Form C

Implementation

As of January 1, 2019, all companies, whether licensed as a Disability carrier or HCSC, must have rates and forms filed before offering a small group stand-alone dental or stand-alone vision plan for sale to the public.

- Companies should identify the portfolio of small group stand-alone dental or vision plans that they wish to offer in market starting January 1, 2019, and file the rates and forms. OIC will prioritize review of small group stand-alone vision or dental filings in the Fall of 2018.
- Companies that offer or renew small group stand-alone dental or vision plans with an effective date on or after January 1, 2019 that do not meet these regulatory requirements may be subject to enforcement action.

Questions?

Contact Information

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