VENDOR INQUIRY RESPONSES: DENTAL v1.0

Note: Version 1.0 includes responses to questions received by Covered California by or before 1/16/2013. Covered California intends to release v2.0 with additional responses in the near future.

#	Inquiry Category	Bidder Inquiry	Exchange Response to Inquiry
D001	Benefits & Plan Design	Our understanding is that dental plans are required to offer at least one standardized EHB plan (DPPO vs. DHMO), and further, that for every standardized plan, it must be issued at both the high and low AV levels. Can you confirm that understanding? Also, are there any similar minimum bidding requirements that attach to the Supplemental (DPPO vs. DHMO) dental offering, and, if so, can you elaborate on what those are? Or is supplemental completely voluntary?	Yes, for EHB benefits plans must offer either the PPO or HMO benefit, and may offer both. Additionally, both actuarial values must be offered. Bidding on supplemental products is voluntary. For supplemental benefits, bidders should respond to the standard supplemental benefit design outlined in Attachment 16.
D002	Benefits & Plan Design	In Section II, B, 1, a – The RFP indicates that separate bids are required for EHB and for the Supplemental Plan. Does this mean that the Exchange would require two completely separate proposals for both the EHB and Supplemental Plan?	Please see the answer to Question D004.
D003	Benefits & Plan Design	Page 12 B2A: "For EHBs, bidders should demonstrate the extent to which their bid includes participation of dental providers with a history of serving low-income and uninsured populations." Is there a requirement for what percentage of providers are needed to serve the low income population?	No, there is no minimum percentage requirement for providers serving the low-income population.
D004	Benefits & Plan Design	Page 12: Please clarify the requirement for separate bids. For example, if an Issuer intends to offer both EHB and supplemental plans in both markets, would two bids be required (one for EHB in both markets and one for supplemental in both markets? Or would four bids be required (one each for individual EHB, small group EHB, supplemental individual and supplemental group)? By “bid”, do you mean solicitation response?	The separate bids relate to the premium rates and benefit designs offered. Separate bids for each of the combinations of coverage type should be provided. The common components of the solicitation response that apply to the offering do not need to be repeated. However, if a carrier wants to bid to provide both Dental and Vision benefits, separate responses must be submitted.
D005	Benefits & Plan Design	How will the subsidy for members under 400% of the Federal Poverty Level work for the Dental EHB and Dental Supplemental standalone plans? Will it apply before the medical, after the medical, or a pro-rated amount proportional to the medical subsidy?	The federal government has provided guidance on subsetting the premium subsidies for stand-alone dental coverage for EHB benefits, which the Exchange will follow. No subsidies are available for supplemental benefits.
D006	Employer	How will billing work for the Individual and SHOP exchanges?	Billing for Individual plans will be handled directly by Dental and Vision Issuers. Billing for SHOP will be aggregated and managed by Covered California, the SHOP vendor.
D008	Benefits & Plan Design	Can you confirm that the EHB plan design also applies to the medical embedded plan design?	Yes, the same plan designs must be offered for dental benefits embedded in medical policies.

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D009	Employer	In the SHOP exchange, how is eligibility determined? If an individual adult or child under an employer-sponsored plan is eligible for CHIP, Medicaid, or subsidized coverage, are they re-directed to the Individual exchange?	The Exchange's eligibility determination policies are not fully defined at this time and are subject to federal guidance and regulations. Eligibility and enrollment for SHOP and Individual will likely display on the Covered California website via an interface with CalHEERS. The Exchange anticipates that MediCal and CHIP will have little to no participation in SHOP for Supplemental Dental and Vision Benefits.
D010	Employer	Please provide information on the open enrollment period and whether the dental benefits (Essential and Supplemental adult benefits) would follow the same guidelines as the other benefits in regards to limitations on when members might enroll or disenroll from the plan.	For SHOP, open enrollment will not be limited to same period as the Individual market. Employers can enroll employees throughout the calendar year. For the Individual Exchange, it is likely that Annual Open Enrollment will coincide with the annual medical open enrollment cycle.
D011	Benefits & Plan Design	Attachment #15 (EHB): This includes less detailed procedure placement, frequency (2 in 12) and age requirements than Attachment #1. Will more information be forthcoming?	No, Attachment 15 has been updated and provides the standard benefit plan design for the pediatric EHB plans. For detailed information, please see the answer to Question D044.
D012	Benefits & Plan Design	Attachment #15 (EHB): This lists the in-network benefits. What are the required out-of network benefits?	There are no required out-of-network benefits for Pediatric EHB. Issuers may include Out-of-network benefits at their discretion.
D013	Benefits & Plan Design	Why are implants a covered benefit for the EHB when that coverage is not included in Healthy Families which is the basis for the benchmark plan?	Implants are not a covered benefit for Pediatric EHB plans. Attachment 15 has been modified to remove implants from the list of major services.
D014	Benefits & Plan Design	We also note that the header on Attachment 15 suggests that the plan design is for the Dental EHB and Supplemental benefits, when it is our understanding that this plan design is limited to only EHB benefits.	The Plan Design in Attachment 15 is limited only to Pediatric Dental EHB benefits. The top header ("California Health Benefit Exchange") indicates the project, the middle header ("Solicitation for Pediatric Dental EHB & Supplemental Dental Benefits") indicates the activity that the document relates to, and the bottom header ("Attachment 15 – Essential Health Benefit Standard Plan Designs") indicates the unique title of the document.
D015	Benefits & Plan Design	We note that Attachment 15 – EHB Standard Plan Design includes mention of Implants under the category Major Services; however, implants are not a covered service under the Healthy Families' Program, and therefore is not a part of the scope of benefits under the chosen Essential Health Benefits Benchmark Plan (EHBP). Reference to implants therefore needs to be removed.	Please see the answer to Question D013.

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D016	Exchange Admin	In Attachment 12 - Percentage of members who received a treatment for caries or a caries-preventive procedure. Is the criteria referring to just caries prevention procedures or does this also include fillings, crowns, root canals? It is not always known "why" a filling was done. It may or may not be due to decay.	When calculating the percentage of members who received treatment for caries or a caries-preventive procedure, please also include fillings, crowns and root canals in the criteria.
D017	Benefits & Plan Design	Does the EHB Standard Plan Designs cover implants?	Please see the answer to Question D013.
D019	Benefits & Plan Design	Please describe the levels of dental deductible and co-payments that are being proposed for the Essential Dental Benefits and if these levels would change in various metal level benefits. Please provide the same information for the supplemental adult benefits.	Please refer to Attachment 15 for the two required Actuarial Value levels for the Essential Health Benefits and Attachment 16 for the Actuarial Values for Supplemental Benefits. Please see the answers to Questions D044 and D033 for additional information.
D020	Benefits & Plan Design	Please confirm that the California Healthy Families Program's dental benefit structure will be used as the basis for the Essential Dental Benefits plus the orthodontic benefits.	Please see the answer to Question D044.
D021	Benefits & Plan Design	If there are changes under Essential Dental Benefits in the different categories of metal benefits, would the supplemental adult benefits reflect the same level of changes or could the adults choose any category of dental benefits?	Adults can choose their preferred coverage level for Supplemental Benefits.
D022	Benefits & Plan Design	What is the carrier's liability for EHB orthodontia benefits? Is the carrier responsible for the examination and referral to CCS, or is it responsible for the full cost of the orthodontic treatment?	The carrier is responsible for all medically-necessary orthodontia for children. Cosmetic orthodontia is not a covered benefit.
D023	Exchange Admin	Attachment 12 – Performance Measures Regarding Utilization Measure #5, is the measure of members who received one or more fillings in the last year and who received a topical fluoride or sealant application within the last year?	Yes, this is the intention of the question.
D024	Benefits & Plan Design	Are Child-only policies (medical and stand-alone dental for the pediatric benefit) required just in the Individual exchange, or both in the Individual and SHOP exchanges?	Child-Only policies are required in both the Individual and SHOP Exchanges.
D025	Benefits & Plan Design	Does the Family supplemental plan embed the pediatric EHB or will the pediatric EHB only be sold in Child Only policies? If the latter, can a childless adult who purchases Medical without Dental purchase the Family supplement?	The supplemental benefit does not embed the Pediatric EHB benefit. A childless adult would be expected to choose a benefit that covers their dental needs. There would be no purpose for a childless adult to purchase the Family supplement.

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D027	Benefits & Plan Design	Will California define the pediatric age similar to recent HHS rules have (up to age 19) or does the State intend to define the pediatric age higher than 19? This defined age will be important in our efforts to accurately respond to the Solicitation. For example, what specific rating factors should be considered when responding to the rating section of the solicitation? Age bands and/or other rating factors? The template displays tiered rating, but does the exchange intend to also accept PMPM rates? More direction on what kind of rating assumptions we should be using in supplying the rates for the Exchange will be helpful, recognizing that recent ACA rules suggest that rating factors do not necessarily apply to standalone dental plans.	The Exchange will define the Pediatric Essential Health Benefit in accordance with federal regulations. As of November 26, 2012, pediatric dental coverage is defined for individuals up to age 19. Please see the answer to Question 083.
D028	Benefits & Plan Design	This question refers to the Individual and SHOP Exchanges. Does the pediatric dental EHB offering need to be issued as a separate child only policy, or can we integrate these benefits into the Supplemental coverage as one full family policy (a policy that would include pediatric dental EHB benefits as well as adult/adult child coverage).	No, the EHB offering must be separate from the Supplemental offering.

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D029	Benefits & Plan Design	Please explain EHB and Individual Supplement purchasing model. Consider this example: Example: A family is 2 adults and 3 children (ages 22, 17, and 12). They intend to buy dental coverage for all family members on the public individual exchange. - What do they buy? A Supplemental "2 Adult and 3+ Children" plan, or a "EHB 2 Children Plan" (for children ages 17 and 12) and a "2 Adult and 1 Child" Supplemental plan (for 2 adults plus child age 22)? - If they only have to buy the Supplemental "2 Adult and 3+ Children" do the benefits for the Children 17 and 12 have to match the EHB (Attachment 15) and the other members (2 adults and child age 22) get the Supplemental Benefits (Attachment 16)? - Can a family buy from two separate insurance carriers for dental: one dental policy for EHB (Attachment 15) with one insurance carrier, and one dental policy for Supplemental Dental (attachment 16) with another insurance carrier? - What if the EHB is already embedded in the major medical plan purchased on the public exchange? Or will the dental EHB purchase always be broken out from the medical? If the EHB is already embedded in the major medical plan purchased on the public exchange, will the family only be shown the Supplemental Dental plans & rates? - What happens when a child turns 19 on an "Adult + Children" plan? Do they stop being covered under EHB (Attachment 15), and start being covered under the Supplemental Health (Attachment 16) benefits?	All children must be covered for EHB benefits through an EHB policy. Pediatric EHB benefits are available only through pediatric EHB plans. Adult members and dependent children would receive all dental benefits through supplemental plans. Families may also choose to include children in supplemental policies if the additional coverage, largely for orthodontia, is of value to them. Families would not be obligated to purchase their EHB and Supplemental Benefits from the same carrier. When a child on a Pediatric EHB Plan turns 19 on an "Adult + Children", the plan ends when the child is no longer under 19. When pediatric members age out of a pediatric EHB dental plan, they can purchase an adult supplemental dental plan or be added to an adult supplemental plan purchased by their parents, however this process will not be automatic.
D030	Benefits & Plan Design	Page 12: Please clarify the meaning of “plan design” in the definition of “dental plan product” under B.1.	In the definition of dental plan product, “plan design” refers to the standardization of benefits and cost-sharing.
D031	Employer	Will members be allowed to change during the year from "1 Child" to "2 Child" rates & coverage? If so, are there any limitations that this is only by a qualifying life event: birth, death, divorce, marriage, etc? Or can they only change coverage at the annual open enrollment?	For both the SHOP and Individual markets, adding or deleting dependents outside of open enrollment will be subject to standard eligibility rules for qualifying events.
D032	Benefits & Plan Design	Attachment 15 - Deductibles: If dental has a separate deductible, is the deductible included in the out of pocket accumulator? For example, if a consumer pays a $50 deductible and the out of pocket maximum is $1,000, is his/her remaining out of pocket $1000 or $950 ($1000 minus the $50 paid for the deductible)?	Under current federal guidance, the deductible required under the stand-alone dental benefit does not accumulate towards the total deductible for medical plans.

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D033	Benefits & Plan Design	Attachment 16 - Alternate Plan Designs: May we submit alternate plan designs for adult plans?	Comments, questions, and suggestions for Supplemental Products have been received and are under review. A revised supplemental dental and vision standard plan is forthcoming. At this time, bidders should respond to the standard benefit design and should not include alternate plan designs.
D034	Benefits & Plan Design	Can we put a limitation on the number of services received, for example five crowns per year?	For EHB benefits, such limits are not permitted under the Affordable Care Act. For Supplemental Benefits, there is a total benefit limit, so further limits on the number of services provided are not permitted.
D035	Benefits & Plan Design	Can we translate the standardized cost sharing in the plan designs from coinsurance to a comparable copay amount? This would provide more transparency for members.	No, the standardized benefits must be offered as presented. However, all carriers may choose to offer the DHMO benefit design if they prefer.
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 answer to Question D033
D037	Benefits & Plan Design	Will the Exchange allow plan designs (for pediatric dental EHB as well as Supplemental plans) which utilize a fee schedule in lieu of UCR (Usual Customary and Reasonable) as the basis for reimbursement for Out of Network expenses?	Yes, for Supplemental Plans only. For Pediatric EHB, please see the answer to Question D012.
D038	Benefits & Plan Design	Are the rates requested from the dental plans for a 12-month period?	Yes, rates should be presented for a 12-month period.

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D039	Benefits & Plan Design	Would the Exchange consider a dual choice benefit model (DHMO / PPO) allowing members to change networks at any time, rather than a single product format?	There is no flexibility in the format of the Pediatric Dental EHB. For the proposed Supplemental Benefit Plan Design, please see the answer to Question D033.
D040	Benefits & Plan Design	Attachment 15 - Plan Designs: Could you provide Frequencies and Limitations for the EHB Standard Plan Designs, as well as full Copay Schedules (including all dental procedure codes) for the DHMO plans?	For detailed information pertaining to covered dental procedure codes, co-pay amounts, frequencies and limitations, bidders can refer to California Health Families Program (CHFP) at www.healthyfamilies.ca.gov.
D041	Benefits & Plan Design	We'd like to clarify to what extent plan standardization is expected of eventual certified dental plans. For the essential pediatric benefit, does the published Standard Plan Design in Attachment 15 reflect the one design that all certified dental plans are expected to submit, with the exact same cost-sharing structure to achieve the high and low actuarial values (AV) of 85% and 75% respectively? Or is there some flexibility in the plan design such that the coinsurance levels, copays or deductibles might be altered slightly whereby the plan still arrives at the required AV's, plus or minus the allowed 2% deminimis range?	The EHB benefit designs presented in Exhibit 15 may not be modified.
D042	Benefits & Plan Design	Attachment 15 – The EHB Standard Plan Designs give a range for the DHMO High and DHMO Low plans for benefits. It also indicates the "average copayment" amount should be set according to the chart. Is there guidance on how a plan determines the exact copayment amount including the ADA codes for each procedure (similar to the Supplemental Plan Design)?	Attachment 15 has been modified to remove the term "Average" from the Copay column headings. The copays listed are absolute values of actual copayment amounts. At this time, the Exchange has not established predefined copayment amounts for Pediatric EHB procedures not listed in Attachment 15. For ADA code information, please see the answer to Question D084.
D043	Benefits & Plan Design	For the DHMO EHB Standard Plan Design – The benefit schedule has conflicting information regarding benefits. It lists that medically necessary Orthodontic care is an average copayment of $1,700 while it also states the Orthodontic lifetime maximum is $1,000. Finally, with the Out of Pocket maximum being $1,000, does this mean that a person who has medically necessary orthodontics would only pay the first $1,000 of the $1,700 copayment? Please give further guidance on this benefit.	Attachment 15 has been modified to correct this error. The total Out-of-Pocket amount for DHMO benefits is $1,000, inclusive of medically-necessary orthodontia.
D044	Benefits & Plan Design	Is there a listing of Frequency, Exclusion and Limitations for the EHB Standard Plan Designs?	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.

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D046	Benefits & Plan Design	Does the Exchange have guidance or a definition of medically necessary orthodontia?	Please see the answer to Question D072.
D047	Benefits & Plan Design	Does the Exchange intend on having standard Exclusions and Limitations for the EHB Plan design, or can carriers create their own Exclusions and Limitations for the EHB??	Please see the answer to Question D044.
D048	Employer	Attachment #16 (Supplemental Dental): Includes a reference to R&C. What level is this at? R&C 90th percentile? R&C 80th percentile? R&C 50th percentile?	At this time, "Reasonable and Customary" should be considered at 80th percentile.
D049	Employer	Does the exchange intend to have the out of network benefits on the supplemental plan on the low plan higher that high plan?	The Exchange will review benefit design and confirm out of network benefits for High and Low plans. Please see the answer to Question D033.
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 answer to Question D033
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?	Please see the answer to Question D033
D052	Benefits & Plan Design	Attachment 16 - Supplemental Plan Designs: Would members with pediatric children need to purchase an EHB plan to meet the EHB requirement, and then if they want Supplemental Benefits they would also purchase one of the supplemental plans for the child?	Yes, all children must be covered by an EHB dental plan, and families may choose to purchase Supplemental Benefits.
D053	Benefits & Plan Design	Can we bid for a family supplemental plan, in addition to or in lieu of the individual supplemental adult “wrap”?	Please see the answer to Question D033
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 answer to Question D033

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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.	Exchange will review benefit design and consider modifications and update to CDT-13 codes. Please see the answer to Question D033.
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 answer to Question D033.
D057	Benefits & Plan Design	For the supplemental plan design, we are confused by the inclusion of child coverage. Wouldn't child coverage in the supplemental benefit that is already covered in the EHB be duplicative and not necessary? Does the Exchange mean to cover children for anything other than non-medically necessary orthodontia in the supplemental PPO and HMO plans? Also, the Supplemental DPPO and DHMO do not appear to offer equal coverage for adults; can you explain the discrepancy?	Supplemental Plans do not include EHB or duplication of coverage. Issuers should assume Pediatric Dental EHB is met through Stand-Alone dental or QHP when bidding Supplemental Plan Designs. A childless adult would be expected to choose a plan that covers his/her dental needs. There would be no purpose for a childless adult to purchase the Family Supplement. Please see the answer to Question D033.
D058	Employer	Is the proposed supplement plan design (attachment 16) the same as an existing voluntary adult buy up plan option?	Yes. Please see the answer to Question D033.

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D059	Benefits & Plan Design	Attachment 15 – EHB Standard Plan Designs Attachment 15 only provides a summary and not a specific plan design. A full plan schedule, such as the one included in Attachment 16 for the "Supplemental Standard Plan Designs," is not included for the EHB Standard Plan Designs. We assume the exchange would like to avoid a situation where the EHB Standard plan varies significantly between the different health/dental plans. As noted in Attachment 16, within each procedure category there are numerous procedure codes. Without further guidance, should each plan decide which of these detailed procedures they will include in their EHB plan as well as which ones will have a copayment and which ones will not? Does each plan have the flexibility to determine their own frequency limitation and exclusions? The EHB Plan Design indicates that the "copayments" are "average" amounts. Is there any guidance as to how the average is determined? Are there any limitations to the amount of any specific copayments.	Please see the answer to Question D060.
D060	Benefits & Plan Design	Attachment 16 – Supplemental Standard Plan Designs Attachment 16 includes one very specific plan design for the Supplemental Dental HMO. We want to confirm that unlike the EHB Standard Plan, there is no flexibility to vary frequency limitations, exclusions, covered procedure codes or copayments associated with the Supplemental Dental HMO.	There is no flexibility on the frequency limitations, exclusions, or covered procedures for Pediatric EHB Dental. Pediatric EHB Standard Plans must follow the specifications as outlined in Attachment 15. For additional information on plan specifics, please see the answer to Question D044. For questions pertaining to procedure codes, please refer to Question D040. For questions pertaining to the Supplemental Dental HMO, please refer to Question D033.
D061	Employer	Are we limited to the 75% and 885% actuarial values for the supplemental plan designs, or can we create supplemental plan designs with different actuarial values?	The Exchange requests that bidders respond to the Standard Supplemental Benefit Plan at this time. Supplemental Benefits are not subject to AV and do not include EHB. Please see the answer to D033 for additional information.
D062	Benefits & Plan Design	Can the Supplemental Plan Design include procedures for dependents that are not covered under the EHB plan (e.g. cosmetic orthodontia?)	Yes, the intent of the Supplemental Plan Design is to include procedures that are not covered under the EHB Plan. Please see the answer to Question D033.
D063	Employer	The Supplemental Plan does not define if Endodontics, Periodontics, and Oral Surgery are in Class II (Type B) or Class III ((Type C). Do plans have flexibility in placing these services in either category to reach the appropriate actuarial values?	Periodontics and Endodontics should be included in Class III (Type C). Supplemental plans are not subject to AV. Please see the answer to Question D033.

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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 answer to Question D033.
D065	Benefits & Plan Design	Attachment 15 - Ortho Max: Federal regulations prohibit a dollar max on in-network EHBs. Please advise.	The benefit description should read “OOP Maximum".
D066	Benefits & Plan Design	Attachment 15 - Ortho Max: Is the out of pocket max applicable to ortho? If yes, - Could you explain how the DHMO EHB plan would handle an ortho case with a $1700 copay, $1000 Lifetime max, and a $1000 annual out of pocket max? These 3 amounts seem to be in conflict with each other, so an example of an orthodontia case would be very helpful.	This error has been corrected. The total Out-of-Pocket amount for DHMO benefits is $1,000, inclusive of medically-necessary orthodontia.
D067	Benefits & Plan Design	Attachment 15 - Ortho Max: Is the out of pocket max applicable to ortho? If yes, - For a PPO ortho case, if the member uses up the $1000 Lifetime max benefit but has also met the $1000 out of pocket max for that year, is the plan still responsible for additional payment for the ortho treatment?	This error has been corrected. The total Out-of-Pocket amount for DHMO benefits is $1,000, inclusive of medically-necessary orthodontia.
D068	Benefits & Plan Design	Attachment 15 - Ortho Max: What guidelines will be used to define medically-necessary ortho?	Please see the answer to Question D072.
D069	Benefits & Plan Design	Can you please provide greater clarity on what is covered under the term medically necessary orthodontics?	Please see the answer to Question D072.
D070	Benefits & Plan Design	Typically, there is no orthodontic lifetime maximum in a dental HMO plan. Can we presume that the $1,000 orthodontic lifetime maximum is in error?	This error has been corrected. The total Out-of-Pocket amount for DHMO benefits is $1,000, inclusive of medically-necessary orthodontia.
D071	Benefits & Plan Design	Attachment 15: Please confirm that the Ortho Lifetime Maximum of $1000 is the maximum liability of the insurer.	This error has been corrected. The total Out-of-Pocket amount for DHMO benefits is $1,000, inclusive of medically-necessary orthodontia.

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D072	Benefits & Plan Design	Please describe the limitations under the Orthodontic benefits? Will the orthodontic benefits be limited to "medically necessary / significant malocclusion" benefits only?	For Pediatric Dental EHB, orthodontic coverage is to be included as permitted in the California Healthy Families Program, which is defined by California Children's Services' (CCS) criteria for medically-necessary orthodontia.
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 answer to Question D033.
D074	Benefits & Plan Design	What type of orthodontic treatments are to be included? Are we to cover interceptive orthodontics, Invisalign, appliances, records and retention? Are we only covering a typical 24 month treatment plan?	Please see the answer to Question D072.
D075	Benefits & Plan Design	Attachment 15 – EHB Plan Design What is the Exchange's definition of "medically necessary"?	Please see the answer to Question D072.
D078	Employer	We understand that the Exchange will assess plans approximately 3% of premium for the running of the Exchange. Should this fee be built into the rates or will that amount be placed on top of the agreed upon premiums?	The Exchange will assess dental and vision plans at the same rate structure defined for QHPs.
D079	Employer	Please describe the collection of premiums and who would be responsible for this part.	Please see the answer to Question D006.
D080	Employer	What is the process for adjusting the premium rates after the initial period.	During the initial period, dental Issuers will provide a 12-month rate guarantee and will provide a renewal notice subject to standard notification rules for QHP.
D081	Benefits & Plan Design	Attachment 8 – Premiums EHB (Also applies to Attachments 9 and 10): How is "Adult" and "Child/Children" defined for supplemental plans? Is there any overlap in the child age for or duplication of coverage between EHB and Supplemental plans? How will a child age 25 be classified – as a child or another adult on the contract? (Note: The Coverage Tiers listed only permit 2 adults; the Rule limiting rating to no more than 3 children applies to dependents who are under age 21 – see Health Insurance Market Rules Proposed Rule §147.102(c)). Is orthodontia coverage required for Adults under the Supplemental coverage?	Medically-necessary orthodontia coverage is only required for Pediatric Dental EHB and is not required for Adults under the Supplemental Benefits. Please see the answer to Question D057.
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 D027.

#	Inquiry Category	Bidder Inquiry	Exchange Response to Inquiry
D083	Employer	Page 15: It is noted that premium may vary only by rating region, coverage tier and actuarial value. Does this mean that Issuers cannot vary premiums by age or tobacco use as permitted by PPACA and the Health Insurance Market Rules Proposed Rule? PPACA §1201 (amending PHS §2701 Fair Health Insurance Premiums) and the Health Insurance Market Rules Proposed Rule §147.102(a) allow premium rates to vary by four factors: (1) individual or family; (2) age; (3) rating area; and (4) tobacco use.	Supplemental Plan premiums can vary by age, but Pediatric Dental EHB premiums cannot. Page 15 of HBEX 15 - Dental Solicitation indicates that this limitation applies only to Pediatric EHB. Age and Tobacco are not allowable rating factors for Pediatric. Dental and Vision Issuers should provide rates which match the tiers for QHP rating.
D084	Employer	Are the ADA codes submitted with the supplemental HMO modeled after the CHIP plan?	No. Comments, questions, and suggestions for Supplemental Products, including those pertaining to ADA CDT codes, have been received and are under review. A revised supplemental dental and vision standard plan is forthcoming. At this time, bidders should respond to the standard benefit design and should not include alternate plan designs.
D085	Employer	Attachment 11 – Technical Specifications indicates in question 15 that the Carrier is agreeing to accept the enrollment business rules implemented by the Exchange. Please direct us to where we can locate these rules.	SHOP enrollment rules will follow standard open enrollment practices in the small group market. Individual rules are defined by the ACA and subject to policy decisions not yet defined with QHP's.
D086	Employer	Attachment 11 – Technical Specifications # 15: Please clarify what the enrollment business rules will be so that Issuers can determine whether they can comply?	Please see answer to Question D085.
D087	Benefits & Plan Design	#31: What is meant by the phrase "… beyond the preventive and diagnostic dental services covered by the EHB"?	Attachment 11 Item #31 refers to the use of a health assessment tool to identify existing need for restorative treatment among newly-enrolled pediatric members.
D088	Benefits & Plan Design	Please describe if any subsidies would be distributed towards the Essential Dental Benefits offered in the Exchange.	The federal government has provided guidance on sub-setting the premium subsidies for standalone dental coverage for EHB benefits, which the Exchange will follow. No subsidies are available for supplemental benefits.
D089	Exchange Admin	Has the exchange identified the cost for exchange participants? In other words, how will the exchange be funded after 2015?	After 2014, the Exchange will be self-supporting from fees paid by health plans and insurers participating in the Exchange. The Exchange has not released predefined costs for exchange participants at this time.
D090	Benefits & Plan Design	Has the California HBEX developed a dental-specific summary of benefits and coverage (SBC)?	The Exchange is using the federal Uniform Summary of Benefits and Coverage for an SBC of Pediatric Dental EHB.
D091	Exchange Admin	The attachments to respond in are in PDF format. Can we get them in word?	Bidders should utilize the formatted attachments provided to prepare their responses.

#	Inquiry Category	Bidder Inquiry	Exchange Response to Inquiry
D092	Exchange Admin	In the SHOP exchange, when an Employer is determining what plan designs to offer their employees, how will they be able to do this? Will there be a summary of the plan designs, will they go out there and "shop" for what they want then advise the exchange what plan designs employees can select from, etc?	Employers will have a "Shop and Compare" tool for online comparison. Employers will also have access to printed materials and brochures which allow for paper enrollment.
D093	Exchange Admin	What is the employer purchasing model in the SHOP exchange? Can the employer select the plan on behalf of employees?	Employers can select a single plan on behalf of their employees in SHOP, or they can select a group of plans from which their employees can choose.
D094	Exchange Admin	Are we required to provide out of state dental and vision benefits?	Issuers are only required to provide out of state benefits for dental emergencies. Federal proposed rules allow for out of state employees to enroll with the CA plan if access to providers is reasonable. Out of state employees may also enroll in the state exchange where they reside.
D095	Exchange Admin	Do we need to submit products and networks with the regulators on 3/1 or can we submit them at a later date?	Bidders are required to submit products and networks to regulators by March 1, 2013. Bidders must report these filings to the Exchange to meet proposal submission requirements (see: Attachments 3, 4, & 5).
D097	Exchange Admin	Will the Exchange provide an attachment for us to demonstrate the full extent of our network and also the participation of FQHCs in that network?	Bidders must complete the "Provider Network" Section of Attachment 11. In addition to the required maps of contracted FQHCs and other providers serving the low-income population, Bidders may prepare (in a format of their choice) supplemental materials that clearly demonstrate the full extent of their network including participation of FQHCs.
D098	Benefits & Plan Design	We request additional clarification on 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 answer to Question D084.
D099	Exchange Admin	Due to limited time available from the release of the RFP to the deadline for submitting the LOI, we elected to provide an LOI for a broad geographic area. As we learn more about the specific requirements of the Exchange, we might elect to provide a response to the RFP for a narrower geographic area. Please let us know how plans would be able to adjust the proposed geography? Would this be part of the response to the RFP or are the plans expected to submit supplemental information to the Exchange prior to the submission of the responses to the RFP to make such adjustments.	Bidders may submit information different from that provided in the Intent to Bid. The Exchange will evaluate finalized plan information based on what is submitted via proposal by or before the March 1, 2013 deadline.

#	Inquiry Category	Bidder Inquiry	Exchange Response to Inquiry
D100	Exchange Admin	Please describe your view of disease management program identified as an item under question 29 of the RFP.	The Exchange views dental disease management programs as including the following: • Self-service access to wellness and educational materials • Educational outreach and care reminders • Enhanced benefits for certain populations with special oral health needs (e.g. members with diabetes or heart disease and pregnant women) • Risk identification and scoring We would also like to understand any strategies you employ for engaging members in their dental care and in accepting and seeking education and any reporting you are able to provide around disease management programs. While there is currently no mechanism in place to link dental plan offerings with other Exchange health plan offerings, given proven the links between oral health and overall health, this linkage may be a future consideration.
D101	Exchange Admin	Please provide Attachments 11, 12 and 14 in Word format.	Bidders should utilize the formatted attachments provided to prepare their responses.
D102	Exchange Admin	Page 11: Is guaranteed issue for individual and small group markets required? If so, please provide cites related to these requirements. Per Federal Regulators (e.g., HHS and DOL) in multiple sources, when dental or vision coverage is provided in a plan that is separate from or otherwise not an integral part of a major medical plan, that separate coverage is not subject to the general or immediate insurance market reforms in Title XXVII of the PHS Act.	Guaranteed issue is not required as part of ACA regulations but is a requirement of Exchange policy, provided the open enrollment and eligibility terms are met. In the CA Exchange, guaranteed issue is required if eligibility rules are met.
D103	Exchange Admin	Attachment 14 says to include the Exchange logo on "all billing statements and customer communications." Does this also mean that the Summary Plan Description (SPD) issued should have the Exchange name and/or logo on it?	Issuers will be required to place the Exchange's brand name, logo and tagline on all billing statements and related customer communications, including Summary Plan Description (SPD) documents.
D104	Exchange Admin	We are licensed in the entire state as a PPO carrier, however we may not have sufficient network adequacy in rural areas. Should we still submit a bid for those regions?	Yes, still submit. The Exchange prefers statewide coverage.

#	Inquiry Category	Bidder Inquiry	Exchange Response to Inquiry
D105	Exchange Admin	Can we use DentiCal providers in addition to FQHC's that offer dental to demonstrate ECP participation in our networks?	Yes. Per Section B.2.a. on page 12 of the Dental Solicitation document, bidders must prepare maps of contracted FQHC's and maps of other providers who serve the low-income population. Denti-Cal providers would meet the definition of providers who traditionally serve the low-income population. Please see the answer to Question D097.
D106	Exchange Admin	Given the short time period to review the solicitation, we request the opportunity for those who completed the intent to bid have additional time to submit additional questions as we work with our internal teams to complete the dental solicitation.	All questions were due to the Exchange by January 16, 2013. The Exchange will respond to bidder requests and inquiries on a case-by-case basis.
D107	Exchange Admin	In Section IV, C – The RFP indicates that the response for Volume 2 should be included in Excel. Should any of the Attachments for Volume I also be placed in Excel?	No, placing Attachments for Volume 1 in Excel format is not required.
D108	Benefits & Plan Design	Besides the standard plan designs provided by the Exchange, is there a limitation to the number of high and low plans that we can we submit, per product ?	Yes, Bidders can submit no more than two high and low plans per product.
D109	Exchange Admin	Should the complete set of each required volume marked "MASTER COPY" be one of the five copies, or in addition to the five copes, for a total of six complete copies of each volume? The CD of each volume should be enclosed in the envelope with the respective master copy, correct?	The "MASTER COPY" should be one (1) of the (5) copies, for a total of five (5) complete copies of each volume. The CD of each volume should be enclosed within the respective "MASTER COPY" envelope.

#	Inquiry Category	Bidder Inquiry	Exchange Response to Inquiry
D110	Exchange Admin	Page 7 1B - "Issuers are required to submit dental plan bids in all geographic service areas in which they are licensed" Does this mean we are required to bid in all rating regions within the service areas where we are licensed? Or can we choose which rating regions we want to bid in, but have to cover the service area for the entire region where we are licensed? We are required to bid in rating regions, not service areas, so this wording is confusing. Section D references bidding rating regions, not service areas.	Bidders are required to bid their entire licensed service area. Bidders are required to bid all rating regions that fall within that service area (even if they are only partial rating regions), however, Issuers do not need to determine the Rating Regions in which they are bidding because Attachment 7 pre-populates this information when entering their licensed service area zip codes. All zip codes that are covered by the Bidder's licensed service area drive the rating regions. (Example: If an Issuer's licensed service area covers all of Rating Region 1 and half of Rating Region 2, the Issuer is bidding in their entire licensed service area and both Rating Regions 1 and 2, but will not include any zip codes in Rating Region 2 in which they are not licensed.) Please refer to additional information in the Dental Solicitation on Page 12, Section B as well as Attachment 7 to complete the crosswalk of licensed service area zip codes and rating region for each dental plan product.
D111	Exchange Admin	Can a DPPO insurance carrier, or DHMO company be added to our coalition bid due March 1st if they were not identified on our coalition Intent to Bid?	Yes, please see the answer to Question D099.
D112	Exchange Admin	Is a CA licensed insurance agency eligible to be a Primary Issuer, or does it need to be a CA licensed insurance company? (The Exchange Dental Benefits Solicitation indicates coalition proposals require a Primary Issuer to take responsibility for aggregating and managing the coalition members. Kelsey National Corporation is CA licensed insurance agency in good standing. Let me know if I need to direct this question to Katherine. I just want to make sure the coalition proposal has the correct entity as the Primary Issuer.)	To serve as a Primary Issuer, the entity must be licensed to operate as a dental issuer in the State of California.

#	Inquiry Category	Bidder Inquiry	Exchange Response to Inquiry
D113	Exchange Admin	Attachment 11, Technical Specifications Question #35 asks us to indicate which plan sponsor tools/information that we offer and how they can be accessed. Please provide clarification with respect to what administrative services a nod enrollment/billing functions will be handled by Covered California, and which enrollment/billing functions will be handled by the plan. Will Covered California will be handling ongoing eligibility administration for SSHOP group enrollees, or if this task is to occur between the carrier and the SHOP. We have an online employer portal that offers many of these items however it is unclear if we are allowed to offer the SHOP group this tool for ongoing administration.	Please see the answers to Questions D006 and D009.
D114	Exchange Admin	Attachment 11, Technical Specifications Question #36 asks us to confirm if we will be providing plan sponsor training using the online tools. Please define 'plan sponsor' (does it include Navigators?) and indicate the type of training that Covered California envisions for this task.	"Plan sponsor" means the employer group or the benefits administrator at the employer group. The Exchange is asking bidders to describe what, if any, training or information is provided for services outlined in Attachment 11, Question #35.
D115	Exchange Admin	Attachment 1 – Intent to Bid Please clarify what is meant by Plan Name? Will this be a requirement/identifier on the Exchange?	Plan Name describes the unique plan being offered and allows for distinction among each Issuer's proposed plans. Plan Name will likely be displayed on the Exchange website.
D116	Benefits & Plan Design	Page 13 (also applies to Attachment 3): We note that Issuers are required to implement a quality assurance program that complies with Section 1300.70 of the Knox-Keene regulations. Disability insurers licensed under the CA Insurance Code are not subject to the Knox-Keene Act or its regulations. This requirement creates an unfair advantage toward bidders that are licensed under that act. It is suggested that compliance with the noted code section be eliminated.	The Exchange is not eliminating the requirement for a quality assurance program at this time.
D096, V034	Exchange Admin	If we decline to bid for 2014, would we have the opportunity to bid in 2015?	It is not likely. The exchange will reserve the right to accept new plans or bids in 2015, as needed.
D117	Exchange Admin	Page 10 (also applies to Attachments 3 and 4): Bidders must acknowledge whether they are seeking amendments to existing COAs or material modifications. Is participation within an exchange in and of itself considered a material modification filing under 28 CA ADC 1300.52.4(d)(vii) assuming an Issuer is not making any of the other changes detailed under 28 CA ADC 1300.52.4(d)?	No, participation within an exchange is not considered a material modification filing under 28 CA ADC 1300.52.4(d)(vii).

#	Inquiry Category	Bidder Inquiry	Exchange Response to Inquiry
D118	Exchange Admin	Page 12 (also applies to Attachments 3 and 7): Under 1-b) of Plan Network Design Issues, bidders are required to bid their entire licensed service area. Attachment 3 requires confirmation of such "for each rating region for which you have submitted a dental bid". Must an Issuer with a statewide licensed service area submit a bid in all rating regions?	Please see the answer to Question D110.
D119	Exchange Admin	Page 10: We note that letters of good standing do not appear to be required in the QHP solicitation. Both regulators have information on file relative to Issuers' solvency, capital/surplus and enforcement actions. Further, we can see no process for requesting letters of good standing of the nature contemplated in the solicitation on either regulator's website. We suggest that this requirement be removed from the solicitation. In the alternative, what are "appropriate" local state and federal licensing authorities -- Domicile state (Secretary of State or DOI?)? CA DOI/DMHC only? What is the process for obtaining these letters from CA regulators?	Bidders are not required to obtain letters of good standing from regulators. The Exchange requires bidders to confirm that that they are in good standing with all appropriate local, state, and federal licensing authorities. Bidders can refer to "Attachment 3 - Confirmations" for additional details.
D121	Benefits & Plan Design	Page 8: It is mentioned under the bullet "Encourage Alignment with Providers and Delivery Systems that Serve the Low Income Population" that such population will be eligible for premium tax credits and cost sharing subsidies. Cost-sharing subsidies/reductions are not applicable to stand-alone dental plans providing the pediatric dental benefit. See PPACA §1402(c)(5), Special Rule for Pediatric Dental Plans. If an individual enrolls in both a QHP and a stand-alone pediatric dental plan, the cost-sharing reductions do not apply to the portion allocable to pediatric dental benefits. The Notice of Benefit and Payment Parameters for 2014 Proposed Rule §156.440(b) also states, "The provisions of this subpart, to the extent relating to cost-sharing reductions, do not apply to stand-alone dental plans."	The Exchange recognizes that cost-sharing reductions do not apply to stand-alone dental plans.
D122	Exchange Admin	The due date for Intent to Bid submission, January 16th, has passed, is it possible to submit the Intent to Bid Form late and still participate?	You may still submit the Notice of Intent to Bid, however it is not required in order to submit a proposal.
D123	Employer	Attachment 8 - Commissions: If we choose to not offer commissions on the on-exchange products, may we still add commissions to the off-exchange products?	No. Agent commissions should be included in the on-exchange products and must match the non-exchange market. Please see the answer to Question D126.
D124	Employer	Attachment 8 - Exchange Fees: If we add the exchange fee to products on-exchange, may we eliminate the fee for off-exchange products? In other words, is the expectation that the products themselves will be priced the same on and off exchange, or that products + fees will be the same?	The Exchange's expectation is that the benefit products themselves will be priced the same both on and off the Exchange.

#	Inquiry Category	Bidder Inquiry	Exchange Response to Inquiry
D125	Employer	Can we use traditional agents for the SHOP and can we pay them traditional commissions. If so, for SHOP, what is the commission/override schedule for brokers/GAs?	SHOP will set standardized commissions for medical, dental and vision competitive with the non-exchange market. These commission rates may vary slightly from each carrier/Issuer but will seek to "match" as closely to market standards as possible. General Agent overrides are not yet known and will be negotiated through a competitive bid process beginning in February 2013 and completed by June 2013.
D126	Employer	Please describe how agent commissions will be handled in the Individual and SHOP exchanges. Is there a desired level that should be built into the rates?	For the Individual Exchange, agent commissions will match commissions paid in the commercial market and paid by the Issuers. SHOP will set standardized commissions for medical, dental and vision competitive with the non-exchange market. These commission rates may vary slightly from each Issuer but will seek to match as closely to market standards as possible.
D127	Employer	Attachment 14 - Question 1: Is the request for sample materials referring to materials that we currently use?	Yes, to satisfy the request in Attachment 14 for sample materials, please provide sample collateral for agents, employers and consumers that the Issuer currently uses.
D128	Employer	Attachment 14 - Question 9: A "summary brochure" is requested. By summary brochure, do you mean a benefit summary or a marketing brochure? If a benefit summary, are you requesting a brief consumer-focused piece or a detailed contractual summary?	A marketing brochure will satisfy the requirement for a summary brochure.
D129	Employer	Attachment 14 – Marketing and Outreach Activities, Item 10 - Cooperation with the Exchange, states that the Exchange's brand name, logo and tagline will be required on "billing statements and customer communications." Can you define more clearly what will be considered "customer communications" that will require this Exchange branding information?	Issuers will be required to place the Exchange's brand name, logo and tagline on all billing statements and related customer communications, such as Summary Plan Description (SPD) documents and other materials identifying the coverage that will be provided through Covered California (similar to association co-branding).
D130	Employer	Attachment 14 – Additional Questions and Requirements #9: Please clarify what is meant by the Summary Brochure. Is this a proposed dental version of the health SBC or would commercial enrollment literature suffice?	Please see the answer to Question D130.
D132	Employer	Page 15 (also applies to Attachment 14): A footnote appears at the end of F-1 as well as on the corresponding section of Attachment 14, restricting these sections to SHOP bidders only. However, the questions on the Attachment pertaining to F-1 mention both individual and small group markets. Please clarify.	Please disregard the footnote and respond for both Individual and SHOP bidders. Dental Attachment 14 and Vision Attachment 13 have been modified to remove this footnote.

#	Inquiry Category	Bidder Inquiry	Exchange Response to Inquiry
D133	Employer	#33: Who are the intended recipients for the introductory communications pieces? Does the HBEX have a preferred method of distribution?	The Exchange requires Issuers to place the Exchange's brand name, logo and tagline on all related customer communications but has not predefined the recipients (potential customers) or methods of distribution of these materials. The marketing approach is at the discretion of the Issuers.
D134	Technical (IT)	Page 15 of the solicitation states that "dental plans will be required to build data interfaces with the Exchange's eligibility and enrollment systems and to report transactions." Which transactions do they want us to report back to the Exchange? Is it just verification of enrollment, billing/premium payment or other transactions?	In general the transactions will be verification of enrollment, billing/premium payment, termination, etc. The transactions will be in the format of 834 transactions the format of which is still being developed pending input from the FEDS.
D135	Technical (IT)	Will the data exchange interface will be via FTP or Secure FTP and if via FTP will PGP encryption be used? Will data be pushed to the Issuer or will the Issuer pull the date from the CA Exchange?	Our current design is through a Secure FTP and encryption will be used. The data can/will go both ways.
D136	Employer	Attachment 11 – Technical Specifications, question 28 requests confirmation that customer service operating hours will meet required operating hours of 7am to 7pm, seven days per week. We are interested if the Exchange can elaborate on the means by which services can be provided to customers, including the combination of call center representatives, IVR, Web-based tools, etc. during some of these operating hours.	The Exchange asks bidders to indicate how certain member services will be provided during operating hours (see: Attachment 11, Question #26) and confirm or explain hours of operation.
D137	Technical (IT)	Attachment 11; Q53: How can we obtain technical IT requirements for the CalHEERS system, or any other system for which we will need to interface? Who will be our systems contact for the Exchange?	A transaction companion guide is prepared and will be shared with Issuers. The CalHEERS Technical Team (State and Vendor) will work directly with your organization's Technical Team to validate format, test transactions and ensure that the interface content and process is working properly prior to go-live.
D139	Employer	# 27: Is it the intention of the Exchange to require levels of language assistance that exceed the requirements of California's existing LAP, to which California-licensed plans should already comply?	No, the Exchange has no intention of requiring language assistance above that which is required by California's existing LAP.
D140	Employer	# 27: In the proposal, to what degree will bidders be rated for language assistance activities that exceed the requirements of California's LAP?	Bidders who go beyond state requirements are preferred. Please see the answer to Question D139.
D141	Employer	# 29: In the absence of a universally and professionally accepted dental risk assessment tool, the absence of ADA procedure codes for licensed dentists to perform and be paid for dental risk assessment, and the absence of industry-accepted metrics associated with dental risk assessment, what is the Exchange's intention with risk assessment in the context of dental care and how will this area be rated in the proposal and be evaluated during the term of the contract?	Risk assessment capabilities are not a mandatory component of the dental plan offering at this point, and the absence of such capabilities will not heavily weigh against bidders . The Exchange is primarily trying to gain an understanding of bidder thoughts around risk assessment, what capabilities currently exist in the market and what capabilities are planned for the future.

#	Inquiry Category	Bidder Inquiry	Exchange Response to Inquiry
D142	Employer	# 29: In the absence of disease management protocols in the dental profession, the absence of use of diagnosis codes for dental diseases, and the absence of any accepted metrics for dental disease management, what is the Exchange's intention for dental disease management and how will this area be rated in the proposal and be evaluated during the term of the contract?	Disease management programs are not a mandatory component of the dental plan offering at this point, and the absence of such programs will not heavily weigh against bidders. Given the proven links between oral health and overall health, the Exchange is primarily trying to gain an understanding of bidder thoughts around disease management, what capabilities currently exist in the market and what capabilities are planned for the future.
D143	Employer	# 29: What standards will the Exchange use to evaluate prospective dental plans with regard to compliance with dental risk assessment and dental disease management programs?	The Exchange will be using the evaluation criteria specified on Pages 7 and 17 of the Dental Solicitation. A team of appropriately knowledgeable staff and subject matter experts will review all plan proposals through a comprehensive, fair, and impartial evaluation process.
D144	Employer	# 29: What standards will the Exchange use to evaluate contracting dental plans with regard to compliance with dental risk assessment and dental disease management programs on an ongoing basis?	Please see the answer to Question D143.
D145	Employer	#29: Will the Exchange use appropriately experienced, qualified and licensed dentists to evaluate dental plan performance and compliance with regard to dental risk assessment determinations and dental disease management programs?	Please see the answer to Question D143.
D146	Employer	#30: Considering the fact that not all patients need all services, and also considering the well-established fact that a percentage of enrollees will never agree to see a dentist, what does the Exchange mean by requiring a contracting dental plan to ensure that all preventive and diagnostic services are provided and to ensure that all eligible enrollees receive these services within the plan year?	In Attachment 11, item #30, the Exchange is referring to efforts to ensure all newly-enrolled members will receive all clinically appropriate preventive and diagnostic services at the clinically appropriate frequencies. The Exchange is not requiring that every procedure coded as Diagnostic or Preventive be provided to every newly-enrolled Exchange member.
D147	Employer	#30: Considering the fact that current scientific evidence indicates that not all patients need all services within the same intervals as all other patients, (i.e., different patients have different needs based on individual clinical conditions ranging from excellent health to severe disease), what is the Exchange's intention with requiring that all enrollees receive a specific treatment regimen, namely "all preventive and diagnostic services… within the plan year"?	Please see the answer to Question D146.

#	Inquiry Category	Bidder Inquiry	Exchange Response to Inquiry
D148	Employer	#30: What are the Exchange's definitions of "preventive services" and "diagnostic services"? According to the American Dental Association, preventive services include things like space maintainers and diagnostic services include things like microscopic examination of biopsied tissue. Does the Exchange intend that all enrollees are to receive all diagnostic and preventive services even though not all patients need all preventive and diagnostic services? How will the Exchange evaluate dental plan performance when certain preventive and diagnostic services are appropriately not rendered based on the clinical needs of the individual patient?	Please see the answer to Question D146.
D149	Employer	#30: The Food and Drug Administration's and the American Dental Association's recommendations on prescribing dental radiographs indicate that some patients should not receive dental x-rays within a 12 month period based on the clinical condition of the patient (and some patients should receive x-rays more often). Additionally, the ADA's recommendations on prescribing fluoride treatment and prescribing sealants indicate that some patients should not receive fluoride treatment or sealants based on the clinical condition of the patient. How will the Exchange evaluate dental plan performance for patients that appropriately do not receive preventive and/or diagnostic services within a 12 month period due to the patient's clinical condition pursuant to ADA and/or FDA recommendations?	The Exchange expects dental providers to use appropriate clinical judgment in providing individualized dental services to members, and recognizes responses to measure #30 in Attachment 11 will include those members who received or did not receive all preventive and diagnostic at altered frequencies, as appropriate for their care. Please see also the answer to Question D146.
D150	Employer	#30: Will the Exchange use appropriately experienced, qualified and licensed dentists to evaluate dental plan performance and compliance with regard to the dental plans' utilization management of preventive and diagnostic services?	Please see the answer to Question D143.
D151	Benefits & Plan Design	#31: Is the intention of the Exchange for contracted dental plans to cover services that are not part of the coverage contract? If so, what additional compensation arrangements will be made between the Exchange and the contracted dental plans to cover these additional services?	No, it is not the intent of the Exchange that non-contracted services be covered. The question asks whether discounts will be available to members use non-covered services.
D152	Employer	#31: In the absence of professionally-accepted metrics for evidence-based disease management protocols to be used for individualized dental benefit determinations (i.e. increase of available benefits based on clinical need), how will the Exchange evaluate prospective bidders as well as the performance of contracted dental plans with regard to compliance with this requirement?	It is not the intention of the Exchange for dental plans to vary their coverage level based on clinical needs. For EHB benefits all needed services must be covered. For Supplemental benefits there is a specific benefit package that will govern the definition of covered services.

#	Inquiry Category	Bidder Inquiry	Exchange Response to Inquiry
D154	Employer	#31: Will the Exchange use appropriately experienced, qualified and licensed dentists to evaluate dental plan performance and compliance with regard to health assessment determinations?	Please see the answer to Question D143.
D155	Technical (IT)	Page 15 (also applies to Attachment 11, questions 52-55): When can Issuers expect information on reporting and technical interface requirements?	The Technical Interface requirements have been developed based on what we know to date. This includes direction received from Federal and State reporting agencies. We anticipate that the format for initial system release will be final within the next 30 days.