Stand Alone Dental Plans
Form Filing Guidance

State of New Mexico
Office of Superintendent of Insurance
Effective January 1, 2023

Table of Contents

Section I: Overview 4
Section II: General Guidance 5
Sec. 2.1: Applicability 5
Sec. 2.2: Prior approval of Rates and Forms Required 5
Sec. 2.3: One Filing per Market 5
Sec. 2.4: Guaranteed vs. Estimated Basis for Rates 5
Sec, 2.5: Essential Health Benefits (EHB) 6
Sec. 2.6: Pediatric Dental Requirements 6
Sec. 2.7: Rating Areas 6
Sec. 2.8: Variability 7
Sec. 2.9: Treatment of Proprietary Information 7
Sec 2.10: Timeline 9
Section III: Submitting Filings in the System for Electronic Rate and Form Filing ("SERFF") 10
Sec 3.1: Complete submission 10
Sec. 3.2: Administrative Information 11
Sec. 3.3: HIOS Issuer ID 11
Sec. 3.4: Required Use of CMS Review Tools and Data Integrity Tool 12
Sec. 3.5: URLs 12
Sec. 3.6: Alignment of Data Template information with Form filing documentation and OOC 12
Sec. 3.7: Standardized Naming Convention 12
Sec. 3.7.1: Documents Using Standardized Naming Convention 12
Sec. 3.7.2: File Naming Convention 12
Section IV: Dental Requirements 14
Sec. 4.1: Adult Coverage Requirements 14
Sec. 4.2: Benefit Waiting Periods 14
Section V: Marketplace Certification 15
Sec. 5.1: SADP Certification Requirements 15
Sec. 5.2: Filing Fees 15
Sec. 5.3: Certification and Recertification of an SADP 15
Sec. 5.4: Outline of Coverage 15
Sec. 5.5: E Community Provider (ECP) Requirement 16
Sec. 5.6: Actuarial Value 16
Sec. 5.7: Non-Discrimination 16

Sec. 5.8: Licensing and Good Standing 16
Sec. 5.9: Service Area 16
Section VI: Definitions 17
Stand Alone Dental Plan or "SADP" 17
Service Area 17
Qualified Dental Plan or "QDP 17
Outline of Coverage or "OOC" 17

Section I: Overview

This guidance applies to forms submitted to the New Mexico Office of the Superintendent of Insurance ("OSI") with effective dates on or after January 1, 2023, for:

- Pediatric only, adult only, and family (covering both pediatric dental and adult dental services) stand-alone dental plans (SADPs) sold through the New Mexico Health Insurance Exchange (NMHIX), and
- Pediatric only, adult only and family NMHIX-certified dental plans sold outside the NMHIX.

Section II: General Guidance

Sec. 2.1: Applicability

Throughout this document, references to stand-alone dental plans include all NMHIX-certified dental plans sold on the exchange, and their mirrored counterparts. Rate and form filings for SADPs must be submitted as a separate filing from the medical plans.

Stand Alone Dental plans offered outside the NMHIX only to supplement medical plans, such that the medical plans will comply with federal requirements to offer all ten Essential Health Benefits outside the NMHIX as required under the Public Health Services Act, must follow the NMHIX certification filing process.

Sec. 2.2: Prior approval of Rates and Forms Required

A carrier shall not issue, deliver, or use a form associated with applicable dental and vision plans, unless and until such form has been filed with and approved by the superintendent.

A carrier shall not use rates or modified rates for dental and vision plans unless and until such rates are filed with and approved by the superintendent.

Sec. 2.3: One Filing per Market

For QDP certification purposes only, OSI will not accept more than one SADP filing from a carrier for each market (individual or small group). Carriers offering pediatric and adult plans on and off Exchange, must submit one filing per market and include all relevant information in the same Form/Rate filing. In other words, there is no need to file separate "mirror" submissions or separate filings for pediatric and adult plans. SADP carriers may format their actuarial memorandum to adequately address their entire filing. This may include separate sections in the actuarial memorandum for HMO vs. PPO plans for the same carrier, and for adult and pediatric plans. However, separate forms must be submitted for HMO and PPO plans issued by the same carrier, within the same rate/form filing. On-exchange and off-exchange forms must be clearly identified using the prescribed naming convention and filed together under the Forms Schedule tab in SERFF.

Sec. 2.4: Guaranteed vs. Estimated Basis for Rates

Standalone dental plans are not subject to the insurance market reform provisions of the Affordable Care Act, such as guaranteed availability and renewability of coverage.

For all plans other than the SHOP plans, rates should be identified as either "guaranteed" or "estimated" in the Plans and Benefits Template as well as the actuarial memorandum and can

either be individually age rated or family tier rated. For SHOP plans, rates must be "guaranteed" and individually age rated. For rates that are identified as "estimated", dental carriers may make premium adjustments upon enrollment of the consumer but must indicate that rates are not guaranteed.

Although the pediatric essential health benefit ("EHB") does not need to be offered at a particular Actuarial Value (AV), the AV of the Pediatric EHB for each plan must be certified by a member of the American Academy of Actuaries. The AV compares the cost of a plan after member cost-sharing is considered against the same plan assuming 100% payment by the carrier for all covered dental services.

Sec, 2.5: Essential Health Benefits (EHB)

All carriers offering stand-alone dental plans intended to cover EHBs must ensure that all plans covering pediatric dental services comply with the New Mexico Dental EHB Benchmark Plan, which may be found on the CMS website here.

Sec. 2.6: Pediatric Dental Requirements

Stand-alone dental plans that provide coverage for the pediatric dental EHB should cover members until at least the end of the month in which the member turns age 19.

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 EHBs and for adult dental benefits.

Under 45 CFR 156.150(a), SADPs are required to have a reasonable annual limit on pediatric dental EHB cost sharing. For 2023, a pediatric dental EHB cost sharing annual limit at or below $375 for a plan with one child enrollee, or $750 for a plan with two or more child enrollees is considered reasonable. No higher limit will be approved.

Sec. 2.7: Rating Areas

Stand-alone dental issuers in the Individual market must use the five standardized rating areas:

- Rating area 1: Bernalillo, Sandoval, Torrance, Valencia,
- Rating area 2: San Juan
- Rating area 3: Dona Ana
- Rating area 4: Santa Fe
- Rating area 5: All other counties (Catron, Chaves, Cibola, Colfax, Curry, De Baca, Eddy, Grant, Guadalupe, Harding, Hidalgo, Lea, Lincoln, Los Alamos, Luna, McKinley, Mora, Otero, Quay, Rio Arriba, Roosevelt, San Miguel, Sierra, Socorro, Taos, Union)

An Issuer must identify the service area associated with each proposed SADP and disclose it in the EOC. An Issuer must offer at least one plan with a state-wide service area. Any other service area must cover a minimum geographic area that is at least the entire geographic area of a county, or a group of counties, unless OSI determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interests of qualified individuals and employers. (45 C.F.R. § 155.1055(a)) OSI will review to ensure that the service area of an SADP has been established without regard to racial, ethnic, language, or health status-related factors as specified under section 2705(a) of the ACA, or other factors that exclude specific high utilizing, high cost or medically underserved populations.

Sec. 2.8: Variability

Variability in Stand Alone Dental Plans will be allowed in very limited circumstances. An example of permissible variability is to allow for administrative changes such as to populate the policy number, insured's name(s) and effective date(s). All variability must be clearly described in a Statement of Variability (SOV). For specific variable language, the SOV must state the exact language as it will appear in the form that will be issued to the consumer. If language is bracketed because it will either be included or excluded, the SOV must state so and explain under what circumstances the information will be included or removed.

Stand Alone Dental Plan cost sharing cannot be variable. Exact values must be provided in each Outline of Coverage (OOC).

Nested brackets, indicating variability within the variable information is not allowed.

General and vague explanations are insufficient. Use of phrases such as "as necessary," "as negotiated by the policyholder," "flexibility in plan design," "but not limited to" or "will comply with statutory requirements" are too vague and non-descript and are not allowed.

No change in variability can be made which in any way expands the scope of the wording being changed.

Sec. 2.9: Treatment of Proprietary Information

OSI recognizes that carriers may consider certain information to be proprietary and confidential. Therefore, carriers are required to submit confidentiality requests at least 10 days in advance of a SADP Application submission, pursuant to Bulletin #2022-003. Upon the filing disposition, public access will be granted to all parts of a filing that are not approved by OSI as "confidential." Please note that upon request the rates will remain confidential during the entire review period. Issuers are expected to submit their best competitive and actuarily sound rates with their initial SADP application

SADP carriers must use the Confidentiality Request Form and Determination Notice required by OSI. A copy may also be requested from Freya Tschantz via email at freya.tschantz2@state.nm.us.

Sec 2.10: Timeline

PY2023 QHP and SADP Certification Submission Schedule	
Activity	**Date**
Confidentiality Request	Due 10 days prior to filing submission date
QHP and SADP Application submission window opens	4/22/2022
QHP and SADP Application submissions deadline (Form/Rate Filings, Binders, as well as Transparency in Coverage and Plan ID Crosswalk data)	05/31/2022
Individual QHP and SADP Application Transfer to beWellnm (Forms and Rates)	06/06/2022
SHOP QHP and SADP Application Transfer to beWellnm (Forms and Rates)	06/07/2022
Risk Adjustment rate revisions	07/08/2022-07/15/2022
48-hour turn-around on carrier responses to form and rate review objections	08/01/2022
24-hour turn-around on carrier responses to form and rate review objections	08/08/2022
Approval, Certification and Transfer of Individual and SHOP Plans	**08/15/2022**
URL Template Links	09/12/2022
Open Enrollment Starts	11/01/2022

Section III: Submitting Filings in the System for Electronic Rate and Form Filing ("SERFF")

Sec 3.1: Complete submission

Each rate/form filing submission is expected to stand on its own and must not refer to any other filing. SADP carriers are expected to submit a combined rate/form filing in SERFF, under the specific tabs listed. The following documents must be included with each rate/form filing:

- Forms Schedule tab
    1. Clean copies of Policy, Certificate, Schedule of Benefits, Rider, Endorsement, Application and Enrollment forms, as applicable
- Rate/Rule Tab
    1. Rate manual
    2. Sample rate calculation
- Supporting Documentation Tab
    1. Actuarial Memorandum including required exhibits, prepared in accordance with Section IV below, and addressing all items in the SADP rate Checklist
    2. Additional supporting information/exhibits
    3. Stand-Alone Dental Plan Actuarial Value Supporting Documentation and Justification
    4. Stand - Alone Dental Plans - Description of EHB Allocation
    5. Dental rate filing checklist
    6. Dental form filing Checklist
    7. Additional supporting information/exhibits
    8. Redlined versions of all related forms:
        - Outline of Coverage
        - Policy/Contract/ Evidence of Coverage
        - Certificate of coverage (group plans)
        - Rider, endorsement
    9. Redlined versions of rate related materials
    10. Statement of Variability
    11. Certificate of Readability
    12. Copy of approved confidentiality request (per OSI Bulletin #2022-003)
- Filing Fee Tab
    1. Filing fess due pursuant to 59A-6-1V - $80 per package/Schedule of Benefits or Outline of Coverage

The following documents must be included with SERFF Binder in Plan Management:

- Associated Schedule Items
    1. All form and rate filing forms must be associated appropriately
- Templates Tab
    1. Plan and Benefit Template
    2. Network ID Template
    3. Service Area Template
    4. Essential Community Provider (ECP)/Network Adequacy Template
    5. Rate Data Template
    6. Rating Business Rules Template
    7. Transparency in Coverage Template
- Binder Supporting Documentation Tab
    1. QHP Issuer Compliance Plan and Organizational Chart Cover Sheet Template
    2. Cover Sheet
    3. Compliance Plan
    4. Organizational Chart
    5. Essential Community Provider Supplemental Response Form
    6. Statement of Detailed Attestation Responses for SBM Issuers
    7. Partial County Service Area justification if applicable
    8. Stand Alone Dental Plan Actuarial Value Supporting Documentation and Justification
    9. Stand Alone Dental Plans - Description of EHB Allocation
    10. A screen print of the output obtained from running the CMS tools
    11. Plan ID Crosswalk Template
    12. Issuer URL Template
    13. Frozen Template
    14. Administrative Data Template
    15. Network Adequacy Attestation

Sec. 3.2: Administrative Information

The SADP certification process requires an Issuer to submit administrative data that will be used for operational purposes. An Issuer is required to submit this information annually as part of their Binder Submission and report changes to previously reported information within 30 days. Issuers must contact OSI for details on the data elements to be collected and their method of delivery to OSI and NMHIX.

Sec. 3.3: HIOS Issuer ID

Prior to completing a Plan and Benefits Template and submitting an SADP application, an Issuer must register their HIOS Product IDs via HIOS and obtain HIOS Issuer ID for Rate Review.

Sec. 3.4: Required Use of CMS Review Tools and Data Integrity Tool

An Issuer must use the CMS Review tools prior to submitting data to OSI and submit a screen print of the tool review outputs. Failure to identify and correct errors identified by the CMS review tools prior to submission may result in denial of an SADP certification. The review tools are available at https://www.qhpcertification.cms.gov/s/Review%20Tools.

Sec. 3.5: URLs

A SADP Issuer must submit CMS mandated URL data for the plan(s) it intends to offer on the Exchange. Each URL should lead to a live, active webpage that contains accurate information by the deadlines below.

URL Type	Submission Deadline	Live and Active Deadline
Transparency in Coverage	May 16, 2022	Upon Submission
OOC, Plan Brochure, Payment, and Network	May 16, 2022	September 12, 2022

Sec. 3.6: Alignment of Data Template information with Form filing documentation and OOC

All data contained within an SADP Application must be complete, accurate and consistent. The information included in the policy documents, OOC, data templates and supplemental documentation submitted as part of the application must be consistent. In addition, the information reported in HIOS and the NMHIX Plan Management portal must be consistent with the information included in the SADP Application submitted via SERFF.

Sec. 3.7: Standardized Naming Convention

Sec. 3.7.1: Documents Using Standardized Naming Convention

Carriers are expected to submit the following documents using the standard naming convention, as outlined below:

- All forms under the Forms Schedule Tab
- Actuarial memorandum
- Dental Form and Rate Combined checklist

All naming conventions and terminology must be consistent between the form filing, binder and templates. For example, each form filing naming convention should reflect the name of the plan as it is stated in the binder and listed within the PBT. In addition, the plan names should reflect if the plan is high/low and pediatric/adult.

Sec. 3.7.2: File Naming Convention

CarrierName_YYYYmkt_ Plantype_v#_ Filedesc.filetype

- **CarrierName**: Up to 6 Characters which identify the carrier

- **MMDDYY**: e.g., 010123 for filings effective January 1, 2023
- **mkt**: **indicate one of the following**:
    - "i" for individual (non-group)
    - "s" for filings that include small groups only, (2 to 50 employees)
    - "l" for filings that include large groups only (more than 50 employees)
    - "g" for filings that include groups of all sizes (more than 2 employees)

- **Plantype: indicate one of the following**
    - SADPF (Family dental coverage – pediatric and adult)
    - SADPP (Pediatric only coverage)
    - NSADPF (Non SADP - Family)
    - NSADPA (Non SADP – Adult only)
    - NSADPP (Non-SADP Pediatric only)

- **V#:** v followed by the version number (increment for each update to the filing)
- **Filedesc**: indicate one of the following:
    - **AMR** – Actuarial Memorandum – redacted
    - **AM** – Actuarial memorandum – unredacted
    - **RTCK** – Rate checklist
    - **FMCK** – Form checklist
    - **CER** = Certificate/EOC
    - **OOCH** = Outline of Coverage (High)
    - **OOCL =** Outline of Coverage (Low)
    - **POL** = Policy/Contract
    - **AP** = Application
    - **EF** = Enrollment form
    - **End** = Endorsement
    - **Form**=Formulary
    - **Rd** = Rider
    - ID or RX Card
    - **RT** – Rates Template
    - **ECPT -** Essential Community Providers Template

Rate Filing Example: ABC_010123_i_SADPF_v1_RTCK. xlsx is the initial 2023 SADP rate filing checklist for the ABC Health Plans individual filing for both pediatric and adult coverage.

Forms Example: ABC_010123_i_SADPP_v2_Plan1_OOCH.xlsx is the 2nd revision of the Outline of Coverage for the High individual Pediatric Only Plan, named Plan 1*, offered by ABC Health Plans.
*Plan 1 is the name of the plan as it is stated in the title of the OOC and is listed under the Plans tab in the binder and specified as the plan name in the PBT.

Section IV: Dental Requirements

Sec. 4.1: Adult Coverage Requirements

For coverages effective on or after January 1, 2022, in addition to the federal requirements, all carriers providing ***adult*** dental coverage must comply with the requirements of 13.10.35 NMAC. These requirements are listed in the New Mexico Form filing checklist.

- General prohibited Policy Provisions – 13.10.35.8 NMAC
- General Standards for Policies and Benefits 13.10.35.9 NMAC
- Dental Plans 13.10.35.10 NMAC
- Coordination and Combination of Benefits 13.10.35.12 NMAC
- Coverage Documentation 13.10.35.13 NMAC
- Network Adequacy 13.10.35.14 NMAC
- Utilization Management Determinations 13.10.35.15 NMAC
- Consumer Complaints 13.10.35.15 NMAC

Sec. 4.2: Benefit Waiting Periods

Waiting periods are not allowed for essential health benefits. Carriers can no longer require a waiting period for pediatric orthodontia.

Sec.4.2: Coordination of Benefit Provisions

A coordination of benefits provision in a health plan must:

- be explicitly authorized by, and conform to, New Mexico or federal law,
- be supported by an express agreement between multiple carriers, or
- be included in a plan that is expressly approved by the OSI to provide excess or supplemental coverage,
- not provide first dollar coverage and is rated accordingly.

Sec. 4.3: Exclusions

An exclusion removes coverage for a loss that would otherwise be covered. Including a list of excluded procedures and treatments that would not normally be covered may be considered by the OSI to be deceptive, misleading, and confusing, and will not be allowed. A carrier may add language to clarify that any services not listed in the policy or contract are not covered but may not list services as excluded if they are not normally covered under this type of policy or contract.

Section V: Marketplace Certification

Sec. 5.1: SADP Certification Requirements

All SADPs intended to be sold on the Exchange must be approved and certified by NMHIX. An Issuer may apply to offer a SADP that includes coverage of pediatric dental essential health benefits. An Issuer may also apply to offer a SADP that includes both pediatric and adult dental benefits, or adult-only coverage.

Only a SADP certified by OSI can be offered through NMHIX. Each SADP must be certified annually and satisfy these general requirements:

- Issuer is licensed and in good standing;
- Issuer complies with non-discrimination rules;
- SADP meets service area and network access requirements, including ECPs; and
- SADP complies with benefit design standards such as cost-sharing limits, actuarial value requirements and essential health benefits designed for an SADP.

Sec. 5.2: Filing Fees

NMSA 1978, §59A-6-1(V) requires a rate filing fee to be submitted for each SADP variation. This means that a $50 fee is due for the rates associated with each OOC. A package submission fee must be paid for each combination of a single policy, its associated application, OOC, and riders or endorsements. For example, if the filing submission includes 1 Policy, 1 Certificate and 10 OOCs, the total fees due would be 10 x (50+30)=$800.

Sec. 5.3: Certification and Recertification of an SADP

An Issuer must submit SERFF filings and the associated Binder to OSI by the applicable submission deadline. The Plan Management Binder must be accurately associated with the form and rate filing and contain all templates and requested SADP data elements.

Sec. 5.4: Outline of Coverage

An Issuer must provide an Outline of Coverage (OOC) for each SADP. The file name for each OOC must indicate if the plan provides adult or pediatric dental coverage and whether it is a high or low plan. In addition, the terms used in the OOC must be consistent with the terms used in the policy forms, binder and template. For example, an Outline of Coverage should not use the terms “Basic”, “Intermediate” and “Major Services”, when the P&B template uses the terms “Routine Dental Services”, “Dental Check-Up”, “Basic Dental Care”, “Orthodontia” and “Major Dental Care”.

As with all forms, each OOC must have a form number in the lower left corner and a HIOS Plan Standard Component ID in the right lower corner of the form.

Sec. 5.5: E Community Provider (ECP) Requirement

An SADP network must include ECPs as required in 45 C.F.R. §156.235.

Sec. 5.6: Actuarial Value

Pediatric SADPs must provide the pediatric dental EHBs mandated by the NM Benchmark plan and meet the actuarial value requirement specified in 45 C.F.R. § 156.150.
Adult dental benefits are not subject to any actuarial value requirement.

Sec. 5.7: Non-Discrimination

An Issuer and its SADP must not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation, and must not have benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs. 45 C.F.R. § 156.200(e) and 156.225(b). OSI will review information contained in the contract, Plans and Benefits Template, OOC and all relevant documents, including, but not limited to the "explanations" and "exclusions" sections, to identify potentially discriminatory anomalies or wording.

Sec. 5.8: Licensing and Good Standing

An SADP Issuer must be licensed and in good standing in New Mexico. 45 C.F.R. § 156.200(b)(4). OSI, in consultation with CMS and NMHIX, will consider any complaints it receives and other QHP issuer oversight findings, including state enforcement findings, to determine whether an Issuer is in good standing.

Sec. 5.9: Service Area

An Issuer must identify the service area associated with each proposed SADP and disclose it in the EOC. An Issuer must offer at least one plan with a state-wide service area. Any other service area must cover a minimum geographic area that is at least the entire geographic area of a county, or a group of counties, unless OSI determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interests of qualified individuals and employers. 45 C.F.R. § 155.1055(a). OSI will review to ensure that the service area of an SADP has been established without regard to racial, ethnic, language, or health status-related factors as specified under section 2705(a) of the ACA, or other factors that exclude specific high utilizing, high cost or medically underserved populations.

Section VI: Definitions

Stand Alone Dental Plan or "SADP" - a dental plan that provides pediatric oral services established as an essential health benefit under ACA § 1302(b) and defined under the New Mexico Benchmark plan.

Service Area – the geographical area where the insurer's members can get covered care under their plan.

Qualified Dental Plan or "QDP**"** - a Stand-Alone Dental Plan certified to be sold through the New Mexico Health Insurance Exchange, beWellnm.

Outline of Coverage or "OOC" **-** the schedule of benefits pages or summary of benefits and coverage that includes the cost-sharing features of the plan.