Adopt Section 6446 to read:

SECTION 6446: PEDIATRIC DENTAL HEALTH PLAN SOLICITATION

(a) The Exchange will solicit bids from Dental Plan Issuers to offer market and sell Pediatric Essential Health Benefits Dental Plans. Bids are sought for statewide and regional dental plans.

(b) Definitions: For purposes of this section, the following terms mean:
  (1) Bidder: A Dental Plan Issuer seeking to enter into a contract for the sale of Pediatric EHB Dental Plans through the Exchange.
  (2) Coalition: A group of individual Dental Plan Issuers who together submit a bid to provide statewide dental coverage through the Exchange.
  (3) Dental Plan Issuer: A carrier licensed to provide dental coverage in the state of California.
  (4) Member or Enrollee: an individual who is enrolled in a Pediatric EHB Dental Plan.
  (5) Pediatric Essential Health Benefits Dental Plan or Pediatric EHB Dental Plan: A dental benefit plan for children up to age 19, providing dental services coverage and which must meet all applicable requirements of the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), including actuarial value requirements and prohibiting the imposition of frequency limitations on covered dental care.
  (6) Pediatric EHB Dental Standard Benefit Plan Design: Benefit plan design adopted by the Exchange which stipulates required coverage levels, cost-sharing amounts, covered services and deductible levels in accordance with required actuarial values.
  (7) Primary Issuer: A Dental Plan Issuer responsible for aggregating and managing members of a Coalition.
  (8) Solicitation: The California Health Benefit Exchange 2012 – 2013 Solicitation to Dental Issuers And Invitation to Respond v2, dated February 1, 2013.

(c) To be considered for participation as a Pediatric EHB Dental Plan, Bidder must meet the following requirements when submitting responses to the Solicitation:
  (1) Bidder must hold the required licenses to operate as a Dental Plan Issuer in the State of California. Bidder must verify whether it is in good standing with all appropriate local, state and federal licensing authorities. Good standing means that the Bidder has had no fines, penalties levied, citations, or ongoing disputes, which are of a material

nature, with either the California Department of Insurance or the Department of Managed Health Care in the last two years.

(2) Bidder must verify whether it is seeking a certificate of authority or an amendment to an existing certificate of authority from the appropriate regulatory agency, which is either the California Department of Insurance or the Department of Managed Health Care, in order to meet the requirements of individual and small group products to be offered in the California Health Benefit Exchange.

(3) In response to this Solicitation, Bidder must submit all material necessary to obtain approval of Pediatric EHB Dental Plans to the appropriate California regulatory agency.

(4) Bidder must bid to cover its entire licensed service area, and must verify that it has done so.

(5) Bidder must use low-income population data provided by the Exchange in the Bidder's Library on the HBEX 15 Solicitation at http://www.healthexchange.ca.gov/Solicitations/Documents/Dental%20Providers.pdf to create and submit maps showing contracted Federally-Qualified Health Centers and other dental providers serving low-income populations plotted by county.

(6) Bidder must have the ability to show the Exchange an example of a member website.

(7) Bidder may only vary the premium for the Pediatric EHB Dental Plan by geography (rating region), by coverage tier, and by actuarial value level.

(8) If a Bidder chooses to submit a bid for statewide coverage as a Coalition of multiple Dental Plan Issuers, a Primary Issuer must take responsibility for aggregating and managing Coalition members. All Dental Plan Issuers who are members of the Coalition must be a party to the Coalition contract with the Exchange and must individually meet the Exchange's requirements in this section.

(9) A successful Bidder must attest that it will use a health assessment tool to identify enrollees who are in need of covered restorative treatment services at the time of enrollment.

(10) A successful Bidder must attest that it will provide reports to the Exchange related to utilization, costs, quality, operations and performance guarantees.

(11) A successful Bidder must attest that it will build data interfaces with the Exchange's eligibility and enrollment systems and report transactions to the Exchange.

(12) A successful Bidder must attest that it will be ready to accept enrollment as of October 1, 2013.

(13) Bidder must maintain a system of accountability for quality improvement in accordance with all applicable statutes and regulations.

(14) Bidder must provide its active dental membership, as of July 1, 2012, in the state of California, defined by market segment (individual, employer-sponsored vs. voluntary).

(15) Bidder must describe three attributes of its organization Bidder believes distinguishes itself from its competitors.

(16) Describe up to three examples of Bidder's successful innovations to improve service quality and reduce costs.

(17) Verify whether Bidder offers discount programs related to non-covered services.

(18) Provide a brief description of any outside vendors that Bidder will utilize to serve the Exchange.

(19) Provide the physical location of all administrative teams that Bidder proposes to serve The Exchange.

(20) Describe whether the account team members (e.g. implementation manager, claims specialist, member services manager, etc.) will be dedicated to the Exchange.

(21) Describe whether a dedicated implementation manager will be assigned to lead and coordinate the implementation activities with the Exchange.

(22) Describe the services and support Bidder will provide during the implementation process and what information and resources will be required of the Exchange.

(23) Should Bidder's organization be selected, explain how Bidder plans to accommodate the additional enrollees.

(24) Describe whether Bidder will provide the Exchange with a dedicated claims processing unit.

(25) Verify whether the Exchange will retain the right to annually audit/assess the plan administrator's compliance with the terms of the contract, including but not limited to a claims audit or audit for cause of irregular activity, either directly or through its authorized agents. Verify whether you will provide 2 years' worth of claims experience with no limit on the number of claims that may be reviewed and that any audits will be completed with no additional cost to the Exchange.

(26) Describe Bidder's claims administration procedures

(27) What guarantees does Bidder provide to ensure members will not be balance billed for in-network services?

(28) Describe how Bidder identifies and addresses inappropriate patterns of treatment.

(29) Describe Bidder's fraud and abuse program.

(30) Describe what steps Bidder takes to protect patient privacy and how Protected Health Information (PHI) is handled?

(31) Verify whether the Exchange will be provided a dedicated member services unit.

(32) Verify whether Bidder will provide a dedicated interactive voice response member services number and indicate which member services options are available via interactive voice response.
(33) Bidder must indicate the ways in which Bidder's member services organization is able to accommodate the special language needs of enrollees.
(34) Confirm that the following programs or services will be made available to enrollees in 2014: risk assessments, disease management programs, and care reminders.
(35) Provide a description of Bidder's standard communications materials.
(36) Bidder must indicate any plan sponsor tools and information Bidder offers, how it may be accessed, the training on those tools and information, and the level of guaranteed availability for the tools and information.
(37) Describe whether Bidder owns its provider networks or contracts with other organizations and if Bidder contracts with other organizations, please provide those organizations' names.
(38) Verify whether Bidder's provider network directory is available online.
(39) Describe how often Bidder's online and printed directory is updated.
(40) Bidder must specify the number of contracted providers for each provider type, and the number of open practices for each provider type for each rating region.
(41) Bidder must describe its network growth plan for the California network in 2014.
(42) Bidder must describe its process for recruiting new dentists.
(43) Bidder must provide the percentage of Bidder's network providers that are not accepting new patients.
(44) Bidder must provide the percentage of Bidder's network providers that have office visit waiting times in excess of 30 days.
(45) Bidder must provide its network turnover rate or rate of termination?
(46) Bidder must describe in detail its credentialing and re-credentialing processes for providers.
(47) Provide a description of the quality indicators used to evaluate Bidder's provider network and whether Bidder has an incentive program for network providers.
(48) Describe the steps Bidder takes to investigate member-reported quality of care issues regarding a provider and whether it has terminated network dentists based on its investigation of a member-reported quality complaint.
(49) Bidder must provide its target and actual performance on its customer service performance measures, utilization performance measures, rating performance measures, and any other metrics that are in place to monitor the performance of member services.

(50) Describe any new positions proposed for Bidder's Exchange-related sales and marketing activities.

(51) Describe Bidder's plan to cooperate with Exchange marketing and outreach efforts, including internal and external training, collateral materials, and other efforts.

(53) Bidder must implement a quality assurance program in accordance with California Code of Regulations, Title, 2 § 1300.70, for evaluating the appropriateness and quality of the covered services provide to members.

(d) Bidder must submit a bid for at least one of the following standard plan designs (PPO and/or DMHO):

	PPO:		DHMO:	
Procedure Categories	**PPO High**	**PPO Low**	**DHMO High**	**DHMO Low**
	Plan Pays:		Copays:	
Diagnostic & Preventive (D&P) X-rays, Exams, Cleanings Sealants	100%	100%	$0	$0
Office Visit	n/a	n/a	$0	$20
Basic Services - Basic Restorative	80%	50%	$40	$95
Major Services - Crowns & Casts, Prosthodontics, Endodontics, Periodontics, Oral Surgery	50%	50%	$365	$365
	Enrollee Pays:			
Orthodontics (Medically Necessary)	50%	50%	$1,000	$1,000
Deductible	$50 (not applied to D&P)	$60 (applied to all services)	None	None
Annual Maximum	None	None	None	None
OOP Maximum	$1,000	$1,000	$1,000	$1,000
Waiting Periods (Major & Ortho)	None	None	None	None
Actuarial Value (AV)	86%	72%	87%	72%
			DHMO copayments for Basic Services and Major Services vary by procedure within these categories. Using a statistically significant set of claims data, the Bidder's average copay charged for procedures in this category cannot exceed the stated amount.	

(e) The evaluation of dental plan bids will be guided by the following principles of evaluation:
   (1) The Exchange will seek to encourage value competition based on quality, service, and price.
   (2) The Exchange will seek to encourage competition based upon meaningful dental plan choice and product differentiation by requiring Bidders to submit one of the Exchange's adopted standardized benefit plan designs in each region for which they submit a bid.
   (3) The Exchange will seek to encourage competition throughout the State by requiring that dental plan issuers submit bids in all geographic service areas in which they are licensed.
   (4) The Exchange will seek to encourage alignment with providers and delivery systems that serve the low-income population through additional consideration for bids that demonstrate an ongoing commitment or capacity to serve the cultural, linguistic, and dental care needs of the low income and uninsured populations, beyond the minimum requirements adopted by the Exchange.

(f) Bidder must comply with the following response instructions:
   (1) Responses are due by 5:00 pm Pacific Time on April 2, 2013. Responses received after the response deadline will be rejected.
   (2) Each firm may submit only one response as a primary vendor, and up to one response as a member of a Coalition. For the purposes of this paragraph, "firm" includes a parent corporation of a firm and any other subsidiary of that parent corporation. If a firm submits more than one response, as either a primary vendor or as a member of a coalition, the Exchange will reject all responses submitted by that firm.
   (3) Responses must include a cover letter with the following information: Bidder's company name, mailing address and telephone number, contact person's name, title, email address, telephone number and fax number, title of this bid, federal tax identification number, submission date of proposal, original signature of an individual authorized to enter into contracts on behalf of the bidder (provided in blue ink).

Authority: Government Code Section 100504

Reference: Government Code Sections 100502, 100503, 100504, 100505, and 100507