



**Qualified Dental Plan Certification  
Application**

Plan Year 2017  
Individual Marketplace

COVERED CALIFORNIA, 1601 Exposition Blvd., Sacramento, CA 95815

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**1. General Information and background**

**1.1 Attestation**

The Exchange intends to make this application available electronically. Applicant must complete the following:

Issuer Name: \_\_\_\_\_

NAIC Company Code: \_\_\_\_\_

NAIC Group Code: \_\_\_\_\_

Regulator(s): \_\_\_\_\_

Federal Employer ID: \_\_\_\_\_

HIOS/Issuer ID: \_\_\_\_\_

Corporate Office Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Primary Contact Name: \_\_\_\_\_

Contact Title: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_

Contact Email: \_\_\_\_\_

On behalf of the Applicant stated above, I hereby attest that I meet the requirements in this Certification Application and certify that the information provided on this Application and in any attachments hereto are true, complete, and accurate. I understand that Covered California may review the validity of my attestations and the information provided in response to this application and if any Applicant is selected to offer Qualified Dental Plans, may decertify those Qualified Dental Plans should any material information provided be found to be inaccurate. I confirm that I have the capacity to bind the issuer stated above to the terms of this Certification Application.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

## 1.2 Purpose

The California Health Benefit Exchange (Exchange) is accepting applications from eligible Dental Insurance Issuers<sup>1</sup> (Applicants) to submit proposals to offer, market, and sell qualified dental plans (QDPs) through the Exchange beginning in 2016, for coverage effective January 1, 2017. All Dental Issuers currently licensed at the time of application response submission are eligible to apply for certification of proposed Qualified Dental Plans (QDPs) for the 2017 Plan Year. The Exchange anticipates QDP issuers selected for the 2017 Plan Year will execute multi-year contracts with the Exchange, and application for certification for Plan Years 2018 and 2019 will be limited to those QDP issuers contracted for Plan Year 2017 that continue to meet certification standards and performance requirements, and plans newly licensed and offering in the applicable market after May 2, 2016. The Exchange will exercise its statutory authority to selectively contract for health care coverage offered through the Exchange to review submitted applications and reserves the right to select or reject any Applicant or to cancel the Application at any time.

Issuers who have responded to the Notice of Intent to Apply will be issued a web login for on-line access to the final application, and instructions for use of the login for the QDP Certification Application.

## 1.3 Background

Soon after the passage of national health care reform through the Patient Protection and Affordable Care Act of 2010 (ACA), California enacted legislation to establish a qualified health benefit exchange. (California Government Code § 100500 et seq.; Chapter 655, Statutes of 2010-Perez and Chapter 659, Statutes of 2010-Alquist.) The California state law is referred to as the California Patient Protection and Affordable Care Act (CA-ACA).

The California Health Benefit Exchange offers a statewide health insurance exchange to make it easier for individuals to compare plans and buy health insurance in the private market. Although the focus of the Exchange is on individuals who qualify for tax credits and subsidies under the ACA, the Exchange's goal is to make insurance available to all qualified individuals. The vision of the California Health Benefit Exchange is to improve the health of all Californians by assuring their access to affordable, high quality care coverage. The mission of the California Health Benefit Exchange is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers

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<sup>1</sup> The term "Dental Issuer" used in this document refers to both dental plans regulated by the California Department of Managed Health Care and insurers regulated by the California Department of Insurance. It also refers to the company issuing dental coverage, while the term "Qualified Dental Plan" refers to a specific policy or plan to be sold to a consumer that has been certified by Covered California. Qualified Dental Plans are also referred to as "products". The term "Applicant" refers to a Dental Issuer who is seeking to have its products certified as Qualified Dental Plans.

consumers to choose the health plan and providers that give them the best value.

The California Health Benefit Exchange is guided by the following values:

- **Consumer-Focused:** At the center of the Exchange's efforts are the people it serves. The Exchange will offer a consumer-friendly experience that is accessible to all Californians, recognizing the diverse cultural, language, economic, educational and health status needs of those it serves.
- **Affordability:** The Exchange will provide affordable health insurance while assuring quality and access.
- **Catalyst:** The Exchange will be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities.
- **Integrity:** The Exchange will earn the public's trust through its commitment to accountability, responsiveness, transparency, speed, agility, reliability, and cooperation.
- **Transparency:** The Exchange will be fully transparent in its efforts and will make opportunities available to work with consumers, providers, health plans, employers, purchasers, government partners, and other stakeholders to solicit and incorporate feedback into decisions regarding product portfolio and contract requirements.
- **Results:** The impact of the Exchange will be measured by its contributions to decrease the number of uninsured, have meaningful plan and product choice in all regions for consumers, improve access to quality healthcare, promote better health and health equity, and achieve stability in healthcare premiums for all Californians.

In addition to being guided by its mission and values, the Exchange's policies are derived from the federal Affordable Care Act which calls upon Exchanges to advance "plan or coverage benefits and health care provider reimbursement structures" that improve health outcomes. The California Health Benefit Exchange seeks to improve the quality of care while moderating cost not only for the individuals enrolled in its plans, but also by being a catalyst for delivery system reform in partnership with plans, providers and consumers. With the Affordable Care Act and the range of insurance market reforms that are in the process of being implemented, the health insurance marketplace is transforming from one that has focused on risk selection to achieve profitability to one that rewards better care, affordability, and prevention.

The Exchange needs to address these issues for the millions of Californians who enroll through the Exchange to get coverage, but it is also part of broader efforts to improve care, improve health, and stabilize rising health care costs.

The California Health Benefit Exchange must operate within the federal standards in law and regulation. Beyond what is framed by the federal standards, California's legislature shapes the standards and defines how the new marketplace for individual and small group health insurance operates in ways specific to their context. Within the requirements of the minimum Federal criteria and standards, the Exchange has the responsibility to "certify" the Qualified Health Plans that will be offered in the Exchange.

The state legislation to establish the California Health Benefit Exchange gave authority to the Exchange to selectively contract with carriers so as to provide health care coverage options that offer the optimal combination of choice, value, quality, and service and to establish and use a competitive process to select the participating health issuers.

These concepts, and the inherent trade-offs among the California Health Benefit Exchange values, must be balanced in the evaluation and selection of the Qualified Health Plans that will be offered on the Individual Exchange.

This application has been designed consistent with the policies and strategies of the California Health Benefit Exchange Board which calls for the QHP selection to influence the competitiveness of the market, the cost of coverage, and how value is added through health care delivery system improvement.

#### **1.4 Application Evaluation and Selection**

The evaluation of QDP Certification Applications will not be based on a single, strict formula; instead, the evaluation will consider the mix of health and dental plans for each region of California that best meet the needs of consumers in that region and the Exchange's goals. The Exchange wants to provide an appropriate range of high quality health and dental plans to participants at the best available price that is balanced with the need for consumer stability and long term affordability. In consideration of the mission and values of the Exchange, the Board of the Exchange articulated guidelines for the selection and oversight of Qualified Health Plans which are used when reviewing the QDP application proposals for 2017. These guidelines are:

##### **Promote affordability for the consumer— both in terms of premium and at point of care**

The Exchange seeks to offer dental plans, plan designs and provider networks that are as affordable as possible to consumers both in premiums and cost sharing while fostering competition and stable premiums. The Exchange will seek to offer health and dental plans, products, and provider networks that will attract

maximum enrollment as part of its effort to lower costs by spreading risk as broadly as possible.

### **Encourage "Value" Competition Based upon Quality, Service, and Price**

While premium will be a key consideration, contracts will be awarded based on the determination of "best value" to the Exchange and its participants. The evaluation of Issuer QDP proposals will focus on quality and service components, including past history of performance, administrative capacity, reported quality and satisfaction metrics, quality improvement plans and commitment to serve the Exchange population. This commitment to serve the Exchange population is evidenced through general cooperation with the Exchange's operations and contractual requirements which includes, provider network adequacy, cultural and linguistic competency, programs addressing health equity and disparities in care, innovations in delivery system improvements and payment reform. The application responses, in conjunction with the approved filings, will be evaluated by Covered California and used as part of the selection criteria to offer issuers' products on the Exchange for the 2017 plan year.

### **Encourage Competition Based upon Meaningful QHP Choice and Product Differentiation: Standard Benefit Plan Designs<sup>2</sup>**

The Exchange is committed to fostering competition by offering QDPs with features that present clear choice, product and provider network differentiation. QDP Applicants are required to adhere to the Exchange's standard benefit plan designs in each region for which they submit a proposal. The exchange is interested in having both DHMO and DPPO products offered statewide. Within a given product design, the Exchange will look for differences in network providers and the use of innovative delivery models. Under such criteria, the Exchange may choose not to contract with two plans with broad overlapping networks within a rating region unless they offer different innovative delivery system or payment reform features.

### **Encourage Competition throughout the State**

The Exchange must be statewide. Issuers must submit QDP proposals in all geographic service areas in which they are licensed and have adequate networks, and preference will be given to Issuers that develop QDP proposals that meet quality and service criteria while offering coverage options that provide reasonable access to the geographically underserved areas of the state.

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<sup>2</sup> The 2017 Standard Benefit Designs will be finalized when the 2017 federal actuarial value calculator is finalized.



### **Encourage Alignment with Providers and Delivery Systems that Serve the Low Income Population**

Performing effective outreach, enrollment and retention of the low income population that will be eligible for premium tax credits and cost sharing subsidies through the Exchange is central to the Exchange's mission. Responses that demonstrate an ongoing commitment to the low income population or demonstrate a capacity to serve the cultural, linguistic and health care needs of the low income and uninsured populations beyond the minimum requirements adopted by the Exchange will receive additional consideration. Examples of demonstrated commitment include: having a higher proportion of essential community providers to meet the criteria of sufficient geographic distribution, having contracts with Federally Qualified Health Centers, and supporting or investing in providers and networks that have historically served these populations in order to improve service delivery and integration.

### **Encourage Delivery System Improvement, Effective Prevention Programs and Payment Reform**

One of the values of the Exchange is to serve as a catalyst for the improvement of care, prevention and wellness as a way to reduce costs. The Exchange wants QDP offerings that incorporate innovations in delivery system improvement, prevention and wellness and/or payment reform that will help foster these broad goals. This will include models of patient-centered dental homes, targeted quality improvement efforts, participation in community-wide prevention or efforts to increase reporting transparency in order to provide relevant health care comparisons and to increase member engagement in decisions about their course of care.

### **Demonstrate Administrative Capability and Financial Solvency**

The Exchange will review and consider the Applicant's degree of financial risk to avoid potential threats of failure which would have negative implications for continuity of patient care and to the healthcare system as a whole. The technology capabilities of the Issuer is a critical component of being successful on the Exchange so the technology, and associated resources of the Issuer are heavily scrutinized as this relates to long term sustainability for consumers. Additionally, we recognize that there is significant investment that will continue to be needed in areas of quality reform and improvement programs, so the Exchange is offering a multi – year contract agreement through the 2017 application. Application responses that demonstrate a commitment to the long-term success of the Exchange's mission are strongly encouraged.

## **Encourage Robust Customer Service**

The Exchange is committed to ensuring a positive consumer experience, which requires Issuers to maintain adequate resources to meet consumers' needs. To successfully serve Exchange consumers, Issuers must invest in and sustain adequate staffing, including hiring of bilingual and bicultural staff as appropriate and maintaining internal training as needed. Issuers demonstrating a commitment to dedicated administrative resources for Exchange consumers will receive additional consideration.

### **1.5 Availability**

The Applicant must be available immediately upon contingent certification as a QDP to start working with the Exchange to establish all operational procedures necessary to integrate and interface with the Exchange information systems, and to provide additional information necessary for the Exchange to market, enroll members, and provide health plan services effective January 1, 2017. Successful Applicants will also be required to adhere to certain provisions through their contracts with the Exchange, including meeting data interface requirements with the California Healthcare Enrollment, Eligibility, and Retention System (CalHEERS). Successful Applicants must execute QDP Issuer contract before public announcement of contingent certification. The successful Applicants must be ready and able to accept enrollment as of October 1, 2016.

### **1.6 Application Process**

The application process shall consist of the following steps:

- Release of the Final Application;
- Submission of Applicant responses;
- Evaluation of Applicant responses;
- Discussion and negotiation of final contract terms, conditions and premium rates; and
- Execution of contracts with the selected QDP Issuers.

### **1.7 Intention to Submit a Response**

Applicants interested in responding to this application are required to submit a non-binding Letter of Intent to Apply indicating their interest in applying and their proposed products and service areas and to ensure receipt of additional information. Only those Applicants acknowledging interest in this application by submitting a notification of intent to submit a proposal will continue to receive application-related correspondence throughout the application process.

The Applicant's letter of intent must identify the contact person for the application process, along with contact information that includes an email address, a

telephone number, and a fax number. On receipt of the non-binding letter of intent, Covered California will issue instructions and login and password information to gain access to the online portion(s) of the Application.

An Issuer's submission of an Intent to Apply will be considered confidential information and not available to the public; the Exchange reserves the right to release aggregate information about Issuers' responses. Final Applicant information is not expected to be released until selected Issuers and QDP proposals are announced in August 2016. Applicant information will not be released to the public but may be shared with appropriate regulators as part of the cooperative arrangement between the Exchange and the regulators.

The Exchange will correspond with only one (1) contact person per Applicant. It shall be the Applicant's responsibility to immediately notify the Application Contact identified in this section, in writing, regarding any revision to the contact information. The Exchange shall not be responsible for application correspondence not received by the Applicant if the Applicant fails to notify the Exchange, in writing, of any changes pertaining to the designated contact person.

**Application Contact: Taylor Priestley**  
 Taylor.Priestley@covered.ca.gov  
 (916) 228-8397

**1.8 Key Action Dates**

Action	Date/Time
Release of Draft Application for Comment	February 2016
Letters of Intent due to Covered California	February 19, 2016
Application Opens	March 1, 2016
Completed Applications Due (include 2016 Proposed Rates & Networks)	June 1, 2016
Negotiations between Applicants and Covered California	July 2016
Final QDP Certification Decisions	July 2016
QDP Contract Execution	July 2016

**2. Licensed & Good Standing**

**2.1 Indicate Applicant entity license status below:**

- Applicant currently holds all of the proper and required licenses from the Department of Managed Health Care to operate as a dental issuer as defined herein

- Applicant currently holds all of the proper and required licenses from the Department of Insurance to operate as a dental issuer as defined herein
- Applying is currently applying for licensure from the Department of Managed Health Care to operate as a dental issuer as defined herein
- Applicant is currently applying for licensure from the Department of Insurance to operate as a dental issuer as defined herein

**2.2** In addition to holding or pursuing all of the proper and required licenses to operate as a dental issuer as defined herein, the Applicant must indicate that it has had no material fines, no material penalties levied or material ongoing disputes with applicable licensing authorities in the last two years (See Appendix A Definition of Good Standing). Covered California, in its sole discretion and in consultation with the appropriate health insurance regulator, determines what constitutes a material violation for the purpose of determining Good Standing. Applicant must check the appropriate box. If Applicant does not confirm, the application will be disqualified from consideration.

- Confirmed
- Not confirmed

**2.3** If not currently holding a license to operate in California, confirm your business entity has had no material fines, no material penalties levied or material ongoing disputes with applicable licensing authorities in the last two years.

- Confirmed
- Not confirmed

### **3. Applicant Dental Plan Proposal**

Applicant must submit a dental plan proposal in accordance with submission requirements outlined in this section. Applicant may submit proposals to offer both a Children’s Dental Plan and a Family Dental Plan. Applicant’s proposal will be required to include at least one of the standard plan designs and use the same provider network for each type of standard plan design in a set of standard plans or insurance policies for specified metal level actuarial values.

In addition to being guided by its mission and values, the Exchange’s policies are derived from the Federal Affordable Care Act which calls upon the Exchanges to advance “plan or coverage benefits and health care provider reimbursement structures” that improve health outcomes. The California Health Benefit

Exchange seeks to improve the quality of care while moderating cost not only for the individuals enrolled in its plans, but also by being a catalyst for delivery system reform in partnership with plans, providers and consumers. With the Affordable Care Act and the range of insurance market reforms that have been implemented, the health insurance marketplace will be transformed from one that has focused on risk selection to achieve profitability to one that will reward better care, affordability and prevention.

Tiered networks are not permitted. Applicants must agree to adhere to the Exchange's standard benefit plan designs without deviation.

#### Plan or Policy Submission Requirements

QDP Applicant may submit DPPO and DHMO product proposals in its proposed rating regions. Applicant's proposal must include coverage of its entire licensed geographic service area for which it has adequate network.

**3.1** Applicant must certify its proposal includes a dental product including the pediatric dental Essential Health Benefit meeting an actuarial value of 85% for each individual plan it proposes to offer in a rating region. If not, the Applicant's response will be disqualified from consideration. Complete Attachment A (Plan Type by Rating Region (Individual Market)) to indicate the rating regions and number and type of plans for which you are proposing a QDP in the Individual Exchange.

- Yes, completed Attachment to indicate the rating regions and number and type of plans proposed
- No

**3.2** Applicant must confirm it will adhere to Covered California naming conventions for on-Exchange plans and off-Exchange mirror products pursuant to Government Code 100503(f).

- Confirmed
- Not confirmed

**3.3** Applicant must comply with 2017 Standard Benefit Plans Designs. Applicant must complete and upload through System for Electronic Rate and Form Filing (SERFF) the Plans and Benefits template located at:  
<https://www.cms.gov/ccio/programs-and-initiatives/health-insurance-marketplaces/qhp.html>.

- Confirmed, template submitted
- Not confirmed, template not submitted

**3.4** Applicant must indicate how it provides plan enrollees with current information regarding annual out-of-pocket costs, status of deductible, status of benefit limit if applicable, and total oral health care services received to date. Select all that apply.

- Status of deductible, out-of-pocket costs, and oral health services received to date provided through member login to the dental plan website
- Status of deductible, out-of-pocket costs, and oral health services received to date provided by mailed document upon request
- Status of deductible, out-of-pocket costs, and oral health services available upon member request to customer service
- Other, describe:
- Status of deductible, out-of-pocket costs, and oral health services received to date not provided

**3.5** Applicant must indicate if proposed QDPs will include coverage of non-emergent out-of-network services.

- Yes, proposed QDPs will include coverage of non-emergent out-of-network services. If yes, with respect to non-network, non-emergency claims, describe the terms and manner in which Applicant administers out-of-network benefits.
- No, proposed QDPs will not include coverage of non-emergent out-of-network services.

**3.6** If yes to 3.5, and applicable to response, can Applicant administer a “Usual, Customary, and Reasonable” (UCR) method utilizing the nonprofit FAIR Health ([www.fairhealth.org](http://www.fairhealth.org)) database to determine reimbursement amounts? What percentile does Applicant target for non-network UCR? Can Applicant administer different percentiles? What percent of Applicant’s in-network contract rates does Applicant’s standard non-network UCR method reflect?

**3.7** Applicant must submit as attachment draft Evidence of Coverage or Policy language and draft Schedules of Benefits describing proposed 2017 QDP benefits. This draft language is to be submitted with the response to this application, prior to or contemporaneous to filing with the applicable regulator.

**3.8** Preliminary Premium Proposals: Final negotiated and accepted premium proposals shall be in effect for coverage effective January 1, 2017. Premium

proposals are considered preliminary and may be subject to negotiation as part of QDP certification and selection. Premium proposals will be due June 1, 2016. To submit premium proposals for Individual products, QDP applicants must complete and upload through System for Electronic Rate and Form Filing (SERFF) the Rates Template located at: <https://www.cms.gov/ccio/programs-and-initiatives/health-insurance-marketplaces/qhp.html>. Premium may vary only by geography (rating region), by age, by coverage tier, and by actuarial value metal level.

Applicant shall provide, upon the Exchange's request, in connection with any negotiation process as reasonably requested by the Exchange, detailed documentation on the Exchange-specific rate development methodology. Applicant shall provide justification, documentation, and support used to determine rate changes, including adequately supported cost projections. Cost projections include factors impacting rate changes, assumptions, transactions and other information that affects the Exchange-specific rate development process. The Exchange may also request information pertaining to the key indicators driving the medical factors on trends in medical, pharmacy or other healthcare provider costs. This information may be necessary to support the assumptions made in forecasting and may be supported by information from the Applicant's actuarial systems pertaining to the Exchange-specific account.

3.9 Applicant must certify that for each rating region in which it submits a dental plan proposal, it is submitting a proposal that covers the entire geographic service area for which it is licensed within that rating region. To indicate which zip codes are within the licensed geographic service area by proposed Exchange product, complete and upload through SERFF the Service Area Template located at <https://www.cms.gov/ccio/programs-and-initiatives/health-insurance-marketplaces/qhp.html>.

- Yes, dental plan proposal covers entire licensed geographic service area; template uploaded
- No, dental plan proposal does not cover entire licensed geographic service area; template uploaded

#### **4. Provider Network**

Network sections will be replicated as needed according to number of network products being offered (identified in 4.1.1)

#### **4.1 Network Offerings**

4.1.1 Please indicate the different network products applicant intends to offer on the exchange individual market for coverage year 2017

	Offered	Network Name(s)
DHMO		
DPPO		

## 4.2 DHMO

### 4.2.1 Network Strategy

4.2.1.1 Does Applicant conduct provider negotiations and manage its own network or does Applicant lease a network from another organization?

- 1: Applicant contracts and manages network,
- 2: Applicant leases network

4.2.1.2 If Applicant leases network, describe the terms of the lease agreement:

- Length of the lease agreement
- Start Date
- End Date
- Leasing Organization
- Ability to influence provider contract terms for:
  - Transparency
  - Implementation of new programs and initiatives
  - Acquire timely and up-to-date information on providers
  - Ability to obtain data from providers
  - Ability to conduct outreach and education to providers if need arises
  - Ability to add new providers

4.2.1.3 Does Applicant contract with providers directly, at the individual practitioner level or at the risk-bearing organization (e.g. dental groups, independent practice associations) level only?

- 1: Direct contract only,
- 2: Group/Delegated/Capitated contracting,
- 3: Both: If a combination of both, please answer the next table

4.2.1.4 By rating region covered, please provide the percentages of providers in capitated vs non capitated arrangements:

	Direct Contract	Capitated	Other (explain in comments)	Comments
Region 1				



Region 2				
Region 3				
Region 4				
Region 5				
Region 6				
Region 7				
Region 8				
Region 9				
Region 10				
Region 11				
Region 12				
Region 13				
Region 14				
Region 15				
Region 16				
Region 17				
Region 18				
Region 19				

4.2.1.5 Does Applicant currently have contracted providers or networks not offered on the Exchange in regions where Exchange coverage is offered? (Off- Exchange networks in same regions as Exchange networks)

Response	
If yes, do the Exchange networks contain fewer providers compared to the comparable off exchange network of same type (DHMO, DPPO, DEPO, etc.) i.e. narrow networks?	
If yes, explain in detail how these more selective networks are developed including details on rationale and criteria used for selection	

4.2.1.6 Describe in detail how Applicant ensures access to care for all enrollees. This should include:

- If and how Applicant assesses geographic access to primary and specialist care based on enrollee residence.
- If and how Applicant analyses utilization data to assess and address differing demographic and cultural needs.

- If and how Applicant tracks ethnic and racial diversity in the population and ensures access to appropriate culturally competent providers.

4.2.1.7 Many California residents live in counties bordering other states where the out of state services are closer than in-state services.

Does Applicant offer coverage in a county or region bordering another state?

1: Yes. If yes, does the Applicant allow out of state (non-emergency) providers to participate in networks to serve Exchange enrollees? If yes, explain in detail how this coverage is offered.

2: No

## 4.2.2 Network Quality

### 4.2.2.1 Networks Built on Quality

As a contractual requirement in future contract years, applicants must base all provider and facility selection decisions on the following factors.

- Quality including clinical quality
- Patient safety
- Cost Efficiency
- Patient reported experience

4.2.2.1.1 Does Applicant currently use Patient safety as a criterion for provider selection for Exchange networks? If yes, please explain in detail: this should include the assessment process, the source of the patient safety assessment data, specific measures and metrics, thresholds for inclusion and exclusion.

1: Yes, please explain,

2: No

4.2.2.1.2 Does Applicant currently use cost efficiency as a criterion for provider selection for Exchange networks? If yes, please explain in detail: this should include the assessment process, the source of the assessment data, specific measures and metrics, thresholds for inclusion and exclusion.

1: Yes, please explain,

2: No

4.2.2.1.3 Does Applicant currently use patient reported experience as a criterion for provider selection for covered California networks? If yes, please explain in detail: this should include the assessment process, the source of the patient reported

experience assessment data, specific measures and metrics, thresholds for inclusion and exclusion.

- 1: Yes, please explain,
- 2: No

4.2.2.1.4 To what extent does Applicant encourage use of high quality network dental providers?

- 1: Auto-assign members to high-performing dental providers,
- 2: Identify high-performing providers through the provider directory or other web site location,
- 3: Customer service referral to dental provider,
- 4: Other (please explain) [Text],
- 5: Applicant does not encourage use of high-performing dental providers

4.2.2.1.5 If Applicant encourages use of high-performing dental providers, what criteria does the Applicant use to identify high-performing providers?

- 1: Dental quality measures,
- 2: Health improvement initiatives,
- 3: Preventive services rendered,
- 4: Patient satisfaction,
- 5: Low occurrence of complaints and grievances,
- 6: Other (please explain) [Text],
- 7: Applicant does not encourage use of high-performing dental providers

4.2.2.1.6 If Applicant does not currently identify or encourages use of high-performing dental providers, please report how the Applicant intends to identify high-performing dental providers.

### 4.2.3 Network Stability

4.2.3.1 Identify the number of participating providers who have terminated from the provider network between 1/1/2015-12/31/2015, by rating region.

	Terminated by Issuer	Terminated by Provider
Region 1		
Region 2		

Region 3		
Region 4		
Region 5		
Region 6		
Region 7		
Region 8		
Region 9		
Region 10		
Region 11		
Region 12		
Region 13		
Region 14		
Region 15		
Region 16		
Region 17		
Region 18		

Region 19		
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4.2.3.2 Identify groups, clinics or health centers terminated between January 1, 2015 and December 31, 2015, including any Dental Groups, Federally Qualified Health Centers or community clinics that had a break in maintaining a continuous contract during this period. Indicate reason for termination: non-agreement on rates, non-compliance with contract provisions, re-design of network or other (explain). Total Number of Contracted Dental Groups/Clinics (provide information by product by region):

	Number of Contracted Entities
Region 1	
Region 2	
Region 3	
Region 4	
Region 5	
Region 6	
Region 7	
Region 8	
Region 9	
Region 10	
Region 11	

Region 12	
Region 13	
Region 14	
Region 15	
Region 16	
Region 17	
Region 18	
Region 19	

4.2.3.3 Total Number of Terminated Dental Groups/Clinics 1/1/2015- 12/31/2015  
(provide information by product by region):

Name of Terminated Group or Clinic	Terminated by:	Reason	Reinstated

4.2.3.4 Describe any plans for network expansion, by product, including the addition of dental provider groups or clinic systems.

4.2.3.5 Describe any plans for other network changes that will affect Exchange products or enrollees

4.2.3.6 Provide information on any known or anticipated potential network disruption that may affect the Applicant's 2017 provider networks. For example: list any pending terminations of dental groups which can include Independent Practice Associations

#### **4.2.4 Provider Data and Reporting**

4.2.4.1 Describe the timeline and process for provider information changes (including demographic, address, network or panel status) to be reflected in Applicants online directory from time change was reported. Applicant should detail process for individuals and groups.

4.2.4.2 Describe in detail Applicant's process for assuring provider data accuracy,

4.2.4.3 Describe in detail Applicant's process for validating provider information during initial contracting and when a change is reported (including demographic, address, network or panel status)

4.2.4.4 Please describe in detail Applicant's process for ensuring providers report changes (including demographic, address, network or panel status) in a timely and consistent manner. Listing incentives, penalties etc.

4.2.4.5 Describe any contractual agreements with Applicant's participating providers that preclude Applicant's organization from making contract terms transparent to plan sponsors and members.

Applicant must confirm that, if certified as a QDP, to the extent that any Participating Provider's rates are prohibited from disclosure to the Exchange by contract, Applicant shall identify such Participating Provider. Issuer shall, upon renewal of its Provider contract, but in no event later than July 1, 2017, make commercially reasonable efforts to obtain agreement by that Participating Provider to amend such provisions, to allow disclosure. In entering into a new contract with a Participating Provider, Applicant agrees to make commercially reasonable efforts to exclude any contract provisions that would prohibit disclosure of such information to the

Exchange.

- What is Applicant's organization doing to change the provisions of contracts going forward to make this information accessible?
- List provider groups or facilities for which current contract terms preclude provision of information to plan sponsors.
- List provider groups or facilities for which current contract terms preclude provision of information to members.

4.2.4.6 Provider network data must be included in this submission for all geographic locations to which applicant is applying for certification as a QDP. Submit provider data according to the data file layout in Appendix I Covered California Provider Data Submission Guide. The provider network submission for 2017 must be consistent with what will be filed to the appropriate regulator for approval. The Exchange requires the information as requested to allow cross-network comparisons and evaluations.

## **5. Essential Community Providers**

Applicant must demonstrate that its QDP proposals meet requirements for geographic sufficiency of its Essential Community Provider (ECP) network. All of the below criteria must be met.

- i. Applicants must use Essential Community Provider Network Data Submission to indicate contracts with all providers designated as ECP.
- ii. Applicants must demonstrate sufficient geographic distribution of a mix of essential community providers reasonably distributed throughout the geographic service area.

Determination that an essential community provider network meets the standard of sufficient geographic distribution with a balance of appropriate providers and serves the low-income population within the proposed geographic service area requires the Applicant to apply interactively the criteria above. The Exchange will evaluate whether the Applicant's essential community provider network has achieved the sufficient geographic distribution and requirements.

Federal rules currently require health issuers to adhere to rules regarding payment to non-contracted FQHCs for services when those services are covered by the QDP's benefit plan. Certified QDPs will be required in their contract with the Exchange to operate in compliance with all federal rules issued pursuant to the Affordable Care Act, including those applicable to essential community providers.

Essential Community Providers include dental providers included in the Covered California Consolidated Essential Community Provider List available at:

<http://hbex.coveredca.com/stakeholders/plan-management/>



Low-income is defined as a family at or below 200% of Federal Poverty Level. The ECP data supplied by Applicant will allow the Exchange to plot contracted ECPs on maps to compare contracted providers against the supply of ECPs and the distribution of low-income Covered California enrollees.

## **6. Operational Capacity**

### **6.1 Administration and Account Management Support**

6.1.1 Provide the legal name of Applicant entity.

6.1.2 In what year was Applicant's entity founded?

6.1.3 Provide the location of Applicant's corporate headquarters.

6.1.4 Indicate Applicant entity's tax status:

- Not-for-profit
- For-profit

6.1.5 Provide name used in consumer-facing materials or communications.

6.1.6 Complete Attachments C1 Current and Projected Enrollment and C2 California Off-Exchange Enrollment to provide current enrollment and enrollment projections.

- Attachments completed
- Attachments not completed

6.1.7 Indicate any experience Applicant has participating in Exchanges or marketplace environments:

- State-based Marketplace(s), specify state(s) and years of participation:
- Federally-Facilitated Marketplace, specify state(s) and years of participation:
- Private Exchange(s), specify exchange(s) and years of participation:

6.1.8 Provide a summary of Applicant's capabilities, including how long Applicant has been in the business as an Issuer.

6.1.9 Does Applicant anticipate making material changes in corporate structure in the next 24 months, including:

- Mergers
- Acquisitions
- New venture capital
- Management team
- Location of corporate headquarters or tax domicile

- Stock issue
- Other

If yes, Applicant must describe the material changes.

6.1.10 Provide a description of any initiatives, either current or planned, over the next 24 months which may impact the delivery of services to Exchange members during the contract period. Examples include:

- System changes or migrations
- Call center opening, closing or relocation
- Network re-contracting
- Other

6.1.11 Does Applicant routinely subcontract any significant portion of operations or partner with other companies to provide dental plan coverage? If yes, identify which operations are performed by subcontractor or partner and provide the name of the subcontractor.

- Billing, invoice, and collection activities
  - Yes
  - No
- Database and/or enrollment transactions
  - Yes
  - No
- Claims processing and invoicing
  - Yes
  - No
- Membership/customer service
  - Yes
  - No
- Welcome package (ID cards, member communications, etc.)
  - Yes
  - No
- Other (specify)
  - Yes
  - No

6.1.12 Are any of Applicant's operations, such as member services call centers, conducted outside of the United States? If yes, describe the operations.

- Yes
- No

6.1.13 Submit a copy of business continuity plans in event of an emergency or disruption of services to Exchange members.

6.1.14 Applicant must include an organizational chart of key personnel who will be assigned to Covered California. The Key Personnel and representatives of the Account Management Team who will be assigned to Covered California must be identified in the following areas:

- Executive
- Finance
- Operations
- Contracts
- Plan and Benefit Design
- Network and Quality
- Enrollment and Eligibility
- Legal
- Marketing and Communications
- Information Technology
- Information Security
- Policy

Applicant must identify the individual(s) who will have primary responsibility for servicing the Exchange account. Please indicate where these individuals fit into the organizational chart requested above. Please include the following information and repeat as necessary:

- Name
- Title
- Department
- Functional Area
- Phone
- Fax
- E-mail
- Percent of time dedicated to Covered California account

6.1.15 Applicant must complete and upload through SERFF the Administrative Data template.

- Template completed and uploaded
- Template not completed or uploaded

## 6.2 Implementation Performance

6.2.1 Will an implementation manager and support team (not part of the regular account management team) be assigned to lead and coordinate the implementation activities with the Exchange? If yes, specify the name and title of the individual(s) including the supervisor of this manager and support team. If no, please explain why and how Applicant will manage implementation.

- Yes
- No
- No, Applicant is currently operating in the Exchange

6.2.2 Provide a detailed implementation project plan and schedule targeting a January 1, 2017 effective date and including Open Enrollment readiness.

6.2.3 Applicant must indicate current or planned procedures for managing the new enrollee transition period. Check all that apply and describe:

- Request transfer from prior health or dental plan, if applicable
- Utilize information received from prior health or dental plan to continue plan or benefit accumulators
- Load claim history from prior health or dental plan, if any
- Services that have been pre-authorized but not completed as of the effective date must also be pre-authorized by new plan
- Will make customer service line available to new or potential Enrollees prior to the effective date
- Provide member communications regarding change in health or dental plans

6.2.4 If certified by the Exchange, explain how Applicant anticipates accommodating the additional membership effective January 1, 2017. Identify the percentage increase in membership which will require increases to current resources and describe resource adjustment(s) to accommodate additional membership:

Resource	Membership Increase (as % of Current Membership)	Resource Adjustment (specify)	Approach to Monitoring
Members Services			
Claims			

Account Management			
Clinical staff			
Disease Management staff			
Implementation			
Financial			
Administrative			
Actuarial			
Information Technology			
Other (List)			

### 6.3 Customer Service

6.3.1 Applicant must confirm it will respond to and adhere to the requirements of California Health and Safety Code Section 1368 relating to consumer grievance procedures.

6.3.2 If certified, Applicant will be required to meet contractual member services performance standards. During Open Enrollment, Exchange operating hours are 8 a.m. to 8 p.m. Monday through Friday (except holidays) and 8 a.m. to 6 p.m. Saturdays.

Applicant must confirm it will match Exchange Open Enrollment Customer Service operating hours. Describe how Applicant will modify and monitor customer service center operations to meet Exchange-required operating hours if applicable.

Confirmed

Not confirmed

6.3.3 Applicant must provide Customer Service Representative ratio to members.

6.3.4 Describe how Customer Service Center Representative training will be modified to include training on Exchange products.

6.3.5 Applicant must list languages spoken by Customer Service Center Representatives.

- Arabic
- Armenian
- Cantonese
- English
- Hmong
- Korean
- Mandarin
- Farsi
- Russian
- Spanish
- Tagalog
- Vietnamese
- Lao
- Cambodian
- Other, specify

6.3.6 Applicant must describe any other modifications that will be required to allow for quality service to Exchange consumers.

6.3.7 How are after-hours and holiday telephone inquiries handled? If applicable, include description of recorded message, Interactive Voice Response System (IVR), Live Response, dental plan website, and any other applicable mechanisms.

## **6.4 Financial Requirements**

6.4.1 Applicant must confirm it has in place systems to invoice members effective October 1, 2016.

- Yes, confirmed
- No, not confirmed

6.4.2 Describe systems to invoice members, including issuance of ID cards and record retention. If not currently in place, describe plans to implement such systems, including the use of vendors for any functions related to invoicing, if applicable, and an implementation workplan.

6.4.3 Applicant must confirm it has in place systems to accept from members effective October 1, 2016 the following premium payment types:

- Paper checks
- Cashier's checks

- Money orders
- Electronic Funds Transfer (EFT)
- Credit cards and debit cards
- Web-based payment, which may include accepting online credit card payments, and all general purpose pre-paid debit cards and credit card payment.

6.4.4 If such systems are not currently in place, describe plans to implement such systems, including the use of vendors for any functions related to premium payment, if applicable, and an implementation workplan. QDP must accept premium payment from members no later than October 1, 2016. Note: QDP issuer must accept credit cards for binder payments and is encouraged, but not required, to accept credit cards for payment of ongoing invoices.

6.4.5 Describe how Applicant will comply with the federal requirement 45 CFR 156.1240(a)(2) to serve the unbanked, specifying the forms of payment available for this population for binder and ongoing payments for both on-Exchange and off-Exchange lines of business.

6.4.6 Applicant must confirm it can provide detailed documentation as defined by Covered California, including member level detail specified in Appendix B Issuer Participation Fee Billing Discrepancy Resolution and Appendix C, PMPM\_Member\_Level\_Detail\_Response SAMPLE, to substantiate each participation fee payment.

6.4.7 Applicant agrees not to impose any fees or charges on any members who request paper invoices for premiums due for any individual products sold by issuer in California.

## **6.5 Fraud, Waste and Abuse Detection**

The Exchange is committed to working with its QDPs to establish common efforts to minimize fraud, waste and abuse.

**Fraud** - An intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in some unauthorized benefit to him/herself, itself or some other person or entity. It includes any act that constitutes fraud under applicable federal or state law.

**Waste** - Waste is the intentional or unintentional, thoughtless or careless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste also includes incurring unnecessary costs as a result of inefficient or ineffective practices, systems, or controls.

Abuse – Behaviors or practices of providers, physicians, or suppliers of services and equipment that, although normally not considered fraudulent, are inconsistent with accepted sound medical, business, or fiscal practices. The practices may, directly or indirectly, result in unnecessary costs to the program, improper payment, or payment for services that fail to meet professionally recognized standards of care, or which are medically unnecessary. Abuse can also occur with excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services. Abuse can occur in financial or non-financial settings.

Check here if Applicant has completed the Covered California QDP Certification Application for Plan Year 2017 Covered California for Small Business, and responses apply to this submission.

- 6.5.1 Describe the processes used in determining when investigations for fraud, waste, and abuse are needed. Include specific event triggers, descriptions of overall monitoring, audits and fraud risk assessment.
- 6.5.2 Describe the method for determining whether fraud, waste and abuse has occurred.
- 6.5.3 Describe the processes for fraud, waste and abuse investigation follow-up and corrective measures.
- 6.5.4 Describe the processes for recovery of fraud funds.
- 6.5.5 Describe the controls in place to confirm enrollment and disenrollment actions are accurately and promptly executed.
- 6.5.6 Provide a brief description of your member fraud detection policy.
- 6.5.7 Provide a brief description of your provider fraud detection policy.
- 6.5.8 Submit a sample copy of your fraud, waste, and abuse report. Reports can include: investigation reports, fraud summary reports, trends analysis, forecasting, adjudicated investigations, referrals, number of complaints, number of cases.
- 6.5.9 What was Applicant’s recovery success rate and dollars recovered for fraudulent activities?

	<b>Total Loss from Fraud</b>		<b>% of Loss Recovered</b>		<b>Total Dollars Recovered</b>	
	Covered California,	Book of Business	Covered California,	Book of Business	Covered California, if applicable	Book of Business



	if applicable		if applicable			
Calendar Year 2013						
Calendar Year 2014						
Calendar Year 2015						

- 6.5.10 Describe Applicant's revenue recovery process to recoup erroneously paid claims.
- 6.5.11 Describe Applicant's procedures to educate members to identify and report possible fraud scams.
- 6.5.12 Describe Applicant's procedures to report fraud scams to law enforcement.
- 6.5.13 Describe how you safeguard against Social Security and Identity fraud.
- 6.5.14 What steps are taken after identification of social security and identity fraud? Include services offered to impacted participants.
- 6.5.15 Indicate how frequently internal audits are performed for each of the following areas.

Claims Administration

- Daily
- Weekly
- Monthly
- Quarterly
- Other

Customer Service

- Daily
- Weekly
- Monthly
- Quarterly
- Other

Network Contracting

- Daily
- Weekly
- Monthly

- Quarterly
- Other

#### Eligibility and Enrollment

- Daily
- Weekly
- Monthly
- Quarterly
- Other

#### Utilization Management

- Daily
- Weekly
- Monthly
- Quarterly
- Other:

#### Billing

- Daily
- Weekly
- Monthly
- Quarterly
- Other:

6.5.16 Overall, what percent of Claims are subject to internal audit?

6.5.17 Indicate if external audits were conducted for Claims administration for your entire book of business for the last two (2) full calendar years.

- 2015
  - Audit Conducted
  - Audit Not Conducted
- 2014
  - Audit Conducted
  - Audit Not Conducted

6.5.18 Describe Applicant's approach to the following controls to confirm non-contracted providers who file claims for amounts above a defined expected threshold of the reasonable and customary amount for that procedure and area.

- 6.5.19 Describe Applicant's approach to use of the Healthcare Integrity and Protection Data Bank (HIPDB) as part of the credentialing and re-credentialing process for contracted Providers.
- 6.5.20 Describe Applicant's controls in place to monitor referrals of Plan Members to any health care facility or business entity in which the Provider may have full or partial ownership or own shares.
- 6.5.21 Indicate the types of Claims and Providers that Applicant typically reviews for possible fraudulent activity. Check all that apply.
- General Practice Dentist
  - Pediatric Dentist
  - Endodontist
  - Oral and Maxillofacial Surgeon
  - Orthodontist
  - Periodontist
  - Prosthodontist
- 6.5.22 Describe the different approaches Applicant takes to monitor these types of Providers.
- 6.5.23 Describe Applicant's system for flagging unusual patterns of care identified at time of claim submission.
- 6.5.24 Describe Applicant's system for flagging unusual patterns of care through data mining.
- 6.5.25 Describe Applicant's system for flagging unusual patterns of care through plan member referrals.
- 6.5.26 Describe Applicant's system for flagging unusual patterns of care through other methods.
- 6.5.27 Applicant must confirm that, if certified, it will agree to subject itself to the Exchange for audits and reviews, either by the Exchange or its designee, or the Department of General Services, the California State Auditor or its designee, as they deem necessary to determine the correctness of premium rate setting, the Exchange's payments to agents based on the Issuer's report, questions pertaining to enrollee premium payments and participation fee payments Issuer made to the Exchange. Issuer also agrees to all audits subject to applicable State and Federal law regarding the confidentiality of and release of confidential Protected Health Information of Enrollees.
- Yes, confirmed
  - No, not confirmed

## **6.6 System for Electronic Rate and Form Filing (SERFF)**

6.6.1 Applicant must be able to populate and submit SERFF templates in an accurate, appropriate, and timely fashion at the request of Covered California for:

- Administrative Information
- Rates
- Service Area
- Benefit Plan Designs
- Network

6.6.2 Applicant confirms that it will submit and upload corrections to SERFF within three (3) business days of notification by Covered California, adjusted for any SERFF downtime.

6.6.3 Applicant may not make any changes to its SERFF templates once submitted to Covered California without providing prior written notice to Covered California and only if Covered California agrees in writing with the proposed changes.

## **6.7 Electronic Data Interface**

6.7.1 Applicant must provide an overview of its system, data model, vendors, and interface partners. Applicant must submit a copy of its system lifecycle and release schedule.

6.7.2 Applicant must be prepared and able to engage with the Exchange to develop data interfaces between the Issuer's systems and the Exchange's systems, including the eligibility and enrollment system used by the Exchange, as early as June 2016. Applicant must confirm it will implement system(s) in order to accept and generate 834, 999, TA1 and other standard format electronic files for enrollment and premium remittance in an accurate, consistent and timely fashion and utilize the information received and transmitted for its intended purpose. See Appendix L EDI 834 Companion Guide Design v9.0 for detailed 834 transaction specifications. Covered California requires QDP Issuers to sign an industry-standard agreement which establishes electronic information exchange standards in order to participate in the required systems testing.

6.7.3 Applicant must describe its ability and any experience processing and resolving errors identified by a TA1 and 999 file as appropriate and in a timely fashion. Applicant must confirm that it has the capability to accept and complete non-electronic enrollment submissions and changes.

- 6.7.4 Applicant must communicate any testing or production changes to system configuration (URL, certification, bank information) to the Exchange in a timely fashion.
- 6.7.5 Applicant must be prepared and able to conduct testing of data interfaces with the Exchange no later than June 1, 2016 and confirms it will plan and implement testing jointly with Covered California in order to meet system release schedules. Applicant must confirm testing with the Exchange will be under industry security standard: firewall, certification, and fingerprint. Applicant must confirm it will make dedicated, qualified resources available to participate in the connectivity and testing effort.
- 6.7.6 Applicant must describe its ability to produce financial, eligibility, and enrollment data on a monthly basis for the purpose of reconciliation. Standard file requirements and timelines are documented in Appendix D Reconciliation Process Guide. Applicant must provide description of its ability to make system updates to reconcilable enrollment fields on a timely basis and provide verification of completion.
- 6.7.7 Does Applicant proactively monitor, measure, and maintain the application(s) and associated database(s) to maximize system response time/performance on a regular basis and can your organization report status on a quarterly basis? Describe below.
- Yes
  - No

## **6.8 Healthcare Evidence Initiative**

- Check here if Applicant has completed the Covered California QDP Certification Application for Plan Year 2017 Covered California for Small Business, and responses apply to this submission.
- 6.8.1 In order to fulfill its mission to ensure that consumers have available the plans that offer the optimal combination of choice, value, quality, and service, Covered California relies on evidence about the enrollee experience with health care. QDP data submission requirements are an essential component of assessing the quality and value of the coverage and health care received by Covered California enrollees. The capabilities described in this section are requirements of QDP data submission obligations.
- 6.8.2 Can Applicant adjudicate 100% of fee-for-service (FFS) or price 100% of encounter records for the following claim types? If not, or if yes with deviation, explain.

Claim Type	Yes	No	If No or Yes with deviation, explain.
Professional			
Institutional			
Pharmacy, if applicable			
Drug (non-Pharmacy), if applicable			

6.8.3 Covered California is interested in QDP Issuer data that represents the cost of care. Can Applicant provide complete financial detail for all applicable claims and encounters? If not, or if yes with deviation, explain.

Financial Detail to be Provided	Yes	No	If No or Yes with deviation, explain.
Submitted Charges			
Discount Amount			
Allowable Charges			
Copayment			
Coinsurance			
Deductibles			
Financial Details to be Provided			
Coordination of Benefits			
Plan Paid Amount (Net Payment)			
Capitation Financials (per Provider / Facility) <sup>3</sup>			

6.8.4 Can Applicant provide member and subscriber IDs assigned by Covered California on all records submitted? In the absence of other Personally Identifiable Information (PII), these elements are critical for the HEI Vendor to generate unique encrypted member identifiers linking eligibility to claims and encounter data, enabling the HEI Vendor to follow the health care experience of each de-identified member, even if he/she moves from one plan to another. If not, or if yes with deviation, explain.

Detail to be Provided	Yes	No	If No or Yes with deviation, explain.
Covered CA Member ID			
Covered CA Subscriber ID			

<sup>3</sup> If a portion of Applicant provider payments are capitated. If capitation does not apply, check "No" and state "Not applicable, no provider payments are capitated" in the rightmost column.

6.8.5 Can Applicant supply Protected Health Information (PHI) dates in full year / month / day format to the HEI Vendor for data aggregation? If not, or if yes with deviation, explain.

PHI Dates to be Provided in Full Year / Month / Day Format	Yes	No	If No or Yes with deviation, explain.
Member Date of Birth			
Member Date of Death			
Starting Date of Service			
Ending Date of Service			

6.8.6 Can Applicant supply all applicable Provider Tax ID Numbers (TINs), National Provider Identifiers (NPIs), and National Council for Prescription Drug Programs (NCPDP) Numbers (pharmacy only) for individual providers? If not, or if yes with deviation, explain.

Provider IDs to be Supplied	Yes	Yes, unless values represent individual provider Social Security numbers	No	If No or Yes with deviation, explain.
TIN				
NPI				
NCPDP Number				

6.8.7 Can Applicant provide detailed coding for , procedures, etc. on all claims for all data sources? If not, or if yes with deviation, explain.

Coding to be Provided	Yes	No	If No or Yes with deviation, explain.
Procedure Coding (CPT, HCPCS)			
Revenue Codes (Facility Only)			
Place of Service			
NDC Code (Drug Only)			

6.8.8 Can Applicant submit similar data listed above for other data feeds not yet requested, such as Disease Management or Lab data? If so please describe.

6.8.9 Can Applicant submit all data directly to the HEI Vendor or is a third party required to submit the data on Applicant's behalf?

6.8.10 If data must be submitted by a third party, can Applicant guarantee that the same information above will also be submitted by the third party?

## 6.9 Privacy and Security Requirements for Personally Identifiable Data

Check here if Applicant has completed the Covered California QDP Certification Application for Plan Year 2017 Covered California for Small Business, and responses apply to this submission.

6.9.1 HIPAA Privacy Rule: Applicant must confirm that it complies with the following privacy-related requirements set forth within Subpart E of the Health Insurance Portability and Accountability Act [45 CFR §164.500 et. seq.]:

6.9.1.1 Individual access: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that it provides consumers with the opportunity to access, inspect and obtain a copy of any PHI contained within their Designated Record Set [45 CFR §§164.501, 524].

- Yes, confirmed
- No, not confirmed

6.9.1.2 Amendment: Applicant must confirm that it provides consumers with the right to amend inaccurate or incomplete PHI contained within their Designated Record Set [45 CFR §§164.501, 526].

- Yes, confirmed
- No, not confirmed

6.9.1.3 Restriction Requests: Applicant must confirm that it provides consumers with the opportunity to request restrictions upon Applicant's use or disclosure of their PHI [45 CFR §164.522(a)].

- Yes, confirmed
- No, not confirmed

6.9.1.4 Accounting of Disclosures: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that it provides consumers with an accounting of any disclosures made by Applicant of the consumer's PHI upon the consumer's request [45 CFR §164.528].

- Yes, confirmed
- No, not confirmed

6.9.1.5 Confidential Communication Requests: Applicant must confirm that Applicant permits consumers to request an alternative means or location for receiving their PHI than what Applicant would typically employ [45 CFR §164.522(b)].



- Yes, confirmed
- No, not confirmed

6.9.1.6 Minimum Necessary Disclosure & Use: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that Applicant discloses or uses only the minimum necessary PHI needed to accomplish the purpose for which the disclosure or use is being made [45 CFR §§164.502(b) & 514(d)].

- Yes, confirmed
- No, not confirmed

6.9.1.7 Openness and Transparency: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that Applicant currently maintains a HIPAA-compliant Notice of Privacy Practices to ensure that consumers are aware of their privacy-related rights and Applicant's privacy-related obligations related to the consumer's PHI [45 CFR §§164.520(a)&(b)].

- Yes, confirmed
- No, not confirmed

## 6.9.2 Safeguards

6.9.2.1 Applicant must confirm that it has policy, standards, processes, and procedures in place and the information system is configured with administrative, physical and technical security controls that meet or exceed those standards in the National Institute of Standards and Technology, Special Publication (NIST) 800-53 that appropriately protect the confidentiality, integrity, and availability of the Protected Health Information and Personally Identifiable Information that it creates, receives, maintains, or transmits.

- Yes, confirmed
- No, not confirmed

6.9.2.2 Applicant must confirm that all Protected Health Information (PHI) and Personally Identifiable Information (PII) is encrypted at rest and in transit employing the validated Federal Information Processing Standards (FIPS) Publication 140-2 Cryptographic Modules.

- Yes, confirmed

No, not confirmed

6.9.2.3 Applicant must confirm that it operates in compliance with applicable federal and state security and privacy laws and regulations, and has an incident response policy, process, and procedures in place and can verify that the process is tested at least annually.

- Yes, confirmed  
 No, not confirmed

6.9.2.4 Applicant must confirm that there is a contingency plan in place that addresses system restoration without deterioration of the security measures originally planned and implemented, and that the plan is tested at least annually.

- Yes, confirmed  
 No, not confirmed

6.9.2.5 Applicant must confirm that when disposal of PHI, PII or the decommissioning of media occurs they adhere to the guidelines for media sanitization as described in the NIST Special Publication 800-88.

- Yes, confirmed  
 No, not confirmed

### 6.9.3 Breach Notification

6.9.1.3 Applicant must confirm that it currently has policies and procedures in place to determine when a Breach which compromises the security or privacy of consumer PHI has occurred [45 CFR §164.402 et seq] (the “Breach Notification Rule”).

- Yes, confirmed  
 No, not confirmed

6.9.3.2. Applicant must confirm that it currently has policies and procedures in place to notify consumers whose PHI has been subject to a Breach in accordance with applicable provisions of both the HIPAA Breach Notification Rule [45 CFR §164.404] and the California Information Practices Act [CA Civil Code §1798.29].

- Yes, confirmed  
 No, not confirmed

## 6.10 Sales Channels

6.10.1 Does Applicant have experience working with Insurance Agents?

- Yes. If yes, 6.10.2 through 6.10.7 required.
- No. If no, 6.10.8 required.

6.10.2 Review Appendix E Covered California Individual Market Agent of Record policy. Applicant must submit a copy of its Agent of Record policy and procedures. The policy and procedures should include the following criteria:

- Appointing Agents
- Agent of Record Changes
- Vested Agents
- Procedures used to manage changes when the Agent of Record files are received on an 834 or other electronic file.

6.10.3 Applicant must provide a primary point of contact for broker or agent services and include the following contact information:

- Name (if applicable)
- Phone Number
- Email Address

6.10.4 If Applicant contracts with general agents, please list the general agents with whom you contract and how long you have maintained those relationships.

6.10.5 Applicant must provide health plan commission schedule for individual and small group business in California. Note: successful Applicants will be required to use a standardized Agent compensation program with levels and terms that result in the same aggregate compensation amounts to Agents whether products are sold within or outside of the Exchange; successful Applicants will not vary Agent compensation levels by metal tier; successful Applicants will pay the same commission during Open and Special Enrollment for each plan year.

Individual Market - Commission Rate		
	On-Exchange Business	Direct Business

Provide Commission Rate or Schedule		
Does the compensation level change as the business written by the agent matures? (i.e., Downgraded)		
Specify if the agent is compensated at a higher level as he or she attains certain levels or amounts of enforce business.		
Does the compensation level apply to all plans or does it vary by plan?		
Describe any business for which Applicant will not compensate Agents.		
Describe any business for which Applicant will not make changes to Agent of Record.		
Additional Comments		

Small Business Market - Commission Rate		
	On-Exchange Business	Direct Business
Provide Commission Rate or Schedule		
Does the compensation level change as the business written by the agent matures? (i.e., Downgraded)		
Specify if the agent is compensated at a higher level as he or she attains certain levels or amounts of enforce business.		
Does the compensation level apply to all plans or does it vary by plan?		
Describe any business for which Applicant will not compensate Agents.		

Describe any business for which Applicant will not make changes to Agent of Record.		
Additional Comments		

6.10.6 Indicate if Applicant’s agent of record policy, appointment process or commission schedule differs outside of California. If so, describe how.

- Agent of Record Policy
  - Does not differ outside of California
  - Differs outside of California (describe):
  
- Appointment Process
  - Does not differ outside of California
  - Differs outside of California (describe):
  
- Commission Schedule
  - Does not differ outside of California
  - Differs outside of California (describe):

6.10.7 What initiatives is Applicant undertaking in order to partner more effectively with the agent community?

6.10.8 If Applicant does not currently work with Insurance Agents, describe Applicant approach to develop an agent program. Include plan to develop agent appointment process. Plan should include the following components:

- Appointing Agents
- Agent of Record Changes
- Vested Agents
- Procedures used to manage changes when the Agent of Record files are received on an 834 or other electronic file.
- Applicant must provide a primary point of contact for broker/agent support and include the following contact information:
  - Name
  - Phone Number
  - Email Address

6.10.9 Review Appendix F Covered California’s Plan-Based Enrollment (PBE) Program. Are you currently participating in the Plan-Based Enrollment Program?

- Yes. If yes, questions 6.10.10 through 6.10.18 required.
- No. If no, question 6.10.19 required.

6.10.10 Do you contract Captive Agents? If yes, are Captive Agents contracted independently or through a vendor?

- Yes, Captive Agents contracted independently
- Yes, Captive Agents contracted through vendor
- No, do not contract Captive Agents

6.10.11 Do you contract with Issuer Application Assisters? If yes, are Issuer Application Assisters contracted independently or through a vendor?

- Yes, Issuer Application Assisters contracted independently
- Yes, Issuer Application Assisters contracted through a vendor
- No, but intend to contract with Issuer Application Assisters independently or through a vendor
- No, no intention to contract with Issuer Application Assisters

6.10.12 Describe Applicant business cycle, including description of permanent resources, potential seasonal hiring adjustments, and use of temporary resources. If applicable, include anticipated Plan-Based Enroller (Captive Agents and Issuer Application Assisters) volume.

6.10.13 How does Applicant provide agent support? Include use of call centers, number and location(s) of call centers, if applicable.

6.10.14 How do consumers contact the Plan-Based Enrollers? If call center environment, what is Applicant's Service Level Agreement?

6.10.15 Does Applicant offer additional locations where in-person assistance is available to consumers? If yes, provide total number of in-person assistance location, where they are located, and number of Plan-Based Enrollers at each location.

6.10.16 Do the customer service representatives refer consumers to Plan-Based Enrollers for account updates (i.e., reporting changes, termination, etc.)? If so, describe which changes are referred to Plan Based Enrollers.

6.10.17 If Applicant is not currently participating in the PBE program but intends to, what is the expected volume of agents that you anticipate participation in the Plan-Based Enrollment program?

- 6.10.18 Is Applicant participating in a program that is similar to the Plan-Based Enrollment Program? If yes, please describe the program or provide a model of your program.
- 6.10.19 Describe any experience Applicant may have working with navigators or similar enrollment entities.

## **6.11 Marketing and Outreach Activities**

- 6.11.1 The Exchange expects all successful Applicants to promote enrollment in their certified QHPs, including investment of resources and coordination with the Exchange's marketing and outreach efforts. Applicant must provide an organizational chart of its Individual Sales and Marketing Department(s), including names and titles. Applicant must identify the individual(s) with primary responsibility for sales and marketing of the Exchange account, indicate where these individuals fit into the organizational chart and include the following contact information for those who will work on Covered California sales and marketing efforts: Name, title, phone number, fax number and email address. Note also which staff oversee Member Retention/Member Communication and Social Media efforts.
- 6.11.2 Applicant must confirm that, upon contingent certification, it will adhere to Exchange requirements to adhere to the Appendix G Covered California Brand Style Guide when co-branding materials, including: ID cards, premium invoices, and termination notices issued to Exchange enrollees. Co-branded items must be submitted prior to use and in a timely manner; ID cards are to be submitted to the Exchange at least 30 days prior to Open Enrollment. The Exchange retains the right to communicate directly with Exchange consumers and members. Please identify the Applicant's marketing team member who will be responsible for submitting these co-branded materials to the Exchange for review.
- 6.11.3 Applicant must confirm it will cooperate with Exchange Marketing, Public Relations, and Outreach efforts, which may include: internal and external trainings, press events, social media efforts, collateral materials, member communications, and other efforts. This cooperative obligation includes contractual requirements to submit materials and updates according to deadlines established in the QDP Issuer Model Contract.
- 6.11.4 Applicant must complete and submit Attachment D1 Member Communication Calendar, including proposed Exchange member communications.

- Confirmed, attachment complete
- Attachment not completed

6.11.5 Applicant must provide a proposed Marketing Plan for the Exchange Individual Marketplace line of business.

Proposed marketing plan must include the following components:

- Regions to be supported with marketing efforts
- Proposed marketing investment
- Enrollment goals
- Strategy and tactics
- Target audience parameters (age range, household income, ethnicity, gender, marital status)
- Timing
- Proportion of marketing expenditure for on-Exchange QDPs in relation to off-Exchange plan marketing expenditure
- Attachment D2 Media Plan Flowchart

6.11.6 Applicant must use Attachment D3 Estimated Media Spend by Designated Market Area template provided to indicate estimated total expenditures and allocations for Individual Marketplace related marketing and advertising functions. Information supplied in this attachment must match dollars represented in Attachment D2 Media Plan Flowchart.

## **7. Quality**

The Exchange's "Triple Aim" framework seeks to improve the patient care experience including quality and satisfaction, improve the health of the entire California population and reduce the per capita cost of Covered Services. The Quality and Delivery System Reform standards outlined in the QDP Contract describe the ways the Exchange and Contracted QDP Issuers will focus on the promotion of better care and higher value for plan enrollees and other California health care consumers.

- Check here if Applicant has completed the Covered California QDP Certification Application for Plan Year 2017 Covered California for Small Business, and responses apply to this submission.



## 7.1 Quality Improvement Strategy

7.1.1 Consistent with the Exchange’s mission to promote better care, better health and lower cost as part of a Quality Improvement Strategy, Applicants must confirm it will implement a quality assurance program in accordance with Title 2, CCR, Section 1300.70, for evaluating the appropriateness and quality of the covered services provided to member.

- Confirmed
- Not confirmed

7.1.2 Applicant must confirm it will maintain a system of accountability for quality improvement in accordance with all applicable statutes and regulations, monitoring, evaluating and taking effective action to address any needed improvements, as identified by the Exchange, in the quality of care delivered to members.

- Confirmed
- Not confirmed

7.1.3 Describe two Quality Improvement Projects (QIPs) conducted by Applicant within the last five (5) years. Include information about results of the QIP, why the QIP was undertaken and why it ended or has continued, if applicable. Describe the QIP scalability, if it was successful. Also include the following information:

Start/End Dates:
QIP Name/Title:
Problem Addressed:
Rationale (why selected):
Targeted Population:
Study Indicator(s):
Baseline Measurement:
Results:
What Best Practices have been implemented to sustain Improvement (if any):

## 7.2 Care Management

7.2.1 Applicant must confirm it will make available to Exchange enrollees the following programs and services:

- Care Reminders
- Risk Assessments
- Disease Management Programs

7.2.2 Which of the following activities are used by the Applicant to encourage use of diagnostic and preventive services?

- Mailed printed materials about preventive services with \$0 cost-share to members (oral exam, cleaning, X-rays)
- Emails sent to membership about preventive services with \$0 cost-share to members (oral exam, cleaning, X-rays)
- Automated outbound telephone reminders about preventive services with \$0 cost-share to members (oral exam, cleaning, X-rays)
- Other (please explain)
- No current activities used to encourage use of preventive services

7.2.3 Discuss any planned activities to encourage use of diagnostic and preventive services.

7.2.4 If Applicant indicated that any of the activities in 7.2.2 are used to encourage use of diagnostic and preventive services, please upload as an attachment screenshots and/or materials demonstrating these activities.

7.2.5 Which of the following activities are used by the Applicant to communicate oral health and wellness (i.e. self-care for maintaining good oral health)?

- Mailed printed materials about oral health self-care
- Emails sent to membership about oral health self-care
- Other (please explain)
- No current activities used to encourage oral health self-care

7.2.6 Discuss any planned activities to communicate oral health and wellness information to Enrollees.

7.2.7 If Applicant indicated that any of the activities in 7.2.5 are used to communicate oral health and wellness, please upload as an attachment screenshots and/or materials demonstrating these activities.

7.2.8 Indicate the availability of the following demand management activities and health information resources for Exchange members. (Check all that apply)

- Teledentistry

- Decision support
- Self-care books
- Electronic Preventive care reminders
- Web-based health information
- Web-based self-care resources
- Integration with other health care vendors
- Other (describe)

### **7.3 Health Status and Risk Assessment**

7.3.1 Indicate features of the oral health risk assessment to determine enrollee oral health status. Select all that apply.

- Oral health risk assessment offered online or in print
- Oral health risk assessment offered through telephone interview with a live person
- Oral health risk assessment offered in multiple languages
- Upon completion of oral health risk assessment, risk-factor education is provided to member based on member-specific risk, e.g. if member reports tobacco use, education is provided on gum disease risk
- Personalized oral health risk assessment report is generated with risk modification actions
- Member is directed to interactive intervention module for behavior change upon risk assessment completion
- Email on self-care generated based on enrollee responses
- Email or phone call reminders to schedule preventive or diagnostic visits generated based on enrollee responses
- Oral health risk assessment not offered

7.3.2 Does the Applicant collect information on enrollee oral health status using any of the following sources of data? Select all that apply.

- Oral health risk assessment
- Claims data
- Other (please explain)
- Data on oral health status not collected

7.3.3 Discuss any planned activities to build capacity or systems to determine enrollee oral health status.

7.3.4 Does the Applicant use any of the following sources of data to track changes in oral health status among Plan Enrollees? Select all that apply.

- Oral health risk assessment
- Claims data
- Other (please explain)
- Data on oral health status not used

7.3.5 Discuss any planned activities to build capacity or systems to track changes in enrollee oral health status.

7.3.6 How does the Applicant currently identify at-risk enrollees, which may include members with existing or newly diagnosed needs for dental treatment or members with co-morbid conditions?

- Claims data
- Website registration prompts self-report of existing/newly diagnosed need for dental treatment and/or co-morbid conditions
- Oral health risk assessment
- Other (please explain)
- Plan does not currently identify at-risk enrollees

7.3.7 Discuss any planned activities to identify at-risk enrollees.

7.3.8 Please report the number of enrollees who have been identified as “at-risk.”

	Exchange Enrollees, if applicable	Book of Business
Number of enrollees who have been identified as “at-risk”		
Number of enrollees		

## 7.4 Enrollee Population Management

7.4.1 Describe practices in place to address population health management across enrolled members. Include measurement strategy and any specific ability to track impact on Exchange enrollees.

- 7.4.2 Describe ability to track and monitor member satisfaction. Include measurement strategy and any specific ability to track impact on Exchange enrollees.
- 7.4.3 Describe ability to track and monitor cost and utilization management (e.g., admission rates, complication rates, readmissions). Include measurement strategy and any specific ability to track impact on Exchange enrollees.
- 7.4.4 Describe ability to track and monitor clinical outcome quality. Include measurement strategy and any specific ability to track impact on Exchange enrollees.

**7.5 Innovations**

- 7.5.1 Describe institutional capacity to plan, implement, evaluate, and replicate future healthcare quality and cost innovations for Exchange Members. Of special interest to Exchange are programs with focus on at-risk enrollees (e.g.: communities at risk for health disparities, enrollees with chronic-conditions and those who live in medically underserved areas).

**7.6 Reducing Health Disparities and Assuring Health Equity**

- 7.6.1 Identify the sources of data used to gather members’ race/ethnicity, primary language, and disability status. The response “enrollment form” pertains only to information reported directly by members or passed on by CalHEERS. Report on Exchange membership if applicable.

Data Element	Data Collection Method (Select all that apply)	Percent of membership for whom data is captured
Race/ethnicity	<ul style="list-style-type: none"> <li>○ Enrollment form</li> <li>○ Oral health risk assessment</li> <li>○ Information requested upon website registration</li> <li>○ Inquiry upon call to customer service</li> <li>○ Indirect method such as surname or zip code analysis</li> <li>○ Other (please explain)</li> <li>○ Data not collected</li> </ul>	
Primary language	<ul style="list-style-type: none"> <li>○ Enrollment form</li> <li>○ Oral health risk assessment</li> <li>○ Information requested upon website registration</li> <li>○ Inquiry upon call to customer service</li> <li>○ Indirect method such as surname or zip code analysis</li> <li>○ Other (Please explain)</li> <li>○ Data not collected</li> </ul>	
Disability	<ul style="list-style-type: none"> <li>○ Enrollment form</li> <li>○ Oral health risk assessment</li> </ul>	

	<ul style="list-style-type: none"> <li>○ Information requested upon website registration</li> <li>○ Inquiry upon call to customer service</li> <li>○ Indirect method such as surname or zip code analysis</li> <li>○ Other (Please explain)</li> <li>○ Data not collected</li> </ul>	
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7.6.2 If Applicant answered “data not collected” in the data elements (7.6.1) above, please discuss how the Applicant intends to collect data elements to support improving health equity.

7.6.3 Indicate how race/ethnicity, primary language, and disability status data are used to address quality improvement and health equity. Select all that apply.

- Assess adequacy of language assistance to meet members’ needs
- Calculate dental quality performance measures by race/ethnicity, language, or disability status
- Calculate member experience measures by race/ethnicity, language, or disability status
- Identify areas for quality improvement
- Identify areas for health education/promotion
- Share provider race/ethnicity/language data with member to enable selection of concordant dentists
- Share with dental network to assist them in providing language assistance and culturally competent care
- Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care
- Analyze disenrollment patterns
- Develop outreach programs that are culturally sensitive (please explain)
- Other (please explain)
- Race/ethnicity data not used for quality improvement or health equity
- Language data not used for quality improvement or health equity
- Disability data not used for quality improvement or health equity

7.6.4 If the Applicant answered “data not collected” in the data elements (7.6.1) above, please discuss how the Applicant intends to use data elements to support improving health equity.

**7.7 Promotion Development and Use of Care Models**

7.7.1 If applicable to Applicant’s delivery system, please report the number of enrollees who have been assigned a primary care dentist.

	Exchange Enrollees, if applicable	Book of Business
Number of enrollees who have been assigned a primary care dentist		
Number of enrollees		

7.7.2 If assignment to a primary care dentist is not required, describe how Applicant encourages member’s use of dental home.

7.7.3 If assignment to a primary care dentist is not required, describe how Applicant encourages contracted providers to retain patients for continued care.

**7.8 Provider Cost and Quality**

7.8.1 Indicate how the Applicant provides members with cost information for network providers. Select all that apply.

- Web site includes a cost calculator tool for dental services (e.g. crowns, casts, endodontics, periodontics, etc.)
- Web site provides information on average regional charges for dental services (e.g. crowns, casts, endodontics, periodontics, etc.)
- Cost information on provider-specific contracted rates available upon request through Web site or customer service line
- Members directed to network providers to request cost information
- Other (please explain)
- Cost information not provided to membership

7.8.2 If the plan does not currently provide members with cost information, please report how the Applicant intends to make provider-specific cost information available to members.

## 7.9 Community Health and Wellness Promotion

7.9.1 Applicant must indicate the type of initiatives, programs, and projects the Applicant supports and describe how such activities specifically promote community health and/or address health disparities. Select all that apply and provide a narrative report in the “details” describing the activity.

Type of Activity	Details
Internal facing, member-related efforts to promote oral health (e.g. oral health education programs)	
External facing, high-level community facing activities (e.g. health fairs, attendance at community coalitions, participation in health collaboratives)	
Engaged with non-profit health systems or local health agencies to conduct community risk assessments to identify high priority needs and health disparities related to oral health	
Community oral health effort built on evidence-based program and policy interventions, and planned evaluation included in the initiative	
Funded community health programs based on needs assessment or other activity	
Plan is currently planning a community health promotion activity	
Plan does not conduct any community health initiatives	

## 7.10 Utilization

7.10.1 Applicant must provide dental utilization for the most recent benefit year for the following utilization measures. Provide current Covered California membership if applicable, and California book of business. Pediatric membership is defined as younger than 19 years of age. Adult membership is defined as 19 years of age and older.

Pediatric Utilization	Exchange enrollees, if applicable	California Book of Business
Percentage of membership that received any covered dental service		
Percentage of membership that received a preventive/diagnostic dental service		
Percentage of members receiving dental treatment services (excluding preventive and diagnostic services)		



Percentage of members who received a treatment for caries or a caries-preventive procedure		
Percentage of members with one (1) or more fillings in the past year who received a topical fluoride or sealant application		
Percentage of pediatric membership identified as moderate or high caries risk		

Adult Utilization	Exchange enrollees, if applicable	California Book of Business
Percentage of membership that received any covered dental service		
Percentage of membership that received a preventive/diagnostic dental service		
Percentage of members receiving dental treatment services (excluding preventive and diagnostic services)		
Percentage of members who received a treatment for caries or a caries-preventive procedure		
Percentage of members with one (1) or more fillings in the past year who received a topical fluoride or sealant application		
Percentage of membership identified as high risk		
Percentage of members whom reached the plan's maximum annual benefit, if applicable		

7.10.2 Applicant must submit copies of the most recent Dental Medical Loss Ratio Reports filed with the applicable regulator.