August 6, 2012

Diana Dooley, Chair
California Health Benefits Exchange Board
1000 G Street
Sacramento, CA 95814
Via email: info@hbex.ca.gov

RE: Qualified Health Plans: Dental Benefits

Dear Secretary Dooley:

On behalf of the California Dental Association (CDA) we are writing to present our comments on the analysis of the Qualified Health Plan (QHP) regarding dental benefits. CDA represents over 24,000 California dentists with a mission of commitment to the success of its members in service to their patients and the public. Our members provide primary and specialty oral health care to infants, children, adolescents and patients with special medical and developmental needs, and will be providing the pediatric dental component of the Essential Health Benefit.

As the Exchange moves to establish the criteria that determine which stand-alone dental plans and QHPs are offered to consumers, it is imperative that there be an understanding that dental "benefits" have historically functioned and been treated differently from medical "insurance." Dental benefits are unique and are best described as a "prepaid" benefit with capped, established limits rather than a capitated medical model that pays an actuarially established rate to a health plan to manage all medically necessary services on a risk basis. Care models that incentivize patients to obtain preventive care (utilization) and dentist participation (network adequacy), combined with robust operation and evaluation standards, are pivotal to delivering a meaningful benefit in a way that will reduce the state's rate of dental disease and have a positive impact on overall health.

For dental benefits in either a stand-alone plan or QHP to function effectively, plan designs must:

- Incentivize early care and disease prevention
- Institute performance measures for plans and providers that represent a cross section of care (not just time to first visit or 1 visit/year)
- Allocate funding in an actuarially sound manner
- Establish an appropriate portion of funding for actual care

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- Share risk between the plan and the actual care provider that recognizes the unique nature and cost of dental benefits. This means in a dental managed care environment, the plan does not pay the dentist a capitated rate to provide all needed care – a model that is especially unworkable in high-needs populations. Risk should be more equitably shared by the plans in a hybrid managed care model whereby plans pay to dentists a fee for services actually delivered, giving plans a higher contractual and financial stake in the care enrolled beneficiaries receive. This is a direction taken by other state Medicaid dental programs that is showing improved results.

Comments on Specific QHP Dental Benefits Recommendations

CDA supports offering supplemental dental benefits in both the Individual and SHOP Exchanges. This is the best option for ensuring that current adult dental consumers and those customers new to the dental benefit marketplace have the best access to dental coverage. According to the National Association of Dental Plans, more than 16 million Californians are currently enrolled in a private dental plan. While a majority currently obtain coverage through their employer, it is unclear how employers will change the benefit packages they offer once the Exchange becomes operational in 2014. Therefore, it is important to offer adult dental products in both Exchanges. In addition, offering coverage in the Individual Exchange will allow individuals purchasing adult dental benefits to access Exchange pricing, making care more affordable and sustainable. Finally, the Exchange would benefit by providing supplemental adult dental coverage, because it will act as an enticement for more consumers to enter into the Exchange to access health coverage.

Offering supplemental adult dental coverage in both the Individual and SHOP Exchanges offers the most consumer choice, does nothing to interfere with the current market practice, and allows the Exchanges to be the central location for comprehensive access to health and oral health benefits for both children and adults.

CDA supports offering stand-alone dental plans. A fundamental requirement for access and consumer choice with regard to dental benefits is maintaining the option to purchase those benefits from a stand-alone dental plan in the Exchange.

Allowing stand-alone dental plans as an option in the Exchange creates parity and consistency with the current marketplace and the future marketplace outside of the Exchange. In the current market, most dental coverage is offered as a supplemental benefit from stand-alone plans, whether purchased separately from a stand-alone dental plan or from dental plans that are subcontracted to medical plans. In order for the Exchange to be a robust competitive marketplace and entice more participants, consumers must have the same options in the Exchange as they currently have outside of the Exchange.

Additionally, allowing stand-alone dental plans, dental benefits integrated with medical benefits through QHPs, as well as dental plans subcontracted with medical plans provides for optimum plan flexibility and pricing. Ensuring plans can create the types of products and packages that they believe will entice consumers, be well managed and at all price points, allows plans the opportunity to design packages that best meet their needs and the needs of their consumers.

It is important to note that there remain many unanswered questions about how dental benefits imbedded with medical QHPs will be treated in the Exchange. Federal guidance is not yet available explaining whether the cap on lifetime or annual benefits would be applied to dental care offered integrated with medical coverage or as a subcontracted plan with a medical plan. As this issue remains unclear, it provides another reason why stand-alone dental plans must be offered in the Exchange.

Other issues to consider

Sustainability. Dental coverage will be particularly at risk of adverse selection. CDA is concerned that adults may purchase a stand-alone adult benefit, getting the maximum out of their annual benefit, and then dropping coverage. Dental plans should be able to include industry-standard waiting periods for specific procedures. In addition, stand-alone dental benefits should be subject to the same open enrollment periods as medical plans, but dental plans should not be required to continue to pay for services on stand-alone dental benefits beyond 30 days for non-payment of premiums.

Quality. The Exchange should review the long-term compliance history of carriers seeking to contract with the Exchange prior to certification as a QHP. For example, plans should be able to demonstrate a history of complying with the state's provider network adequacy requirements and the prompt payment of claims. This would include reviewing the results of periodic audits, as well as any pattern of complaints reported to the agencies by enrollees and subscribers, or policyholders, and healthcare providers. For plans that have been the subject of clinical or access enforcement actions, the Exchange should consider whether these plans are capable of providing appropriate access to patients. CDA suggests that for plans with recent (within the previous 24 months) enforcement actions by either DMHC or CDI for complaints or inadequate accessibility or timeliness standards, the Exchange should consider refusing to contract for a period of time or limiting enrollment based on the carrier's plan to improve its network adequacy and comply with the regulations and applicable law.

Network Adequacy: Given the potential population, plans should also be able to demonstrate that providers in the network are linguistically and physically accessible to patients with language barriers or physical disabilities. CDA would suggest that the DMHC and CDI links to plan network filings also be clearly linked through the Exchange portal and website so consumers can review the provider network before purchasing coverage. This information should be updated no less than quarterly, but ideally,

monthly and reflect providers accepting new patients. Furthermore, CDA does not believe that network adequacy should be monitored through a complaint-driven process. Recent history in Sacramento County has shown that a significant number of consumers had delayed or unsuccessful treatment before state agencies stepped in to address the underlying problem. Therefore, routine monitoring and evaluation should be enforced through interagency agreements with CDI and DMHC, as well as internal network "spot-checks" through the use of secret shoppers or other mechanisms. Also, Knox-Keene regulations require health plans to conduct random quality assurance audits of providers in their networks to assure that providers are adhering to standard practices in complying with health and safety requirements, and also standard patient treatment recordkeeping. The CDI does not have a similar quality assurance audit requirement, but the Exchange Board should require adoption of the DMHC audit requirement.

Best Practices and Accountability. Providing pediatric oral health exams starting at age one, and early preventive and disease intervention services, ensures that a child embarks with the best possible opportunity for a lifetime of routine, rather than restorative, oral health care. Plans should be actively encouraging providers to provide all the clinically indicated services for children based on established guidelines and accepted periodicity schedules, emphasizing preventive care. Data confirming this emphasis should be available to the Exchange when negotiating contracts – and should be available to consumers when making a plan purchase.

We appreciate that you are on a tight timeframe to resolve these complex issues related to dental qualified health plans; CDA would be pleased to act as a resource for you as you move ahead in your decision-making. Please feel free to contact me for more information.

Sincerely,

Carrie Gordon
Vice President of Government Affairs

cc: Health Benefit Exchange Board Members
Peter Lee, Executive Director Health Benefit Exchange Board
Andrea Rosen