Pediatric Dental Coverage: Background and Policy Options

SUMMARY

This Board Recommendation Brief explains the history and rationale for the current structure and selection of pediatric dental plans that Covered California will offer in 2014, requests Board action regarding the question of mandatory purchase of the pediatric oral care benefit, details some stakeholder concerns for consideration, and outlines the issues, considerations and process Covered California can take to improve upon pediatric dental policies as we go forward.

BACKGROUND

Of the 2.6 million Californians eligible for subsidized coverage in Covered California in 2014, approximately 140,000 (5%) are children aged 18 years old and younger. Of the 1.7 million Californians who are not subsidy eligible but are projected to purchase through Covered California or through the broader individual marketplace, approximately 280,000 (16%) are children. These children will generally be in families with an income above 250 percent of the federal poverty level that will enroll in Covered California, or in the individual market outside of Covered California, because they do not have affordable employer-sponsored coverage. Also notable are the more than 6.5 million children whose family income is below 250 percent of the federal poverty level and are eligible for, and may receive, coverage through Medi-Cal. Many of these children will have parents who are eligible for subsidies in Covered California and will be in "mixed households" with the parents receiving coverage through Covered California, while their children are enrolled on a very low or no-cost basis in Medi-Cal. While dental coverage is provided for those enrolled through Medi-Cal, this paper focuses on pediatric dental coverage issues for children who get coverage through Covered California, in particular those in lower income families who will be eligible for premium assistance.

Over the past year, Covered California has conducted a solicitation and selection process both for Qualified Health Plans (QHPs) offering health care services, and a solicitation and selection process for dental benefit insurers. Based on those processes, Covered California currently has a portfolio of health care and dental products that offers consumers affordable options reflecting a mix of plans and a range of competitive pricing. In June, Covered California announced its selection of six dental offerings, with a mix of products (HMO, PPO and EPO) priced as low as $10 to $15 per month for dental HMO offerings, and $20 and more for dental PPO offerings. (Note: Stand alone dental rates for families with 2+ children are rated anywhere from 2 to 2.5 times the individual rate depending on issuer.)

While Covered California believes the offerings for consumers are affordable and competitive, we also note that in our process over the past months, we did not complete the necessary analysis nor properly engage the Board and key stakeholders to consider if there were alternative ways to structure pediatric dental coverage that might be better than the current offerings. With this Board Recommendation Brief we seek to review the status of the law and regulations, summarize stakeholder concerns for consideration, investigate the issues, and outline the steps Covered California can take to move forward quickly with, as appropriate, the implementation of any improvements relative to pediatric dental coverage.

Federal and State Standards for Pediatric Dental Coverage

What follows are key provisions of federal and state law and policy related to pediatric dental coverage. See the References for source material and Appendix 1 for an overview and citations to federal and state law.

Pediatric dental benefits: Pediatric services, including dental and vision care, comprise one of the ten essential health benefits (EHBs) that must be covered by non-grandfathered health plans in the individual and small group markets beginning 2014. The pediatric dental component is often referred to as a ".5" benefit, where all other benefits are collectively "9.5" (which include pediatric vision coverage), and in sum represent the ten EHBs. Under federal law Covered California must allow health plans to offer 9.5 and .5 plans, but it also must offer the pediatric dental EHB in conjunction with the other essential health benefits as described below.

Options for offering the pediatric dental EHB within Exchanges: The Affordable Care Act requires the pediatric dental EHB to be offered in exchanges through stand-alone dental plans. This is a unique provision that does not apply to the remaining 9.5 benefits, all of which must be offered by QHPs that are certified by exchanges. Under federal regulations, exchanges must allow the offering of limited scope dental plans (referred to in this paper as stand-alone dental plans) when such plans:

- Do not impose annual or lifetime limits on pediatric EHB dental;
- Meet the exchange certification standards except for those QHP standards that cannot be met by dental plans; and
- Otherwise comply with applicable federal laws relating to excepted dental benefits.

[Note: Covered California staff assumes that at least one stand-alone dental plan will meet these federal criteria in each plan year. Therefore, the staff assumes that Covered California must offer stand-alone dental plans each year.]

If a stand-alone dental plan is offered in an exchange, federal rules allow otherwise qualified health plans without pediatric dental EHB coverage to participate in the exchange, even without offering pediatric dental benefits. This provision allows the offering of 9.5 plans to complement .5 stand-alone dental plans.

In addition to offering the pediatric dental EHB through stand-alone dental plans, Covered California must allow issuers – at their option – to provide the benefit in conjunction with a QHP. The Centers for Medicare and Medicaid Services (CMS) have described two options for offering the pediatric dental EHB in conjunction with a QHP: (1) as an embedded plan or (2) through bundled arrangements. Federal descriptions of these options are provided below (CMS: Qualified Health Plan Webinar Series FAQ #10: question 28).

- The pediatric dental benefit is considered **embedded** in a medical plan when it is offered like any other benefit under same premium and included in the same actuarial value calculation for that medical plan. Although the medical plan issuer may contract with a dental issuer to offer the pediatric dental benefit the dental benefits provided under the contract would only be considered embedded if the medical plan issuer fully assumes all risks and liabilities of covering the dental benefit. A medical plan with an embedded dental benefit provided under contract would be considered a single plan for purposes of calculating the out-of-pocket maximum and actuarial value.

- Under a **bundled** arrangement, a medical plan issuer would pair with a stand-alone dental plan to offer the pediatric dental benefit. The issuer of each of these plans would assume the risks and liabilities associated with providing coverage under its own plan. In this situation, the medical plan and the stand-alone dental plan would each be considered a separate plan, with the stand-alone dental plan considered an excepted benefit under title XXVII of the Public Health Service Act. Accordingly, each plan would be held to applicable standards, including those related to the out-of-pocket maximum and actuarial value.

[Note: In April 2013, Covered California incorrectly instructed health plans not to bid embedded plan offerings. While most of the plans engaged in the QHP solicitation process had indicated to Covered California that they had no intention or desire to offer an embedded option, Covered California should have welcomed bids of embedded, bundled or stand-alone offerings.]

Advance premium tax credits and cost sharing reductions: Federal advance premium tax credits (APTC) and cost sharing reductions will be available to Covered California enrollees within specific income ranges to reduce premium and out-of-pocket costs, respectively. Internal Revenue Service (IRS) rules specify that a consumer's maximum APTC is **calculated** based on the premium for the second-lowest-cost plan available to that consumer in the silver metal tier. IRS rules also require that APTC for individuals and families must first apply to QHP premiums. Remaining tax credits, if any, may be **allocated** to stand alone dental coverage. With regard to federal rules for cost sharing reductions – which provide for potentially substantial reductions in out-of-pocket obligations according to income level – those mechanisms do not apply cost sharing reductions to stand-alone dental plans, only those that are embedded.

Under Covered California's current understanding of federal standards, the pediatric dental premium is included in the calculation of APTC only when the pediatric dental benefit is embedded in the benchmark QHP. If the benchmark QHP does not contain pediatric dental benefits, the stand-alone plan premium is not included in the APTC calculation. This discrepancy is the result of IRS interpretation and guidance, independent of Covered California policy decisions or product offerings.

Benefit designs and plan pricing: Federal rules require and allow different benefit design features and pricing options.

- The **actuarial value** for stand-alone dental plans must be either 70 or 85 percent as opposed to the 60, 70, 80 or 90 percent required for QHPs.
- For a stand-alone dental plan covering the pediatric dental essential health benefit, federal rules allow exchanges to determine a separate "reasonable" annual limit on cost sharing, or **out-of-pocket maximum**, applicable to in-network dental services. Based on clarification from CCIIO, we understand that the application of these separate out-of-pocket maximums would mean that there would be distinct maximums for health-related and dental expenses. In the plan year 2014, Covered California's maximums are $6,350 for health-related expenses and $1,000 for dental. In contrast, in a QHP with an embedded pediatric dental essential health benefit, the out-of-pocket maximum would be set at $6,350/individual and $12,700/family for 2014. Covered California is seeking clarification on whether it is possible to allocate the maximum out-of-pocket between health and dental (for example $5,350 for medical and $1,000 for dental), within the federally-established out-of-pocket maximum.

Pediatric Dental coverage offered outside of the Exchange: Under federal law, issuers outside of an exchange have to offer all ten essential health benefits unless the issuer obtains an assurance that the

individual has pediatric dental coverage through a stand-alone dental plan. However, states may require issuers outside an exchange to cover all ten essential health benefits without the reasonable assurance exception. Under California law, all ten essential health benefits must be offered outside of the Exchange without the reasonable assurance exception. California's health insurance regulators, the California Department of Insurance and the Department of Managed Health Care, have confirmed this requirement.

Pediatric dental coverage offered inside the Exchange: Under federal rules, individuals purchasing coverage through Covered California are not required to purchase pediatric dental EHB coverage. Similarly, California state law does not require the purchase of pediatric dental EHB coverage within Covered California. Rather, the requirement is to offer coverage. As noted by the Health Insurance Alignment Project, "the essential health benefits requirements in federal law (and California law) is a requirement on the issuer to include the ten EHBs in any new health plans offered starting in 2014 to individuals and small employers, including coverage through Exchanges. The EHB requirement is not a requirement imposed on the purchasers of coverage or on individuals subject to the federal minimum essential coverage requirement." (Kelch: *Pediatric Dental Essential Health Benefits FAQ).*

Federal rules do not require the purchase of the pediatric dental EHB; however, there is nothing in federal law to prohibit a state exchange from requiring the purchase of the pediatric dental EHB. While there may be some dispute on the question of whether the Board has the authority to require the purchase of pediatric dental plans as a condition of participating in Covered California, we believe the Board's broad statutory authority under the California Affordable Care Act permits it to impose this condition on enrollees.[*] This authority comes from Covered California's ability to set the criteria for eligibility and enrollment in the Exchange, which could include purchase of pediatric dental coverage for some or all enrollees. Covered California is also responsible for determining when coverage commences and its scope. Finally, Covered California has the authority to take all actions reasonably necessary to comply with the Affordable Care Act and the California Affordable Care Act, which the federal government has informed California permits mandatory pediatric dental purchase on the state level. The different standards inside and outside the Exchange have implications both for subsidy eligible and non-subsidy eligible children and for individuals who do not have children.

Pediatric Dental: Pricing, Product and Portfolio

Within the federal and state guidelines described above, state exchanges have a variety of options for offering pediatric dental coverage. These options are described in a framework which includes price, product and portfolio. We note that while these are presented as three distinct elements, their impacts overlap. This framework is revisited below in this discussion of options for 2014 and 2015.

Pricing of pediatric dental needs to be considered in the context of its impact and implications on the price of QHP health care premiums and how those costs are distributed. The pediatric dental EHB price will also vary depending on whether and how the benefit is "community rated" with benefit costs included in premiums for all enrollees and whether purchase of the benefits is mandatory or optional and by whom. For example, the pediatric dental benefit may be community rated with an assumption of mandatory purchase for all enrollees or priced separately for stand-alone plans with an assumption of voluntary purchase only for children. Product options discussed below will impact pricing.

[*] Note: Insurance Commissioner Dave Jones, on July 31, 2013, expressed the view that the Board mandating pediatric dental coverage would be beyond its authority.

Product options for the pediatric dental EHB include stand-alone dental plans, bundled arrangement with a QHP or plans with an embedded pediatric dental benefit. Product options can result in differences in cost sharing structures such as out-of-pocket maximums, deductibles and copayments, as well as the treatment of the advanced premium tax credits. Finally, products can have different administrative features including combined or separate premium billing and evidence of coverage documents.

Portfolio options describe the range of products offered to a consumer in any market, in this case both within and outside Covered California. When pursuing a policy goal, it is important to understand the impact of the full portfolio offering, as the set of offerings can affect enrollment, retention, and other key market measures, as well as plan pricing and consumer behavior in plan selection. In this case, Covered California's portfolio could include stand-alone, bundled and/or embedded products, while offerings in the individual market outside Covered California may be either bundled or embedded.

Covered California's 2014 Pediatric Dental Solicitation Process and Current Coverage Approach

Covered California originally solicited bids for QHPs on November 16, 2012, and stated its expectation to seek premium quotes for child-only coverage and family coverage. Covered California requested each quote be submitted in two versions: one with the pediatric dental EHB included and a second version without. Aware of the Affordable Care Act's provision that permits the pediatric dental EHB to be offered via a stand-alone dental plan and that federal guidance regarding this excepted benefit plan would be forthcoming, the solicitation noted that "[d]epending on future federal guidance and rules, QHP Bidders may be required to separate their bid for certain pediatric essential health benefits (dental or vision) from their bid for remaining essential health benefits."

Federal rules released on February 25, 2013, confirmed that all state exchanges must certify a QHP even if that QHP does not offer pediatric dental benefits, and that exchanges must permit the offering of stand-alone dental products that included the pediatric dental essential health benefit. Acting on these February 25, 2013 rules, Covered California sent an updated notice to pediatric stand-alone dental plan bidders advising them that the solicitation would be extended to accept bids for stand-alone dental plans covering solely the pediatric dental EHB.

In light of the federal rules, on April 3, 2013, Covered California sent a notice to QHP bidders requiring bids for the pediatric dental EHB bundled with a QHP medical plan rather than as an embedded plan. Covered California changed the bidding requirement to create administrative and benefit design uniformity and to address concerns raised by many bidders about the impossibility of administering a single out-of-pocket maximum for medical and dental services within an embedded plan in 2014. In hindsight, Covered California should have raised this issue more clearly at the time with our Board, stakeholders and regulators.

In parallel with the solicitation and bidding process, Covered California, with the Department of Health Care Services, has been overseeing the design and build of the Covered California's enrollment website – the California Eligibility, Enrollment and Retention System or CalHEERS. In June of 2013 Covered California staff identified that the designed and built specifications for CalHEERS would only have the functionality to support display or purchase of embedded plans with a single out-of-pocket maximum or stand-alone plans in time for the initial open enrollment for 2014, meaning that CalHEERS could not accommodate the bundled plan bids received for 2014. Following this finding, Covered California

notified QHPs that it would only have the technical capability to offer 9.5 QHPs with stand-alone dental plans in 2014.

Throughout the pediatric dental solicitation process, Covered California was focused on meeting the October 2013 open enrollment deadline. Decisions were informed by the best possible understanding and prudent interpretation of federal requirements as they emerged at various points in time. Based on that understanding, staff made decisions about health plan bidding, information technology design, and other topics, but the major and core policy decisions are rightly the domain of the Covered California Board. In the focus on many issues regarding the QHP solicitation and other matters, staff have not effectively engaged the Board and key stakeholders in the complex issues that warrant both additional deliberation and decision by the Board. The last sections of this brief provide a strategy and timeline for bringing the full range of these policy decisions before the Board to set Covered California's approach to pediatric dental coverage policies. The next section describes issues for consideration for plan year 2014.

ISSUES FOR CONSIDERATION FOR PLAN YEAR 2014

Covered California staff believe that each issue under consideration needs to be reviewed in the context of five critical factors:

1. Affordability and stability (including premium, cost at point-of care and availability of tax credit);
2. Consumer protection/service (how the design assures consumers have clear options and effective protection;
3. Alignment of Covered California's marketplace and the broader market;
4. Meeting federal and state requirements; and
5. Operational feasibility – technically and administratively.

This section outlines the following three issues for potential Board action that would impact pediatric dental EHB coverage in 2014: (1) potential offering of embedded plans; (2) mandating the purchase of the pediatric dental EHB benefit; and (3) enforcement of consumer protections through the pediatric dental plan contracting process. Please note that these issues are revisited in the following section as part of the full consideration of pediatric dental policy issues for 2015 and beyond.

Offering of Embedded Plans

Covered California should have allowed for the submission of embedded plans in April of 2013 and conducted a full analysis at that time to assess – to the extent any plans bid such structures – the relative advantages and disadvantages of that offering compared to stand-alone and bundled offerings. By not considering embedded plans as options for 2014 early in the solicitation process, Covered California has hindered its ability to offer this type of product for 2014 open enrollment.

In response to concerns raised by legislators, consumer advocates and regulators about affordability of stand-alone dental coverage, Covered California has done initial exploration of the option of offering embedded plans in 2014. Consumer premiums for embedded plans can be included the calculation of the APTC, thus allowing a larger tax credit and generating consumer savings for those who qualify for subsidies. In addition, consumer and children's health groups have emphasized that requiring all plan participants to pay a single rate that covers both health and dental (community rating) creates cost advantages for consumers. From this perspective, spreading the cost of the pediatric dental EHB across all Covered California enrollees through community rating would lower premium costs for families with

children. In addition, mandating purchase by all enrollees would alleviate issues of adverse selection. Finally, embedded plans must adhere to certain market and rating rules, discussed below, that stand-alone dental plans are not required to meet under federal law (although Covered California has included a robust set of consumer protective provisions in its draft model contract for stand-alone dental providers).

While embedded plans offer important advantages to some consumers, Covered California must carefully weigh the potential advantages and disadvantages of this option and must also consider operational risks that would be introduced by reopening the QHP solicitation. To evaluate the extent to which Covered California might be able to offer embedded plans, on July 18 Covered California surveyed all of the plans selected to participate in its individual marketplace to assess if and when they could offer embedded dental coverage. Of the ten plans that responded, six said the soonest they could offer embedded plans would be in January 2015, two noted that they were not interested in offering embedded rates, and two said they could possibly offer an embedded plan prior to 2015, although one of these plans is a regional carrier with a very limited geographic scope. See additional detail in Appendix 2. In addition, Covered California was notified by the California Association of Health Plans via a letter dated July 16, 2013, that requiring the embedding of all pediatric dental in 2014 is not feasible at this late date and would be opposed by the QHPs.

To offer embedded plans in compliance with the Affordable Care Act, Covered California would have to create a new plan design which would either mean losing the dedicated $1,000 out-of-pocket maximum or repricing medical services. Under the first scenario – if the dental out-of-pocket maximium were removed – families could be responsible for up to $6350 in dental out-of-pocket expenses annually. Under the other scenario, if part of the $6350 out-of-pocket maximum were “reserved” for dental expenses, the health plan’s out-of-pocket maximum would change significantly. This is a change in the plan design on which health plans bid, and could in turn affect pricing in a variety of ways. It would require either reopening rate negotiations with health plans and dental providers, or creating a new solicitation and bid process for an embedded product. Premiums for adults would rise to offset the impact of lowering the maximum cost sharing form $6350 to $5350. Additional actuarial analysis is needed to more precisely quantify the consumer cost impacts of embedded versus stand-alone dental plan options.

Covered California staff has weighed the resources needed to complete these tasks against the other launch activities underway that are crucial to delivering affordable QHPs to all Covered California enrollees in 2014. The following activities would need to occur in order to offer embedded plans:

- Development of a new standard benefit design;
- Development of solicitation documents;
- Evaluation of bids by Covered California and regulators;
- Modification of plan contracts;
- Loading of plan information into CalHEERS; and
- Training of enrollment personnel including service center representatives, certified enrollment counselors, agents and county eligibility workers on the new benefit design and products.

However, even if a plan responded to bid embedded, Covered California would be faced with offering both embedded and 9.5 plans in the same portfolio. As distinct options, each product type has predictable enrollment probabilities and is rather simple to price. However, including both stand-alone and embedded products in one portfolio and asking consumers to choose one or the other complicates this predictability and adds risk which must be considered in pricing. This added risk includes whether

only families with eligible children will choose embedded products and families or individuals without eligible children will choose the QHP with 9.5 coverage . In such a scenario the embedded product ends up not being community rated in the pure sense, thereby negating the benefit of embedded and community product pricing.

Recommendation: due to uncertainties in the impact to consumer costs and operational risks, Covered California staff does not recommend soliciting bids for embedded dental plan for 2014, but instead conducting the analysis needed to improve our offering in 2015.

[Note: Covered California staff have also considered alternative approaches to address affordability concerns. Staff explored the idea of establishing a payment pool to offset the projected costs of unsubsidized dental plans for eligible consumers. Such a pool could raise the premium cost of all QHPs by a nominal amount which would be transferred to stand-alone dental plans for the purpose of reducing premiums. The administrative arrangements necessary for this solution will not be possible in time for 2014; however, Covered California will explore this option for 2015 and beyond. Covered California staff will also continue to work with federal partner agencies including the IRS to seek a policy change in the calculation of the APTC for stand-alone dental plans.]

Mandatory or Voluntary Pediatric Dental Plan Purchase

Covered California has not, to date, made an explicit policy decision about whether or not to require the purchase of the pediatric dental EHB. In the context of offering the 9.5 QHP along with stand-alone dental plans in 2014, the Board could:

1. Mandate the purchase of a stand-alone dental plan in addition to a 9.5 QHP.
2. Apply the mandate to either of two groups: families with children 18 and younger, or to all consumers.

For families with children, the most important advantage of mandatory pediatric dental plan purchase appears to be the assurance of high levels of pediatric dental care coverage for children. However, because the cost of the stand-alone dental premium cannot be included in calculating the tax credit for consumers, mandating consumer purchase adds to consumer cost without the benefit to consumers of an offsetting tax credit. In addition, Covered California has not yet analyzed the impact of mandatory purchase on health plan (in contrast to dental plan) purchase. There is the potential for lowering overall enrollment in health plans when an add-on benefit is required. Table 1 illustrates the options for mandating the purchase of pediatric dental EHB in 2014, and the converse of this decision which would allow consumers to voluntarily purchase the benefit.

Table 1. Mandatory or Voluntary Purchase of the Pediatric Dental EHB in 2014	
Mandatory Purchase	
All Consumers	**Children 18 and Younger**
SUMMARY: All consumers would be required to purchase a .5 plan and a 9.5 plan.	**SUMMARY:** Require that parents of children 18 and younger purchase a .5 plan and a 9.5 plan.
PRO: • Mirrors the offerings outside of Covered California.	**PRO:** • Greater take up of pediatric dental EHB for children enrolled in Covered California. • Promotes the important coverage of dental services.
CON: • Added cost and highlighting "empty" benefit for adults. • In absence of process to spread costs, the requirement would not necessarily result in reduced costs for families with children. • Difficulty of enforcing ongoing payment of dental premiums as condition of maintaining coverage.	**CON:** • ATPC calculation will not include the cost of stand-alone dental premium, raising affordability concerns for lower income families.
Voluntary Purchase	
SUMMARY: Purchase of .5 plans would be voluntary for all.	
PRO: • Subsidy-eligible families without access to tax credits would not be required to purchase coverage	
CON: • Potential adverse selection if families with children who may have high dental needs disproportionately choose the benefit. • Potential costs to issuers or provider if children obtain intensive dental services, and then discontinue coverage after dental care is obtained. • Potentially fewer children will have the important coverage for dental services.	

While the decision to mandate purchase of the pediatric dental EHB is more straightforward in the context of an embedded plan design as opposed to a stand-alone plan design, the decision to mandate is further complicated by portfolio choices. In an embedded plan design consumers have to select just one plan, and community rating can easily be applied. However, as noted above, offering both stand-alone dental plans and embedded plans poses challenges to community rating, as many without children will opt to purchase a 9.5 plan. This and other portfolio issues need additional analysis before a fully informed decision can be made to require the purchase of the pediatric dental EHB.

Recommendation: Given the implications of the tax credit calculation for families, and the consumer experience for adults who could not use the .5 plans, voluntary purchase of the pediatric dental benefit is recommended for 2014. While additional research needs to be conducted, consideration will be given to the option of only offering embedded plans along with stand-alone dental plans in 2015 to the extent allowable by federal rules. Covered California will explore the federal requirement to offer 9.5 QHPs, and how to do so as part of a portfolio with embedded plans.

Consumer Protections

Consumer advocates have expressed concerns that as excepted benefits, stand-alone dental plans do not offer the same consumer protections as QHPs. It is correct that under the Affordable Care Act and California law, stand-alone pediatric dental plans are not subject to insurance market reform provisions including medical loss ratio standards; rating standards related to age, family size, rating area and tobacco use; guaranteed availability standards and guaranteed renewability standards. However, federal law requires that stand-alone-dental plans be offered without waiting periods or annual or lifetime limits. Covered California stand-alone dental plans, in addition to offering protections in accord with law relating to waiting periods and limits, also include a $1,000 out-of-pocket maximum, an important consumer protection, among other protections.

The Covered California Board has the authority to impose additional conditions of participation on dental plan carriers. The draft dental model contract includes a section entitled "Consumer Protection and Certification" in which Covered California staff proposes to require the stand-alone dental plans to be subject to the following key patient protection features of the Affordable Care Act:

- Guaranteed issue;
- Prohibition of preexisting conditions or exclusions based on health status;
- Fair health insurance premiums;
- Guaranteed availability of coverage;
- Guaranteed renewability of coverage;
- Prohibition of discrimination against individuals on the basis of health status;
- Nondiscrimination of health care;
- Elimination of waiting periods as adopted in our standard dental plan designs;
- Elimination of annual and dollar limits as adopted in our standard dental plan designs;
- Network adequacy (although not required in the Affordable Care Act for dental plans); and
- Timely access to care.

Note that, in addition to recommending these changes to the standard dental contract, staff recommend removing the contract section that calls on QHPs to offer the exact same products outside of the Exchange. Since the offering of the 9.5-only coverage can only be offered in Covered California, outside of the marketplace plans will need to present bundled or embedded offerings.

Recommendation: Covered California staff will proceed with finalizing the dental model contract to formalize the consumer protections listed above.

ISSUES FOR CONSIDERATION FOR PLAN YEARS 2015 AND BEYOND

Covered California is committed to exploring the full range of pricing, product and portfolio options described above for plan years 2015 and beyond. These options, and their inherent trade-offs, will take careful but rapid consultation with health plan partners, stakeholders and California's regulators. This final section of this paper summarizes the suggested approach that Covered California staff plan to begin in the coming weeks. In all cases, Covered California will consider the five factors earlier identified.

In analyzing **pricing** options, Covered California will assess the cost impacts associated with community rating and mandatory pediatric dental purchase for families and/or childless adults. This analysis will

look at cost impacts under the full range of product and portfolio options including stand-alone dental only or stand-alone dental combined with embedded and/or bundled offerings.

Covered California will analyze **product** options for the pediatric dental EHB, including stand-alone dental plans, bundled arrangements with a QHP, and embedded plans. A primary focus will be on cost impacts on premiums, both positive and negative, for families and in the consumer population as a whole. This will include actuarial analysis of various out-of-pocket maximums, deductibles and copayment structures for each of the three product types. Consumer cost trade-offs between separate and combined out-of-pocket maximums will be analyzed.

Finally, Covered California will analyze the ramifications of various **portfolio** options to understand how combinations of stand-alone, bundled and embedded products, or the potential of allowing only embedded plans, will affect pricing, consumer purchase behavior and APTC calculations.

Throughout the course of this analysis, consumer and plan input will be solicited and consideration will be given to the development of administrative policies such as billing practices, dental provider contracting options and changes needed to rate and benefit templates to align with product designs.

During the course of this work, Covered California will work with federal partner agencies to confirm our understanding of existing law and regulation and seek clarification on open questions, and request federal policy interpretations in the best interest of consumers such as the previously-discussed modification of the APTC calculation. For example, Covered California will request clarification as to whether an exchange may elect to offer bundled or embedded products, rather than both.

Next Steps and Timeline

Covered California has engaged the Wakely Consulting Group to analyze the actuarial and policy impacts of the various pediatric dental pricing, product and portfolio options. The analysis will include an assessment of the potential transition from the planned 2014 stand-alone dental approach to different design options. Finally, the analysis will explore the feasibility of creating a payment pool for dental benefits, as mentioned above, and explore implications for operating such a pool alongside embedded, bundled, and/or stand-alone plans.

A suggested timeline for pediatric dental policy analysis is presented below. The analysis will be publicly available and presented at upcoming Board meetings. Consistent with Covered California practice, stakeholder feedback will be solicited on the analysis to ensure that final recommendations are informed by the full range of stakeholder perspectives. Covered California will post products from this project and instructions for submitting comment on the webpage for the Plan Management and Delivery System Reform Advisory Group.

Pediatric Dental Policy Development Suggested TimeLine	
Date	**Milestone**
August 22	Scope of work developed and shared at scheduled Board meeting
October 15	Draft analysis completed
October – November	Draft analysis shared with stakeholders for comment
November 21	Recommendations presented to the Board for discussion and public comment
December 19	Recommendations presented to the Board for action

APPENDIX 1: FEDERAL AND STATE LAW AND REGULATIONS

		Issue	Citation
Essential Health Benefits			
1	Federal	Pediatric services, including oral and vision care, are included as one of the ten essential health benefits (EHBs). The pediatric dental component is often referred to as a ".5" benefit, where all other benefits are collectively "9.5", and in sum represent the ten EHBs.	42 U.S.C. § 18022(b)(1)(5); 45 C.F.R. § 156.110(a)(10)
2	State	Non-grandfathered health plans sold to individuals and small employers are required to include coverage for all ten EHBs, including pediatric dental coverage.	CA Health and Safety Code (HSC) §1367.005 and CA Insurance Code (CIC) §10112.27 (AB 1453, Chapter 854, Statutes of 2012 and SB 951, Chapter 866, Statutes of 2012 respectively.)
Stand-alone Dental Plans			
3	Federal	The Exchange must allow the offering of limited scope dental plans.	45 C.F.R. § 155.1065 (a)
4	Federal	The ACA allows an issuer of stand-alone dental to offer the plan through the Exchange, either separately or in conjunction with a qualified health plan (QHP), if the dental plan provides pediatric dental benefits that comply with the pediatric EHB dental requirement and the dental plan: • Does not impose annual or lifetime limits on pediatric EHB dental; • Meets the Exchange certification standards except for those QHP standards that cannot be met by dental plans; and • Otherwise complies with applicable federal laws relating to excepted dental benefits.	42 U.S.C. § 300gg-11; 45 C.F.R. § 155.1065(a)
5	Federal	Exchange may allow the dental plan to be offered as a stand-alone dental plan; or in conjunction with a QHP.	45 C.F.R. § 155.1065(b)
6	Federal	Exchanges must consider the collective capacity of stand-alone dental plans to ensure sufficient access to pediatric EHB dental coverage.	45 C.F.R. § 155.1065(c)
7	Federal	If a stand-alone dental plan (a .5 plan) is offered in an Exchange, QHPs without pediatric dental coverage (9.5 plans) will still be allowed.	45 C.F.R. § 155.1065(d)
Advance Premium Tax Credit and Cost Sharing Reductions			
8	Federal	**Tax Credit Calculation:** The tax credit is calculated based on the premium for the second-lowest-cost silver plan, whether or not the plan includes pediatric dental.	26 C.F.R. § 1.36B-3(d), (f), (k)
9	Federal	**Tax Credit Allocation:** Tax credits for individuals and families must first apply to QHP premiums. Remaining tax credits, if any, may be applied to stand-alone dental coverage.	26 C.F.R. § 1.36B-3(k); 45 C.F.R. § 155.340(e)
10	Federal	Cost-sharing reductions to do apply to stand-alone dental plans.	45 C.F.R. 156.440(b)
Purchase Requirements			

		Issue	Citation
11	Federal	Individuals purchasing coverage through the Exchange are not required to purchase pediatric dental EHB coverage.	45 C.F.R. § 155.150; 77 Fed. Reg. 12853 (Feb. 25, 2013)
12	State	State law does not mandate pediatric dental purchase within the Exchange.	Ins. Code § 10112.27(j), (k); Health & Safety Code § 1367.005(j), (k); 10 Cal. Code Regs. § 2594.3(a)(1)
13	Covered CA	The Covered CA Board has the authority to mandate pediatric dental purchase.	Gov. Code § 100503(a), (s)
Requirements Outside of the Exchange			
14	State	California law requires all health coverage outside of the Exchange to include all ten EHBs.	Ins. Code § 10112.27 Health & Safety Code § 1367.005

APPENDIX 2: SUMMARY OF QHP RESPONSES TO REQUEST FOR INFORMATION ON EMBEDDED DENTAL OPTIONS

Responses to Informal Request for Information to Bidders for Pediatric Dental – July 2013 (Note: plans responded with the specific understanding that their responses would be made public in the aggregate.)	
Responses:	
TOTAL Plans Contacted	13
Responses	10
No Response Provided	3
Intent in developing embedded offerings:	
Willing to develop embedded rate	8
Not willing to develop embedded rate	2
When the plan might be able to offer embedded:	
No earlier than 2015 for developing embedded rate	6
Might develop in 2014 or before 2015	2

REFERENCES

Any references not linked below are available in the stakeholder comment document for the August 8, 2013, Board meeting: http://www.healthexchange.ca.gov/BoardMeetings/Documents/Comments%20to%20the%20Board%20-%20Table%20of%20Contents_August%208th_MASTER.pdf

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