Comments to the Board

Table of Contents

August 8th, 2013 Board Meeting

Covered California Plans

- National Union of Healthcare Workers regarding Kaiser Good Standing – July 24, 2013
- National Union of Healthcare Workers regarding Kaiser Good Standing – August 2, 2013

Pediatric Dental

- Advocate Consortia
- California Association of Dental Plans
- California Association of Health Plans
- California Dental Association
- California Dental Association
- Children's Advocate Consortia
- Children's Partnership and Children Now
- Children's Partnership and Children Now
- Consumer Advocate Consortia
- Dave Jones (Department of Insurance) – June 27, 2013
- Dave Jones (Department of Insurance) – July 3, 2013
- Dave Jones (Department of Insurance) – July 31, 2013
- Dave Jones (Department of Insurance) – August 7, 2013
- Delta Dental
- Delta Dental
- Health Insurance Alignment Project – Kelch Policy Group
- Sacramento County Medi-Cal Dental Advisory Committee
- Senator Ed Hernandez, Senator William W. Monning, and Assembly Member Richard Pan

Quality Reporting System

- Kaiser Permanente, SHARP Health Plan, and Western Health Advantage

Voter Registration

- Cause of Action

NATIONAL UNION OF HEALTHCARE WORKERS

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6849

July 24, 2013

Mr. Peter V. Lee, Executive Director
Ms. Diana S. Dooley, Board Chair
Ms. Kimberly Belshé, Board Member
Mr. Paul Fearer, Board Member
Ms. Susan Kennedy, Board Member
Dr. Robert Ross, Board Member
Covered California
560 J Street, Suite 290
Sacramento, CA 95814

RE: KAISER FOUNDATION HEALTH PLAN's FAILURE TO MEET "GOOD STANDING" REQUIREMENT

Dear Mr. Lee, Ms. Dooley, Ms. Belshé, Mr. Fearer, Ms. Kennedy and Dr. Ross:

We are writing to alert you that Kaiser Foundation Health Plan, Inc. ("Kaiser") is currently ineligible to participate as a "Qualified Health Plan" in Covered California because Kaiser does not meet the regulatory "good standing" requirement that is a condition of participation in California's health benefit exchange.

Covered California's "Qualified Health Plan Contract" requires that each contracting Health Plan be in "good standing" with the regulatory agency that licenses it to operate in California. Section 3.02 of the contract defines "good standing" as "the absence of any material statutory or regulatory violations, including penalties, during the year prior to the date of the Agreement and throughout the term of the Agreement, with respect to the regulatory categories identified at Attachment 3 ('Good Standing')."

Attachment 3 further defines "good standing" as an "Affirmation of no material statutory or regulatory violations, including penalties levied, in the prior year in relation to" a variety of areas, including the plan's "network adequacy and accessibility standards" as well as its "quality assurance/management policies and practices."

Four weeks ago, the California Department of Managed Health Care (DMHC) fined Kaiser $4 million for "serious" noncompliance with a variety of California's laws and regulations, including its breaches of "network adequacy and accessibility standards" and "quality

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assurance/management policies and practices." **It is the second largest fine in the DMHC's history**. Kaiser was also cited for violations of California's mental health parity law and was ordered to "cease and desist" from committing additional violations.

The DMHC's recent determinations are clearly sufficient grounds to render Kaiser ineligible to participate in Covered California.

In addition, there is substantial additional evidence of Kaiser's ongoing noncompliance with California's laws and regulations.

The following is a chronological review of the recent determinations and sanctions imposed on Kaiser by the DMHC:

- On March 18, 2013, the DMHC issued a 23-page "Final Report" of its survey of Kaiser's Behavioral Health Services. The report cited Kaiser for deficiencies in multiple areas including its inadequate quality assurance and monitoring systems, its failure to provide enrollees with timely access to mental health appointments, its inadequate provider networks, its failure to ensure clinically appropriate care to its enrollees, its failure to undertake effective action to remedy substandard care when deficiencies are identified internally, and its failure to "provide accurate and understandable effective behavioral health education services" to its enrollees. The DMHC noted that Kaiser's network adequacy and timely access violations are "serious." For example, the DMHC's report identifies three of Kaiser's medical centers in Southern California where "less than half" of the patients were seen within the required timeframe.[1] At some facilities, these failures persisted for ten consecutive months and were so grave that only one-third of Kaiser's patients were seen in a timely fashion during certain months.[2] In total, the DMHC cited Kaiser for violations of more than a dozen sections of California's statutes and regulations. [3] Furthermore, the DMHC concluded that that Kaiser had not corrected its deficiencies and that Kaiser's corrective action plan was inadequate for each of the deficiencies.

- On June 25, 2013, the DMHC announced a $4 million fine against Kaiser as well as an order to "cease and desist" from committing further violations of California laws and

[1] DMHC, "Final Report: Routine Medical Survey of Kaiser Foundation Health Plan, Inc, Behavioral Health Services, March 18, 2013, p. 13-14.

[2] DMHC, "Final Report: Routine Medical Survey of Kaiser Foundation Health Plan, Inc, Behavioral Health Services, March 18, 2013, p. 14.

[3] The DMHC's "Final Report" cites Kaiser for violations of Title 28 of the California Code of Regulations sections 1300.67.2.2, 1300.67.2.2(c), 1300.67.2.2(c)(1), 1300.67.2.2(c)(5), 1300.67.2.2(d), 1300.67.2.2(d)(3), 1300.67(f)(8), 1300.70, 1300.70(a)(1), 1300.70(a)(3), 1300.70(b)(1)(D), 1300.70(b)(2)(G)(3), and 1300.80(b)(6)(B). In addition, the Department cited Kaiser for violations of California Health and Safety Code Section 1374.72.

regulations. The DMHC's Cease and Desist Order states: "The Department finds that the Plan's deficiencies are serious and may have put some of its members at risk of harm." [4]

- According to the DMHC, it will conduct a follow-up survey of Kaiser's behavioral health services in October of 2013 in order to determine whether Kaiser has come into compliance with the minimum standards governing California's HMOs.

- In a filing[5] dated June 17, 2013, Kaiser reported to the DMHC that it does not plan to come into compliance with state statutes and regulations until October of 2013, which then must be independently verified. In its filing, Kaiser failed to provide a timeline for "when in the future the Plan projects its mental health provider network will be adequate to ensure that timely access standards are met in all of its service areas." This inaction reflects Kaiser's failure to adequately address the violations identified by the DMHC.

- New data indicate that Kaiser has continued to remain severely noncompliant with California's standards during eleven months since the DMHC formally notified Kaiser of its multiple violations. The DMHC delivered such notification to Kaiser on August 8, 2012 when it delivered its "Preliminary Report" to the plan. For example, during January of 2013, only 40% of first-time adult patients at Kaiser's Oakland Psychiatry Department were provided with timely routine mental health appointments. Currently (that is, during July of 2013), first-time adult patients are waiting in excess of three weeks for routine mental health appointments at Kaiser's Psychiatry Department in Fremont, California, according to internal records. In San Francisco, children requiring autism assessments currently wait for approximately three months for first-time appointments.

Kaiser, rather than working cooperatively with its mental health clinicians and the DMHC to correct its substandard practices, has instead begun retaliating against licensed mental health clinicians in an apparent effort to suppress evidence of Kaiser's ongoing noncompliance with state statutes and regulations. On July 17, 2013, Kaiser took the extraordinary step of disciplining one of its licensed mental health clinicians after the clinician made a clinical note in a patient's medical chart indicating that the first-time patient needed more rapid access to Kaiser's services. The clinician evaluated the patient via a telephone triage assessment and discovered that the clinic's first available appointment was more than three weeks later. Under California's timely access regulations, health plans are required to offer enrollees non-urgent mental health appointments within ten business days of the patient's request for an appointment. In disciplining the licensed clinician, Kaiser claims that the clinician's clinical note – "patient

[4] DMHC, "Cease and Desist Order on Kaiser Foundation Health Plan, Inc. Matter No: 11-543;," June 24, 2013, p. 7.
[5] Kaiser Foundation Health Plan, Inc, "DMHC Filing - AMENDMENT #5 Response to DMHC's June 7, 2013 Comment Letter re: HBEX QHP Bid 2013 - Qualified Health Plan in California Health Benefit Exchange," June 17, 2013.

should be seen sooner" – was "a political statement." NUHW is in the process of filing complaints with state and federal agencies related to Kaiser's illegal retaliation against the clinician.

Given Kaiser's failure to meet Covered California's requirement that it be in "good standing" with its licensing agency, we request that Covered California disqualify Kaiser from participating in California's health benefits exchange. Such action will ensure California's consumers that they can trust the Exchange's products and its system for ensuring quality coverage for consumers.

Sincerely,

Sal Rosselli, President

John Borsos, Secretary-Treasurer

August 2, 2013

Mr. Peter V. Lee, Executive Director
Ms. Diana S. Dooley, Board Chair
Ms. Kimberly Belshé, Board Member
Mr. Paul Fearer, Board Member
Ms. Susan Kennedy, Board Member
Dr. Robert Ross, Board Member
Covered California
560 J Street, Suite 290
Sacramento, CA 95814

RE: ADDITIONAL MATERIALS ON KAISER FOUNDATION HEALTH PLAN's FAILURE TO MEET COVERED CALIFORNIA's "GOOD STANDING" REQUIREMENT

Dear Mr. Lee, Ms. Dooley, Ms. Belshé, Mr. Fearer, Ms. Kennedy and Dr. Ross:

In a letter dated July 24, 2013, we notified you that the Department of Managed Health Care's recent regulatory sanctions against Kaiser Foundation Health Plan, Inc. ("Kaiser") appear to disqualify it from participating as a "Qualified Health Plan" in Covered California. As you know, Covered California's rules require HMOs to meet Covered California's regulatory "good standing" requirement in order to participate in California's health benefit exchange.[1]

Today, we are writing to alert you of additional regulatory violations for which Kaiser was recently cited by the Department of Managed Health Care ("DMHC" or "Department").

On June 3, 2013, the DMHC released a 19-page report that cited Kaiser for five violations of California's statutes and regulations.[2] These violations were discovered during a "Supplemental Routine Medical Survey" conducted by the Department. The DMHC cited Kaiser for violating more than ten provisions of the Knox-Keene Health Care Service Plan Act of 1975 (codified in

[1] This requirement is specified in Section 3.02 of Covered California's "Qualified Health Plan Contract" and is further detailed in Attachment 3 ('Good Standing') of the "Qualified Health Plan Contract."
[2] DMHC, "Final Report: Supplemental Routine Medical Survey of Kaiser Foundation Health Plan, Inc, A Full Service Health Plan," June 3, 2013. The report is available at: http://www.dmhc.ca.gov/library/reports/med_survey/surveys/055full060313.pdf

the California Health & Safety Code) as well as Title 28 of the California Code of Regulations.[3] The Department's report notes that Kaiser has not corrected four of the five deficiencies and that the Department will conduct "a Follow Up Survey" in the fall of 2013 to determine whether Kaiser has come back into compliance with California's statutes and regulations.[4]

According to the DMHC's report, Kaiser's violations are "systemic," are related to "essential functions," and "negatively affect an enrollee's ability to access healthcare services and effectively appeal a denial of healthcare services." The DMHC's report also states the following:

> "This survey revealed that the Plan does not ensure adequate oversight of **essential functions** related to utilization management, both within the Plan's organization and its contracted medical groups. The Plan could not demonstrate adequate oversight of medical policy development, the denial of services requested by providers, and the communication of decisions to approve or deny services to enrollees. These **systemic issues** negatively affect an enrollee's ability to access healthcare services and effectively appeal a denial of healthcare services." [5] (emphasis added)

Also in June, the DMHC fined Kaiser $4 million for committing "serious" violations of more than a dozen provisions of California's statutes and regulations. The Department ordered Kaiser to "cease and desist" from committing additional violations and announced it will conduct a follow-up survey of the HMO in October of 2013 in order to determine whether it has corrected the violations. The DMHC's $4 million fine against Kaiser is the second largest in the Department's history.

<u>The DMHC's recent determinations are clearly sufficient grounds to render Kaiser ineligible to participate in Covered California.</u>

Furthermore, we understand that Kaiser is under additional regulatory investigation due to its apparent violation of California's whistleblower protection laws. This investigation stems from Kaiser's disciplinary actions against licensed caregivers who have expressed concerns about substandard care delivered to Kaiser's enrollees.

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[3] The DMHC's "Final Report" cites Kaiser for violations of California Health and Safety Code, Sections 1363.5; 1367.01(a) and (f); 1370; 1370.1; 1367.01(h)(3) and (4); 1374.30(e); 1367.63; and 1381(a). In addition, the Department cites Kaiser for violations of Title 28 of the California Code of Regulations, Sections 1300.70(a)(3); 1300.70(b)(2)(G); and 1300.70(b)(2)(B).

[4] DMHC, "Final Report: Supplemental Routine Medical Survey of Kaiser Foundation Health Plan, Inc, A Full Service Health Plan," June 3, 2013, pp. 2-3.

[5] DMHC, "Final Report: Supplemental Routine Medical Survey of Kaiser Foundation Health Plan, Inc, A Full Service Health Plan," June 3, 2013, p. 1.

Given Kaiser's failure to meet Covered California's requirement that it be in "good standing" with its licensing agency, we request that Covered California disqualify Kaiser from participating in California's health benefit exchange. Such action will ensure California's consumers that they can trust the Exchange's products and its system for ensuring quality coverage for consumers.

Sincerely,

Sal Rosselli, President

John Borsos, Secretary-Treasurer

May 9, 2013

The Honorable Jack Lew, Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

Dear Secretary Lew:

As organizations that work to improve health and health care for children, we write in regard to an issue important to children's health—the affordability of coverage for dental benefits under the Affordable Care Act. As detailed below, we urge Treasury to apply the premium tax credit provisions of the ACA such that dental benefits receive the same affordability support as other essential health benefits. And Treasury should assure that the treatment of separate dental plan premiums in computing premium credits is clearly stated in public documents.

Oral health is critical to children's overall wellbeing. Congress recognized as much when it included oral care for children as one of the essential health benefits specified in the ACA. Congress also intended that the purchase of the entire essential health benefits package be supported with premium tax credits. In a recent letter to Marilyn Tavenner, Acting Administrator of the Centers for Medicare and Medicaid Services, nine U.S. Senators noted the "intent of Congress to provide affordable benefits for families to access routine and necessary care, including pediatric oral health care."[1] Additionally, in a 2011 Senate colloquy, three Senators clarified that the law intends that "children receiving coverage through an exchange would have the same level of benefits and consumer protections, including all cost sharing and affordability protections, with respect to oral care. This holds true whether they received pediatric oral care coverage from a standalone dental plan or from a qualified health plan."[2]

Despite this Congressional intent, direct communications from Internal Revenue Service officials indicate that IRS plans to make premium tax credits available to support the purchase of stand-alone pediatric dental plans only in very limited circumstances. Many taxpayers' premium tax credits will be calculated with reference to the cost of a "benchmark" plan—often defined as the second-lowest cost silver plan that would cover the taxpayer's family. In many cases, however, a single benchmark plan will not provide coverage for an entire family for all of the essential health benefits (EHBs). Specifically, we expect that in many state exchanges, pediatric dental benefits will be offered through separate plans. When pediatric dental coverage is purchased through a separate plan, our understanding is that IRS intends to ignore the cost of a stand-alone dental plan when computing the cost of the second-lowest cost silver plan that would cover the taxpayer's family.

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[1] Cardin, et al. Letter to Marilyn Tavenner. March 19, 2013.
[2] Senator Stabenow (MI). "Affordable Care Act." *Congressional Record 157: 144 (September 26, 2011).*

We urge you to reverse this IRS policy and instead include the cost of a stand-alone dental plan in the total cost of benchmark coverage when stand-alone plans are the only dental benefits available to a family. This will allow premium tax credits to support the purchase of pediatric dental benefits just as they do for other essential benefits.

The Affordable Care Act allows the costs for stand-alone dental coverage to be included in the cost of benchmark coverage. Internal Revenue Code section 36B, paragraph (b)(3)(E), provides that "For purposes of determining the amount of any monthly premium," a premium paid for a separately offered EHB dental benefit should be considered a premium payable for a qualified health plan. The law's reference to "any" monthly premium must be interpreted to apply to the benchmark plan premium that determines a taxpayer's premium credit amount. Without such a reading, some families would be required to pay more than their applicable percentage of income to purchase coverage for all the EHBs—this is not what Congress intended.

Further, regulations at 26 CFR 1.36B-3(f)(3) seem to allow for the premium for more than one policy to be added together when computing the cost of the applicable benchmark plan if one plan will not cover a taxpayer's entire family.[3] Some families will need to purchase two or more policies to cover all of their members—a stand-alone dental plan and at least one other plan to cover the rest of the EHBs. In such situations, the premium for a stand-alone plan should be added to the premium for the rest of the family's coverage to arrive at the appropriate benchmark cost. IRS officials, however, have stated verbally that they will not apply paragraph (f)(3) to stand-alone pediatric dental plan premiums. We urge Treasury and IRS to express this interpretation in writing and provide opportunity for public comment on this important policy choice.

Adding the cost of a stand-alone pediatric dental plan would raise the premium credit amount for many families, allowing them to afford dental care for their children. Getting preventive dental care and restorative services when needed will keep children healthier and will likely reduce health care costs over the lifespan. Without premium credits for stand-alone dental plans, many families will be tempted to forego dental coverage since there is no federal requirement that it be purchased in the exchanges when offered separately. This would represent an enormous missed opportunity to provide oral health services to children who need them and circumvent Congressional intent that pediatric dental benefits be included in the essential benefits that exchange enrollees will receive. As a result, children

[3] *Silver level plan not covering a taxpayer's family.* If one or more silver level plans for family coverage offered through an Exchange do not cover all members of a taxpayer's coverage family under one policy (for example, because of the relationships within the family), the premium for the applicable benchmark plan determined under paragraphs (f)(1) and (f)(2) of this section may be the premium for a single policy or for more than one policy, whichever is the second lowest cost silver option.

would experience poorer health outcomes due to neglected oral health needs and families would incur higher out-of-pocket costs when seeking dental care for their children.

Treasury has an important role to play in supporting children's health by assuring that premium credits are applied as intended by the Affordable Care Act. Our organizations would be happy to meet with your staff to provide further details on how premium credits would impact dental care for children. Thank you for your consideration.

Sincerely,

American Academy of Pediatric Dentistry
American Association for Dental Research
American Dental Association
American Dental Education Association
American Dental Hygienists' Association
American Network of Oral Health Coalitions
Association of State and Territorial Dental Directors
Children Now
Children's Alliance
Children's Alliance of New Hampshire
Children's Defense Fund
Children's Dental Health Project
Community Catalyst
Delta Dental Plans Association
DentaQuest
Easter Seals
Families USA
Georgetown University Center for Children and Families
Health Action New Mexico
Hispanic Dental Association
Kansas Action for Children
Kentucky Oral Health Coalition
Maine Children's Alliance
Maine Dental Access Coalition
Maryland Dental Action Coalition
Milwaukee County Oral Health Coalition
National Assembly on School-Based Health Care
National Association of Dental Plans
National Health Law Program
New England Alliance for Children's Health
New Mexico Alliance for School-Based Health Care
Ohio Consumers for Health Coverage
Oral Health Access Council
Oral Health Florida

Oral Health Kansas, Inc.
Pew Children's Dental Campaign
Rhode Island KIDS COUNT
Southwest Women's Law Center
Texas Oral Health Coalition, Inc.
The Children's Partnership
The Los Angeles Trust for Children's Health
UHCAN Ohio
Virginia Oral Health Coalition
Voices for America's Children
Washington State Oral Health Coalition
Wisconsin Oral Health Coalition

CADP

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July 11, 2013

California Health Benefit Exchange/Covered California
Attn: Peter Lee and Andrea Rosen
560 J Street, Suite 290
Sacramento, CA 95814
info@hbex.ca.gov

RE: Pediatric Dental Plans in Covered California

Dear Mr. Lee and Ms. Rosen:

On behalf of the California Association of Dental Plans, I am writing you to address the status of pediatric dental coverage offered through Covered California. Recent events and media coverage have raised the profile of the pediatric dental benefit and how it is currently structured to be offered by Covered California. A special Board meeting has been scheduled to further discuss pediatric dental policy on August 8th, and our members are concerned about the challenges they face at this very late date in meeting the extremely tight deadlines to become operational on the Exchange.

My purpose in this letter is to discourage Covered California from making any dramatic changes to the way pediatric dental—stand-alone or otherwise—is offered in 2014. Our concerns stem from the following facts:

- The timing simply will not allow for any seismic shifts that change the competitive landscape inside the Exchange, since health and dental plans already accepted and approved in Covered California could be required to re-file and/or re-price the products already submitted and approved for offer by Covered California. There is simply not enough time left to undertake such changes, given that only 75 days remain before open enrollment is scheduled to occur.

- The dental industry generally supports "embedded" pediatric dental benefits (offered under a single combined medical-dental policy) as an option, but a careful and thoughtful discussion needs to occur before such an option could be implemented. The discussion needs to include whether there is a standard design that an embedded dental benefit would need to follow, how this design might differ from the template stand-alone pediatric dental designs already required in terms of cost sharing and other benefit limitations, and how transparency to the consumer could be achieved for such products so that these potentially very different benefits are fully understood at the time of purchase.

Of particular concern is the application to pediatric dental of the combined medical-dental deductible and out-of-pocket maximum, which affects if and when children become eligible for preventive and diagnostic services – services that many people mistakenly assume are automatically covered at 100 percent under the Affordable Care Act. The point is, there are many issues to be considered on this topic, and the timing of the Exchange suggests that we cannot get there in time to meet the October 1 deadline for open enrollment.

- As noted in the Board meeting of June 20, Covered California already has the ability to require – or at least strongly encourage—the purchase of pediatric dental coverage for children via the web portal and its associated logic. While we support the policy position of requiring the purchase of pediatric dental, some of our members are concerned about the idea of mandatory purchase of these benefits by all consumers including childless adults, versus just for those up to age 19. Once again, many issues to consider here, including the concern of some of our members that a level playing field in pricing should be maintained between various types of dental issuers. Such issues, like the others mentioned above, deserve a fuller discussion, with time to consider the ramifications.

We would welcome any opportunity to meet or speak with you and any appropriate staff to discuss these matters. Please know that we stand ready to help when it comes to implementing the dental benefit provisions of the health care reform law.

If you have any questions, please do not hesitate to call me at (916) 446-3122.

Sincerely,

Jackie Miller
Executive Director

cc: Board of Directors, Covered California
CADP Board of Directors
California Association of Health Plans
California Dental Association
Health Access
The Children's Partnership

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July 16, 2013

Chairperson Diana Dooley and Board Members
Covered California
560 J Street, Suite 270
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VIA ELECTRONIC MAIL:
ddooley@chhs.ca.gov

Re: Pediatric Dental Benefits and Out-of-Pocket Maximus

Dear Chairperson Dooley and Covered California Board Members:

The California Association of Health Plans ("CAHP") represents 40 public and private health care service plans that collectively provide coverage to over 21 million Californians. We write today on behalf of the Qualified Health Plans (QHPs) that will offer coverage through Covered California.

During the June 20, 2013 Covered California Board meeting many concerns were raised about the pediatric dental benefit. It was suggested that the Covered California Board re-visit the decision to allow QHP products in the Exchange that do not include the pediatric dental benefit, which are commonly referred to as "9.5 products."

CAHP and our member plans are extremely concerned with a change in policy at this late date that would eliminate 9.5 products in the Exchange or change the structure of the out-of-pocket maximums (OOPMs). Requiring the embedding of all pediatric dental in 2014 is not feasible at this late date and would be opposed by the QHPs.

Embedding the pediatric dental benefit would require that the pediatric dental benefit be offered in the exact same manner as all other medical benefits, with a single premium, and coordination of all cost sharing, including a single out-of-pocket maximum. This is distinct from the bundling option that QHPs were given where the medical benefit could be paired with a stand-alone dental plan in order to offer all 10 Essential Health Benefits (EHBs), and embedding causes several major operational concerns that are further outlined below.

To embed dental plans, all but one standard plan designs would have to be restructured to absorb the pediatric dental out of pocket limit. A requirement that plans embed the pediatric dental benefit would require increasing other cost-sharing in the standard plans, which would force the QHPs to re-price and re-file all the Exchange products. With a product change this extensive, it is not clear that plans would be ready in time for the October 1 open enrollment.

Additionally, any changes to OOPM policies related to stand-alone dental products are not supported by QHPs at this late date. Health plans are currently unable to cross accumulate out of pocket expenses with bundled dental plan partners and such a requirement would require major and costly systems changes that would not be completed in time for an October 1st launch date.

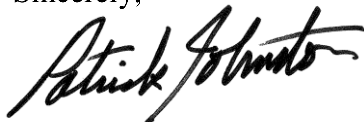
We would respectfully suggest that if Covered California wishes to require purchase of pediatric dental before consumer logs out of the CalHEERS system, then a simple solution could be to change that function in the enrollment system. If an enrollee selects a 9.5 product they can be instructed to select a stand-alone dental plan in order to purchase all 10 EHBs and complete the enrollment process. We do not believe that it is necessary to require all QHPs to embed the pediatric dental benefit and in fact, doing so could prove very problematic.

CAHP held a call with the Center for Consumer Information and Insurance Oversight (CCIIO) on July 2, 2013. On that call CCIIO confirmed that health plans can offer bundled products outside the exchange with the stand-alone dental out-of-pocket-max (OOPM) set at $1,000 and the medical OOPM set at $6,350; for a total OOPM of $7,350. This is consistent with the QHP solicitation requirements, where a 9.5 product can be offered and bundled, or otherwise purchased in conjunction, with a stand-alone dental plan. Therefore, QHPs have developed products for Covered California that reflect this design and these products have already been bid and filed with the regulator and it is too late to make changes that would impact rates and product filings.

It is our understanding that CCIIO communicated this policy clarification to the Department of Managed Health Care, the California Department of Insurance, the California Health and Human Service Agency, and Covered California staff on July 3, 2013. This policy clarification from CCIIO resolves a regulatory problem with the outside exchange products and eliminates the need for Covered California to revise its pediatric dental policy in order to provide parity for products in and out of the Exchange. Any changes at this point in time could seriously jeopardize the implementation timeline of Covered California.

In summary, we urge the board to consider solutions to the concerns of advocates that do not require product or cost sharing changes for QHPs at this late. Doing so will engender opposition from QHPs because it would be incredibly disruptive and could endanger open enrollment. If there are other options that you believe the plans should consider we would be happy to facilitate such a discussion and provide feedback to the Board. We appreciate your consideration of the issues outlined in this letter and look forward to continuing to partner with Covered California.

Sincerely,



Patrick Johnston
President & CEO

cc: Peter Lee, Executive Director, Covered California
Teri Boughton, Assembly Health Committee
Melanie Moreno, Senate Health Committee
Diane Van Maren, Office of the President Pro Tempore of the Senate
Agnes Lee, Office of the Speaker of the Assembly
Joe Parra, Senate Republican Caucus
Peter Anderson, Assembly Republican Caucus

Covered California Stand-Alone Model Contract
Comments from Stakeholders

Model Contract Article/	Article/Attachment Title	Paragraph, Article, or Subpar. No.	Stakeholder Comment	Stakeholder Name
			The Exchange should include in its contracts with all dental plans key patient protections, individual market reforms, and Knox Keene standards to ensure consumers can expect from their dental coverage the same kinds of protections they now enjoy from their health plan coverage. These standards include all of the key patient protections included in the ACA that relate to medical coverage, including development and application of a medical loss ratio, prohibition of preexisting condition exclusions or other discrimination based on health status; fair health insurance premiums; guaranteed availability of coverage; guaranteed renewability of coverage; prohibition against discrimination against individual participants and beneficiaries on the basis of health status; nondiscrimination in health care; and a prohibition of excessive waiting periods. In addition, the Exchange should apply all of the critical Knox-Keene standards regarding network adequacy and timely access to care, as well as requirements to eliminate annual and lifetime caps on care. These are now commonplace expectations for consumers and the Exchange needs to ensure patients are afforded these standard protections from the dental plans under contract with the Exchange. CDA has been working extensively on these issues through the Legislative process and can provide technical assistance to the Exchange in the development of the contract language we are suggesting.	California Dental Association
			The Exchange should prohibit its contractors from building provider networks based on contract adhesion. The Exchange should assure that dental plans build separate provider networks specific for those products and not use the networks these companies have built for products outside the Exchange. Plan contractors should be required to enter into new, Exchange-specific provider contracts to build their Exchange networks.	California Dental Association
Attachment 5	Provider Agreement - Standard Terms		We question the applicability of this section to the field of dentistry. We are interested in learning what kind of subcontracting arrangements the Exchange would anticipate participating dentists would be entering into.	California Dental Association
Attachment 7	Article 3.03: Determining Enrollee Health Status and Use of Risk Assessments		Risk Assessment should be replaced with "Oral Health Assessment." The term "Risk Assessment" does not evaluate the current oral health status of the presenting patient, which is what we intepret to be the intent of this section. A Risk Assessment of a patient in the dental field identifies the risk factors that a patient presents with that may lead to future disease.	California Dental Association
Attachment 7	Article 3.04: Reporting to and Collaborating with the Exchange Regarding Health Status		This section requires the Contractor to agree to work with the Exchange to standarize a variety of indicators, health status measures, and oral health assessment questions. Covered California should work with a broad stakeholder group to develop these measures - not simply the contractors.	California Dental Association
Attachment 7	Article 7: Promoting Higher Value Care		It is our understanding that this section has been stricken to allow the Exchange additional time to form a stakeholder workgroup to address these issues and issues surrounding the idenfication of best practrices. CDA would like to be a part of this group when it is formed. We have experience and expertise that can be helpful to the Exchange in the development of these measures. Specifically, CDA can provide to the Exchange information regarding the Dental Quality Alliance, which is affiliated with the American Dental Association and is actively working to develop standardized quality and performance measures across the dental health care system. As the Exchange continues to explore performance measures for dental products, it will be critical for it to be mindful of the work already going on in the field, and CDA can support those efforts.	California Dental Association

July 22, 2013

Peter Lee, Executive Director
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560 J St., Suite 290
Sacramento, CA 95814

Dear Mr. Lee:

CDA is pleased Covered California is taking a close look at the many complicated issues surrounding the pediatric dental Essential Health Benefit.

CDA's advocacy on these issues has centered on a few key principles: families should have choices inside Covered California similar to the choices they currently have outside of Covered California; access to the pediatric essential health benefit is critical to children's oral and overall health; and there should be easy apples-to-apples comparisons of dental benefits offered in Covered California. We maintain these principles and believe they are in keeping with the principles of the ACA and Covered California.

Covered California's support for families' access to stand-alone dental benefits achieves several of these goals. However, it will be critical for Covered California to adopt policy to ensure families with children purchase the pediatric Essential Health Benefit (EHB) when buying coverage in Covered California.

CDA continues our strong support for Covered California's decision to allow stand-alone dental plans to provide the pediatric dental EHB to families inside Covered California. In addition, we are pleased to see the Department of Managed Health Care (DMHC) state clearly that current law gives them the authority they require to approve QHPs without the pediatric dental benefit, making those dental products viable in Covered California. Stand-alone dental plans represent more than 98 percent of the current marketplace outside of Covered California, already have established robust dental

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networks, and should be available to families inside of Covered California. These decisions will allow families to maintain their relationship with their current dentist, as the ACA intended, and retain continuity of care. In the midst of so much change in the health care insurance system for families, ensuring the dental benefit is stable, predictable, and familiar can be instrumental to the overall success of the ACA implementation for the families of California.

The California Dental Association and its members are strongly committed to protecting continuity of care for patients, and this is a critical step to achieve that goal.

CDA would not oppose Covered California from approving QHPs with an embedded dental benefit in the future. Since offering embedded products is an option afforded our state in the provision of the pediatric dental EHB, Covered California should give it thoughtful consideration. If Covered California approves QHPs with embedded dental benefits, those benefits must be separately priced, separately offered, have a separate actuarial value calculation, and have clearly identified provider networks.

In addition to providing consumers with the information they need, requiring health plans to provide this information on the dental benefit separately is also a benefit to Covered California and DMHC, ensuring that those entities have the information necessary to effectively monitor this brand new endeavor for health plans and ensure this remains a real benefit for families and not just a benefit on paper. We saw the importance of monitoring access to care last year in the tragic stories out of Sacramento and Los Angeles regarding the many problems children had in receiving dental care in the Medi-Cal Dental Managed Care system operated by dental plans. We need to ensure Covered California starts on the right foot and has a strong structure in place to ensure patients can actually get the care they are paying for.

Separate dental pricing and offering can be easily achieved. Once the family selects the health component of their essential health benefit, the Cal-HEERS system, via the next screen, can offer families the dental benefit offerings from the same health plan,

as well as all of the stand-alone options. This will make it simple for families to have an apples-to-apples comparison and choose the plan that best meets their needs.

If Covered California moves forward with approving health plans with embedded dental benefits -- whether in 2014 or in later years -- doing so with these principles in mind will allow families the ability to make well-informed insurance purchases using clear, comparable information.

Finally, the pediatric dental benefit is one of the ten essential health benefits. CDA knows that ensuring families can secure dental benefits for their children is essential to improving oral health and overall health outcomes for California's children. While the federal guidance presented earlier this year allows states flexibility in this issue, California should ensure all children for whom coverage is purchased through Covered California obtain dental benefits.

We understand that implementation of the ACA -- particularly the dental component -- is an exceptionally complex issue and appreciate the work of Covered California's leadership and staff. CDA looks forward to being able to continue our work with you over the next few months to ensure the pediatric dental benefit is implemented in the most efficient and effective manner possible and ensures access to a world-class dental benefit for California's children.

Sincerely,

Nicette Short
Manager, Legislative Affairs

cc: Members, California Health Benefit Exchange Board
Senator Bill Monning

Senator Ed Hernandez

Assemblyman Richard Pan

David Panush

Andrea Rosen

Leesa Tori

Health Access

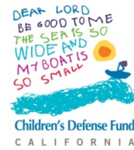
California Association of Health Plans

Children Now

The Children's Partnership

Consumers Union

CH1LDREN NOW



August 2, 2013

Diana Dooley, Chair
Peter Lee, Executive Director
Board Members
California Health Benefit Exchange Board
560 J Street, suite 290
Sacramento, CA 95814

Re: Pediatric Dental policy and plans

Dear Chairwoman Dooley, Board Members, and Mr. Lee:

Thank you for convening a special meeting of the California Health Benefit Exchange Board on August 8, 2013 to publicly discuss and take action on how dental plans will be offered by Covered California. Our coalition of children's health advocacy organizations appreciates the opportunity to participate in the discussion and to share our recommendations with you.

Staff presentations and representations made at the Board's June 20, 2013 meeting generated significant concern and questions. We were surprised to hear at that meeting that the purchase of pediatric dental plans was "voluntary, per state and federal rules," and that pediatric dental coverage was regarded as having a "limited benefit" that is "relatively expensive." The June 20, 2013 staff presentation further announced that "every Covered California Health Plan [is] required to partner with a pediatric dental plan in a bundled approach," that QHP "bidders were required to declare a bundled dental plan partner," and that "no federal subsidies [are] available." To our knowledge, at that time, neither state nor federal rules had addressed the matter of voluntary or mandatory purchase of pediatric dental plans. Further, the requirement of a bundled approach contradicted state plans to offer stand-alone pediatric dental plans; it also had the effect of prohibiting embedded plans, thereby putting families at a disadvantage. Most significantly, none of these issues had been presented to the Board for discussion and decision, and none had been subject to public comment. We joined several organizations in raising these and related concerns in a July 17, 2013 letter to the Board.

Of note, subsequent to the June Board meeting, and to the announcement of selected pediatric dental plans (which included only one bundled plan, and stand-alone plans) it was revealed that a "decision"

had been made that bundled plans would *not* be offered, contrary to requirements announced at the June meeting. It is unclear when, by whom, or why, that decision was made. It is also unclear whether QHP bidders met the requirement to submit "bundled" bids. As a consequence, it appears that at present only stand-alone pediatric dental plans are expected to be offered by Covered California.

As noted at the June Board meeting, in our July 17, 2013 letter, and as expressed at the recent Plan Management Advisory Group meeting on July 22, 2013, we are deeply concerned about the series of decisions that were made, without public notice or opportunity for stakeholder comment, that limit the choice of the pediatric dental essential health benefit to stand-alone dental plans. We respectfully request that the Board articulate a policy that directs Covered California staff to immediately request bids for embedded pediatric dental plans, with the intention of approving such plans for inclusion in the Covered California marketplace as soon as possible. Furthermore, at the July 22 Advisory Group meeting, we understood that Covered California staff expected to receive responses from health and dental plans regarding their interest and ability to submit embedded plan bids. We request that the results of the request for that information be shared at the August 8 meeting.

Embedded pediatric dental plans are needed because bundled and stand-alone plans deprive children of key consumer protections inherent in the Affordable Care Act, and of financial assistance for dental coverage. Additionally, although the ACA sets an out-of-pocket maximum for QHPs (which we believe were always intended to include all ten essential health benefits) of $6350, when stand-alone or bundled dental plans are added to the equation, families lose that cap, and are subject to an additional $1000 in potential out-of-pocket cost obligations.

Some of the most touted and valuable provisions of the ACA include consumer rights to guaranteed issue, and protection from discrimination on the basis of pre-existing conditions. Due to the "excepted" plan status of stand-alone dental plans, these protections are not required of stand-alone or bundled dental plans and accordingly are not available to purchasers of those plans. We do not believe that the California Health Benefit Exchange Board ever intended to deprive children and their families of these protections in dental coverage – and yet that is the consequence of the current prohibition on including embedded pediatric dental plans. Additionally, we know the Board has a commitment to providing affordable coverage through Covered California. In order to make that a reality for families with children, plans that are fully eligible for federal subsidies (embedded plans) must be made available.

We also wish to point out that federal rules (45 CFR section 155.1000 (c) and CMS April 5 guidance) require that if an Exchange chooses to make only stand-alone pediatric dental plans available (as is the current situation) there must be a finding that that is in the "best interest of consumers." We would respectfully suggest such a finding is *not* in the best interest of consumers; and in any case, we note that the Board has not arrived at such a finding, which must precede any decision to allow only stand-alone dental plans. As suggested in our July 17, 2013 letter, we recommend that the Board expressly find that it is not in the best interest of consumers to offer only stand-alone pediatric dental plans.

It is unclear to us, as of this date, if the Board intends to address the issue of mandatory purchase of pediatric dental plans at the August 8 meeting. We recommend that the aforementioned issues of

affordability, consumer protections, increased out-of-pocket maximums, and access to embedded plans be resolved before decisions about mandatory purchase are made. However, should the Board discuss and/or decide that the purchase of pediatric dental plans is mandatory, we are concerned about how such a requirement could be "enforced." We would strenuously object to an enrollee's entire medical coverage being cancelled if a family failed to maintain current payments for a stand-alone pediatric dental plan.

We want to reiterate that we have always supported the availability of stand-alone pediatric dental plans in Covered California. Consumer choice is important, and we recognize that for some families the option to select a stand-alone plan will be attractive. But stand-alone plans must not be the only choice. For the reasons stated above, it is critical that families also have access to embedded plans.

We acknowledge the difficulty in determining whether embedded plans could be bid, evaluated, approved and added to the QHP selection options in time for open enrollment on October 1, 2013. In our view, the only way to find out is to start that process now. We have reason to believe embedded plans have already been designed and priced, since QHPs were originally permitted to submit embedded bids to the Exchange (and some plans developed such bids and submitted them for regulatory approval), and because plans will be required to sell all ten essential health benefits in plans outside the Exchange. With sufficient encouragement from the Board, we believe that an extended bidding opportunity could produce acceptable embedded plans in time for open enrollment.

It has also been suggested in some staff and Advisory Group discussions that CalHEERS might require some system or IT modification in order to add embedded plans. Again, in our view, Covered California should be directed to quickly assess the need for any such changes and begin to make them.

We are not persuaded by arguments that the need for simple "apples-to-apples" plan comparisons should preclude embedded plans. Policy should drive process, not the reverse. It is our hope that at its August 8, 2013 meeting, the Board will articulate policies about what is in the best interest of consumers and families, and polices that ensure that children are equal beneficiaries of the ACA's consumer protections and affordability provisions. Such affirming policies should naturally bring the Board to a decision to include embedded pediatric dental plans.

To recap, we offer the following recommendations for Board action at the August 8, 2013 Board meeting:

1. **The Board should articulate a policy that directs Covered California staff to immediately request bids for embedded pediatric dental plans, with the intention of approving such plans for inclusion in the Covered California marketplace as soon as possible;**
2. **The Board should expressly find that it is not in the best interest of consumers to offer only stand-alone pediatric dental plans; and**
3. **The Board should articulate policies about what is in the best interest of consumers and families, and polices that ensure that children are equal beneficiaries of the ACA's consumer protections and affordability provisions.**

Thank you for your time and attention to these complex and important issues at this critical juncture. We very much appreciate your consideration. If you wish to discuss further, please contact Kathleen Hamilton at The Children's Partnership at 916-706-2917, or at khamilton@childrenspartnership.org.

Sincerely,

Ted Lempert

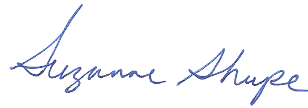
President

Children Now

Peter Manzo

President & CEO

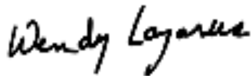
United Ways of California



Suzie Shupe

Executive Director

California Coverage & Health Initiatives



Wendy Lazarus

Founder and Co-President

The Children's Partnership

Jamila Iris Edwards

Northern California Director

Children's Defense Fund-California

Covered California Stand-Alone Model Contract
Comments from The Children's Partnership and Children Now

Model Contract Article/ Attachment No.	Article/Attachment Title	Paragraph, Article, or Subpar. No.	Stakeholder Comment	Stakeholder Name
			We want to ensure that it is clear that the allowance of stand-alone dental plans in the Exchange and the allowance of Qualified Health Plans (QHPs) offered in the Exchange to omit pediatric dental benefits does not prohibit the Exchange from requiring the offer of dental coverage being embedded in QHPs.	The Children's Partnership and Children Now
1.04	Transition between Exchange and Other Coverage	1	Thank you for ensuring there is no wrong door for enrollees to access dental coverage. We request the Exchange create a process to track how many enrollees transition to and from Medi-Cal and other governmental health care programs and coverage.	The Children's Partnership and Children Now
1.05	Coordination, Cooperation	a, ii	We request stakeholder input on the education, marketing and outreach programs that seek to increase enrollment through the Exchange regarding the range of available SADPs in the Exchange.	The Children's Partnership and Children Now
1.05	Coordination, Cooperation	a, iii	We request public disclosure on the numbers of Contractor's existing members who are eligible for Federal subsidies in the Exchange.	The Children's Partnership and Children Now
1.05	Coordination, Cooperation	a, ix	To drive awareness, enrollment and selection of the pediatric EHB, we request information on the joint marketing activities developed by the Exchange, Contractor, and other dental plan issuers.	The Children's Partnership and Children Now
1.05	Coordination, Cooperation	b, v	The Exchange should consider requiring Contractor to monitor numbers of enrollees--by age--who elect to disenroll from dental coverage during the enrollment year. The Exchange should make these data available to stakeholders and the Legislature.	The Children's Partnership and Children Now
2	Exchange Responsibilities	preamble	Through CalHEERS, the Exchange should consider collecting data on how pediatric EHB is selected - whether via bundled arrangement with SADP or if SADP is purchased separately.	The Children's Partnership and Children Now
3.05	Network Requirements	preamble	We appreciate the inclusion of the applicable codes and regulations that reflect existing law requiring the Department of Managed Health Care and the Department of Insurance to promulgate regulations to ensure that enrollees and insureds have the opportunity to access needed health care services in a timely manner, and to ensure adequacy of numbers of professional providers and institutional providers and that these same standards will apply to standalone dental plans. We request clarification on what is meant by a network "sufficient in number and types of providers" as described in 45 C.F.R. 156.230 whereby a QHP issuer must ensure an adequate network of providers for enrollees. How is sufficiency defined in number and by type of dental provider?	The Children's Partnership and Children Now
3.05	Network Requirements	preamble	Please describe how the Exchange plans to evaluate the adequacy of ethnic and language provider diversity available to enrollees.	The Children's Partnership and Children Now
3.05	Network Requirements	b	We request clarification that the electronic version of the directory will be updated as necessary (and more frequently than quarterly).	The Children's Partnership and Children Now
3.06	Contracting with Dental Providers who Serve the Low Income and Uninsured Populations	preamble	Please define "reasonable and timely access" described in preamble.	The Children's Partnership and Children Now
3.09	Rate Information	a	Existing law which requires health care service plans and health insurance policies to file specified rate information with the Department of Managed Health Care and the Department of Insurance, respectively, at least 60 days before implementing a rate change should also apply to stand-alone dental plans.	The Children's Partnership and Children Now
3.10	Transparency in Coverage		We request the information listed in this section be shared with the State Legislature in a report.	The Children's Partnership and Children Now
3.16/Attachment 6-2	Customer Service/Customer Service Transfers	d, e	We request that the Exchange monitor the number of enrollees--by age--with questions regarding the applicability of the premium tax credit to the selection of a stand-alone dental plan not bundled with a health plan. Additionally, we request that the Exchange require Contractor share data gathered from the types of calls received in a report to the Exchange.	The Children's Partnership and Children Now

Model Contract Article/ Attachment No.	Article/Attachment Title	Paragraph, Article, or Subpar. No.	Stakeholder Comment	Stakeholder Name
3.16/Attachment 6-5.7	Customer Service/Standard Reports		In addition to the items listed in this section, the Exchange should require Contractor to regularly report on the number of enrollees who surpass the $1,000 out-of-pocket maximum. These data should be reported out by age groupings and by how much enrollees pay in out-of-pocket expenses (e.g., by groupings, such as $0-$200, $201-$400, $401-$600, $601-$800, $801-$1000).	The Children's Partnership and Children Now
3.18	Enrollment and Eligibility	a	Per request in Transparency of Coverage (above), information on number of instances that Contractor needed to reconcile premium payment information with enrollment and eligibility information received from the Exchange or its QHP partner - for all enrollees under age 19 - by month should be provided in a report to the Legislature.	The Children's Partnership and Children Now
3.18	Enrollment and Eligibility	b	The Exchange should consider requiring Contractor to use these opportunities to facilitate the selection of the pediatric EHB if the enrollee is under 19 years of age.	The Children's Partnership and Children Now
3.22	Premiums	a, iii	The Exchange should require Contractor to provide data and publicly report on the impact of premiums paid for stand-alone dental plans by enrollees under age 19 and by whether the plan was purchased as a bundled option or a separate stand-alone plan.	The Children's Partnership and Children Now
3.23	Notice to Provider Regarding enrollee's Grace Period Status		The Exchange should require Contractor to track the number of enrollees under age 19 receiving a federal subsidy who are disenrolled from coverage due to nonpayment. The Exchange should make these data public.	The Children's Partnership and Children Now
3.25	Appeals and Grievances	a	We appreciate the contractual expectation that the Contractor shall maintain an internal review process to resolve enrollee's dissatisfaction with Contractor and/or Provider, including "appeals of claims and benefit determinations, and complaints" relating to the scope of services required by the stand-alone dental plan. The right to appeal is a critical consumer protection for families. Based on this internal review process, the Exchange should consider requiring the Contractor to provide reports to the Exchange that could be shared publicly regarding the types of complaints about the scope of services available to enrollees under age 19.	The Children's Partnership and Children Now
4.01/Attachment 7	Promoting Higher Quality and Better Value	preamble	The preamble should be clear that the Exchange will engage consumer advocates and other stakeholders in the effort to define and implement additional initiatives and programs to continuously improve quality and value.	The Children's Partnership and Children Now
4.01/Attachment 7/Article 1	Coordination and Cooperation	1.01	We appreciate the inclusion of stakeholders in effort to improve care for enrollees through the Exchange's Plan Management and Delivery System Reform Advisory Group.	The Children's Partnership and Children Now
4.01/Attachment 7/Article 1	Coordination and Cooperation	1.01	Partnerships to improve coordination and cooperation should explicitly reference coordination between Qualified Health Plans and Dental plans, if they are stand-alone or bundled.	The Children's Partnership and Children Now
4.01/Attachment 7/Article 1	Participation in Collaborative Quality Initiatives	1.02	Consumer advocates should be included in efforts to identify and evaluate effective programs for improving care for enrollees and should advise the Exchange on how to incorporate these programs into Contractors' future contracts. Evaluation of effective programs should address appropriate strategies by age.	The Children's Partnership and Children Now
4.01/Attachment 7/Article 1	Reducing Health Disparities and Assuring Health Equity	1.03 (c)	Consumer advocates should be included in the effort to identify strategies to address health disparities.	The Children's Partnership and Children Now
4.01/Attachment 7/Article 3	Dental Utilization Reporting	3.01- 3.03	As appropriate, data submitted to the Exchange should be made public and posted online, on a regular basis. The Exchange should work with consumer advocates and other stakeholders to determine which data are useful in what format to advise on how the Exchange and Contractors can improve the oral health of their enrollees.	The Children's Partnership and Children Now
4.01/Attachment 7/Article 4	Prevention Health and Wellness	4.01-4.03	Reports developed for the purpose of this Article should be made public and posted online.	The Children's Partnership and Children Now
4.01/Attachment 7/Article 5	Encouraging Consumers' Access to Appropriate Care		Include in Article 5 that dental plans must comply with timely access standards network as prescribed by 3.06 above; Contractors should report to the Exchange on how it is complying with timely access standards. Such data should be made public and posted online.	The Children's Partnership and Children Now

Covered California Stand-Alone Model Contract

Comments from The Children's Partnership and Children Now

Model Contract Article/ Attachment No.	Article/Attachment Title	Paragraph, Article, or Subpar. No.	Stakeholder Comment	Stakeholder Name
4.01/Attachment 7/Article 5	Encouraging Consumers' Access to Appropriate Care		Include in Article 5 that dental plans must comply with network adequacy standards as prescribed by 3.05 above; Contractors should report to the Exchange on how it is complying with network adequacy standards. Such data should be posted online.	The Children's Partnership and Children Now
4.01/Attachment 7/Article 5	Encouraging Consumers' Access to Appropriate Care	5.01	Geographic accessibility and family member assignment should be priorities in assigning a dental provider. These factors should rank higher than the enrollees' gender and other factors.	The Children's Partnership and Children Now
4.01/Attachment 7/Article 7	Value Based Reimbursement Inventory and Performance	7.02	Please clarify the oral health-related reimbursement methodologies. The model contract does not specify oral health value measures.	The Children's Partnership and Children Now
4.01/Attachment 7/Article 7	Payment Reform and Data Submission	7.05	As appropriate, information provided to the Exchange noted in all areas of Article 7 should be made public posted online.	The Children's Partnership and Children Now
6.01	Performance Measurement Standards	a	1) The Exchange should consider adding a measure to determine the Treatment to Caries Prevention Ratio; 2) Include measures related to ensuring provider network adequacy, including providers who demonstrate ethnic/cultural competency.	The Children's Partnership and Children Now

CH1LDREN NOW

July 26, 2013

Andrea Rosen
Covered California
Interim Health Plan Management Director
Via email: qhp@covered.ca.gov

Dear Ms. Rosen,

We appreciated the webinar on Tuesday about the redline version of the stand-alone dental plan (SADP) contracts. The requirements outlined in these contracts are of paramount importance to ensure that children who are enrolled in SADPs are provided with quality oral health services in a timely manner. Furthermore, it is critical to monitor and assess the provision of SADPs so that adjustments can be made in how the pediatric dental essential health benefit is structured to meet the oral health care needs of children in a cost effective way for families.

Our organizations submitted joint comments during the requested public comment period. Below, we are offering additional comments based on what we heard on the webinar. Also, having read the redline version of the contract and corresponding attachment, we would like to reiterate some of our more critical comments for consideration by Covered California.

Additional Performance Measures Needed; Benchmarks Should Apply in 2014

First, with respect to the performance measurement standards expected of SADPs, we were pleased overall with the selection of measures and initial benchmarks. Per our original comments, we ask Covered California to consider adding the following measures to evaluate access to prevention services and availability of diverse providers:

1) Treatment to caries prevention ratio: This measure is one of several that are already in effect with the dental managed care plan contracts to serve children enrolled in Medi-Cal.

2) Measures to determine ethnic/cultural competency of network providers

We were troubled to hear on the webinar the comment about whether the performance standard benchmarks outlined in the draft contracts should apply to the first year of Covered California. We strongly encourage the benchmarks be implemented for plan year 2014. This is critical to ensure the plans are meeting their obligations in assuring quality dental care for children from the start.

The dental plans which have already been awarded contracts — Anthem Dental, Blue Shield of California, Delta Dental of California, Health Net Dental, LIBERTY Dental Plan, and Premier Access Dental—have had experience through the Healthy Families Program and/or Medi-Cal in meeting certain performance measure standards, including several mentioned in the SADP draft contract. Course corrections can be put in effect for future plan years and could be based on overall and aggregate plan performance in a previous plan year. We are concerned that if no benchmarks are applied in the initial year, future contracts may have benchmarks set too low, possibly based on averages. There will be plenty of lessons to learn from the first full year of contract implementation, which we expect Covered California to track and monitor in order to improve these contracts for future plan years.

Covered California Should Sufficiently Educate Consumers About Pediatric Dental EHB and Monitor How Pediatric SADPs are Selected and Purchased

Our organizations are concerned about how the pediatric dental EHB will be offered and sold inside the Exchange. Of paramount importance is to ensure consumers are educated about the pediatric dental EHB and families' options for obtaining dental benefits for their children. We echo comments heard on the webinar to ensure that a specific training component for Assister Enrollment Entities (AEE) and Individual Assisters should focus on the pediatric dental EHB so that adults with children understand their children's eligibility for dental benefits.

Furthermore, we urge Covered California to track families' take-up of the pediatric dental EHB. In addition, we strongly encourage Covered California to collect data on how many families elect to drop dental coverage and/or reach or exceed the $1,000 maximum during the 2014 plan year, given that services provided by SADPs will be subject to an additional and separate out-of-pocket maximum. Such information will be helpful to determine whether and which changes need to be made for the 2015 plan year.

Support for Stakeholder Process

Per our comment in the preceding section, we are pleased to hear Covered California consider the establishment of a stakeholder group to examine and identify strategies to address health disparities. Such a group convened regularly throughout 2014 will be extremely beneficial to discuss and focus on to improve contracts and services in future plan years. We urge you to establish and convene this group right away.

Thank you for your commitment to ensuring eligible families who choose SADPs for their children's oral health coverage have timely access to quality care. Please contact us if you have any questions about our comments.

Sincerely,

Eileen Espejo
Director, Media & Health Policy
Children Now
510-763-2444, x114
eespejo@childrennow.org

Jenny Kattlove
Director, Strategic Health Initiatives
The Children's Partnership
310-260-1220
jkattlove@childrenspartnership.org

CH1LDREN NOW

July 17, 2013

Diana Dooley, Chair
Peter Lee, Executive Director
Covered California Board
560 J St., Ste. 200
Sacramento, CA 95814

Re: Pediatric Dental Benefit Policy

Dear Ms. Dooley and Mr. Lee,

Our organizations urge the adoption of a policy by the California Exchange that assures that all enrollees are able to purchase Qualified Health Plans (QHPs) that include pediatric dental benefits. To accomplish this, we ask that the Exchange prioritize the inclusion of QHPs with embedded dental benefits to the extent practicable for the 2014 rate year and as a standard for the 2015 rate year.

We have reviewed the July 16, 2013 letter sent by Mr. Lee to Senators Hernandez and Monning and Assemblymember Pan in their capacities as the authors of the essential health benefits legislation and the chairs of the relevant policy committees. We appreciate the recognition by the Exchange staff of the need to revisit the issue of pediatric dental benefits. This letter and the accompanying policy paper are intended to help further that discussion.

Our organizations support the reliance on embedded pediatric dental benefits for the following reasons:

- **Affordability**: Inclusion of pediatric dental benefits in an embedded plan allows consumers to apply the advance premium tax credit to all ten essential benefits, not a subset of those benefits. As detailed in the attached policy paper, for the 140,000 children in moderate-income families between 250%FPL-400%FPL, this maximizes the affordability of coverage.
- **Consumer protections**: Many of the key consumer protections in California law apply to full service plans but not to specialized plans. These include guaranteed issue, community rating,

rate review and medical loss ratio. Stand-alone dental plans thus lack the consumer protections that are available to enrollees through embedded plans.

- **Comprehensive benefits**: Under both state and federal law, pediatric dental is an essential health benefit, not a supplemental or incidental benefit. Comprehensive benefits include benefits that many enrollees will never use: some will never need maternity coverage, others will never need prostate cancer screening, and children need neither, yet all of the plans cover both.
- **Market distortions**: California has a long history in which different rules in different parts of the market have resulted in market shifts. Allowing consumers in the Exchange to purchase a partial benefit package that does not include pediatric dental benefits while requiring consumers in the outside market to buy all ten essential health benefits will have predictable, unfortunate market consequences.

Given these impacts, we believe that the Exchange should determine that it is not in the best interest of consumers to offer only stand-alone pediatric dental plans. We provide more detail in support of this position in the attached policy paper.

We recognize that the hour is late for changes for 2014. It may however still be possible that one or more QHP bidders, if permitted to do so, could offer embedded plans, though perhaps not by October 1.

Discussions about the 2015 rate year begin now. Just as last year, the Exchange Board approved in August the initial draft of the QHP solicitation, this is the time that the Exchange Board and staff should consider the changes that they wish to make for the 2015 rate year. We encourage the Exchange to adopt a policy that maximizes the offering of embedded pediatric dental plans to ensure that all ten essential health benefits are included in QHPs offered both inside and outside the Exchange.

We recognize that there are other policy issues to resolve, but the first issue should be, how the Exchange can benefit consumers by offering affordable, comprehensive coverage that is consistent with California and federal law and that provides the same benefits as offered in the outside market.

We look forward to the opportunity to discuss next steps with you. If you have any questions or concerns, please contact Julie Silas or Betsy Imholz at Consumers Union (415) 431-6747.

Sincerely,

Ellen Wu, California Pan-Ethnic Health Network
Suzie Shupe, California Coverage and Health Initiatives
Jamila Edwards, Children's Defense Fund – California
Kelly Hardy, Children Now
Julie Silas and Betsy Imholz, Consumers Union
Anthony Wright, Health Access
Michelle Lilienfield and Kimberly Lewis, NHeLP
Kathleen Hamilton, The Children's Partnership
Judy Darnell, United Ways of California
Elizabeth Landsberg, Western Center on Law & Poverty

Important Consumer Considerations in Design of Pediatric Dental Benefits

Pediatric dental benefits are essential health benefits (EHBs) under federal and state law.[1] Both inside and outside of the Exchange, non-grandfathered health plans in the individual and small group markets have to provide all ten EHBs, including pediatric dental health benefits.

Federal law requires Exchanges to *allow* Qualified Health Plans (QHPs) to offer the pediatric dental EHB through stand-alone plans. Outside of the Exchange, however, pediatric dental EHBs must be provided in all plans; they cannot be offered as stand-alone products.[2]

The Centers for Medicare and Medicaid Services (CMS) permits Exchanges to offer pediatric dental EHBs exclusively in stand-alone plans, but only if the Exchange determines that this is in the **best interest of consumers**.[3]

It is not in the best interest of California consumers to offer *only* stand-alone pediatric dental plans in Covered California and to fail to offer "embedded" pediatric dental benefits.[4] First, offering only stand-alone pediatric dental benefits has serious implications for the affordability of the pediatric dental EHB. Second, important consumer protections that govern QHPs do not apply to stand-alone pediatric dental plans, but do apply to embedded plans. Third, the differences in affordability and consumer protections between Exchange products and those offered outside the Exchange violates one of the fundamental policy premises of California law, that the rules for products inside and outside the Exchange should be the same.

[1] Kelch, Deborah, Pediatric Dental Essential Health Benefits FAQ, Health Insurance Alignment Project, pages 1 and 9, July 12, 2013.

[2] "The ACA does not provide for the exclusion of a pediatric dental EHB outside of the exchange as it does … for QHPs. Therefore, individuals enrolling in health insurance coverage not offered on an Exchange must be offered the full ten EHB categories, including the pediatric dental benefit." Preamble to the Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule Federal Register, Volume 78, No. 37, p. 12853, February 25, 2013. The only exception is when an outside plan can provide reasonable assurance that the enrollee is covered through a stand-alone dental plan certified by the Exchange.

[3] 45 C.F. R. §155.1000(c). See also, Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers 77 FR 59, page 18411, March 27, 2012; Letter to issuers on federally-facilitated and state partnership exchanges, page 32, April 5, 2013.; and Preamble to newly proposed regulations on risk corridors. Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, Premium Stabilization Programs, and Market Standards; Proposed Rule 78 FR 118, page 37041, fn 18, June 19, 2013.

[4] See Kelch, page 5 for definition of "embedded."

1. Affordability of pediatric dental EHBs:

It is not in the best interests of consumers to offer pediatric dental benefits only through stand-alone plans. It greatly impacts the availability of premium tax credits to enrollees eligible for tax credits.

The premium tax credits consumers would be eligible for in the Exchange will not be increased as a result of purchasing stand-alone pediatric dental plans. (See Attachment A regarding how the advance premium tax credit is calculated). As a result of increased costs related to offering stand-alone dental plans for children to access dental coverage, consumers may opt out of purchasing the pediatric dental EHBs entirely.

Premiums for stand-alone pediatric EHB products are not included when calculating the advance premium tax credits. Because stand-alone plans are not part of a full QHP package, but are separate, the premiums for the pediatric dental are not considered part of the second lowest silver plan, used to calculate premium tax credits, but instead are considered separately. Thus, the portion of the premium purchased separately for the stand-alone pediatric dental EHB cannot be used in the premium calculation equation.

What does this mean for Californians eligible for help paying for coverage? This means that families eligible for tax credits who purchase stand-alone pediatric dental alongside their QHP will have to pay a higher percentage of their income for such coverage than families with the same exact income who choose not to purchase the pediatric dental EHB.

Covered California staff has asserted that even when pediatric dental benefits are "embedded" in a QHP—i.e. are part of a fully integrated QHP—the premium associated with those benefits is not included in the advance premium tax credit calculation. This assertion is incorrect. As CMS has stated:

> When the pediatric dental benefit is embedded in a health insurance plan subject to standards set forth in §§156.130 and 156.140, we do not distinguish it from other benefits with respect to AV and cost-sharing requirements."[5]

The IRS regulations affirm that the second lowest silver plan premium is "adjusted only for the age of each member of the coverage family."[6] Therefore, it is not adjusted based on whether the QHP includes all 10 EHBs, or excludes pediatric dental coverage (also known as "9.5 plans").

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[5] Federal Register, Volume 78, No. 37, p. 12853, February 25, 2013.
[6] 26 C.F.R. §1.36B-3.

By allowing only stand-alone pediatric dental plans in Covered California, the families of more than one hundred thousand children who are low- and moderate-income[7] may be forced to pay more than 9.5 percent of their family income—the percentage above which consumers become exempt from having to get mandated coverage—in order to access both a QHP and pediatric dental EHBs.

The scenarios below illustrate the practical, detrimental effect of stand-alone pediatric dental plans on affordability. In Scenario 1, the hypothetical Chin family, consisting of two parents and two children living in Vacaville, has an annual income of $64,000, less than 300% FPL.

Scenario 1 shows the additional financial resources that will be required for the Chin family to purchase dental benefits for their two children if only stand-alone dental plans are available. Based on the second lowest silver plan in their region (which does not include pediatric dental), they are entitled to $6,232 in advance premium tax credits. However, because the dental coverage is in a stand-alone plan, the family would have to pay out-of-pocket an additional $27/month for each of their two children (in the lower-priced and lower actuarial value Anthem PPO 70% AV plan), which would increase the total amount they would have to pay $6,728, which is 10.5% of their income.

Chin Family – Vacaville, CA – **Scenario 1**
(stand-alone, separate dental premium at 70% AV)

Two adults – John (40 yrs) & Susan (40 yrs)

- Amy – 12 years
- Mark – 10 years

Family income - $64,000 (<300% FPL)

QHP – Anthem PPO w/o embedded dental

Expected annual contribution: 9.5% = $6.080 ($507/month)
Adult benchmark plan: $8,232/yr ($343/month x 2); Child benchmark plan $4,080/yr ($170/month x 2)
Total family benchmark plan: $12,312/annual ($1,026/month)
Premium credit: $12,312 - $6,080 = **$6,232** ($519/month) – 51% of total premium
Total family cost: $6,080 ($507/month)
9.5% of MAGI

Dental – Anthem DPPO (70% AV)

Child dental plan: $648/yr ($27/month x 2)
Total premiums: $12,312 + $648 = $12,960
Premium credit: **$6,232**
Total family cost: $6,728 ($561/month) = $6,080 (9.5% of income) + $648 additional/year ($27/month x 2)
10.5% of MAGI

[7] CalSIM version 1.8 Statewide Data Book 2014–2019, page 6, March 2013.

In contrast, as shown in Scenario 2, if pediatric dental were embedded in the second lowest silver plan, at the rate of $15 additional monthly premium,[8] the Chin family would only be required to contribute $6,080 toward their premiums and be able to get full dental coverage for both of their children.

Chin Family – Vacaville, CA – **Scenario 2**
(embedded dental benefits)

Two adults – John (40 yrs) & Susan (40 yrs)
- Amy – 12 years
- Mark – 10 years

Family income - $64,000 (<300% FPL)

QHP – Anthem PPO with embedded dental adding to base premium $8/month

Expected annual contribution: 9.5% = $6.080 ($507/month)

Adult benchmark plan: $8,592/yr ($358*/month x 2) Child benchmark plan $4,440/yr ($185*/month x 2)

Total family benchmark plan: $13,302/annual ($1,108/month)

Premium credit: $13,302 - $6,080 = **$7,222** ($519/month) – 54% of total premium

Total family cost: $6,080 ($507/month)

9.5% of MAGI

* includes additional $15/month for each dental embedded in the plan

Table 1 below summarizes the financial impacts on the Chin family when only stand-only dental plans are offered in the Exchange. In order to have dental coverage for their children, their monthly premiums are much higher than they would be if the dental benefits were embedded. They will have less advance premium tax credit to use to shop in Covered California. In order to keep their premiums no more than 9.5% of their income, they may be forced to choose a lower monthly cost bronze plan that would increase their exposure to out-of-pocket costs and deductibles.

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[8] We understand from plans that embedded pediatric dental would increase the QHP premiums by $6 to $12 per person, per month. In order to be conservative, we created this scenario assuming that the embedded pediatric dental would increase the base QHP premium by $15 per person, per month.

Table 1:

	Scenario 1	Scenario 2
Total credit	$6,232	$7,222
Cost to family	$6,728	$6,080
Out-of-pocket max (total)	$8,350*	$6,350
Family deductible	$2,120**	$2,000
Premium % of MAGI	10.5%	9.5%

* Family OOP max: $6,350 + separate dental $1,000 x 2 (per child)

** Family deductible: $2,000 deductible + separate dental $60 deductible x 2 (per child)

Thus, Covered California's decision to prohibit QHPs from offering embedded pediatric dental coverage would result in higher out-of-pocket costs, and in some cases, would thrust families over the 9.5% income threshold and into an exemption from the mandate to have coverage, leaving families with the option not to purchase health insurance at all. For some, the additional costs associated with the stand-alone dental plans will put them in an untenable position and will force them to forego dental coverage for their children.

Tax credit subsidies can be used to pay for stand-alone dental plans if, after a family purchases their QHP health plans, they have some of the tax credit left over. [9] However, the federal regulations make clear that stand-alone dental plans must be able to process and accept advance payments of the premium tax credit, so that consumers don't have to wait until tax time to avail themselves of the credit. [10] We are not aware of whether the current bidders of pediatric dental stand-alone plans have this capacity. Further, as shown by the scenarios above, in most situations, the amount of premium tax credit available to families is likely to push low- and moderate-income families into situations where they are only able to afford bronze level plans, in order to be able to purchase stand-alone pediatric dental benefits and remain below the 9.5% income affordability threshold.

[9] This comes from the final regulations on Benefit and Payment Parameters addressing §155.340(e), which focuses on the allocation of a tax credit when individuals in the tax filers' tax household are enrolled in more than one QHP or stand-alone dental plan. The process requires that first the subsidy allocation be spread across the multiple QHPs (if family members are enrolled in more than one QHP plan), "to ensure that the majority of the tax credit is allocated to the most costly portion of an individual's coverage." 78 FR 47, page 15477, March 11, 2013.. Section 155.340(e)(2) states that "any remaining advance payment of the premium tax credit must be allocated among the stand-alone dental policies in a reasonable and consistent manner specified by the Exchange." See 78 F.R. 47, page 15533.
10 78 FR 47, page 15477.

2. Important consumer protections do not apply to stand-alone plans:

It is not in the best interest of consumers to allow only stand-alone plans since such plans are not required to meet many of the most fundamental consumer protections of the ACA. Under California law, these consumer protections apply to full service health care service plans, but not to specialized plans. Consumers purchasing embedded coverage would receive these protections while those purchasing a stand- alone dental benefit would not.

Federal rules and California law do not apply these key consumer protections to stand-alone pediatric dental plans offered by specialized health plans:

- Guaranteed issue: the requirement that coverage be sold regardless of pre-existing conditions or health status;
- Limits on pre-existing condition exclusions and waivers;
- Modified community rating, which bases premiums on age, family size and geographic region rather than health status or pre-existing condition;
- Rate review;[11] and
- Medical loss ratio rules.

All of these consumer protections apply to pediatric dental coverage when offered by a health care service plan which is not a specialized plan and thus apply to pediatric dental benefits offered outside the Exchange. The lack of guaranteed issue and community rating of pediatric dental benefits is especially troublesome since it directly affects the affordability of the benefit.

In the past, dental benefits have been supplemental or incidental benefits. The enactment of the essential health benefits requirements in both federal and California law move pediatric dental from a supplemental benefit to a core benefit. It is unfortunate that existing California law does not provide the same consumer protections to stand-alone dental benefits offered by specialized health plans. In the absence of a change in California law, the only way to provide these important consumer protections is to provide pediatric dental benefits through health plans or insurers subject to the more comprehensive consumer protections.

Some protections do apply regardless of the plans' stand-alone status. For example, cost-sharing limits and restrictions on annual and lifetime limits apply to stand-alone dental plans for coverage of the pediatric dental EHB.[12] And, contrary to statements made by Covered California staff, stand-alone plans must meet QHP certification

[11] 45 C.F.R. §146.145(c)(3).

[12] 45 C.F.R. section 146.145(c)(3); Section 155.1065(a)(3) (See also, 77 F.R. 59, page 18411, March 27, 2012.)

standards, such as network adequacy.[13] Specialized plans that are regulated by DMHC are subject to network adequacy and timely access requirements under existing law.

3. Comprehensive Benefits, Not Partial Benefits

Under both federal and state law, pediatric dental is one of the ten essential benefits. It is not a supplemental or incidental benefit. Comprehensive benefits, by their nature, include benefits that many enrollees will never use: some of us will never need maternity coverage, others among us will never need prostate cancer screening; and children need neither, yet all of our QHP offerings include both benefits. The list of benefits that many of us hope we never need is even longer: coverage for numerous diseases and conditions is part of the core benefits that everyone pays for.

Pediatric vision has been included without question in the coverage to be sold to all consumers both inside and outside the Exchange. Pediatric dental should not be treated differently than pediatric vision.

4. Market Impacts: Same Rules Inside and Outside the Exchange

A guiding principle of the California legislation enacted to implement and improve on the federal Affordable Care Act has been that the rules for the insurance market should be the same inside and outside the Exchange. California has a long history with the market-distorting effects of allowing different parts of the market to play by different rules. An earlier effort at a small group purchasing pool collapsed due to adverse selection because risk rating was different for the purchasing pool than the outside market. The California individual market shifted from 80% of the covered lives with maternity benefits to only 20% in less than five years because premiums without maternity coverage are cheaper than premiums for more comprehensive coverage.

Allowing individuals to purchase coverage without pediatric dental benefits is no different than allowing individuals to purchase coverage that does not include maternity benefits (or prostate cancer or childhood immunizations): it will impact the market. If all of those in the individual market outside the Exchange are required to purchase all ten benefits, while those purchasing individual coverage through the Exchange have the option to decline pediatric dental coverage, it will create market distortions between the outside market and the Exchange.

If those purchasing through the Exchange can obtain coverage without pediatric dental benefits, that will drive up the cost of pediatric dental benefits for those families purchasing through the Exchange who choose to purchase pediatric dental benefit, since the cost (and risk) of the pediatric dental benefit will not be spread across the entire Exchange population. Further, treating pediatric dental as a supplemental or

[13] See 77 F.R. 59, page 18412.

optional or incidental benefit ignores the policy principle that health coverage should cover a comprehensive set of benefits rather than a pick and choose menu of what consumers think they might need or might be able to afford. California has consistently improved on what the federal law permits or requires.

Conclusion

Stand-alone pediatric dental plans that are an optional purchase in the Exchange cost consumers more, reduce the *value* of the available tax credit to families, push some consumers above the 9.5% affordability threshold, offer fewer consumer protections and undermine insurance market rules. Providing stand-alone dental benefits as the only option is not in the best interests of consumers. Embedded products should also be offered, if at all possible for the 2014 rate year, if not as a policy direction for the 2015 rate year.

Attachment A:

Figuring out Advance Premium Tax Credits

Advance premium tax credits are determined by looking at two things:

- The individual or family's modified adjusted gross income (MAGI), based on the number of people in the family; and
- The cost of second lowest silver tier plan premium in their geographic region for each family member's age (think of this as the "benchmark" premium for each person).

Step 1: Determine the maximum amount the family will be required to pay in premiums

The ACA established an income cap (a percent of income) for each income level between 139% to 400% of the federal poverty level (FPL). The first step is to establish what the percentage cap is for the individual or family's income level. The income cap is never more than 9.5% for those eligible for premium tax credits. If expenditures exceed the 9.5% cap, the family is exempt from the "individual mandate" to have coverage.

For example, suppose Rachel Smith makes $33,000 annual modified adjusted gross income. The most she will have to pay toward her annual premium is 9.5% of her modified adjusted gross income, which would be $3,135.

Step 2: Determine what the benchmark premium is for her age.

To find the benchmark premium for each person, you look at the geographic region where she lives, her age bracket , and find the second lowest cost silver plan premium amount for her age.

Suppose that Rachel Smith is 40 years of age and lives in Vacaville, which is in Solano County. If you use Covered California's booklet for Region 2 (Napa, Sonoma, and Solano County),[14] you will see five silver tier plans offered in the region for a 40 year old single adult.

[14] Covered California, Health Insurance Companies and Plan Rates for 2014, page 25 (May 23, 2013, updated June 28, 2013).

Pricing Region 2
Napa, Sonoma, Solano, Marin

40-YEAR-OLD				
Plan	Bronze	Silver	Gold	Platinum
Anthem PPO	$259	$343*	$416	$482
Blue Shield EPO	$282	$338	$402	$461
Health Net PPO	$348	$396	$450	$507
Kaiser Permanente HMO	$275	$365	$448	$482
Western Health Advantage HMO	$257	$369	$434	$471

24 | May 23, 2013 Covered California Health Insurance Plans

The second lowest silver tier plan is the Anthem PPO product. The unsubsidized premium per month for the Anthem product is $343 per month (annual $4,116).

Step3: Figure out the amount of the premium tax credit.

To figure out the amount of the tax credit, subtract the family's maximum premium contribution from the total annual premium of the lowest cost silver plan:

Annual premium for second lowest silver plan $ _____

Subtract maximum family contribution - $ _____

Federal tax credit $ _____

For Rachel Smith (above) who is 40 years old, single, and lives in Vacaville (Region 2) the equation would be:

Annual premium for Anthem PPO ($343/month) $4,116

Maximum contribution (9.5% MAGI) - $3,135

Federal tax credit $ 981

For the Chin family, a family of four (2 children and 2 adults) living in Vacaville with $64,000 in modified adjusted gross income (MAGI), the equation would be based on the family premium rate for Region 2:

Pricing Region 2

Napa, Sonoma, Solano, Marin

FAMILY OF FOUR				
Plan	Bronze	Silver	Gold	Platinum
Anthem PPO	**$774**	$1,026*	$1,245	$1,444
Blue Shield EPO	$844	**$1,012**	**$1,204**	**$1,379**
Health Net PPO	$1,041	$1,187	$1,347	$1,518
Kaiser Permanente HMO	$823	$1,092	$1,341	$1,443
Western Health Advantage HMO	$769	$1,106	$1,300	$1,410

Family of four = two parents age 40 and two children under the age of 21

Covered California Health Insurance Plans *updated June 28, 2013* | 25

The Anthem PPO is the second lowest silver plan for a family of four. Hence, the Chin family calculation of advance premium tax credits would be:

Annual premium for Anthem PPO ($1,026/mo)		$12,312
Maximum contribution (9.5% MAGI)	-	$6,080
Federal tax credit		**$6,232**

STATE OF CALIFORNIA — Dave Jones, *Insurance Commissioner*

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June 27, 2013

Chairwoman Diana Dooley and Board Members
Covered California
California Health Benefit Exchange
560 J Street, Suite270
Sacramento, CA95814

Re: Pediatric Dental Coverage and Exchange Action to Require Carriers to Remove it from Health Insurance Policies filed with their Regulators

Dear Chairwoman Dooley:

I write to reiterate my request that the Covered California Board reverse the decision made to prevent health insurers and health plans from including pediatric dental coverage within individual market products sold through the California Health Benefit Exchange.

Covered California's decision barring health insurers and health plans from including pediatric dental coverage in the health insurance policy is contrary to state and federal law and will reduce children's access to dental care.

Pediatric Dental coverage is an essential health benefit. Federal and state law provide that children's dental care should be covered when their parents purchase health insurance coverage for them for 2014. Coverage of pediatric dental care meets an important health care need and is also consistent with the coverage provided to children in the Medi-Cal program and the Healthy Families program.

While it is true that federal law prevents Covered California from rejecting as a Qualified Health Plan (QHP) a health insurance product that covers 9.5 of the 10 Essential Health Benefits (all, except pediatric dental), there is nothing in law that authorizes Covered California to require health insurers and plans to exclude pediatric dental coverage in order to be approved as a QHP by Covered California. In fact, to the contrary, state law makes clear that all 10 Essential Health Benefits, including pediatric dental, must be covered by individual health insurance policies and plans in 2014.

I ask that the Board of Covered California reconsider the decision to require that pediatric dental be separated out from the health insurance policies sold in the Exchange. Those health insurers and health plans that submitted products with pediatric dental coverage embedded in their health insurance policy form should be permitted to cover pediatric dental in their health insurance policies. We have learned that at least some health insurers or health plans that originally

submitted a product with pediatric dental coverage embedded only pulled out that coverage at Covered California's insistence and are now indicating that the cost of the stand alone or bundled product will be significantly higher than it would have been if pediatric dental coverage was embedded in their health insurance products – both in terms of the premium charged and due to the imposition of a separate out-of-pocket maximum.

It was only in the last couple of weeks that health insurers and health plans were required by Covered California to take the pediatric dental coverage out of their QHP submissions to Covered California, so it is not too late to reverse course. It is my understanding that as recently as last week health insurers were still working to come into compliance with your contracting provision to remove pediatric dental coverage from QHP submissions.

The best outcome for children and one that is consistent with state and federal law is for you to permit health insurers and health plans to embed the pediatric dental coverage in their health insurance policies. A child's overall health and well-being requires access to dental care to ensure oral health. That is why pediatric dental coverage is one of the essential health benefits specified in the Affordable Care Act and California's essential health benefits law passed by the Legislature and signed by Governor Brown last year.

We all are working hard to ensure the success of Covered California. One of the key measures of that success --children's access to care-- is jeopardized if Covered California continues to require dental coverage to be sold in a way that makes pediatric dental coverage more expensive and less likely to be included in the health insurance products offered through Covered California. All of the individual market and small group market products sold outside of Covered California will include pediatric dental coverage.

You still have the opportunity to make affordable pediatric dental coverage available through Covered California. I hope that you will announce to the health insurers and health plans that had pediatric dental embedded in their health insurance products that they can put it back in rather than requiring them to separate it out. This will help ensure that children whose parents purchase coverage through Covered California will have greater access to dental care that will improve both their oral health and their overall health and well-being.

Sincerely,

DAVE JONES
Insurance Commissioner

cc: Peter Lee, Executive Director, Covered California

STATE OF CALIFORNIA Dave Jones, *Insurance Commissioner*

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July 3, 2013

Mr. Peter V. Lee
Executive Director
California Health Benefit Exchange
560 J Street, Suite 270
Sacramento, CA 95814

Re: Request that Covered California Reverse Decision Banning Embedded Pediatric Dental Coverage for Policies Sold Outside the Exchange and Comments on Stand-Alone Dental Plan Contract

Dear Mr. Lee:

Covered California has decided, through its contracts with health insurers and plans selling in the Exchange, to prevent health insurers and plans from including pediatric dental coverage as an embedded benefit in their individual and small group market health insurance or health plans sold outside the Exchange.

Covered California's decision to ban embedded pediatric dental coverage outside the Exchange through its contracts with health insurers and health plans selling in the Exchange is contrary to both state and federal law.

I write to request that Covered California remove from its contracts any language that would prevent health insurers or health plans from embedding pediatric dental coverage in policies sold outside the Exchange.

This request is in addition to our request by letter dated June 27th that Covered California also reverse its decision to ban embedded pediatric dental coverage in health insurance and health plans sold inside the Exchange, which is also contrary to state and federal law.

Below you will find the Department's specific comments concerning the stand-alone dental plan model contract dated June 19, 2013. We set forth first in italics the contract language and then our comments on that language.

1. Article 3. Contractor's Responsibilities

3.04 Offerings Outside of Exchange

(a) Contractor acknowledges and agrees that SADPs bundled with Qualified Health Plans and substantially similar plans offered by Contractor outside the Exchange must be offered at the same rate whether offered inside the Exchange or whether the plan is offered outside the Exchange directly from the issuer or through an agent as required under applicable laws, rules and regulations, including those required under 45 C.F.R. § 156.255(b), 42 U.S.C. § 18021, 42 U.S.C. § 18032. In accordance with Government Code Section 100503(f), Insurance Code Section 10112.3(c), and Health and Safety Code Section 1366.6(c), and other applicable State and Federal laws, regulations or guidance in the event that Contractor sells products outside the Exchange, Contractor shall fairly and affirmatively offer, market and sell all products made available to individuals and small employers in the Exchange to individuals and small businesses purchasing coverage outside the Exchange.

Covered California's attempt to dictate by contract a construction of Insurance Code section 10112.3(c) that will govern the outside Exchange implications of its decision to require insurers to omit coverage of the pediatric dental essential health benefit on the Exchange is contrary to state and federal law.

This proposed contract provision conflicts with state law. The essential health benefits statute, section 10112.27 of the Insurance Code, mandates that health insurers cover the pediatric dental essential health benefit in 2014 individual and small group policies. The only exception to this coverage mandate is for health insurance policies sold on the Exchange when a stand-alone dental plan is also available on the Exchange. While the Exchange may impose requirements by contract for its marketplace not in conflict with state law, it is not a regulator and has no legal authority over the insurance market outside the Exchange.

Federal law provides that the Exchange may not exclude qualified health plans that cover all the essential health benefits with the exception of pediatric dental (often referred to as 9.5 plans). However, state and federal law require coverage of all ten essential health benefits outside the Exchange. Additionally, the Department's essential health benefits regulation states that a "health insurance policy sold on the Exchange shall not omit coverage of the pediatric oral essential health benefit when sold outside of the Exchange pursuant to subdivision (c)(1) of Insurance Code section 10112.3 or otherwise." (10 C.C.R. § 2594.3(a)(1).) Consequently, insurers participating in the Exchange are not permitted to sell Exchange products which omit coverage of the pediatric dental essential health benefit outside the Exchange.

In sum, when insurers sell Exchange-standardized products outside the Exchange, they must embed the pediatric dental essential health benefit in the policy. This will ensure that health insurance policies covering all ten essential health benefits are available to families with children at a lower price, and without an additional $1,000 out-of-pocket maximum for dental care. This rule is both consistent with the state's essential health benefits law and in the best interests of children's health and well-being.

In conclusion, the Exchange may not impose an illegal contract provision on participating insurers. This contract provision must therefore be eliminated from the stand-alone dental plan contract and any other contract with health insurers or health plans selling on the Exchange.

2. Article 3. Contractor's Responsibilities
3.04 Offerings Outside of Exchange
(b) Contractor agrees that, to the extent not already required to do so by law, effective no later than December 31, 2013, it shall terminate or arrange for the termination of all of its non-grandfathered individual health insurance plan contracts or policies which are not compliant with the applicable provisions of the Affordable Care Act. Contractor agrees to promote ways to offer, market and sell or otherwise transition its current members into plans or policies which meet the applicable Affordable Care Act requirements. This obligation applies to all non-grandfathered individual insurance products in force or for sale by Contractor whether or not the individuals covered by such products are eligible for subsidies in the Exchange. All terminations made pursuant to this section shall be in accord with cancellation and nonrenewal provisions and notice requirements in California Health and Safety Code Section 1365, California Insurance Code Sections 10273.4, 10273.6 and 10713, and relevant state regulations and guidance.

There is nothing in law that authorizes or compels such a requirement. This provision is contrary to state law that allows people to keep their insurance until their renewal date in 2014. The individual market reforms apply to policies "issued, amended, or renewed on or after January 1, 2014." In addition, this provision in the Exchange's contract will conflict with provisions in existing health insurance contracts that currently guarantee coverage to a renewal date that falls after December 31, 2013.

This provision also would also deprive California consumers of the January 1, 2014-March 31, 2014 portion of the open enrollment period which they are entitled to in order to make important decisions regarding health care coverage. Assembly Bill 1X-2, signed by the Governor on May 9, 2013, provides at Insurance Code section 10965.3(c)(1) that Californians may make their choice as late as March 31, 2014:

> (c) (1) A health insurer shall provide an initial open enrollment period from October 1, 2013, to March 31, 2014, inclusive, and annual enrollment periods for plan years on or after January 1, 2015, from October 15 to December 7, inclusive, of the preceding calendar year.

Thus, while new customers will have until March 31, 2014 to make their health insurance purchasing decisions, existing customers will, as result of the Exchange's decision, have a dramatically shortened period in which to choose their insurance coverage.

Unfairly hastening the time when Californians lose their existing coverage, while simultaneously shortening the time in which they must choose new coverage, is contrary to state law. It will also be unnecessarily disruptive to people who intended to stay in their health insurance policy for 12 months. Californians reasonably understood President Obama's statement about keeping their coverage to mean that they wouldn't have to give it up earlier than their health insurance contract indicated.

I urge the Exchange to eliminate this provision, as well as the parallel provision in the Final Health Plan Contract.

Thank you for considering the Department's comments on the model contract, and please feel free to contact me or Deputy Commissioner Janice Rocco at (916) 492-3500 to discuss any of these issues in greater detail.

Sincerely,

DAVE JONES
Insurance Commissioner

STATE OF CALIFORNIA Dave Jones, *Insurance Commissioner*

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By electronic transmission and first class mail

July 31, 2013

Mr. Peter V. Lee
Executive Director
California Health Benefit Exchange
560 J Street, Suite 270
Sacramento, CA 95814

Re: Pediatric Dental Coverage

Dear Mr. Lee:

Thank you for your July 16, 2013 letter in which you respond to some of the issues raised in my June 27, 2013 and July 3, 2013 letters about pediatric dental coverage.

I understand that "Dental Policy Issues" will be the primary matter under consideration for action at Covered California's August 8, 2013 Board meeting. There are three significant issues to which I want to continue to draw your attention prior to that Board meeting. First, embedded pediatric dental coverage should be an option for consumers shopping for coverage through Covered California and as such you should add health insurance products with embedded pediatric dental coverage for the open enrollment period that begins on October 1, 2013 and ends on March 31, 2014. Second, Covered California does not have the legal authority to require families with children to purchase stand alone dental coverage. Third, the products outside Covered California must all include coverage for all ten Essential Health Benefits (EHBs); accordingly, the provision in your model dental contract that requires the Qualified Health Plans (QHPs) to be sold outside Covered California without including pediatric dental coverage is contrary to law and should be amended to provide that health insurers will be sold outside the Exchange with the addition of pediatric dental coverage.

Embedded Dental Coverage

In an embedded configuration, coverage for the pediatric dental essential health benefit is described in the health insurance policy and offered under the same premium. As you heard from the public testimony at the June 20, 2013 Covered California Board meeting at which this issue was first publicly discussed by Covered California, embedded pediatric dental coverage for health insurance sold through the Exchange is not only consistent with state and federal law, it is also better for consumers because it

is less costly than the alternatives. There are sound economic and public policy reasons for consumers and children's advocates to be strongly fighting for embedded dental coverage to be an option for those whose purchase their health insurance through Covered California.

Based on health insurance filings which included embedded pediatric dental coverage before Covered California inexplicably ordered health insurers to take it out, the portion of the premium associated with embedded coverage is less expensive than for stand-alone dental coverage. In some cases the premium for stand-alone coverage is 400% of what embedded dental would cost. Also, for stand-alone dental (or bundled) coverage there is an additional $1000 out-of-pocket spending maximum for one child and a $2000 out-of-pocket maximum for two or more children.

Coverage of pediatric dental care meets an important health care need. The exclusion of embedded pediatric dental coverage in the Exchange will lead fewer children to have this coverage and fewer children to have access to the dental care they need for their overall health and well-being.

As you know, there were health insurers and health plans that had intended to offer pediatric dental coverage as an embedded benefit before Covered California required that dental coverage be offered separately. After we became aware that Covered California had ordered health insurers to drop embedded coverage, I asked that a solicitation be issued by Covered California to health insurers and health plans to seek bids for health coverage that included pediatric dental as coverage embedded in the health insurance product. To date, that has not occurred and your staff have indicated that no embedded products will be offered through Covered California on October 1st. Carriers selling outside the Exchange are already required to offer coverage for all ten essential health benefits, so it is difficult to believe that Covered California would be unable to offer products that provide embedded pediatric dental coverage by January 1st when the coverage actually goes into effect, if you issued a solicitation now. I renew my request that you solicit bids for January 1, 2014 coverage that covers pediatric dental coverage in the same fashion as all the other Essential Health Benefits – embedded in the health insurance product and as a part of the same premium.

Mandatory Purchase of Stand-Alone Dental Coverage

In your July 16th letter, you indicate that Covered California is considering whether to make the enrollment in pediatric dental coverage mandatory for families with children. Any attempt to do so is simply beyond the authority of Covered California and contrary to law.

The duties and powers of the California Health Benefit Exchange Board are expressly enumerated in statute. None of the Exchange's enumerated powers extend to placing new legal burdens on individuals. While it is the case that you may impose contractual

requirements that don't exceed your authority or otherwise violate state or federal law on the carriers and contractors you select, you do not have the authority to impose mandatory purchase requirements on individuals and families who must either purchase health insurance coverage through Covered California or forgo federal premium subsidies.

On a separate note, the idea that coverage would be mandatory for families with children, but not those without children, is contrary to the intent of the Affordable Care Act. In 2014, health insurance carriers are to offer coverage that includes the Essential Health Benefits, with the cost of services such as maternity care and prostate cancer screening and treatment spread out over the whole risk pool, rather than just to those expected to utilize the particular benefit. Requiring purchase of the pediatric dental essential health benefit by some families, and not others, would lead the dental coverage to be more expensive than it otherwise would be.

It also defies logic to require health insurers that intended to embed pediatric dental coverage to remove that coverage (as Covered California did) and then require families to purchase stand-alone dental coverage at a higher cost than the cost at which embedded coverage could have been available to that same family.

Products sold outside the Exchange must include Pediatric Dental Coverage

As was detailed at length on Pages 2-3 of the Department's July 3, 2013 letter to Covered California, when insurers sell products outside the Exchange in the individual and small group markets, those products are required under state and federal law to include coverage for all ten Essential Health Benefits. The most recent version of your model dental contract (available on your website) continues to call for the QHPs to sell their products that exclude dental coverage outside the Exchange. This contractual provision needs to be amended to clarify that the products will be sold outside the Exchange with the addition of pediatric dental coverage. If that change is not made, the contract provision is contrary to law.

Thank you for your attention to these matters. As was the case with the June 20, 2013 Board meeting, the Department of Insurance will be present at the August 8th Board meeting to participate in the discussion of these issues before any decisions are made. Please feel free to contact me or Janice Rocco, Deputy Commissioner for Health Policy and Reform at (916) 492-3500 to discuss any of these issues.

Sincerely,

DAVE JONES
Insurance Commissioner

STATE OF CALIFORNIA Dave Jones, *Insurance Commissioner*

DEPARTMENT OF INSURANCE
EXECUTIVE OFFICE
300 CAPITOL MALL, SUITE 1700
SACRAMENTO, CA 95814
(916) 492-3500
(916) 445-5280 (FAX)
www.insurance.ca.gov

By electronic transmission and first class mail

August 7, 2013

Diana Dooley, Chairperson
And Board Members of Covered California
Covered California
560 J Street, Suite 290
Sacramento, CA 95814

Re: Pediatric Dental Coverage

Dear Chairperson Dooley and Board Members,

The Department of Insurance (CDI) has reviewed Covered California's "Board Recommendation Brief" regarding Pediatric Dental coverage for your August 8, 2013 Board meeting, which became available on your website last night. As referenced in this "Board Recommendation Brief", I previously wrote to Covered California about pediatric dental coverage issues in letters dated June 27, 2013, July 3, 2013 and July 31, 2013. These letters are in addition to the numerous discussions between CDI staff and Covered California staff, as well as CDI's testimony during your June 20, 2013 Board meeting about working to ensure that consumers who shop through Covered California have the option to purchase health insurance policies that offer pediatric dental coverage in the same manner as the rest of the Essential Health Benefits – embedded in the same health policy, as part of the same premium and without an additional out-of-pocket maximum.

There are three significant objections which we have to Covered California's actions to date.

First, we object to Covered California ordering health insurers and plans not to embed pediatric dental coverage. Your Board should direct staff to immediately solicit health insurers and plans that are willing to embed pediatric dental coverage to revise their health policies to embed pediatric dental coverage. Embedded pediatric dental coverage should be an option for consumers shopping for coverage through Covered California in 2014. CDI staff learned during your August 6, 2013 Covered California Plan Management Advisory Group Webinar/Meeting that two carriers just communicated to Covered California that they can provide pediatric dental coverage as an embedded benefit "now", rather than waiting until 2015 to do so. I reiterate my request that health insurance products with embedded dental coverage be made

available to consumers in the Covered California product offerings for coverage that begins January 1, 2014.

Second, we object to the staff proposal that presents for consideration whether your Board should require families with children to purchase stand alone pediatric dental coverage. Covered California simply does not have the legal authority to require families with children to purchase stand alone dental coverage. Moreover, requiring families to do so is bad for consumers -- such an order will result in families paying more than would be the case were pediatric dental coverage embedded. Should your Board take action requiring families to purchase stand alone dental, as the Department charged with upholding state consumer protection laws related to insurance, we will be forced to consider legal action.

Third, despite the fact that my Department has repeatedly objected to the illegal provision in the Qualified Health Plan (QHP) contract requiring insurers and plans participating in the Exchange to sell their 9.5 plans (plans that omit coverage of the pediatric dental essential health benefit) outside the Exchange, those contracts were executed without alteration.

Embedded Dental Coverage

In an embedded configuration, coverage for the pediatric dental essential health benefit is described in the health insurance policy and offered under the same premium. As you heard from the public testimony at the June 20, 2013 Covered California Board meeting at which this issue was first publicly discussed by Covered California, embedded pediatric dental coverage for health insurance sold through the Exchange is not only consistent with state and federal law, it is also better for consumers because it is less costly than the alternatives. There are sound economic and public policy reasons for consumers and children's advocates to be strongly fighting for embedded dental coverage to be an option for those whose purchase their health insurance through Covered California.

Based on health insurance filings which included embedded pediatric dental coverage before Covered California incorrectly ordered health insurers to take it out, the portion of the premium associated with embedded coverage is less expensive than for stand-alone dental coverage. In some cases the premium for stand-alone coverage is 400% of what embedded dental would cost. Also, for stand-alone dental (or bundled) coverage there is an additional $1000 out-of-pocket spending maximum for one child and a $2000 out-of-pocket maximum for two or more children.

Coverage of pediatric dental care meets an important health care need. The exclusion of embedded pediatric dental coverage in the Exchange will lead fewer children to have this coverage and fewer children to have access to the dental care they need for their overall health and well-being.

There were health insurers and health plans that had intended to offer pediatric dental coverage as an embedded benefit in 2014 policies before Covered California required that dental coverage be offered separately. After we became aware that Covered California had ordered health insurers to drop embedded coverage, I asked that a

solicitation be issued by Covered California to health insurers and health plans to seek bids for health coverage that included pediatric dental as coverage embedded in the health insurance product. To date, that has not occurred and your staff have indicated that no embedded products will be offered through Covered California when open enrollment begins on October 1st, despite the fact that two carriers have indicated that they can provide embedded coverage now and that CalHEERS can accommodate both embedded and stand-alone in 2014 (just not bundled). Carriers selling outside the Exchange are already required to offer coverage for all ten essential health benefits. I renew my request that Covered California make available to consumers for January 1, 2014, health insurance products that cover pediatric dental coverage in the same fashion as all the other Essential Health Benefits – embedded in the health insurance product and as a part of the same premium in policies for which coverage begins.

Mandatory Purchase of Stand-Alone Dental Coverage

In the Board Recommendation Brief, staff indicate that Covered California is considering whether to make enrollment in pediatric dental coverage mandatory for families with children. As I explained in my July 31st, letter any attempt to do so is simply beyond the authority of Covered California and contrary to law.

The duties and powers of the California Health Benefit Exchange Board are expressly enumerated in statute. None of the Exchange's enumerated powers extend to placing new legal burdens on individuals or families. While it is the case that you may impose contractual requirements that don't exceed your authority or otherwise violate state or federal law on the carriers and contractors you select, you do not have the authority to impose mandatory purchase requirements on individuals and families who must either purchase health insurance coverage through Covered California or forgo federal premium subsidies. Covered California's authority to determine eligibility does not extend to imposing a new mandate on individuals and families. Nor may Covered California "boot strap" a new mandate to purchase stand alone dental on consumers through its eligibility determination. Determining eligibility is different than requiring consumers to purchase stand-alone dental coverage.

An additional reason why Covered California should not mandate that families purchase stand alone dental coverage is making coverage mandatory for families with children, but not those without children, is contrary to the intent of the Affordable Care Act. In 2014, health insurance carriers are to offer coverage that includes the Essential Health Benefits, with the cost of services such as maternity care and prostate cancer screening and treatment spread out over the whole risk pool, rather than just to those expected to utilize the particular benefit. Requiring purchase of the pediatric dental essential health benefit by some families, and not others, would lead the dental coverage to be more expensive than it otherwise would be.

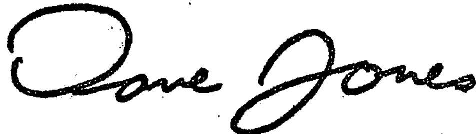
It also defies logic to require health insurers that intended to embed pediatric dental coverage to remove that coverage (as Covered California did) and subsequently require families to purchase stand-alone dental coverage at a higher cost than the cost at which embedded coverage could have been available to that same family.

Illegal QHP Contract Provision

Despite the fact that the Department has repeatedly objected to the provision of the QHP model contract, which requires QHPs that sell products outside the Exchange to "sell all products made available to individuals and small employers in the Exchange to individuals and small businesses purchasing coverage outside the Exchange," this provision was never changed. Both state regulators have promulgated regulations prohibiting the sale of 9.5 plans outside the Exchange. The Exchange has now executed a contract containing an illegal provision which is void and unenforceable because it contradicts state law.

Thank you for your attention to these objections. As was the case with the June 20, 2013 Board meeting, the Department of Insurance will be present at the August 8th Board meeting to participate in the discussion of these issues before any decisions are made. Please feel free to contact me or Janice Rocco, Deputy Commissioner for Health Policy and Reform at (916) 492-3500 to discuss any of these issues.

Sincerely,



DAVE JONES
Insurance Commissioner

July 19, 2013

Peter Lee, Executive Director
California Health Benefit Exchange/Covered California
560 J Street, Suite 290
Sacramento, CA 95814
info@hbex.ca.gov

RE: The Offering of Pediatric Oral Benefit Plans in Covered California

Dear Mr. Lee:

On behalf of Delta Dental, I am writing to address the status of pediatric dental coverage offered through Covered California. The heightened attention that the pediatric dental benefit has received over the last few weeks has not gone unnoticed, and we want to similarly engage in the policy discussion in advance of the special Board meeting that is scheduled for August 8th.

My purpose in this letter is to emphasize the distinct advantages of stand-alone dental plans under the current pediatric coverage approach, and to encourage Covered California to stay the course for the availability of the pediatric dental benefit in 2014, primarily for the following reasons:

- Our internal actuarial analysis is available to show how the embedding of the pediatric dental benefit has serious disadvantages that much of the policy discussion ignores – a combined out-of-pocket maximum and unallocated high deductible levels — that do not favor the consumer whose children require dental services. Quite simply, the appearance of a lower premium attached to an embedded pediatric dental product is likely the result of a lesser true dental benefit due to higher cost-sharing attributable to the dental benefit within the medical plan.
- The introduction of newly minted embedded plan offerings at this stage of the game will undercut all of the previous work, product development and filing review of stand-alone dental plan offerings to date. Those products could be left at a serious competitive disadvantage as a result, unless they can be restructured to react to any new policy directions, which is not likely in the short amount of time left before open enrollment. What is more likely is the withdrawal of approved plan designs that are rendered infeasible by the different approach that the Exchange is being asked to consider.
- The standard plan approach that Covered California decided to take in the offering of all essential health benefits, including pediatric dental, will be diminished with the additional offering of embedded plans. The dramatic differences in the cost-sharing and actuarial value rules that apply to embedded products versus separate stand-alone pediatric oral products will

make comparison shopping much more confusing for consumers, something that the California Exchange recognized early in its evolution, and which is one of the primary reasons for the standard plan approach, so consumers do not have to comprehend difficult health insurance concepts like coinsurance, deductibles, copays and AV. This can be overcome with sophisticated decision tools in the web technology, but our understanding is these features are not likely to be ready in 2014, and will need more time to develop.

- As noted during the Board meeting of June 20th, Covered California has the capacity to encourage the purchase of pediatric dental coverage for children. While we support the policy position of requiring the purchase of pediatric dental, we support it only for the under-19 child population who can actually use the benefit, as opposed to mandatory purchase for all consumers.
- Finally, we understand the recent decision to bar the inclusion of bundled products in Covered California due to technical issues with CalHEERS, but we are strongly in support of this product approach, and look forward to the bundled option being returned to the product mix as soon as it is possible.

We would welcome any opportunity to meet or speak with you and/or any appropriate staff to discuss these matters. Please know that we stand ready to help when it comes to implementing the dental benefit provisions of the health care reform law.

If you have any questions, please do not hesitate to call me at (415) 972-8418.

Sincerely,

Jeff Album
Vice President
Public & Government Affairs

cc: Ken Wood
Andrea Rosen
Michael Lujan

Understanding Why Embedded Dental is Not Always a Better Choice for Consumers

Covered California has been urged to allow pediatric dental benefits to be embedded within a single QHP policy because such policies allegedly offer several advantages to the consumer. While embedded dental could be a reasonable option under certain circumstances, those advancing this option fail to consider all the aspects of "affordability" that are in play when comparing stand-alone and bundled pediatric dental with embedded benefits.

A recent brief circulated by consumer groups argues three points, summarized below:

1) Advocates claim that offering only stand-alone pediatric dental benefits has serious implications for the affordability of the pediatric dental EHB.

2) Advocates claim that important consumer protections that govern QHPs do not apply to stand-alone pediatric dental plans, but do apply to embedded plans, and

3) Advocates claim that the differences in affordability and consumer protections between Exchange products and those offered outside the Exchange violate one of the fundamental policy premises of California law: that the rules for products inside and outside the Exchange should be the same.

Upon closer inspection, however, each of these assertions falls short.

THREE MYTHS ABOUT EMBEDDED PEDIATRIC DENTAL BENEFITS

MYTH 1: "Offering only stand-alone pediatric dental benefits has serious implications for the affordability of the pediatric dental EHB**:**

REALITY: The Advocates' Analysis of "AffordabilIty" is Based Only on Premiums and Subsidies, and not Patient Costs

In fact, embedded pediatric dental benefits have far greater serious implications for the affordability of pediatric dental benefits than stand-alone and/or bundled stand-alone pediatric dental benefits. Any analysis of what is affordable needs to go beyond just the per member, per month premium charged, or total eligible tax subsidy calculated, and should include the far more basic and important question: How much will the average pediatric aged patient have to pay for his or her own care in out-of-pocket expense when enrolled in such programs?

Stand-alone dental HMO plans, with a 70 percent Actuarial Value, will cost on average from $10 to $12 per child per month. Under an embedded arrangement the cost could be perhaps half that amount, achieving ***annual premium savings of around $60 to $72 per child per year***. But these modest savings do not tell the story about affordability when pediatric dental benefits are embedded in a single combined medical-dental policy.

The reason premiums are reduced in an embedded program is that under terms dictated by the Affordable Care Act, a significantly higher deductible and out-of-pocket maximum can be applied, which together work to greatly ***decrease*** actual coverage for most children, when compared with the coverage that occurs in standalone or bundled stand-alone dental plans.

Under an embedded arrangement, for instance, a child could face a $2,000 deductible (versus $50 to $60 for stand-alone dental) and a $6,350 out-of-pocket maximum (versus $1,000 for stand-alone dental), depending on the metal tier of benefits chosen by the family. This means under an embedded arrangement, a child could face up to $2,000 in dental costs that the parents must pay themselves before a single dollar of coverage is provided by the insurance carrier; a child with unusually high dental claims (e.g. a child with medically necessary orthodontia needs) could in fact face up to $6,350 in out-of-pocket costs in a single year.

The Out-of-Pocket Costs Exceed the Savings
One of Covered California's goals is to increase the percentage of children who receive preventive dental coverage. Yet under an embedded medical/dental program, routine visits to the dentist would be subject to the full combined deductible (up to $2,000), and therefore must be paid out of pocket. The out-of-pocket cost for just two routine annual visits (with cleaning, fluoride and examinations) ***would already exceed in additional cost the $60 to $72 in annual premium savings*** that the embedded plan provides. Worse, having to face such prohibitive costs could discourage lower-income parents from bringing their children to the dentist in the first place.

Bundled Stand-Alone Pediatric Dental Plans Are Like Embedded Plans Without Higher Patient Costs
Ironically, the chief advantages of embedded medical/dental plans – one-stop shopping and uniform billing to ease the consumer experience – is available from a bundled medical-dental option, but without any decrease in coverage because the separate lower deductible and out-of-pocket maximum still applies to the bundled arrangement.

Issues of Tax Credits and Ensuring the Purchase Dental Can be Addressed With or Without Allowing Embedded Dental
The concern that too many parents may choose to opt out of purchasing pediatric dental benefits in Covered California is completely unrelated to the question of whether pediatric dental benefits should be offered separate, bundled, embedded or all three. While the federal government has decided that in Federally Facilitated Market states they will not mandate purchase, Covered California could choose to require parents with children younger than 19 years of age to purchase pediatric dental in any form offered. The plan to include "bundled" stand-alone dental offerings in the Exchange would have made available in fact a plan design that binds medical and dental policies together in the exact same manner as when dental is embedded in a Qualified Health Plan, but without the downside of a larger deductible and out-of-pocket maximum that a child must meet in an embedded dental plan before actual coverage kicks in.

On the premium tax credits, the stand-alone dental industry is in full agreement that the method of calculating Advance Premium Tax Credits should be changed so that the calculation can be based on the combined premiums of medical and dental *when offered either as embedded or as stand-alone*. Both the National Association of Dental Plans and the Delta Dental Plans Association have joined with oral health advocacy groups and the American Dental Association to lobby HHS and IRS aggressively for this precise change in the rules. We are glad to report that the early response to this proposal has been positive, and that it is under active consideration by the IRS. A Senate sign-on letter urging the IRS to adopt this change is anticipated. We note, however, that even under today's rules – with no change in the APTC calculation – the small gain in tax credits and lower premiums resulting from an embedded dental benefit option still would not offset the losses in total out-of-pocket patient costs for most pediatric-aged Covered California enrollees.

MYTH 2: Important consumer protections that govern QHPs do not apply to stand-alone pediatric dental plans, but do apply to embedded plans.

REALITY: Stand-Alone Plans Already Provide all of the Important Consumer Protections
The concerns regarding the outlined key consumer protections required of embedded dental plans is irrelevant, because stand-alone plans already, and have always, applied the majority of these protections to their programs since the very inception of dental benefits in 1955, and will continue to do so as offered within Covered California. The only two protections not applied voluntarily by specialized plans themselves – rate review and medical loss ratio requirements – are either inappropriate or unnecessary for stand-alone pediatric oral benefits for the following reasons:

1. Rate review is unnecessary for pediatric dental because Covered California as a selective contractor is already reviewing rates as a condition for allowing any stand-alone issuer to participate. The Exchange is driving down these rates still further by suggesting to plans when they are high or low relative to the competition, allowing them to revise rates accordingly. The Exchange then subsequently locks in these

rates when the issuer signs its contract with the Exchange. In future years, should issuers propose rates that rise to an unreasonable level, the Exchange can and will simply choose not to renew those contracts. When pediatric dental benefits are embedded in a QHP, the cost of those benefits are not in fact subject to rate review at all because the QHP is only required to submit its single combined premium for rate review, not its dental rate specifically. The QHP in effect can hide the claims cost for pediatric dental, which makes it unavailable for comparative purposes when consumers shop alternative offers.

2. As with 1 above, medical-loss ratios are also not applied to embedded pediatric dental because once again, the MLR requirement follows the total QHP, of which the embedded pediatric dental benefit is a very small and relatively inconsequential part. A QHP could in fact offer an embedded pediatric dental plan with a 50 percent MLR, and still meet its 80 percent MLR requirement for the overall combined medical-dental offering.

MYTH 3: The differences in affordability and consumer protections between Exchange products and those offered outside the Exchange violate one of the fundamental policy premises of California law: that the rules for products inside and outside the Exchange should be the same.

REALITY: We Agree the Playing Field Should Be Even Inside and Outside the Exchange
The stand-alone dental industry is equally concerned about the lack of equitable markets both inside and outside state exchanges. The Center for Consumer Information and Insurance Oversight (CCIIO) attempted to bridge this gulf in guidance with the concept of "reasonable assurance," which seeks to allow stand-alone issuers to participate outside as well as inside exchanges in the provision of essential pediatric dental benefits. California regulators, however, are informing dental issuers that while they will accept bundled stand-alone medical and dental offers of EHB outside the exchange, they will not allow health plans to waive pediatric oral services from their policies outside the Exchange, even if "reasonably assured" these benefits are being offered by an Exchange-certified stand-alone dental plan.

This hurdle to equitable markets notwithstanding, differences between who must purchase pediatric dental benefits in versus outside Covered California is unrelated to the question of whether or not Covered California should allow embedded dental inside the Exchange. Bundled medical-dental plans, which will be allowed outside the Exchange, offer the same advantages and a better value proposition to consumers, while ensuring the offer of all 10 EHBs purchased together at the same time. And even without bundled plans being available in 2014, the Exchange board still has the flexibility to require all children to select *BOTH* a separate medical and dental policy inside the Exchange, thereby assuring all 10 EHBS are purchased.

As for spreading the cost of pediatric dental to childless adults, versus assigning that cost only to parents with children, such a proposal has tremendous unintended consequences that would lead to unfair competitive conditions for dental issuers, force adults without children to pay for benefits they cannot use, and other unintended consequences. The oft repeated refrain "pediatric dental should be just like maternity benefits," fails to acknowledge that dental benefits have always been sold under completely separate policies, are viewed very differently by consumers, and are supported by totally separate claims and service center platforms, as well as providers with no connection to physician or hospital networks.

Pediatric dental benefits have special status under the ACA in recognition that the existing dental benefits marketplace is comprised primarily of separate, stand-alone policies, administered by specialized health plans with the widest and most efficiently managed dentist networks, and with specific expertise in the area of dental claims and utilization management, customer service and quality assurance protections for consumers.

CONCLUSION
Stand-alone pediatric dental plans *increase* the value of dental coverage to most children, as measured in the average out-of-pocket cost that most children will incur as a result of their anticipated dental care needs. While the option to provide embedded dental benefits under a single policy is worth exploring, there are significant issues concerning actual

consumer costs and transparency that should first be explored by the Covered California Board before proceeding down such a path.

Making Sense of Health Insurance Oversight in California

KELCH POLICY GROUP
kelchpolicy.com

July 12, 2013

To: Policymakers and interested stakeholders
From: Deborah Kelch, Health Insurance Alignment Project
Subject: Pediatric Dental Essential Health Benefits FAQ

Attached please find for your review and background Frequently Asked Questions relating to pediatric dental essential health benefits in California. The Health Insurance Alignment Project (Alignment Project) developed this background to inform and support the current policy discussions the state is having relating to how best to offer this benefit in the context of the federal Affordable Care Act and state law.

The Alignment Project is funded by a grant from the California Healthcare Foundation to conduct independent research and technical assistance aimed at advancing effective state implementation of the federal Affordable Care Act (ACA) health insurance market reforms, with a focus on supporting consistency and uniformity in consumer protection and public accountability across state agencies responsible for market oversight.

The attached FAQs include detailed questions relating to the applicable federal laws and policies (Questions 1-13) and California law and policy (Questions 14-17). Question 18 lays out for consideration some of the key issues and questions for policymakers as they deliberate on this issue given the framework of state and federal law and policy.

We hope you find it useful and informative.

Frequently Asked Questions (FAQs)

Pediatric Dental Coverage in California Under the ACA

Under the federal Affordable Care Act (ACA), pediatric oral care is an essential health benefit,[1] one of ten essential health benefits which, starting in 2014, must be included by health insurance issuers selling non-grandfathered individual and small group coverage.[2] Inclusion of pediatric EHB dental coverage, mandated as an essential component of the broader package of core essential health benefits, represents a change to the existing market for dental insurance coverage where dental coverage is typically sold and purchased as a separate product, distinct and apart from medical coverage.[3]

This series of Frequently Asked Questions (FAQs) outlines key provisions of federal and state law and policy (as they are known as of this writing) that affect coverage for pediatric dental services in California in two sections, highlighting federal law and policy, and then following with relevant California law and policy applicable to the California Health Benefit Exchange ((California Exchange), branded as Covered California).

Federal Law and Policy

1. Is pediatric dental coverage required to be covered as an essential health benefit?

Yes. Under the ACA, pediatric oral care (along with pediatric vision care) is one of ten essential health benefits that are minimum requirements for non-grandfathered coverage sold in the individual and small group markets.[4] The ACA requires the Secretary of the Department of Health and Human Services (DHHS) to define the scope of the essential health benefits and ensure that the benefits are equal to the benefits provided under a "typical employer plan." The ACA also requires the Secretary to ensure that if a stand-alone dental plan is offered in an Exchange, qualified health plans (QHPs)[5] without pediatric dental coverage will still be allowed.[6]

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[1] ACA essential health benefits include at least the following ten general categories: Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

[2] "Grandfathered" coverage refers to individual and small group coverage in effect as of March 23, 2010, which continues to meet specific federal requirements, including limited benefit and coverage changes. Grandfathered plans are exempt from some of the ACA requirements that generally apply in the individual and small group markets, including the essential health benefits requirement.

[3] National Association of Dental Plans (NADP) and Delta Dental Association. *Offering Dental Benefits in Health Exchanges: A Roadmap for Federal and State Policymakers*. September 2011. Available online at: http://www.nadp.org/advocacy/HealthCareReform/ExchangeWhitePaper.aspx

[4] 42 United States Code (USC) §18022(b).

[5] Under the federal ACA, a QHP is a health coverage product or plan certified by an exchange to provide coverage for individuals or small employers who choose to buy coverage in the exchange. In federal law, the health insurance company or entity that offers the QHP is referred to as the QHP *issuer*. In this FAQ, use of the term QHP refers specifically to coverage of the full scope of essential health benefits, even though dental plans in the Exchange will also be certified as QHPs.

[6] 42 USC §18022(b).

Pursuant to federal guidance,[7] and subsequent federal rules,[8] states can choose from among ten designated "benchmark" or reference plan options to define essential health benefits, including policies sold in the state to small and large employers and coverage provided to federal and state employees in that state.

If the benchmark the state chooses does not include coverage for pediatric oral care, states must "supplement" or add a pediatric oral benefit based on either the pediatric dental benefits available to federal employees or dental benefits available to children enrolled in a state's separate Children's Health Insurance Plan (CHIP).[9]

2. What is meant by the term "9.5 plan"?

The term has emerged as shorthand for coverage that includes all ten essential health benefits except for pediatric dental coverage.

3. What provisions of the ACA apply to pediatric dental coverage?

Applicability of ACA provisions to dental coverage depends on whether the coverage is offered as an integral part of a health insurance plan or policy covering medical care (health plan) or as a separate or "stand-alone" dental plan.

When provided under a separate policy, certificate, or contract of insurance, or when they are otherwise not an integral part of a health plan, in federal law limited dental benefits are considered "excepted benefits"[10] and thus are not subject to many of the ACA insurance market reforms, such as guaranteed availability (guaranteed issue), guaranteed renewability of coverage, the prohibition on pre-existing condition exclusions and ACA rating rules.[11]

In a health plan that integrates health and dental coverage into one policy, the health plan is subject to the insurance market reforms of the ACA based on the market for the policy (i.e., individual, small group, large group, etc.).

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[7] Centers for Consumer Information and Insurance Oversight (CCIIO). *Essential Health Benefits Bulletin.* December 16, 2011.

[8] 45 Code of Federal Regulations (CFR) §155.100.

[9] 45 CFR §156.110(b)(2).

[10] 45 CFR §146.145(c)(3)(i).

[11] Centers for Medicare and Medicaid Services (CMS). *Affordable Exchanges Guidance: Letter to Issuers on Federally-facilitated and State Partnership Exchanges*. April 5, 2013. See also: CMS. *Qualified Health Plan Webinar Series FAQ #10: Selected Responses*. May 9, 2013.

4. What federal requirements apply to the offering of pediatric dental coverage in state-administered Exchanges? [12]

Exchanges must do all of the following relating to pediatric dental coverage in the Exchange:

- Allow QHP issuers[13] in the Exchange to offer a health plan that does not cover pediatric dental as an essential health benefit.[14]
- Allow an issuer of stand-alone dental to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the dental plan provides pediatric dental benefits that comply with the pediatric essential health benefits dental requirement (pediatric EHB dental)[15] and the dental plan: (a) Includes and imposes no annual or lifetime limits on pediatric EHB dental; (b) Meets the Exchange certification standards except for those QHP standards that cannot be met by dental plans; and (c) Otherwise complies with applicable federal laws relating to excepted dental benefits.[16]
- Consider the collective capacity of stand-alone dental plans to ensure sufficient access to pediatric EHB dental coverage.[17]
- Collect and display premium rate information for QHPs and dental plans offered in the Exchange, in a standardized and comparable way, and provide specified information including, for example, premium rates and cost sharing, actuarial values, summary of benefits and specified information on quality and consumer satisfaction.[18]

Exchanges may:

- Allow stand-alone dental plans to be offered separately or in conjunction with a QHP;[19]
- *If* an Exchange determines that it is in the [best] interest of consumers, as a condition of certification, Exchanges can require QHPs to offer and price the pediatric EHB dental separately. However, absent the best interest determination by the Exchange, federal law does not allow an Exchange to require QHPs to separately price and offer the pediatric EHB dental. [20]

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[12] State-administered Exchanges, federally-facilitated Exchanges and state partnership Exchanges are generally required to comply with the same federal rules and standards regarding the selection, certification and offering of QHPs and stand-alone dental plans. This FAQ focuses on California which has established a state-administered Exchange.

[13] QHP issuers in the California Exchange must be either health insurers subject to the jurisdiction of the California Department of Insurance (CDI) or health care service plans licensed by the Department of Managed Health Care (DMHC).

[14] 45 CFR §155.1065(d).

[15] 42 USC §18031(d)(2)(B)(i).

[16] 45 CFR §155.1065(a).

[17] 45 CFR §155.1065(c).

[18] 45 CFR §155.205(b).

[19] 45 CFR §155.1065(b). In the Preamble to the Exchange final rule, (Federal Register, Volume 77, No. 59, March 27, 2012, p. 18411) CMS states that this means independent of a QHP or as a subcontractor to a QHP issuer, and limit stand-alone dental products to only one of these options.

[20] 45 CFR §155.1000(c) codifies the standard where the exchange must determine that offering any QHP is in the interests of individuals and small employers [in the Exchange]. In the Preamble to the Exchange final rule (Federal Register, Volume 77, No. 59, March 27, 2012, p. 18411), CMS states that if an Exchange determines that having QHPs separately offer and

5. In addition to offering the pediatric EHB dental through a stand-alone plan independent of any QHP what options are there for Exchanges to offer the pediatric EHB dental "in conjunction with" QHP coverage?

Subsequent to the final Exchange rules issued in 2012, the Centers for Medicare and Medicaid Services (CMS) identified two options for Exchanges to offer pediatric EHB dental coverage in conjunction with a QHP—either embedded or bundled with a QHP.

According to CMS, the pediatric EHB dental benefit is *embedded* in a QHP when it is offered in the same way as all of the other benefits in the plan, financed by a single aggregated premium, and used by the issuer to calculate the actuarial value (metal tier) of the QHP coverage. [21] Therefore, even if the QHP issuer contracts with a dental issuer for the benefit, the QHP issuer assumes the risks and liabilities for all of the coverage, including the dental benefit, and presents consumers with one evidence of coverage (coverage contract or policy) for all ten essential health benefits. This is similar to instances where an issuer subcontracts with specialized health plans for administration of mental health or prescription drug benefits but retains the ultimate risk and legal responsibility for the covered services. For purposes of the annual out-of-pocket maximum, in an embedded offering there would be just one annual maximum applicable to all ten essential health benefits, including the pediatric EHB dental.

CMS describes a *bundled* pediatric EHB dental as one where the QHP issuer pairs with a separate stand-alone dental plan to offer pediatric EHB dental coverage. In a bundled arrangement, the QHP issuer would assume the risk for all essential health benefits except for the pediatric EHB dental (9.5 plan) and the stand-alone dental plan would separately assume the risks and liabilities for the pediatric EHB dental (.5 plan). Each offering would be considered a separate plan and the bundled dental plan would be considered an excepted benefit, a stand-alone. Each of the two plans would be held to the applicable standards for the type of plan, QHP or stand-alone dental, including on issues such as out-of-pocket maximums and actuarial value requirements which are discussed in more detail below.[22] This means, for example, that as a stand-alone plan the bundled dental plan could have a separate out-of-pocket maximum for the pediatric dental EHB.

6. So there are three options for Exchanges to offer the pediatric EHB dental?

Yes. The pediatric EHB dental can be offered by Exchanges through some combination of the following structures:

- Embedded in a QHP that covers all ten EHBs however the dental benefit is provided, including a subcontract with a dental issuer (issuer option);
- In a stand-alone dental plan bundled with a QHP (issuer option); or
- In a stand-alone dental plan entirely separate and independent of any QHP.

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price pediatric dental coverage is in the interest of the consumer the Exchange may do so, but federal rules do not require (or otherwise allow Exchanges to require) that QHPs separately price and offer pediatric EHB dental coverage. The CMS April 5 guidance repeated the same standard for Exchanges related to the pediatric EHB dental with the addition of ***best*** interests of consumers [Emphasis added].

[21] CMS. *Qualified Health Plan Webinar Series FAQ #10: Selected Responses*. May 9, 2013.

[22] Ibid.

7. What federal requirements apply to stand-alone dental plans when offered in Exchanges?

Stand-alone dental plans seeking to participate in Exchanges must meet the QHP certification standards for participation in an Exchange, unless the certification requirement cannot be met because the plan only covers dental benefits.[23] In addition, stand-alone dental plans in Exchanges are subject to the following federal rules:

- Prohibition on annual and lifetime limits. As an essential health benefit, pediatric EHB dental coverage must be offered without annual or lifetime limits.[24]
- Different out-of-pocket limits. Out-of-pocket limits differ if the pediatric EHB dental is embedded or stand-alone (including a bundled stand-alone dental plan). In a QHP with the pediatric EHB dental included (embedded), the ACA limits an individual Exchange enrollee's annual share of costs (copayments, deductibles and coinsurance, etc.) to the federal out-of-pocket limit for Health Savings Accounts, or $6,350 for 2014.[25] For a stand-alone dental plan covering the pediatric EHB dental, federal rules allow for a separate "reasonable" annual limit on cost sharing (above what applies in the QHP the individual selects) applicable to in-network dental services, as reasonable is defined by the Exchange.[26]
- No cost-sharing reductions. Pediatric EHB dental benefits provided through a stand-alone dental plan are not subject to the cost-sharing reductions—which reduce consumer copayments, deductibles and coinsurance—that are otherwise available for eligible individuals in a QHP.[27] The cost-sharing reductions would be applied to the pediatric EHB dental if "embedded" in a QHP covering all ten essential health benefits.
- Dental-only actuarial value requirements. Exchange QHPs must characterize the coverage they offer based on four categories of actuarial value,[28] sometimes referred to as metal levels or coverage tiers, as follows: bronze (60% actuarial value), silver (70%), gold (80%) and platinum (90%); QHP issuers may also offer a catastrophic plan which allows for specific benefit limitations and is available only to adults under 30 and individuals with affordability exemptions from the federal individual coverage requirement. Stand-alone dental plans must offer coverage for pediatric dental EHB at 70% or 85% actuarial value.[29]
- Premium tax credit portion allocated to dental. Advanced payments of the federal premium tax credits for individuals and families must first apply to QHP premiums. Tax credits can only apply to stand-alone pediatric EHB dental if, after the amount of the tax credit which an individual or family is eligible for is first applied to the QHP coverage they choose, there remains a credit to apply to the stand-alone dental coverage.[30]

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[23] 45 CFR §155.1065(d).
[24] 45 CFR §155.1065(2)(a) referencing 45 CFR §147.126.
[25] 45 CFR §147.126.
[26] 45 CFR §156.150(a).
[27] 45 CFR §156.440(b).
[28] Actuarial value is a measure of the percentage of expected health care costs a specific policy or plan will cover, with the remainder to be covered by the enrollee.
[29] 45 CFR §156.150(b) California law imposes additional requirements on the coverage tier offerings of issuers in the Exchange and outside of the Exchange which are outlined below in the section on California law.
[30] 45 CFR §156.340(e).

Federal rules establish a formula for determining the portion of the advance payment of the premium tax credit that would be allocated to the pediatric EHB dental benefit in stand-alone plans for federally facilitated Exchanges.[31] State Exchanges may adopt the federal methodology for allocating the premium tax credits to stand-alone dental policies or "a reasonable and consistent" methodology determined by the Exchange***.***[32]

Note: *There are significant implications for the application of the premium tax credits for eligible low income families in the California Exchange, depending on state policy choices made regarding pediatric EHB dental coverage. These impacts are important considerations beyond the scope of this FAQ which should be considered by policymakers and may be the subject of a future Alignment Project FAQ.*

8. What federal requirements apply to the offering of pediatric EHB dental coverage and stand-alone dental plans outside Exchanges?

The ACA does not allow for the exclusion of the pediatric EHB dental from coverage outside of the Exchange and issuers must offer the full ten benefits in non-grandfathered, non-Exchange coverage plans.[33] Outside of an Exchange, issuers must offer and sell individuals and families coverage of all ten essential health benefits.

Federal rules allow, however, at the issuer's option, in cases where an individual has purchased stand-alone dental coverage that is Exchange-certified and the issuer is "reasonably assured" that the individual has such coverage, the issuer to meet the EHB requirement by offering coverage that combines a health plan (9.5 plan) with the pediatric EHB dental coverage (.5 plan) the individual already has purchased.[34] In this case, the stand-alone pediatric EHB dental benefit need not be purchased in the Exchange but must be certified by the Exchange to ensure that it covers the pediatric EHB.

Although this question summarizes the relevant federal law, California law prohibits offering any coverage outside of the Exchange with less than all ten EHBs (see Question 15). According to Department of Managed Health Care (DMHC), the CMS Center for Consumer Information and Insurance Oversight (CCIIO) has indicated that federal law does not prohibit states from requiring issuers outside of the Exchange to offer all ten essential health benefits without the reasonable assurance option described above.[35]

As discussed above, stand-alone dental plans offered outside of the Exchange are excepted benefits under

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[31] 45 CFR §155.340(f).

[32] 45 CFR §155.340(e)(2). For further discussion and examples of how the tax credits might be applied see the Preamble to the final rule on Benefit and Payment Parameters (Federal Register, Vo. 78, No.47, March 11, 2013, pp. 15475-15477).

[33] Preamble to the Essential Health Benefits final rule (Federal Register, Volume 78, No. 37, February 25, 2013, p. 12853).

[34] Ibid. Note that the discussion in the Preamble of the Essential Health Benefits final rule has not been reduced to regulation and state regulators and stakeholders continue to seek clarification on its meaning and interpretation.

[35] Conference call between the DMHC and CCIIO on June 6, 2013, as reported by the DMHC on June 7, 2013 through a background set of FAQs regarding stand-alone dental plans (DMHC FAQs) provided to legislative staff.

federal law (see question #3 for discussion of excepted benefits).

9. **Can states require QHP issuers in the Exchange to offer all ten essential health benefits in the Exchange?**

   Federal law and regulation require Exchanges to allow QHP issuers in the Exchange to offer coverage with or without the pediatric EHB dental,[36] at the issuer's option, as long as consumers have a stand-alone dental option in the Exchange.

10. **Are Exchanges required to mandate that QHPs only offer coverage that excludes pediatric EHB dental so that dental coverage is only available through stand-alone dental plans?**

    No. Issuers may choose to offer QHPs without the pediatric EHB dental in the Exchange; Exchanges must allow QHPs with or without pediatric EHB dental and Exchanges must allow the offering of stand-alone dental plans covering the pediatric EHB dental.[37] In 2012, CMS stated that Exchanges generally cannot limit the offering of the pediatric EHB dental benefit to just one option (only embedded or only as stand-alone).

11. **Are individuals who purchase coverage in the Exchange required by federal law to purchase a stand-alone dental plan if the QHP coverage they purchase does not include the pediatric EHB dental?**

    No. CMS has stated that "in an Exchange, someone (with a child or without) can purchase a QHP that does not cover the pediatric dental EHB without purchasing a stand-alone dental plan."[38] Proposed rules issued in February 2013 by the Department of the Treasury, Internal Revenue Service, do not require coverage that includes all essential health benefits in order to qualify as minimum essential coverage. For example, coverage that typically does not include all EHBs, such as grandfathered health plans, will constitute minimum essential coverage for purposes of the federal coverage requirement.[39] The essential health benefits requirement 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.

12. **Can states require individuals in the Exchange to purchase all ten essential health benefits, either through one embedded QHP product or through the combination of a QHP without dental and a stand-alone dental plan?**

    Yes. There is nothing in federal law that would prohibit a state from requiring that individuals purchase coverage for all ten essential health benefits, including the pediatric EHB dental, in the Exchange.[40]

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[36] 45 CFR §155.1065(d).
[37] Ibid.
[38] Preamble to the Essential Health Benefits final rule (Federal Register, Volume 78, No. 37, February 25, 2013, p. 12853).
[39] 26 CFR Part 1 (Proposed), §1.5000A-0 through §1.5000A-5. IRS proposed rules entitled, *Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage*. (Federal Register, Vo. 78, No. 22, February 1, 2013).
[40] According to the DMHC FAQs, in the June 6, 2013 conference call CCIIO confirmed that states could impose this requirement.

13. What policy choices did CMS make that will apply to stand-alone dental plans offered in federal and partnership Exchanges?

For the 2014 coverage year, CMS will not require QHP issuers providing the pediatric EHB dental in the federal and partnership Exchanges to offer and price that benefit separately from the rest of the QHP coverage.[41] According to CMS, the federal Exchange will not have the capacity in 2014 to display dental benefits as a "separate or severable benefit" so that the pediatric EHB dental will have to be offered either embedded with a QHP or in a stand-alone dental plan.

CMS set the "reasonable" annual limit on cost sharing for the pediatric EHB dental at or below $700 for a plan with one child enrolled and $1,400 for a plan with two or more enrolled children. CMS will display basic, comparable rate information for stand-alone dental plans on the web portal and for eligible individuals and families will calculate the advance payment of the premium tax credit according to the formula for federally-facilitated Exchanges outlined in regulation.[42]

To allow QHP issuers to exercise the federal statutory option to omit pediatric EHB dental from QHPs in Exchanges where stand-alone dental plans will be available, CMS established a voluntary reporting program for dental issuers planning to seek certification of stand-alone dental plans in federal and partnership Exchanges. CMS reported that the results of the voluntary reporting mean that stand-alone dental plans will be available in every state with a federal or partnership Exchange, so QHP issuers will have the option (but not the requirement) to omit coverage for the pediatric EHB dental.

California Law and Policy

14. How does California law address the issue of pediatric dental as an essential health benefit?

California passed state implementing legislation in 2012 that requires all non-grandfathered health plans sold to individuals and small employers, to include coverage for all ten essential health benefits, including pediatric dental coverage.[43] California selected as the benchmark plan (base benchmark) the Kaiser Foundation Health Plan Small Group HMO 30 (Kaiser Benchmark). Since the Kaiser Benchmark does not include pediatric dental coverage California chose to supplement the benchmark with the dental benefit provided to children enrolled in the 2011-12 state Children's Health Insurance Program (CHIP) program, the Healthy Families Program in California, including medically necessary orthodontic care as required in the 2009 federal CHIP reauthorization.

[41] CMS April 5, 2013 letter.
[42] 45 CFR §155.340(f).
[43] 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.)

15. How does California law impact pediatric EHB dental coverage inside and outside of the California Exchange?

California's essential health benefits law applies equally to issuers inside and outside of the California Exchange.[44] Both issuers in the Exchange and outside of the Exchange are required under California law to cover all ten essential health benefits, including pediatric dental. California's Exchange enabling law also requires that all issuers in the Exchange who elect to also sell coverage outside of the Exchange offer and sell all of the QHPs they offer in the Exchange in the outside market as well.[45] Issuers not participating in the Exchange must offer at least one of the standardized benefit plans adopted by the Exchange in each of the coverage tiers, if the California Exchange adopts standardized benefits (which it did).[46]

16. The federal requirement that Exchanges allow QHPs to offer coverage that either includes or excludes the pediatric EHB dental, at the issuer's option, seems to be in conflict with the California law requiring issuers to cover all ten essential health benefits, whether in the exchange or outside the exchange. How can this be resolved?

Federal law does require Exchanges to allow at least some QHPs to exclude pediatric EHB dental coverage. Given the California law requiring issuers in the individual and small employer markets to cover all ten EHBs in new coverage, DMHC sought federal clarification on these issues and determined the following:[47]

- State Exchanges must allow QHP issuers to sell coverage without pediatric EHB dental (9.5 plans) at the issuer's option. States cannot require QHP issuers in the exchange to offer all ten essential health benefits.
- States can require consumers purchasing coverage in an Exchange to buy all ten essential health benefits, as long as the consumer has a stand-alone dental plan choice.
- California's essential health benefits law includes language that "nothing in this section shall be implemented in a manner that conflicts with a requirement of the Patient Protection and Affordable Care Act (PPACA)" and also that the provisions of the state EHB law "shall be implemented only to the extent essential health benefits are required pursuant to PPACA."[48] DMHC interprets these provisions to require that as a regulator DMHC must allow issuers seeking to be in the Exchange to offer a plan without pediatric dental, a 9.5 coverage plan, to comply with federal law.
- Under federal law, issuers outside of an Exchange do have to offer all ten essential health benefits, including pediatric EHB dental coverage; unless the plan obtains an assurance that the individual has pediatric coverage through a stand-alone dental plan.[49] However, states may require issuers outside the Exchange to cover all ten essential health benefits without the reasonable assurance exception.

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[44] CIC §10112.27(f) and HSC §1367.005(f).
[45] CIC §10112.3 (c)(1)(A) and HSC §1366.6(c)(1)(A).
[46] CIC §10112.3(e) and HSC §1366.6(e). This requirement only applies if the Exchange Board adopts standardized benefit plans. California Exchange did adopt standardized benefit plans through regulations (10 CA Code of Regulations (CCR) §6426).
[47] DMHC FAQs, June 7, 2013.
[48] CIC §10112.27(j) and HSC §1367.005(j).
[49] The stand-alone dental plan must obtain an Exchange certification to ensure that it covers the pediatric EHB dental.

CDI and DMHC interpret the combined state and federal law to require issuers in California to offer all ten benefits outside the Exchange without the reasonable assurance exception.

- Issuers participating in the Exchange who also offer coverage outside the Exchange must add pediatric EHB dental coverage to Exchange QHPs when sold in the outside market in order to comply with both the requirement to cover all 10 and the requirement to offer all Exchange QHPs outside of the Exchange.

In 2014, based on decisions made by the California Exchange to date, issuers in the Exchange will administer two separate out-of-pocket maximums (one for medical ($6,350) and one for dental ($1,000)). According to CDI and DMHC, in recent discussions CMS indicated that under federal law issuers outside the Exchange would also be able to administer two separate out-of-pocket maximums but further analysis of relevant state law is pending.

Both CDI[50] and DMHC[51] recently adopted emergency regulations implementing essential health benefits which allow qualified health plans in the California Exchange to offer both 9.5 and 10 benefit plans at their option if specified conditions are met.

17. What policies related to pediatric EHB dental have to date been adopted by the California Exchange?

Based on review of reasonably available California Exchange Board agendas, minutes, plan solicitation documents / communications and Board-adopted regulations, the following California Exchange policies were adopted or discussed regarding pediatric EHB dental coverage:

- Require *[initially]* QHP issuers to submit bids for all ten essential health benefits, including pediatric EHB dental and vision care, and to also submit a separate bid reflecting the exclusion of the pediatric EHB dental. Pediatric vision care will be included as an embedded benefit in QHPs.[52]
- Allow bids from stand-alone plans offering pediatric EHB dental in both the individual and Small Business Health Insurance Options Program (SHOP) exchanges.[53]

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[50] 10 CCR §2594.3. CDI regulations excerpt:
Essential health benefits are defined to include all of the following: (1) Health benefits within the ten categories of essential health benefits enumerated in subdivision (a)(1) of section 10112.27. Provided that a standalone pediatric dental plan is certified to be offered on the Exchange pursuant to section 1302(b)(4)(F) of PPACA (42 USC §18022(b)(4)(F)), a health insurer participating in the Exchange may, but is not required to, omit coverage of the pediatric oral essential health benefit in a health insurance policy sold on the Exchange. A health insurance policy sold on the Exchange shall not omit coverage of the pediatric oral essential health benefit when sold outside of the Exchange pursuant to subdivision (c)(1) of Insurance Code section 10112.3 or otherwise.

[51] 28 CCR §1300.67.005. DMHC regulations excerpt:
If a stand-alone dental plan described in the PPACA at section 1311(d)(2)(B)(ii) (42 USC §18031 (d)(2)(B)(ii)) is offered on the California Health Benefit Exchange (Exchange), then, pursuant to the PPACA section 1302(b)(4)(F) (42 USC § 18022(b)(4)(F)), health plan contracts offered in the Exchange may, but are not required to, omit coverage of pediatric dental care benefits described in Health and Safety Code Section 1367.005(a)(5). A health plan shall not omit coverage of the pediatric dental EHB for health plan contracts sold outside the Exchange.

[52] California Exchange. *Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability: Options and Recommendations.* August 23, 2012. Adopted by the California Exchange Board.

- Adopt emergency regulations establishing QHP standard benefit designs for all ten essential health benefits (including child dental and vision care) but incorporate the federal definition of QHP that allows a QHP to exclude pediatric EHB dental.[54]
- Adopt emergency regulations establishing standard benefit designs for pediatric EHB dental coverage[55] and require the standard dental benefits to be provided whether embedded in a QHP or offered in a stand-alone dental plan in both the individual and SHOP exchanges. Adopt federal actuarial value requirements of 70% and 85% for the pediatric dental EHB. Require guaranteed issue of pediatric EHB dental in the Exchange although not required in federal law.[56]
- Adopt emergency regulations[57] requiring that the California Exchange conduct the QHP solicitation process according to the QHP solicitation incorporated in the regulations, which requires QHP bidders to include pediatric dental, subject to a requirement to separate that may occur and "will be prescribed through the administrative rulemaking process at a later date" depending on future federal guidance and rules.[58]
- Adopt a QHP Model Contract (final May 21, 2013) which requires QHPs to provide essential health benefits consistent with applicable laws, including specific reference to the state essential health benefits requirements in law, but also allow for QHPs that do not cover pediatric EHB dental coverage
- Adopt emergency regulations incorporating the solicitation for stand-alone pediatric dental plans and establishing the bid requirements and selection criteria.[60]

In addition to the regulations and policy decisions described above, the California Exchange has provided the following relevant information and communications regarding pediatric EHB dental:

- Confidential communication to QHP bidders revising the QHP solicitation requirements relating to pediatric EHB dental as follows: (1) Every QHP must bid the pediatric EHB dental benefit as a bundled option through partnering with a stand-alone pediatric dental plan; (2) Embedded pediatric EHB dental is prohibited; (3) QHPs will be required to generate a single invoice for the bundled product; (4) Federal rules require one out-of-pocket maximum for QHPs with embedded dental but allow a separate annual maximum if the benefit is provided through stand-alone dental plans (including bundled); (5)The revised approach [in the letter to bidders] permits separate annual out-of-pocket maximums for medical and dental; and (6) The separate out-of-pocket maximum for stand-alone pediatric EHB dental in the California Exchange will be $1,000 in 2014.[61]

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[53] Ibid. Staff presentations to the Board at the September 2012 and October 2012 meetings relating to the qualified health plan solicitation content and timeline reaffirmed these policies.
[54] 10 CCR §6410.
[55] 10 CCR §6446.
[56] California Exchange. *Solicitation HBEX 15: Vendor Inquiry Responses (v1.0), Question D102.* February 1, 2013.
[57] 10 CCR §6410, §6420, §6422, §6424, §6440, §6442, and §6444. Adopted as emergency regulations 1/17/13 and readopted by the Board 6/25/13.
[58] California Exchange. *2012-13 Initial Qualified Health Plan Solicitation to Health Issuers*. Final December 28, 2012.
[59] California Exchange. *Final Qualified Health Plan Model Contract*. May 21, 2013.
[60] 10 CCR §6446.
[61] California Exchange. *Rules for QHP bidders for Submission of Pediatric Dental Essential Health Benefit Dental Plans in conjunction with Qualified Health Plans which provide all essential health benefits other than the Pediatric Dental EHB*. April

- Supplemental vision and dental plans (other than pediatric EHB dental coverage) will not be offered in 2014 and further analysis is required to determine how such benefits might be offered through the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) in the future.[62]
- California Exchange staff presented the following at the June 20, 2013 Board regarding pediatric EHB dental: (1) Adopted standard dental plan designs allow for separate out-of-pocket maximum for pediatric EHB dental ($1,000); (2) The purchase of pediatric dental for 2014 is voluntary and any stand-alone dental plan can be purchased with any QHP; (3) Every QHP is required to partner with a stand-alone pediatric dental plan using a "bundled" approach; and (5) Selection of pediatric dental plan bidders will be announced June 25, 2013.
- California Exchange announced the selection of six pediatric EHB dental plans offering three different product types (HMO, PPO and EPO plans) with rates ranging from $9 per month to $44 per month, depending on the benefit plan design, the issuer and the geographic rating region.[63] The Exchange notice of the selected children's dental plans stated that the "purchase of the children's dental health insurance plan is not required." All of the announced dental plan offerings are stand-alone dental plans and no embedded offering of all ten essential health benefits was selected.[64]

18. What is the status of the pediatric EHB dental in the California Exchange? What are some of the issues and policy questions for policymakers and the Exchange Board related to the offering of this benefit in the California Exchange?

As of this writing, all of the QHP offerings in the California Exchange exclude pediatric EHB dental (no embedded offerings), the pediatric EHB dental will only be available in stand-alone dental plan offerings, and purchase of the pediatric EHB dental benefit is voluntary for individuals enrolling in the Exchange. The Exchange Board has scheduled a special Board meeting for August 8, 2013 which will include a focus on and discussion of the pediatric EHB dental benefit.

Stakeholders and policymakers have raised questions and concerns on the proposed structure and design of this benefit offering in the Exchange, including, for example, concerns that all children may not end up with the coverage and that getting the coverage may be an affordability challenge for families since the premium in the offered pediatric EHB dental plans is higher than the premium likely would have been for coverage embedded in a QHP purchased by all individuals in the Exchange.

The questions above highlight the complex array of state and federal laws that apply to this policy choice. Any reconsideration or changes made to how the California Exchange offers the pediatric dental EHB need to be made in that context, but it may be helpful to evaluate options and next steps in three categories:

3, 2013. (This communication was obtained in hard copy and was referenced in the June 4, 2013 Assembly Health Committee analysis of AB 18 (Pan) but at the time of this analysis a reasonable search of the California Exchange web site www.healthexchange.ca.gov) did not yield an electronic version posted on the site.)

[62] California Exchange. *Notice to Supplemental Dental and Vision Bidders: Supplemental Benefits*. February 26, 2013. Staff presentation at April 23, 2013 Board meeting.

[63] California Exchange. *Children's Dental Insurance Plan Rates, 2014*. June 25, 2013.

[64] The Health Net dental coverage offering is bundled with Health Net medical coverage but will not be available as a stand-alone dental plan with other QHPs in the Exchange.

- *Structure of Benefit Offering*. As described above, Exchanges have three options for providing coverage for the pediatric EHB dental– embedded with a QHP, or through a stand-alone dental plan bundled with a QHP or a stand-alone independent of any QHP – in some combination that ensures that consumers have a stand-alone dental option. On the structure question, decision makers will necessarily need to consider and assess:

    - The impact on premium and coverage (expected take-up) for pediatric EHB dental with the current structure and the potential impacts of making changes to the offerings, which could include allowing issuers that want to resubmit QHPs with embedded pediatric EHB dental to do so.
    - The advisability and feasibility of conducting a timely re-bidding or revision to the QHP and/or stand-alone dental offerings in the Exchange for 2014, including the operational and CalHEERS impacts affecting the scheduled October 1, 2013 open enrollment date.
    - Whether there would be adequate time for regulatory review and approval by CDI and DMHC of any new/revised product offerings and rates.

- *Purchase of Pediatric EHB Dental*. The current policy of the California Exchange would make purchase of the pediatric EHB dental benefit voluntary. The purchase rules affect the pricing of the benefit offering and the anticipated number of children who are likely to end up with dental coverage. On the purchase question, decision makers will need to consider and assess:

    - Whether the purchase of pediatric EHB dental should be voluntary or mandatory and what state and federal laws and authority need to be considered to implement either choice. If mandatory, who should be required to purchase the benefit, all purchasers in the Exchange, or only families with children under age 19?
    - Affordability of the dental EHB coverage depending on how it is offered and who is required to purchase it. For example, leaving the purchase voluntary would likely lead to adverse selection, and potentially higher premiums, if families with children who may have high dental needs disproportionately choose the benefit. At the same time, limiting a purchase requirement to families with children, rather than embedding the coverage in QHPs purchased by all individuals buying Exchange coverage, also potentially increases the premiums for families with children.
    - What is the impact on overall affordability for families from the different out-of-pocket maximums for embedded coverage and stand-alone coverage? Impacts related to the level of premium tax credits that will be available for low-income families in California as a result of the structure of the dental offering? Assessment of these and other impacts could be accomplished through development of specific examples and scenarios for individuals and families in different circumstances making different coverage choices.
    - What assistance will be available for families purchasing pediatric EHB dental? Federal rules allow for some allocation of premium tax credits to dental plans as determined by the Exchange but it would be helpful to understand how that might work on a practical level for families in California for each of the structure and purchase requirements under consideration.
    - The premium assumptions incorporated by bidding QHPs and dental plans regarding who would be buying pediatric EHB coverage and how those assumptions (and the resulting

premium rates) would change if policies in the Exchange are changed.

- *Evaluation*. Whatever the final structure and requirements applicable to pediatric EHB dental in the California Exchange in 2014, policymakers and the Exchange Board should develop clear processes for tracking and evaluating the take-up rates and experience with pediatric EHB dental to inform future state decisions on this issue.

For 2015, policymakers, including the Exchange Board, may wish to engage stakeholders early in 2014 in analysis and public discussion of the most effective approaches to offering pediatric EHB dental coverage in the Exchange so as to both maximize the numbers of children covered and ensure the affordability of the coverage. Future discussion of the policy options and implications should include a thorough public vetting of those options in advance of the QHP solicitation and re-certification process for the 2015 coverage year.

The Health Insurance Alignment Project is a project of
The Kelch Policy Group
Supported by a Grant from the
California HealthCare Foundation

Contact: Deborah Kelch
dk@kelchpolicy.com
(916) 691-5176
alignmentproject.org

July 12, 2013

Sacramento County Medi-Cal Dental Advisory Committee
C/O First 5 Sacramento Commission
2750 Gateway Oaks Drive, Suite 330
Sacramento, CA 95833

Peter V. Lee
Executive Director
Covered California
560 J Street, Suite 290
Sacramento, CA 95814

RE: 10 Essential Health Benefits - Kids' Dental Care

Dear Mr. Lee:

Historically, low income families in Sacramento County have had difficulties accessing quality dental care as the only mandatory managed care county in California. Consequently, on July 1, 2012, the Sacramento County Medi-Cal Dental Advisory Committee was established under AB 1467 (Steinberg) to provide oversight and guidance to improve dental care services for dental managed care and fee-for-service for children in Sacramento County. This committee meets monthly to resolve issues and barriers to accessing care for families eligible or participating in the Medi-Cal program.

This committee is pleased that pediatric dental care was identified as one of the 10 Essential Benefits, but we are extremely concerned that dental may be "optional" through the Exchange. In addition, the proposed monthly premiums of between $10 and $40 per child and up to $1000 in annual out-of-pocket expenses will be a substantial barrier for children to receive the recommended dental services for optimal health and wellness. All citizens benefit when children arrive at school healthy and ready-to-learn.

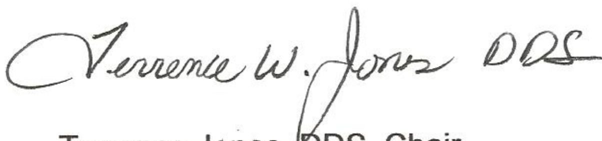
On behalf of the Medi-Cal Dental Advisory Committee, we strongly recommend that dental benefits be required as an essential benefit when open enrollment begins on October 1, 2013. In addition, we believe the following points should be incorporated as policy:

- Pediatric dental plans should be a mandatory requirement, whether embedded in a health plan or provided in a stand-alone product.
- Families purchasing stand-alone pediatric dental plans should be eligible for federal subsidies and receive the benefit at the same cost as those who chose a bundled plan.

- Stand-alone pediatric dental plans should offer essential oral health benefits that do not impose annual or lifetime caps on service.
- Stand-alone pediatric dental plans should have a sufficient provider base that is both linguistically and physically accessible to patients to ensure a maximum level of choice and competition within the networks.
- Finally, there should be adult dental coverage as part of the Essential Health Benefit package.

Thank you for this opportunity to provide input into this important decision making process. We would be happy to provide you with any information you may need.

Sincerely,



Terrence Jones, DDS, Chair
Medi-Cal Dental Advisory Committee
First 5 Sacramento Commissioner
(916) 929-6631
twj.5252@yahoo.com

Debra Payne, MSW
Medi-Cal Dental Advisory Committee Member
First 5 Sacramento Program Planner
(916) 876-5870
paynede@saccounty.net

Cc: Senator Darrell Steinberg
Assemblymember Holly Mitchell
Assemblymember Roger Dickinson
Assemblymember Richard Pan
Sacramento County Board of Supervisors, Phil Serna
California Dental Association, Nicette Short
Sacramento District Dental Society, Cathy Levering
Bee Reporter Jim Sanders
Center for Healthcare Reporting, Emily Bazar
Medi-Cal Dental Advisory Committee

State Capitol
Sacramento, CA 95814

California Legislature

July 1, 2013

Peter Lee, Executive Director
Covered California
560 J Street, Suite 270
Sacramento, CA 95815

Dear Mr. Lee:

We would like to express our sincere appreciation for the important work that you and your staff are doing to rapidly start up Covered California, which will make a significant contribution toward expanding access to comprehensive health coverage for Californians. We are proud of the policy choices that have been made collectively to set California on a path to be a leader among states in the enacting of the federal Patient Protection and Affordable Care Act (ACA). Like you, we are eager to support efforts to assure implementation by October 1, 2013.

As the authors of the legislation that established California's essential health benefit benchmark and the past and present Chairs of the health policy committees in the California Legislature, we wish to clarify our intent with the passage of AB 1453 (Chapter 854, Statutes of 2012) and SB 961 (Chapter 866, Statutes of 2012), that all 10 of the ACA essential health benefits are required benefits per California's Health and Safety and Insurance Codes both inside and outside Covered California.

We appreciate the challenges created by Section 1302 (b) (1) (F) of the ACA which indicates that an Exchange cannot fail to treat a health plan participating in an Exchange as a qualified health plan, if the plan does not offer coverage of pediatric dental benefits that are offered through a separate stand-alone plan. This is further complicated by subsequent guidance that states a person choosing a qualified health plan through an Exchange can opt not to purchase a stand-alone dental plan. Together these policies make the pediatric dental essential health benefit optional in Exchanges. We urge a different approach for Covered California that also maintains participation for stand-alone pediatric dental plans.

With integrated health and dental benefits and health and dental plan partnerships, Covered California can ensure pediatric enrollees receive pediatric dental care along with the other essential health benefits, likely adding only a few additional dollars to the premium due to the spreading out of risk among a larger population of people. Policies that result in fewer families opting for pediatric benefits lead to higher premiums and encourage those who know they will have major dental expenses to be the only purchasers of this coverage further driving up premiums. It is our understanding that there are policy options Covered California can explore that will maximize coverage for families and allow them to afford pediatric dental benefits for

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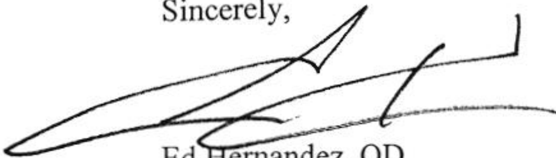
their children. We encourage you and Covered California's Board of Directors to explore options that could include embedding pediatric dental benefits in health plans in Covered California and creating opt-out mechanisms for people who do not wish to purchase pediatric dental coverage.

Unmet oral health needs can have a significant impact on a child's present and future health, education and well-being. Covered California's policies should assure all children have oral health coverage as intended in the ACA. We support the Board and staff of Covered California making choices that ensure the lowest possible premiums for the pediatric dental benefit in order to carry out the intent of the ACA to expand access to comprehensive coverage, including pediatric dental benefits.

Please let us know if you would like to discuss this further.

Sincerely,



Ed Hernandez, OD

William W. Monning

Richard Pan, MD, MPH

August 6, 2013

Peter Lee, Executive Director
Dr. Jeff Rideout, Medical Director
Covered California
Sacramento, CA 95814

Sent electronically via qhp@covered.ca.gov

Dear Jeff and Peter:

We write to indicate our concern with the proposed significant postponement to future years of the Quality Reporting System (QRS) ratings – a critical tool for consumers who hope to factor quality into their value decision – as part of the Cal-HEERS plan selection tool. We urge that this decision be reconsidered in the interest of both transparency to consumers and fair competition among Covered California's plan partners.

Quality Ratings Benefit Consumers. The commitment of the Covered California leadership to highlight, via a consumer-friendly star rating system, the quality ratings of the plans and their care delivery networks that will be available through Covered California, and to display this information prominently on the same screen that shows price and benefit levels, has been and should be applauded. The inclusion of quality ratings in the "smart sort" algorithm is also wise and is widely supported. This approach is in keeping with the vision of Covered California to serve as a catalyst for delivery system reform by promoting competition based on *both* quality as well as price.

The Board of Covered California adopted as its mission "to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value." The Board consciously and appropriately chose "value" as a broader aspiration than "price." Indeed, a review of the six organizational values adopted by the Covered California Board is noteworthy for its focus on improving quality, reducing health disparities, improving value, and other goals independently of, and in addition to, improving affordability.

Quality information must be provided at the launch of mandatory coverage, if Covered California is to ensure a consumer-centric focus in a reformed marketplace. Consumers should not be asked to "click around" on the Covered California website to find quality ratings, nor should the ratings be restricted in some way – such as by preventing consumers from comparing the quality performance of different plan designs. Indeed – that is precisely the choice in front of consumers – a Medi-Cal plan or a commercial plan? A PPO with a limited network, or a broader network, or an HMO? The key, in our view, is to provide consumers with information that is relevant to them, in a manner in which they can easily understand it, and at the point where they can best make use of it – namely, as they are making their choice of plans.

While we recognize the priority that affordability in health coverage has for policymakers, it is wrong to presume that affordability is the only information consumers need when choosing a health plan, or candidly, even that its importance dwarfs all other factors. The strength of different plans in meeting core quality-of-care objectives is vital information, and for this reason, Covered California's previous decision that quality data comparing and contrasting the choices available to consumers must be prominently displayed is the right one. Moreover, we believe it far more closely tracks the priorities of the Covered California Board as laid out in its mission and organizational values last fall.

Dropping Quality Ratings Isn't Putting Consumers First. Regrettably, we understand a tentative decision has been made to abandon quality reporting for consumers in 2014, in response to criticism that 1) some plans selected for participation in Covered California have contracted with provider networks that are dramatically different than those upon which available quality ratings are based, and 2) the available data is "historical" and not based on service to the "Exchange population."

With regard to the latter criticism, we note that all quality data is historical. Quality rankings (in health care or in automobiles) presume that past performance is useful and valuable to consumers in predicting their experience. If the charge is that data presented to Covered California consumers must be drawn from quality scores derived from treating only the "Exchange population," we note two points. First, because of HEDIS score requirements regarding continuous enrollment of one year or longer, this simple-sounding limitation effectively means quality data would not be available to Covered California consumers for either the 2014 or 2015 open enrollment periods. Indeed, some HEDIS scores could not be reported for even the 2016 open enrollment period. As such, accepting a requirement that quality rankings presented to Covered California purchasers be based exclusively on data from the Covered California population as a pre-condition for quality reporting ensures no meaningful quality data will be available to Covered California consumers for two and perhaps three years.

Moreover, we note that a large portion of Covered California members are coming from exactly the two "pools" for which quality reporting today is readily available: the commercial market and Medi-Cal. How then can data drawn from quality performance serving the Medi-Cal and commercial population be dismissed as irrelevant? We also note there is no indication that plan and provider ratings for serving a commercial population, or for serving a Medi-Cal

population, are an insufficient basis for predicting the quality of care that will be experienced by Covered California consumers. Indeed, the evidence indicates quite the opposite. Delivery systems that score well in quality do so because they have organized systems to perform across broadly endorsed metrics of quality. The available evidence strongly indicates that organizations which perform well on one population-based set of quality metrics perform well on all of them.

Quality Ratings Should Match the Network Consumers Have Available To Them. The concern that proposed QRS scores do not reflect the performance of the particular provider networks some plans have contracted to offer to Covered California consumers, in our view, has merit. We disagree with the tentative solution to drop the QRS ratings as part of the plan selection tool, however, and believe it would be unfair to both consumers and those Covered California plan partners who will offer Covered California consumers identical or substantially similar networks as the highly rated networks they offer in the commercial market today. In short, when consumers have a choice of an existing high-quality provider network – a network that has delivered consistently superior performance on numerous quality ranking systems – they deserve to know it. We do not see an acceptable reason to conceal or suppress that information as consumers make their plan coverage choice, any more than it would be acceptable to conceal or suppress the price.

As indicated previously, quality ratings should reflect, as closely as possible, the performance of the plan/provider network that is being made available to consumers. <u>If the networks offered by certain plans in Covered California do not reasonably resemble those of an existing network for which quality data is available, the appropriate information to convey to consumers is "not yet rated," rather than suppress the reporting of quality scores for all plans, including those with identical and highly rated networks.</u>

Just as "the price is the price," and more expensive plans must bear the consequences in seeing a higher price prominently displayed alongside those of lower-priced competitors, so too should quality rankings be clearly shown – and in a manner that tells consumers the unvarnished facts on matters that are highly relevant to them. Simply stated, consumers deserve to know what they are buying – and if they are buying something that is new and innovative, but relatively unproven also, they deserve to know that as well.

Finally, we wish to make a practical observation. If quality reporting is delayed, there will always be future changes in the Covered California marketplace – provider network modifications, new plans entering Covered California, low consumer response rates – that can be used to justify further delays. And, candidly, if stakeholders that score poorly on quality can succeed in delaying the reporting of quality scores, they will be highly motivated to preserve the status quo through further delay. In contrast, if quality metrics are presented for plans that offer comparable networks to Covered California consumers, and other plans are listed as "not yet rated," the incentives will be reversed. <u>All</u> plans will have an incentive to work for rapid and consistent quality reporting.

We appreciate the commitment of you, and of Covered California's Board, to improving the experience of consumers in choosing health insurance. We also recognize your consistent focus on partnership in terms of your relationship with contracting health plans. We believe the right course in light of both is to proceed with the QRS for 2014 for those plans where the data is reliable for the network they have chosen to assemble on behalf of Covered California consumers.

Sincerely,

Jerry Fleming
Senior Vice President
Health Reform Implementation and Policy
Kaiser Permanente

Melissa Hayden Cook
President and Chief Executive Officer
Sharp Health Plan

Garry Maisel
President and Chief Executive Officer
Western Health Advantage

cc: Members of the Board of Covered California

A 501(c)(3) Nonprofit Corporation

July 30, 2013

VIA FIRST CLASS MAIL

Ms. Kathleen Keeshen
General Counsel
Covered California
560 J Street, Suite 290
Sacramento, CA 95814

RE: Potential Liability for Misuse of Federal Grants Funds

Dear Ms. Keeshen:

We write on behalf of Cause of Action, a non-profit, nonpartisan government accountability organization that uses investigative, legal and communications tools to educate the public on how government transparency and accountability protects economic opportunity for American taxpayers. We seek to notify Covered California of potential liabilities that might apply should the taxpayer funds it receives be misused.

As you are aware, Covered California operates as a quasi-governmental organization, specifically an "independent public entity not affiliated with an agency or department."[1] Covered California's mission is to offer an easy-to-use marketplace to connect insurers and health care consumers.[2] California was the first state in the nation to pass legislation creating a health insurance exchange after the enactment of federal health care reform.[3] The Department of Health and Human Services (HHS) has authorized the appropriation of $910,606,370, through the Center for Consumer Information and Insurance Oversight (CCIIO), in the planning and funding of Level I and II Establishment Grants to the state of California ("Grant Funds").[4]

Compliance with the Terms of the Funding Opportunity Announcement

California's Governor signed a bill on September 24, 2012, requiring the California Health Benefit Exchange to facilitate voter registration online for any person applying for service or assistance from the exchange.[5] On its face, this statutory requirement conflicts with the terms of the CCIIO's Funding Opportunity Announcement (FOA) for Exchange Establishment Grants. In this FOA, HHS limited the use of exchange grant funding to twelve Exchange Activity

[1] The Henry J. Kaiser Family Foundation, *State Exchange Profile: California* (as of Apr. 22, 2013), *available at* http://kff.org/health-reform/state-profile/state-exchange-profiles-california/ (last visited Jul. 23, 2013).
[2] Covered California, *About Us, available at* http://www.coveredca.com/about_us.html (last visited Jul. 23, 2013).
[3] Assemb. B. 1602, ch. 661, 2009-10 Reg. Sess. (Ca. 2010) and S.B. 900, ch. 659, 2009-10 Reg. Sess. (Ca. 2010).
[4] Annie L. Mach and C. Stephen Redhead, *Status of Federal Funding and Implementation of Health Insurance Exchanges*, Cong. Research Serv. (June 19, 2013).
[5] S.B. 35, 2011-12 Reg. Session (Ca. 2012).

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Categories.[6] Voter registration activity fails to qualify under any of these categories and is wholly unrelated to exchange planning or activity.

Additionally, the FOA prohibits several uses of Grant Funds, including but not limited to, the following: to meet matching requirements of any other Federal program; to cover excessive executive compensation; and, to contract with organizations that have a conflict of interest, such as individuals or companies that sell insurance or insurance-like products, including discount plans. [7] Covered California is also prohibited from using Grant Funds to improve systems or processes solely related to Medicaid or the Children's Health Insurance Program, or any other State or Federal program's eligibility, particularly as such systems relate to Information Technology.[8] Navigator grants must be drawn from the operational funds of the Exchange.[9] The varied and numerous restrictions placed by HHS/CCIIO on the use of Grant Funds may subject Covered California to a significant risk of liability under the False Claims Act (FCA), as well as sanctions imposed by CCIIO Project Officers, such as restrictions on the use of funds and/or termination of the award.[10]

Compliance with the Byrd Anti-Lobbying Amendment

Section 1352 of Title 31 of the U.S. Code, the Byrd Amendment, expressly prohibits "the recipient of a Federal contract, grant, loan, or cooperative agreement" from using appropriated funds to "influenc[e] or attempt[] to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress" in connection with specified "Federal action[s]." The U.S. Department of Justice, in response to a Senate inquiry concerning HHS grant funding under the Centers for Disease Control and Prevention's Communities Putting Prevention to Work program, stated "[t]he Department is committed to investigating all credible allegations of illegal lobbying activity, which strikes at the heart of the democratic process."[11]

Further, federal regulations require state-created health care exchanges to conduct outreach and education activities that will educate consumers about the exchange and insurance affordability programs to encourage public participation.[12] However, the direct final rule establishing exchanges does not specify the full extent of these outreach and education activities.

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[6] U.S. Dep't of Health and Human Servs., Centers for Medicare and Medicaid Servs., Center for Consumer Information and Insurance Oversight, *Cooperative Agreement to Support the Establishment of the Affordable Care Act's Health Insurance Exchanges*, *available at* http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/Downloads/amended-spring-2012-establishment-foa.pdf, at 10.
[7] *Supra* note 6, at 36-37.
[8] *Id.*; *see also* 2 C.F.R. pt. 222 (previously OMB Circular A-87) regarding cost allocation.
[9] 45 C.F.R. § 155.210(f) (2013); *see also* Patient Protection and Affordable Care Act, March 23, 2010, Pub. L. 11-148, § 1311(i)(6) (codified as amended at 42 U.S.C. § 18031(i)(6) (2011)).
[10] John E. Dicken (Director, Health Care), General Accounting Office, *Patient Protection and Affordable Care Act—HHS's Process for Awarding and Overseeing Exchange and Rate Review Grants to States,* Report to Congressional Requesters, GAO-13-543, May 31, 2013, *available at http://www.gao.gov/assets/660/654994.pdf.*
[11] Letter from Peter J. Kadzik, Principal Deputy Assistant Attorney General, U.S. Department of Justice, to Hon. Patrick Leahy, Chairman, Senate Judiciary Committee (May 7, 2013), at 57, *available at* http://www.judiciary.senate.gov/resources/transcripts/upload/061212QFRs-Holder.pdf.
[12] 45 C.F.R. § 155.205(e).

In order to ensure that Covered California's employees and contractors comply with existing federal law, any such activities must not include direct or grassroots lobbying with appropriated federal funds for or against any pending legislation.[13]

Compliance with OMB Circular A-133 Requirements

Circular A-133, issued by the Office of Management and Budget (OMB), *Audits of States, Local Governments and Non-Profit Organizations*, requires that all subrecipients of $500,000 or more in Federal awards during the subrecipient's fiscal year comply with the audit requirements as set forth in OMB Circular A-133. Covered California, or its subgrantees, is a subrecipient of federal funds within the meaning of the term as used in OMB Circular A-133. Under the Circular, Covered California must engage a licensed Certified Public Accountant that meets all standards concerning qualifications, independence, due professional care and quality control as required by *Government Accounting Standards* to conduct an audit in accordance with OMB Circular A-133. Such audit must be completed no later than nine (9) months after the end of its current fiscal year. It must direct the CPA performing said audit to prepare and submit, within the required timeframes, all reports, statements, schedules, summaries, corrective action plans and such other forms, data and information as may be required by OMB Circular A-133. It shall issue a management decision on audit findings, if any, within 6 months after receipt of the audit report, and shall take timely and appropriate corrective actions with respect to any such findings, as may be required by OMB Circular A-133 and shall send copies of such findings and corrective action to the subgrantee and such other entities as may be required by OMB Circular A-133. The failure to comply with the requirements of OMB Circular A-133 may result in suspension of funding and may affect your eligibility for future funding.

Corporate Governance and Internal Best Practices

In addition, California's Insurance Commissioner recently admitted that California's exchange does not have a plan for investigating any complaints that are submitted to enrollment counselors.[14] Absent a more comprehensive strategy to combat fraud, Covered California is at significant risk of reimbursing subcontractors for unlawful activity. Also, Covered California and its subcontractors may face relator claims under the False Claims Act (FCA) if federal funds are misused.[15] Covered California is required to institute procedures to promote compliance with the financial integrity provisions under Section 1313 of the Patient Protection and Affordable Care Act (PPACA), including the requirements related to accounting, reporting, auditing, cooperation with investigators, and application of the FCA.[16] Given the wide-ranging functions and responsibilities of the state exchanges, it is increasingly plausible that health insurers and subcontractors may misrepresent their credentials and that there will be ample opportunity for vigilant whistleblowers to file FCA *qui tam* suits in response.

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[13] 18 U.S.C. § 1913.

[14] Judy Lin, *Fraud Fear Raised in California's Health Exchange*, Associated Press, Jul. 13, 2013, *available at* http://www.sacbee.com/2013/07/13/5564401/fraud-fear-raised-in-californias.html (last modified Jul. 13, 2013).

[15] 31 U.S.C. ch. 37 (Subtitle III), Pub. L. 97-258, § 3729–3733 (Sept. 13, 1982) (codified as amended at 31 U.S.C. §§ 3729-3733 (January 3, 2012)).

[16] *Supra* note 6, at 52-53.

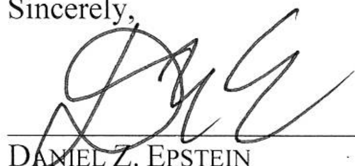
State exchanges have an added responsibility to share certain financial information online, such as required regulatory fees or payments, administrative costs of the exchange, and monies lost to waste, fraud, and abuse.[17] However, an *Associated Press* review of the 17 states that have opted for state-run marketplaces indicates that Covered California was given the most restrictive powers by the State Legislature to limit publicly available information. This includes concealing terms of all contracts for twelve months and concealing indefinitely the amounts paid by the Exchange to any subcontractor.[18] While the California Senate has approved a bill to ease these restrictions, contracts with health insurance plans would still be withheld for twelve months and the payments in those contracts would be withheld for four years.[19] Limiting public access to this kind of information inherently heightens Covered California's risk of using or allocating federal funds in wasteful or fraudulent ways.

Please consider whether Covered California has the oversight capability to ensure federal funds are used in a transparent, accountable and legally compliant manner.

You must promptly refer to HHS Office of Inspector General any credible evidence that a principal, employee, agent, contractor, subrecipient, subcontractor or other person has submitted a false claim under the False Claims Act or has committed a criminal or civil violation of laws pertaining to fraud, conflict of interest, bribery, gratuity, or similar misconduct involving those funds. The HHS Office of Inspector General can be reached at http://ww.oig.hss.gov/fraud/hotline/.

If you have any questions regarding this letter, please contact me at 202-499-4232.[20]

Sincerely,



DANIEL Z. EPSTEIN
EXECUTIVE DIRECTOR

[17] 45 C.F.R. § 155.205(b)(2)(i-v).
[18] Michael R. Blood, *AP Exclusive: Calif. Exchange Board Granted Secrecy*, Associated Press, May 9, 2013, *available at* http://bigstory.ap.org/article/ap-exclusive-calif-exchange-granted-secrecy.
[19] *Calif. bill would cut exchange secrecy*, KCRA, Jul. 8, 2013, *available at* http://www.kcra.com/news/calif-bill-would-cut-health-exchange-secrecy/-/11797728/20889132/-/dpf2r4z/-/index.html.
[20] This letter is not intended to create, and does not create, an attorney-client relationship between you or the California Office of the Governor and Cause of Action. Cause of Action is providing this letter and the information contained herein only as a convenience to Covered California and the California Office of the Governor. It does not constitute legal advice and **MUST NOT** be used as a substitute for the advice of a qualified and independent attorney. Please consult proper counsel in your jurisdiction.

cc: Hon. Patrick Leahy, Chairman, Senate Judiciary Committee
Hon. Charles Grassley, Ranking Member, Senate Judiciary Committee
Hon. Orrin Hatch, Ranking Member, Senate Committee on Finance
Hon. Lamar Alexander, Ranking Member, Senate Committee on Health, Education, Labor, and Pensions
Hon. Roy Blunt, Senate Committee on Appropriations
Hon. Michael Enzi, Ranking Member, Senate Subcommittee on Children and Families, Senate Committee on Health, Education, Labor and Pensions
Hon. Johnny Isakson, Vice Chairman, Senate Select Committee on Ethics
Hon. Richard Burr, Ranking Member, Senate Committee on Veterans Affairs
Hon. Kelly Ayotte
Hon. Darrell Issa, Chairman, House Committee on Oversight and Government Reform
Hon. Fred Upton, Chairman, House Committee on Energy and Commerce
Hon. Timothy Murphy
Hon. Joseph Pitts, Chairman, House Subcommittee on Health, House Committee on Energy and Commerce
Hon. Elijah Cummings, Ranking Member, House Committee on Oversight and Government Reform
Hon. Kathleen Sebelius, Secretary, U.S. Dep't of Health & Human Services
Daniel Levinson, Inspector General, U.S. Dep't of Health & Human Services
Peter Kadzik, Principal Deputy Assistant Attorney General, Office of Legislative Affairs, U.S. Dep't of Justice
Hon. Edmund G. Brown, Jr., Governor of the State of California
Hon. Kamala Harris, Attorney General of the State of California