Options for Covered California to Offer Pediatric Dental Coverage in 2015

Prepared on November 14, 2013

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I. Executive Summary

As of 2014, California's regulatory agencies require licensed health plans to offer non-group and small-group purchasers outside Covered California either a separate pediatric dental policy "bundled" with a separate policy for the other essential health benefits ("EHBs"), or "embedded" pediatric dental coverage in one policy covering all 10 EHBs.[1] For 2014, by contrast, Covered California is offering pediatric *stand-alone* dental plans ("SADP"), plus separate medical plans that cover the other EHBs. Pediatric SADP coverage is referred to as ".5," representing part of one of the 10 "EHBs" required under the Affordable Care Act ("ACA"); and the other EHB coverage is designated "9.5." On the exchange, consumers can mix-and-match any SADP with any 9.5 qualified health plan ("QHP"), or decide to enroll in one and not the other coverage. We refer to this as "SADP+9.5." That choice is not available with bundling or embedding.[2]

The most important objectives for revising Covered California's SADP+9.5 offering in 2015 are (1) to apply federal tax subsidies to the cost of dental benefit, and (2) to ensure that eligible children are enrolled in it. Covered California asked Wakely to identify and assess alternatives to SADP+9.5 that address these and other problems. The obvious alternatives—embedded or bundled pediatric coverage—if added to SADP+9.5 provide a modest improvement in value (as we demonstrate in Section III), but do not address these two primary objectives. To address them also requires a change to the current SADP+9.5 offering, but these changes, in turn, raise questions of compliance with existing federal and state regulations. As regulations are evolving, waivers may be negotiable, but this is not a legal review. Rather than address compliance issues in this paper, we identify the most promising options for further analysis, including legal review.

Wakely was asked by Covered California's staff to imagine new approaches, and assess all reasonable options for achieving their primary objectives. Wakely explored nine options and evaluated all nine against six criteria. Based on these criteria, and considering the first two criteria -- inclusion of the pediatric dental benefit in premium subsidy calculations, and dental coverage for all eligible children —to be "must-have's," four options rise to the top of our list, for further review with Covered California's Executive Director and staff:

1. Instead of SADP+9.5, embed pediatric dental coverage in 10.0 QHPs, with a low dental deductible and a dental OOPM that is integrated with the 10.0 OOPM, and consider adopting an age-factor curve that effectively re-allocates the cost of pediatric dental coverage to the child-specific premium rate. (Option 2)

[1] California Insurance Code § 10112.27 and California Health and Safety Code § 1367.005

[2] Q&A #28, QHP Webinar Series Frequently Asked Questions. Centers for Medicare & Medicaid Services (CMS). 9 May 2013.

2. Continue to offer the current arrangement, but require households with children under 19 to purchase SADPs, if federal rules governing the calculation of advance premium tax credits ("APTCs") change to include SADP coverage (option 6)

3. Instead of SADP+9.5, select a "best-in-class" specialty dental carrier to develop embedded pediatric dental coverage for all (or most) issuers, and adopt the same configuration of deductibles, OOPMs and age-rating curve as in option 2. (Option 9)

4. Embed pediatric dental in 10.0 QHPs, with the same configuration of deductibles and OOPM as in option 2, and also solicit SADPs and 9.5 QHPs at all actuarial values ***except Silver***.

All four options would include pediatric dental benefits in the calculation of federal premium subsidies, and would assure dental coverage for households with children. They differ in the degree to which each balances premiums and out-of-pocket costs, provides flexibility and continuity of care, offers consumer choice, and in their feasibility for 2015. Wakely is reluctant to quantify the evaluation of options against all six criteria because the criteria are not equally important. However, were equal weight assigned to each criterion, and values assigned as follows -- empty circle=0; half-moon=1; and full moon=2 -- each option would receive the summary score indicated in parentheses following its name on the grid below.

By comparison with just one OOPM in embedded option 1, and two completely separate OOPMs in option 3, Wakely recommends the more "efficient" integration of the pediatric dental and overall (10.0) OOPMs in option 2. With two integrated OOPMs, dental spending accumulates against the overall OOPM as well as the dental-only OOPM, and thus provides more protection for dental out-of-pocket spending at roughly the same premium as option 1 (one OOPM), and roughly comparable protection as option 3 (two independent OOPMs) at lower premium. Integration of the OOPMs is only possible when all 10.0 benefits are embedded in a single policy.

One important short-coming of the existing SADP+9.5 coverage (option 5) is its voluntary nature. SADP option 6 is distinguished from 5 by the requirement that households with children must purchase an SADP when they purchase a 9.5 QHP. The other critical disadvantage of option 6 is that SADP premiums do not count toward APTC calculations under current federal rules, so this option is recommended *only* on the condition that the federal rules change. SADP option 7 entails an assessment on 9.5 plans to pay for .5 coverage, but (as explained in Section II) Wakely quickly concluded that this option was not feasible, and therefore has dropped it from further consideration.

Nine Options Assessed on Six Criteria

Options		Criteria					
		1 Include pedi-dental costs in subsidy calculation	2 Minimize premiums for un-subsidized enrollees	3 Assure dental coverage for children	4 Moderate out-of-pocket spending and monthly premiums	5 Protection, access, choice, flexibility, continuity, & simplicity	6 2015 Feasibility for CalHEERs, and issuers
Embed-ded	1 Single OOPM (8)	●	◗	●	◗	◗	◗
	2 Integrated OOPMs (9)	●	◗	●	●	◗	◗
	3 Separate OOPMs for Medical and Dental (8)	●	◗	●	◗	◗	◗
Bundled	4 Separate 9.5 and 0.5 policies & OOPMs (5)	○	◗	●	○	◗	◗
Multiple SADPs & QHPs	5 Mix-and-match 9.5 and 0.5 plans (6)	○	●	○	○	●	●
	6 Children required to have 0.5 plan at checkout (8)	○	●	●	○	●	●
Best-in-Class Dental Carrier	8 Stand-alone or bundled (8)	○	●	●	○	●	●
	9 Embedded in 10.0 plans (9)	●	◗	●	●	●	○
Hybrid	10 10.0 Silver; 10.0 + 9.5 on other AVs (10)	●	●	●	●	●	○

Options 8 and 9 represent variants of competitive bidding to select the "best-in-class" specialty dental carrier. Because option 8 has all the regulatory uncertainty associated with option 6, Wakely recommends only option 9 for further consideration. (Were CMS to change the calculation of APTCs, to include an SADP premium for 2015, option 8 would merit re-consideration.)

The tenth option offers the most choice and flexibility of all, while still solving the two major problems with the current SADP+9.5 offering: including dental in APTCs and requiring dental coverage for children. The only choice not available to enrollees under option 10 is to purchase a 9.5 Silver plan.

Review of these four options with Covered California's staff resulted in dismissing options 6 and 9, holding 10 in reserve as a potential approach were it deemed compliant with current HHS regulations, and a recommendation to move forward with option 2. A key consideration in recommending option 2 is that it does not require change in federal regulations, and therefore can be communicated to the health plans early enough to allow them time to implement for 2015. Nor does option 2 require significant changes in CalHEERS. It does depend on the ability of Covered California to structure a solicitation such that issuers prefer to submit only 10.0 QHPs, rather than 9.5 QHPs. (If this cannot be done, option 10 may need to be re-visited.)

II. Options & Criteria

Wakely reviewed information on the pediatric dental offerings in the federally facilitated marketplace ("FFM") and state-based marketplaces ("SBMs"). We also interviewed and reviewed position papers and testimony of stakeholders in California. The criteria and options have been developed in large measure from these interviews and reviews.

- A review of state-based marketplaces reveals some promising strategies, such as working with issuers to propose only embedded coverage, a waiver from CMS on offering 9.5 coverage, and mandating pediatric dental coverage for children

- We have developed nine distinct options for further evaluation, but no option fully meets our six criteria

This paper excludes a detailed review of the regulation of pediatric dental offerings in California. Nevertheless, some general understanding of the regulatory constraints is required to understand the problem under analysis. (See appendix A for a summary of the rules for calculating and applying premium tax credits for the pediatric dental benefit.) For 2014, California's Department of Insurance ("CDI") and its Department of Managed Health Care ("DMHC") are requiring health plans offered off-exchange in the non-group and small-group markets to bundle or embed pediatric dental coverage with the other 9.5 EHBs into a

comprehensive package.[3] For 2014, by contrast, Covered California is offering pediatric *stand-alone* dental plans ("SADP") in the non-group market, separate from medical plans that cover the other essential health benefits.

The defining characteristic of "embedded" coverage is a single policy and premium covering all 10 EHBs—whether or not a specialty dental carrier operating under contract to the issuer is paying claims and otherwise facilitating coverage. By contrast, the defining characteristic of "bundled" coverage is that carrier(s) offer two distinct insurance policies, sold together as a package. With SADPs available on-exchange, the consumer can mix-and-match any .5 dental plan with any 9.5 medical QHP, or decide to enroll in one and not the other coverage. That choice is not available with bundling and embedding.[4]

In April of 2013, HHS released Affordable Exchange Guidelines[5] which provide guidance on member cost sharing limits for SADPs participating on the FFM. "For the 2014 coverage year in the FFE, CMS interprets the word "reasonable" to mean any annual limit on cost sharing that is at or below $700 for a plan with one child enrollee or $1,400 for a plan with two or more child enrollees." For SADPs on state exchanges, HHS has given states the latitude to define "reasonable" limits on out of pocket spend.

In June, Covered California announced its selection of SADP offerings from six issuers—five in the non-group market--with a mix of products (DHMO and DPPO) offering coverage with $700 and $1,000 OOPMs per child. Monthly premiums range from under $8 to over $30 per child. While the rates appear very competitive, consumer groups and other stakeholders argued that pediatric dental should be included with the rest of medical coverage under a single policy and premium. Their reasoning is that pediatric dental coverage should be included in the cost of coverage on which APTCs are calculated, and all eligible children should have this coverage. At its August 2013 meeting, the Directors of Covered California expressed interest in exploring these and other options for 2015.[6] (Unless otherwise stated, all references in this paper are to plans and benefits in the non-group, on-exchange market only.)

Although this issue has generated considerable debate, it is worth remembering that it impacts a relatively small number of eligible, subsidized children. Some 6.5 million California children are in households with incomes below 251% of FPL, and therefore are eligible for

[3] California Insurance Code § 10112.27 and California Health and Safety Code § 1367.005
[4] Q&A #28, QHP Webinar Series Frequently Asked Questions. Centers for Medicare & Medicaid Services (CMS). 9 May 2013.
[5] HHS, "Affordable Exchanges Guidance", http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf
[6] Board Recommendation Brief, Pediatric Dental Coverage: Background and Policy Options, p. 10. Covered California. 8 Aug 2013.

Medi-Cal. They are untouched by this issue. By contrast, only 140,000 children are in uninsured households above 250% of FPL and still eligible for federal tax credits in Covered California. Of all 2.6 million Californians eligible for subsidized coverage in Covered California, the 140,000 subsidy-eligible children represent about 5%.[7] And of all 3.45 million Californians who might be expected to use Covered California – 100% of the subsidy eligible and half of the unsubsidized non-group market – the 140,000 subsidy eligible children represent just 4.12 percent.

Moreover, the SADP premiums are very modest as well. The 2nd lowest SADP premium in most rating regions for 2014 is $11.49/month, or $12 pmpm trended forward to 2015. With about four percent of enrollees eligible for this subsidy, and the subsidy representing less than four percent of total premium, the inclusion of pediatric dental costs in APTCs amounts to one-to-two tenths of 1% of total premium. This is not to say that the issue for the 140,000 subsidy-eligible children is insignificant, but the dollars at stake are only $6 million out of Covered California's non-group premium flow of $4 billion for 2015.

Table 1: Potential APTC Subsidies for Pedi-dental in Proportion to Covered California's Gross Non-Group Premiums, CY 2015

	Total Non-Group Enrollment & Premium (000's)	**Subsidized Pedi-dental Enrollment & APTCs** (000's)	**Pedi-dental as a Percentage of Total**
Enrollment	999,011*	41,159	4.12%***
Premium/mm	$331*	$12**	3.63%
Revenue	$3,968,071,692	$5,926,896	0.15%

*Mid-year 2015 Base case enrollment and PMPM Premium, includes subsidized and unsubsidized individual enrollees; 2014 premium trended 3.5% to 2015

**Across 19 rating regions, the range for 2nd lowest SAPD premium is $9.60 to $15.14, and most common (by far) is $11.49, which trended 3.5% to 2015 ~ $12.00

***Assumes half of all eligible, unsubsidized enrollees do so thru Covered California, and half enroll direct with carriers

Finally, it should be noted that in September 2013, Governor Brown signed SB 639, which (as of 2015) caps the sum of separate OOPMs for different EHB services at the federal limit on 10.0 OOPMs.[8] That is, the current offerings in Covered California of dental OOPMs per child with

[7] Covered California, Board Brief: "Pediatric Dental Coverage: Background and Policy Options," August 8, 2013, p.1
[8] Covered California, Board Presentation: "Request for Approval of Proposed FY 2013-14 Budget," June 20, 2013, p. 7.

$700 or $1,000 OOPMs, plus OOPMs for 9.5 plans at $6,350 (individual) and $12,700 (family) cannot be offered in 2015; rather, the sum of the two OOPMs cannot exceed $6,350/$12,700 (plus inflation).

The impetus for Covered California to revise its treatment of pediatric dental coverage for 2015 stem from the federal formula for calculating APTCs, based on the 2nd lowest priced Silver plan's premium--even if that QHP excludes pediatric dental coverage--and the related interpretation that .5 EHBs need only be offered (not selected). Another important constraint is CMS' requirement that SADPs which meet QHP certification requirements, other than those criteria which apply only to 9.5 benefits, must be allowed on exchange; and that if SADPs are offered on the exchange, issuers must be allowed to offer licensed 9.5 plans there as well.[9]

To address the most important problems with Covered California's current SADP+9.5 offering -- (1) federal premium subsidies do not cover the cost of the dental benefit, and (2) children are not necessarily enrolled for it -- Covered California asked Wakely to develop and assess options that address these and other issues. The obvious alternatives—embedded or bundled pediatric coverage—if added to SADP+9.5 provide a modest improvement in value (as we demonstrate in Section III), but do not address the primary disadvantages of SADP+9.5. To address these two problems also requires a change to the current SADP+9.5 offering, but these changes raise questions of compliance with existing state and/or federal regulations. We do not address those compliance issues in this paper; rather, we identify the most promising options for further legal analysis.

Wakely identified ten specific options, described further on in Section II. One of the ten we dismiss, without further analysis, because it requires a two-thirds majority vote in the General Assembly for a new assessment, which is considered highly improbable, and virtually impossible within the timeframe for Covered California to make a policy determination and issue a QHP solicitation for 2015. (It may also raise concerns with the IRS.) The other nine options we assess against six criteria, also set forth later in Section II.

Pediatric Dental Offerings Outside of California

Wakely has reviewed information available from exchange websites and the National Association of Dental Plans (NADP) for pediatric dental offerings. We also interviewed officials from the state exchanges for Vermont, Connecticut, Maryland, and Washington for more specifics about their offerings. In general, the marketplaces are offering stand-alone dental and/or embedded plans. For eleven SBMs with available information, the most common arrangement seems to be to solicit both SADP+9.5 and embedded plans. (A state-by-state table

[9] 45 CFR § 155.1065

for pediatric coverage will be appended.) Nevada solicited all three, but does not offer bundled or embedded coverage.

Regulation 45 CFR § 155.1065 requires that exchanges allow SADPs to be offered, if SADPs are proposed that meet the exchange's QHP selection criteria (other than criteria which do not apply to .5 benefits). Moreover, if an exchange offers SADPs, then it must also allow 9.5 QHPs as well. Federal regulations do not require qualified individuals to buy pediatric dental coverage, only to be offered it. As a result, the majority of SBMs solicited and are offering both SADP+9.5 and embedded pediatric dental coverage. Of course, this makes it unlikely that a 10.0 QHP will be the 2nd lowest priced Silver plan, and that all families with children in need of dental coverage will enroll for it. However, several states have apparently addressed these issues, at least for 2014.

Table 2: State Individual Exchange Offerings for 2014

	10.0 EHB Coverage Scenario		
	Medical + SADP	Bundled	Embedded
Colorado	x		x
Connecticut			x
Kentucky	x		
Maryland	x		x
Massachusetts	x		x
Minnesota	x		x
Nevada	x		
New York	x		x
Oregon	x		x
Rhode Island	x		x
Vermont			x
Washington	X		
Washington, DC			x
Total	10	0	10

Maryland, for example, allows SADP+9.5 and embedded coverage, and Maryland's households can purchase coverage either way. However, three of the four issuers offering health plans on Maryland's individual exchange have chosen to embed pediatric dental in all of their plans (36 of 45 QHPs). It so happens that Maryland's newest carrier, its CO-OP, which is the one issuer that does not embed dental, is neither the lowest nor the 2nd lowest priced Silver plan. Because pediatric dental is embedded in the 2nd lowest priced Silver plan, its costs are, by definition, covered by the premium on which tax subsidies for Maryland are calculated, and the resulting APTCs can be applied to any QHP on the individual exchange. (Maryland had been told by the established carriers before their bids were submitted that they preferred to embed pediatric

dental; whether the CO-OP preferred to submit a 9.5 QHP or simply was unable, as a start-up, to embed pediatric dental coverage is unclear.) Vermont also solicited both 9.5 and 10.0 QHPs, but its two issuers submitted only 10.0 QHPs. However, this "happy" result is not assured for 2015 and beyond. Next year, higher priced Silver plans or a new entrant could forego embedding pediatric dental in order to undercut the 2nd lowest QHP's price.

Washington and Nevada only offer SADP+9.5 on their exchanges, but families with eligible children are not allowed to complete the enrollment process ("checkout") until pediatric dental coverage has been selected. Only households without children are allowed to purchase a 9.5 coverage without an SADP. Under this approach and the IRS' current rules, however, because SADP coverage is not embedded in the 10.0 QHPs, APTCs are calculated according to the 2nd lowest priced 9.5 Silver QHP, so there is no subsidy for .5 coverage.

Connecticut's individual exchange solicited only embedded pediatric dental coverage. As a result, pediatric dental costs are automatically included in the 2nd lowest priced Silver plan's costs, and adult-only households are required to purchase pediatric dental benefits. Access Health CT was given a 1-year waiver from CMS' requirement to offer SADP coverage as well.[10]

Many SBMs and the FFM chose not to offer bundled pediatric dental coverage in 2014. Several states cited IT limitations, such as difficulties displaying two separate premiums or OOPMs, as their reason for not offering bundled coverage, but have indicated that they may re-visit bundling for 2015. Nevada appears to be the only state which solicited bundled plans for 2014, but issuers chose not to offer it.

Options for Covered California

Wakely identified ten distinct options. This list includes several variants of embedding the pediatric dental benefit in a single 10.0 plan, of bundling, and of SADP+9.5, as described below. Each is considered on its own, assuming for purposes of this study, that additional options would not be offered by Covered California in 2015:

Embedded: One policy offered by a single licensed entity, covering all 10 EHBs. Covered California could structure this offering with a variety of cost-sharing arrangements:

1. A single OOPM, applicable to all 10.0 services, including all covered pediatric dental services. (This structure best fits the concept of high deductible health plans ("HDHPs") and one large OOPM under catastrophic and HSA-qualified coverage.)

[10] Personal communication from Kevin Counihan, executive director of AcessHealth CT, October 22, 2013.

2. An OOPM applicable to all 10.0 services, plus an integrated (or "protective") dental OOPM. Under this arrangement, out-of-pocket spending on dental services would be capped, and all such spending would also accrue toward the 10.0 OOPM. For example, with a dental OOPM of $1,000 and a comprehensive OOPM of $6,350: the enrollee would be relieved of all pediatric dental cost-sharing after spending $1,000 on covered pediatric dental services, but would still not hit her limit on cost-sharing for all services until she had spent an additional $5,350 on non-dental services; or if she had spent $500 on dental and $5,850 on other services, she would have spent $6,350 in total and hit her OOPM for all 10.0 services. As this option appears to be incompatible with the structure of HSA-compatible High Deductible Health Plans ("HDHP") and with catastrophic plans, it is assumed that a single deductible and OOPM (as in option 1) would be solicited for HDHP and catastrophic coverage.[11]

3. Two separate OOPMs one for covered dental services only and one for 9.5 services only. Under the recently enacted Senate Bill No. 639 (Hernandez), as of 2015, the two OOPMs cannot sum to more than the limit on OOPMs under the ACA, i.e. $6,350/single or $12,700/family in 2014, inflated for 2015.[12] Again, this option does not fit HDHP and catastrophic coverage, which would need to mirror the OOPM design for option 1.

Bundled: Two separate 9.5 and .5 policies, with separate OOPMs, generally offered by two separately licensed entities, but packaged for the enrollee as one, such that the enrollee cannot mix-and-match different 9.5 QHPs with various SADPs, nor can a buyer enroll for one coverage without the other.

4. Two separate OOPMs apply: because the 9.5 and .5 plans are offered in concert, the issuer(s) can bundle plans with two, one or no deductibles, but each *must offer* "side-by-side" OOPMs, which cannot be integrated and cannot, as of 2015 under SB 639, sum to more than $6,350/single or $12,700/family (inflated after 2014).

Multiple SADPs & 9.5 QHPs ("SADP+9.5"): Specialty dental carriers would offer SADPs, insurance companies or managed care organizations would offer 9.5 QHPs, and enrollees could combine any SADP from any dental carrier with any 9.5 QHP.

5. As under the current structure of pediatric dental coverage in Covered California, enrollees would be allowed to either mix-and-match 9.5 and .5 plans, or to enroll only in a 9.5 QHP.

[11] § 156.155 Enrollment in catastrophic plans (a) (3).

[12] Note, this is not the federal actuarial value, as calculated for bronze, silver, gold and platinum levels.

6. A variant of SADP+9.5 would be to structure the mechanics of Covered California's enrollment process so that families with children under 19 cannot "check out" a 9.5 QHP without also enrolling in an SADP. Washington and Nevada have implemented this arrangement as a way to ensure that qualified children are covered for pediatric dental services. (This "mechanical" solution does not address the affordability obstacle in the exchange, nor does it apply off-exchange.)

7. Theoretically, one way to subsidize SADP coverage for families with children, building on the SADP+9.5 approach, would be to make the SADPs free by assessing all 9.5 QHP premiums sufficiently to pay for the expected cost of SADP coverage. This assessment would load the cost of SADP coverage into premiums for the 9.5 QHPs, thereby assuring that the 2nd lowest priced Silver 9.5 QHP would include the cost of .5 benefits, and assess 9.5 QHPs to subsidize SADPs. Zero-premiums for SADPs, combined with a "mechanical" filter to ensure that families with children under 19 actually enroll, would assure 100% take-up for children.

   However, Wakely understands that such an assessment would almost certainly be ruled a tax under the California statute that requires a two-thirds majority vote in the General Assembly. Therefore, it would be extremely unlikely to pass, let alone be enacted in time for Covered California's decision about 2015. For this reason, Wakely has not separately analyzed this option, and has excluded it from further consideration.

<u>Best-in-Class Specialty Dental Carrier:</u> Two more options are suggested under an arrangement by which Covered California would select the "best" proposal from one dental carrier. The plans developed by the specialty dental carrier could be offered as embedded, bundled or SADP, depending on which model Covered California prefers. Admittedly, sole-sourcing has some inherent defects and may seem contrary to the concept of choice in a marketplace. However, in this particular context, it offers several unique advantages: (a) it builds on the advantages that specialty dental carriers all claim for themselves, such as specialized care management, dental network development and claims adjudication; (b) it may actually offer consumers considerable choice of health plan products, and more choice and access to dentists at a better price than other embedded options; and (c) if coordinated with Medi-Cal's dental program, it could substantially reduce disruption from the significant "churn" expected between Medi-Cal and Covered California.

8. Several SADPs from one issuer: this option fits with bundling or SADP+9.5. Although it does not offer consumers a choice of different dental carriers, it can offer two cost-sharing

formulas, and two different types of plans (DHMO and DPPO) with two different dental networks. As in option 6, Covered California might also mandate SADP coverage for households with children under 19. The OOPMs for dental and 9.5 benefits could not be integrated.

9. Embed "best-in-class" pediatric dental coverage into all (or most) 10.0 medical plans. If Covered California prefers embedding, it could require as a threshold criterion that the specialty dental carrier commit to partnering with each of the medical issuers to offer embedded 10.0 plans. The dental carrier would accept capitated payment from the 10.0 issuers (at the rate bid), and it would support these issuers in accumulating patient liability for covered dental services toward an overall OOPM and/or two integrated OOPMs. Similarly, QHP issuers must commit to "partnering" with the specialty dental carrier. Covered California could solicit one or two OOPMs (per options 1 – 3), as it prefers.

Finally, a "hybrid" approach would offer both SADP+9.5 and embedded plans, in such a way as to ensure that only the embedded 10.0 QHPs are available on the Silver level, and therefore would qualify as the 2nd lowest priced Silver plan. Assuming that the intent of the relevant federal regulations is not to prohibit APTCs being calculated on the basis of all 10.0 EHBs—even though this has been the effect in many states--several variants of this approach are possible. We present the most flexible option, with the most consumer choice:

10. The exchange would solicit 10.0 coverage for all metallic levels, SADPs at the two cost-sharing levels, and 9.5 plans on all levels other than Silver. As in option 9, Covered California would solicit one or two OOPMs, as it prefers for the embedded plans; and either embedded or, as in option 6, SADPs could be mandated for households with children under 19.

In addition, it should be noted that a separate, low dental deductible can be combined with any of the options described above, except for HDHP and catastrophic plans. For embedded coverage with a deductible applicable to most services, exempting pediatric dental from the higher deductible, and imposing a lower "first-dollar" cost for dental services, substantially improves access to covered dental care. As long as the two deductibles are treated separately, they can be applied in most embedded, bundled or SADP arrangements.

Criteria for Assessing Options

Wakely has developed the following criteria for evaluating the options described above, based on input from stakeholders and a review of materials from Covered California's staff and Board of Directors.

1. *Include pediatric dental costs in APTCs and apply them to pediatric dental coverage*: under existing federal rules, (a) premiums for the 2nd lowest priced Silver plan dictate the level of APTCs (for any given percentage of FPL); (b) when a 9.5 QHP is the 2nd lowest priced Silver plan, only the premiums for that 9.5 plan are used in this calculation; and (c) APTCs cannot apply toward premiums for SADPs unless they exceed the enrollee's premium for his/her 9.5 QHP.[13] The added premium for an SADP can materially increase a subsidized enrollees' total monthly bill. Therefore, stakeholders agree that it is important to find a way to apply tax credits to the entire 10.0 coverage. Indeed, consumer advocates consider this a "must-have" feature for 2015.

2. *Minimize premiums for unsubsidized enrollees*: In policy debates about cross-subsidies, many Americans feel that "vulnerable" households with fewer resources deserve more protection or consideration than wealthier ones, but there is clearly a wide range of feelings about how much special consideration -- and at whose expense -- is fair. Rather than discriminate among more or less "deserving" households, this criterion focuses on efficient pursuit of an over-riding objective – to cover the most uninsured. Because children with household income up to 250% FPL qualify for Medi-Cal, subsidies on the exchange for pediatric dental coverage only "kick in" at 251% of FPL, but the fact is that young, single adults earning above 300% of FPL and young couples earning above 350% of FPL will contribute all or most of their premiums without subsidies. (And unlike most covered employees, their premiums come out of after-tax income.) It is also true that so-called "young invincibles," who are disproportionately uninsured, are also disproportionately childless. By moderating premiums for young invincibles, the exchange will be able to cover more uninsured Californians and spread the costs of sicker participants. To attract these unsubsidized individuals and couples, it helps to exclude cross-subsidies for pediatric coverage from households without children to those with children. Moreover, virtually all families with children earning right up to 400% of FPL will qualify for APTCs, and if APTCs cover pediatric dental, these families will be federally subsidized for pediatric dental, so a cross-subsidy from adults without children built into the premium for the 2nd lowest priced Silver plan would simply reduce federal subsidies.

3. *Assure pediatric dental coverage for children*: Most public health, consumer and professional groups feel strongly that access to pediatric dental services is an important part of good quality coverage. Even if fully recognized in the calculation of APTCs, lower-income families with children may be tempted to reduce their own premium contributions by foregoing pediatric dental coverage, as will some unsubsidized families.

[13] 26 CFR § 1.36B-3 (d), (f), (k)

Therefore, many stakeholders argue that purchasing such coverage should not only be subsidized for lower-income families, but required or strongly encouraged for all children.

4. *Moderate out-of-pocket spending and monthly premiums for pediatric dental coverage*: The consumer appeal of a separate, low deductible and OOPM for pediatric dental coverage is obvious, but must be balanced against the increased "price" of such coverage. The "price" of special protection for the cost of pediatric dental services can be measured by the associated change in actuarial value ("AV"): to the extent that separate pediatric dental deductibles or OOPMs raise AVs, they either force premium increases or higher cost-sharing elsewhere in the package of benefits. Moreover, risk selection can also raise premiums for SADPs, if families with children are allowed to forego pediatric dental coverage, but opt in when the children need orthodontia work. A wide range of views exists among California's dental carriers on how much adverse selection voluntary opt-in/opt-out creates, and the resulting increase in pediatric dental premiums.[14] This criterion is to maximize access to dental services for children at minimum additional cost.

5. *Promote consumer protections, access to dentists, continuity of care, product choice & flexibility, and simplicity*: a range of health plan features contribute to making the "insurance store" and its products work well for customers. Clearly, some of these, such as choice and simplicity, pull in different directions. Like financial protection versus premium in criterion #4, this one requires a balance among competing values. The criterion is to optimize consumer choice.

6. *Feasible for CalHEERs and issuers*: For 2014, the California Eligibility, Enrollment and Retention System ("CalHEERs") is not able to process two distinct premiums and enrollments for a bundle of plans, and many issuers were not able to accumulate claims towards an embedded OOPM, so consideration of these (and other) options was deferred to 2015. Clearly, any option given serious consideration must prove affordable and feasible, ideally for 2015. Similarly, it is preferred that the national System for Electronic Rate and Form Filing ("SERFF") be able to accept and transmit rating filings and benefits descriptions. (However, we do not address feasibility for SERFF, because it

[14] Wakely did not undertake an actuarial study of this question, but did ask this question of dental carriers in California. Some thought there would be little to no selection impact because the benefits are for children only; some thought there might be a substantial impact i.e., 10% of more on broad DPPO premiums; one carrier indicated that the impact would be far larger than 10%.

is not used for passing rates to Covered California; on the other hand, it is used by California regulators for rate review.)

Narrowing Options for In-depth Analysis

There are many "unknowns" associated with the nine options under review, including the possibility of regulatory changes, waivers and evolving interpretation, and the extent of practical obstacles to timely implementation. To simplify our analysis and address these unknowns, we first analyze the "efficiency" of different ways to structure deductibles and OOPMs for the pediatric dental benefit (Section III). In section IV, we apply the six criteria above to each of the nine options, in an effort to select a subset of the most promising ones for further analysis. For the analysis in Section IV, we evaluate each option separately. (However, as noted previously, existing regulations require exchanges to allow SADPs, and if SADPs are offered, then the exchange must also allow 9.5 QHPs.[15]) In Section V, we qualify the four "recommended" options, in terms of the operational requirements to make each of them most appealing. Finally, based on the transitional issues described in Section VI, Wakely and staff of Covered California recommend that Covered California pursue option 2 with as much advance notice to issuers and specialty dental plans as possible.

III. Various OOPM & Deductible Configurations

- A low deductible dedicated to dental services is the most important component to limiting dental out of pocket expenses *for most children*

- An integrated ("protective") dental OOPM offers protection at low cost for children with serious orthodontia problems deemed medically necessary

A consistent way to compare the relative richness of different plan designs is to apply the cost-sharing features on the claims experience of a standard population. Doing so enables an objective assessment of a plan design's actuarial value, what proportion of the population is likely to hit their OOPMs, and the average amount of out-of-pocket spending likely to occur. In addition, Wakely has examined the impact to high utilizers, and the trade-offs for differing degrees of cost-sharing protection.

[15] 45 CFR § 155.1065

Methodology

To estimate the allowed spend on medical and dental services for the child population anticipated to enroll in Covered California, we constructed a continuance table[16] from two data sources. We use a California subset of the standard population which serves as the basis for the federal actuarial value calculation per the ACA – a national sample of commercial data from Truven Health MarketScan® Research Databases. This standard population represents national commercial medical and pharmacy expenditures for the entire United States population, but does not include dental claims. To construct continuance tables that represent utilization of *medical and dental* services for children in California, we used the following approach:

1) Utilize a modified dental continuance table for children from Tower's Watson HealthMaps ® Dental Rate Manual
2) Construct a medical continuance table for CA children using Truven Health MarketScan® Research Databases
3) Combine continuance tables to produce an aggregate table to which the various plan designs could be applied

Dental Continuance Table

Because the treatment of orthodontic services differs under ACA from a traditional group insurance plan, Wakely adjusted the Towers Watson dental continuance tables. Under a typical commercial pediatric dental plan, orthodontia is subject to a lifetime and/or annual maximum, but not to stringent medical necessity review. Under the ACA, only pediatric dental services deemed "medically necessary" will be covered, and there will not be a lifetime or calendar year maximum. Under the ACA paradigm, most of the commercially covered orthodontia services would not be considered medically necessary.

As Wakely used continuance tables that represent utilization for orthodontia not subject to medical necessity, we had to adjust the frequency of orthodontia claims accordingly. In a 2013 study performed by Milliman on behalf of the National Association of Dental Plans (NADP), Milliman estimated that "30% of commercial orthodontia claims would be considered medically necessary."[17] Wakely used this as a starting point, but found that doing so for California resulted in expected pediatric dental costs that were much higher than were indicated by the premiums SADPs were charging for coverage. Therefore, Wakely has made the assumption that approximately 0.7% of children aged 0-18 would incur orthodontia services on an annual basis that would meet the qualification as medically necessary, roughly half the amount assumed in the Milliman paper.

[16] A continuance table depicts probabilities and frequencies of individuals reaching various levels of annual spend.
[17] Milliman, "Dental Costs Within the ACA";
http://www.nadp.org/Libraries/HCR_Documents/NADP_Memo_and_Milliman_Cost_Analysis_5-9-13.sflb.ashx

The modified dental continuance tables were then tested against the actuarial values resulting from Covered California's own calculations[18]. The cost sharing features of the High and Low DPPO plans were tested against the modified dental continuance table and actuarial values were compared. The actuarial values obtained by Wakely were both within 1% of the values generated by Covered California. As the dental continuance tables used were from 2012, claim experience was trended at 3% per year to the midpoint of 2014

Actuarial Value Comparison		
	PPO High	PPO Low
CC AV	86.0%	72.0%
Wakely AV	86.6%	71.1%

Medical Continuance Table

To build the continuance table reflective of anticipated utilization of medical services for children in California, Wakely used data directly from Truven Health MarketScan® Research Databases[19]. The generous size of this repository allowed Wakely to extract annual claims experience for approximately 750,000 children enrolled in commercial plans in California for the entire 2011 calendar year. The annual claim amounts and frequencies were bucketed into the same 84 levels of stratification as in the federal actuarial value calculator ($0, 0-100… 1M-2M, 2M+). The claim experience was trended at an annual rate of 6.5% to the midpoint of 2014.

Medical + Dental Continuance Table

Several of the plan design structures that Wakely is testing require a continuance table that contains both medical and dental claims. As Wakely was not able to access appropriate datasets that contained members with both medical and dental spend, a combined table was created by taking the product of the medical and dental tables. An inherent assumption in this methodology is that the medical and dental claims for individual members are independent. For example, a child with above average medical spend is equally likely to have higher than average dental spend as a child with below average medical spend.

Before making this assumption, Wakely tested to see whether there was a correlation between medical and dental utilization on a dataset that contained both medical and dental spend for

[18] Covered California – Standard Pediatric Dental Essential Health Benefits Plan Design ; http://www.healthexchange.ca.gov/Solicitations/Documents/FINALSAPDStandardPlanDesign_082013_.pdf

[19] This retrospective claims analysis utilized data from the Truven Health MarketScan® Commercial Claims Database for the period of 1/1/2011 to 12/31/2011. These data included health insurance claims across the continuum of care (e.g. inpatient, outpatient, outpatient pharmacy, carve-out behavioral healthcare) as well as enrollment data from large employers and health plans across the United States who provide private healthcare coverage for millions of employees, their spouses, and dependents.

members in a Medicaid population containing approximately 450,000 children. Wakely found there to be no material correlation[20] between children's medical and dental, so we have proceeded on the assumption that medical and dental utilization are independent.

Cost-Sharing Design Comparison

Six cost-sharing designs were analyzed using the continuance table outlined above. The goals of this analysis were to compare -

1. Total expected annual member cost sharing, separated between medical and dental
2. The ratio between plan payments and total costs
3. The percentage of children who hit their OOPM(s)

To perform the calculations of service costs borne by members and the plan, the following cost-sharing designs were utilized:

- For the stand-alone dental calculations, California's 70% PPO option was used. This plan has a $60 dollar deductible which applies to all services, a $1,000 OOPM, 100% plan paid coinsurance for Diagnostic and Preventive (after deductible), and 50% cost sharing for all other services.

- For the medical portion of the plan, a child-only plan with a $900 deductible, $6,350 OOPM, and 30%[21] member coinsurance was selected. According to the federal actuarial value calculator, a child-only plan with these cost sharing features is classified as Silver.

The seven cost-sharing designs, along with the attributes for comparison are displayed in Table 3.[22] Descriptions of the characteristics and details behind the cost-sharing designs follow.
Table 3:

[20] Correlation coefficient of 1.6%

[21] A child-only plan was selected for technical reasons, but Wakely recognizes that the more common policy would be for two or more enrollees, and can add a comparable analysis for a family of four. This should not change the direction of our findings, but may change their magnitude. A 30% coinsurance was selected to best align with the coinsurance structure of the stand-alone dental plan design. The effective coinsurance on the stand-alone dental plan design is approximately 30%. This allows for a comparable coinsurance structure when comparing stand-alone or bundled plans (#1-2) with embedded plans (#4-#7)

[22] In selecting the medical and dental plan designs that would serve as the basis for the out-of-pocket analysis, Wakely was required to balance emulating Covered California's standard Silver plan design against the requirement of additional assumptions and complexities of performing the actuarial calculations. The federal actuarial value calculator could not be used because the standard population, continuance tables, and the covered services needed for this analysis differ from those in the federal actuarial value calculator. The chosen medical plan has a similar actuarial value to Covered California's standard Silver plan design, but has a more straightforward benefit plan that simplifies the needed actuarial calculations. Were Wakely to use Covered California's standard silver plan design, different conclusions are not anticipated.

Actuarial Value Analysis for Pedatric Dental

	Stand Alone			Embedded			
Column #	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Option #	**N/A**	**3,4,5,6**	**3,4,5,6**	**1**	**2**	**1**	**2**
Option Name	Medical + SAPD in 2014 (2014 offering)	Medical + SAPD (or Bundled) in 2015	Medical + SAPD (or Bundled) in 2015	Embedded Single OOPM	Embedded - Integrated OOPM	Embedded - Single OOPM	Embedded - Integrated OOPM
Note		w/ $1,000 OOPM	w/ $700 OOPM			w/ $60 Dental Ded	w/ $60 Dental Ded
Annual Costs							
Total Cost	$ 2,286	$ 2,286	$ 2,286	$ 2,286	$ 2,286	$ 2,286	$ 2,286
Plan Cost	$ 1,428	$ 1,442	$ 1,435	$ 1,334	$ 1,370	$ 1,416	$ 1,430
Member Cost	858	$ 844	$ 850	$ 952	916	$ 870	$ 856
Medical	$ 728	$ 715	$ 719	$ 694	$ 685	$ 727	$ 727
Dental	$ 130	$ 130	$ 132	$ 257	$ 231	$ 143	$ 129
Actuarial Value	62.5%	63.1%	62.8%	58.4%	59.9%	61.9%	62.5%
% of members who reach Dental OOPM							
% hit $OOPM_D$	2.1%	2.1%	2.8%				
% hit $OOPM_M$	1.4%	1.4%	1.4%				
% hit $OOPM_I$				1.4%	1.4%		
Plan Design							
Ded_1	$ 900	$ 900	$ 900	$ 900	$ 900	$ 900	$ 900
Ded_2	$ 60	$ 60	**$ 90**			$ 60	$ 60
$OOPM_1$	**$ 6,350**	**$ 5,350**	**$ 5,650**	$ 6,350	$ 6,350	$ 6,350	$ 6,350
$OOPM_2$	$ 1,000	$ 1,000	**$ 700**		$ 1,000		$ 1,000
Coinsurance	30%	30%	30%	30%	30%	30%	30%

Notation

Annual Costs – Represent average expected annual per child costs in 2014 in total, for the plan, and for the member.

Actuarial Value (AV) – Actuarial value is a concept that is used to "compare different plan designs to determine how overall cost sharing differs across plans with different cost sharing provisions"[23]. The population utilized in the AV calculations for this study are designed to be reflective of children in California. Thus, it contains materially different costs and frequencies than the continuance tables used in the federal AV calculator. For this reason, the AV for all plan designs is well below the 70% threshold (+/- 2%) for Silver.

[23] American Academy of Actuaries, "Actuarial Value under the Affordable Care Act"; http://www.actuary.org/pdf/health/Actuarial_Value_Issue_Brief_072211.pdf

Percent of members who reach OOPM – This statistic represents the percentage of children expected to reach their medical or dental OOPM.

Plan Design – The two basic plan designs outlined above for medical and dental generally hold. Where there are slight deviations (for example OOPM of $5,350) they are detailed here. A subscript of 2 indicates a dental cost sharing feature, if applicable.

Limitations – While efforts were undertaken to try and ensure as objective and realistic comparison of the seven plan variations, two major caveats / limitations are worth explicitly noting:

1. *In performing the AV calculations and OOP comparisons, children were considered in a vacuum and not part of a larger family structure where claim amounts would also be subject to family deductibles and family OOPMs.*
2. *There will likely be differing levels of selection[24] depending on if an option is compulsory or "offer only"*

The Seven Cost-Sharing Designs

Columns #1 - #3 have completely independent medical and dental cost-sharing features—as in options 3, 4, 5, 6 and 8, analyzed in Section IV; whereas columns #4 - #7 have either one OOPM or integrated OOPMs, as in options 1, 2, 9 and 10.

Column #1: Medical + SADP in 2014 (2014 Offering)

Under this cost-sharing design, the medical and dental plans would be completely separate. There would be no integration or coordination between the deductibles or OOPMs of the SADP and medical plans, or of the bundled pediatric dental and medical policies. It should be noted that the sum of the dental and medical OOPM amount to $7,350, which is representative of what is offered in Covered California for 2014, but will not be allowed under SB 639 in 2015. Expected annual out of pocket costs for dental services are $130.

Column #2: Medical + SADP (or Bundled) in 2015

This represents a variation of column #1, so that the OOPMs sum to $6,350, in compliance with SB 693 for 2015. This will slightly increase the number of children who reach their OOPM.[25] However, there is a .6% increase in AV indicating a slightly richer plan design. However, this cost-sharing design will have "severe" consequences in 2015 for Bronze and Silver level family coverage, where the maximum OOPM on 9.5 medical services ($12,700 + trend) would have to be reduced from by the value of the SADP's $1,000 OOPM *per child*. For a two-child family, the medical OOPM would be reduced from $12,700 to $10,700. This reduction in medical OOPMs for family coverage at the Bronze and Silver levels will either force significant increases in AV

[25] The discrete nature of the continuance table, especially at high levels of annual claims, makes it difficult depict the difference in the number of children who will reach their OOPM.

and premiums or in cost-sharing for other medical benefits, in order to stay within the AV corridors around 60% and 70%.

Column #3: Embedded under a Single OOPM, w/ $700 Dental OOPM

Note that other variations of column #2 are possible, so long as the two OOPMs do not exceed the overall limit under the ACA for OOPMs. For example, instead of $5,350 OOPM on 9.5 + $1,000 OOPM on pediatric dental, a better the design might be $5,650 on medical and $700 on dental. This design is illustrated in column #3. To stay near the 70% AV, the deductible would need to be increased. Under Covered California's Low Option PPO plan design in 2014, Wakely estimates that the deductible would need to move from $60 to approximately $90.

Making these adjustments would mitigate the increase in AV on a standard population as measured by the current Federal AV calculator and would result in lower premium increases or other benefit reductions for adults.

As is noted in table 3, the lower dental OOPM causes more people to run up against their dental OOPM. However, the majority of the child population who do not run up against their OOPM will be paying more with a higher deductible.

Column #4: Embedded under a Single OOPM

Represents pediatric dental coverage that is fully embedded in the Silver medical plan, under a single OOPM (Option 1). As compared to cost-sharing designs in columns #1/#2, there is a substantial increase in the average out of pocket spend ($130 to $257) for pediatric dental services. The reason for this is that the child must go through the entire $900 deductible in a child-only plan — higher in a family plan -- for medical and dental services, before they start paying coinsurance. Comparing the number of children who hit their OOPM to columns #1 - #3, there is no material difference. Even though dental services are included in the OOPM under the embedded plan design, their inclusion does not make it much more likely that someone will hit their OOPM.

Column #5: Embedded under Two Integrated OOPMs

Under cost-sharing design in column #5, there is an additional OOPM for dental services. Once the child hits their dental OOPM, they no longer pay any out of pocket costs for dental services. In addition, out-of-pocket spending for dental services accumulate towards the $6,350. The addition of the dedicated dental OOPM reduces the out of pocket spend from $257 under #4 to $231, which is still well above the $130 in columns #1/#2. The dental OOPM adds protection for those with very high cost dental services (namely orthodontia), but the lack of a dedicated dental deductible offers little protection for those consuming a moderate level of dental services.

Column #6: Embedded under a Single OOPM, with a Dental Deductible

A variant of the cost-sharing design in column #4, where a dedicated dental deductible is added to the plan design. Column #6 lacks the integrated dental OOPM in column #5, but out of pocket costs for dental services ($143) are much lower than under columns #4 or #5. The $60 dental deductible offers more benefit to the child, on average, than the integrated OOPM.

Column #7: Embedded under Two Integrated OOPMs, with a Dental Deductible

The same as cost-sharing design column #6, with an integrated dental OOPM. The increase in the actuarial value (and decrease in out of pocket dental costs) comes from additional protection from those children who have annual dental care costing more than $3,400[26].

Key Findings of Actuarial OOPM & Deductible Comparisons

In general, Wakely's findings based on this actuarial analysis are that:

1. A low deductible dedicated to dental services is the most important component to limiting dental out of pocket expenses *for most children*.
2. An integrated dental OOPM (of $1,000) offers protection at very low cost for children with serious orthodontia problems deemed medically necessary. By contrast, under an embedded plan with only one OOPM, a child with serious orthodontia problems would likely never hit the OOPM.
3. However, as noted previously, the 2-OOPM structure does not fit catastrophic and HDHP plan designs, so would need to be allowed for such plans unless California were to obtain waivers from the IRS (for HDHPs) and from HHS (for the catastrophic plan).

IV. Evaluation of Options

- Among embedded and bundled options, the "efficiency" and added protection of integrating the dental OOPM into the overall OOPM distinguishes this plan design

- Among SADP options, mandating that eligible children enroll for dental coverage addresses one of the major problems with the current SADP+9.5

- Choosing a "best-in-class" specialty dental carrier could offer more value to most consumers than embedding or bundling under options 1 through 4.

[26] To reach their $1,000 dental MOOP, a child would need to have $60 + (1000/30%) or $3,393.33 in total costs

- Offering both embedded and SADP+9.5 plans at all metallic levels, except for SADP+9.5 on Silver, would offer more choice of plans than other options, while solving most of the problems with SADP+9.5 alone.

In this section we apply each of the six criteria in turn to nine options, and provide a summary grid indicating whether the options wholly meet, partially meet, or fail to meet each criterion. Based on these judgments, Wakely highlights options 2, 6, 9 and 10 as worthy of further consideration and legal review.

1. *Incorporate pediatric dental costs in the APTC calculations.* While this criterion seems to be universally endorsed, how to achieve it under current regulations is highly problematic. APTCs are based on the premium of the 2nd lowest cost Silver plan, which is likely be a medical-only policy. If so, enrollees will not receive any premium assistance toward the purchase of pediatric dental coverage. This is one of the primary arguments against bundled plans (option 4) and SADPs (options 5, 6 and 8). By contrast, if only embedded pediatric dental coverage were offered by Covered California in 2015, then the APTC calculation and application would automatically include those costs.

   How much tax subsidy was foregone by not embedding pediatric dental coverage for 2014? With monthly premiums for SADPs in Los Angeles, for example, ranging from just under $8 to just over $39 for a child, and three times that for three or more children, pediatric dental coverage represents a material expense. Table 3 shows pricing information for a family of four (two 40-year old adults and two children) from Los Angeles (Pricing Region 15), using the median SADP price (for 70% AV) and the 2nd lowest priced Silver 9.5 plan's premium. This family would pay an additional 4-8 percent monthly for pediatric dental coverage, depending on its household income:

Table 4: Incremental Enrollee Contribution, After APTCs, for SADP coverage in L.A. (Rating Region 15)

Income as FPL%	Premium of a 9.5 QHP for a Family of Four, less APTCs*	Median SADP Premium (2 children) (70% AV)	SADP Premium as a Percentage of 9.5 Contribution
250%	$ 395	$ 31.60	8.00 %
300%	$ 559	$ 31.60	5.65 %
350%	$ 653	$ 31.60	4.84 %
400%	$ 763	$ 31.60	4.14 %

**Enrollee contribution toward second lowest priced Silver plan, after APTCs*

However, advocates for SADPs claim that a vigorous effort is underway to persuade CMS and IRS to change the calculation is likely to succeed. The National Association of Dental Plans (NADP) recommends that the:

"IRS calculate tax credit eligibility based on all 10 essential health benefits – whether contained in two policies or one for consumers in all states to be treated equally with regard to premium assistance. Further the IRS should segregate a portion of the tax credit to be utilized only when pediatric dental is purchased, as intended by Congress. In each state, the IRS should note:

1. *The total subsidy available for a medical policy covering all 10 essential benefits;*
2. *A portion of the subsidy is reserved for the purchase of pediatric dental under a SADP in addition to a medical policy without a pediatric dental benefit (about 5-6% of the tax credit given that dental benefits average about 1/12th of the annual premium of a medical policy and that only the child portion of a family dental policy is being supported by tax credits)."*[27]

The NADP and other dental organizations have lobbied extensively for the inclusion of dental benefits in the calculation of APTCs. On September 23, 2013, the NADP, in conjunction with the American Dental Association (ADA), Children's Dental Health Project (CDHP), and Delta Dental Plans Association (DDPA), submitted a letter and legal memo to the U.S. Department of the Treasury requesting that the cost of stand-alone dental benefits be included in the calculation of APTCs. The next day, several U.S. Senators wrote a similar letter to the Department of the Treasury. [28]

Dental organizations have indicated that they are working with consumer advocates on recommending a pathway for the Department of the Treasury to include SADPs in the APTC calculation. One such method assumes that since SADPs are offered at 70% ("low") and 85% ("high") AV, and since 70% is close to the "silver" metal level, one could take the 2nd lowest 70% dental plan and use that amount as the basis for the APTC calculation for the consumers who purchase the SADP.

However, Wakely makes no assumption about the likelihood or timing of this campaign succeeding in changing federal regulations. Therefore, as depicted below, options 1-4, 9 and 10 fully meet this criterion, while options 5, 6 & 8 currently fail this criterion. Of course, this evaluation assumes that each option is offered without the others, and no option meets this criterion unless a way can be found to avoid offering 9.5 plans on the Silver level.

	Options								
Criteria	1	2	3	4	5	6	8	9	10
Include pedi-dental costs in subsidy calculations	●	●	●	○	○	○	○	●	●

[27] https://www.statereforum.org/sites/default/files/nadp_issue_brief_on_aca_dental_tax_credits_july_2013.pdf

[28] http://www.nadp.org/Libraries/HCR_Documents/Pediatric_Dental_Tax_Credit_Letter_Final_9_24_13.sflb.ashx http://www.nadp.org/Libraries/HCR_Documents/Letter_and_Legal_Memo_to_IRS_re_Legal_Memo_on_Dental_Tax_Subsidies_9-23-13.sflb.ashx

2. *Minimize premiums for unsubsidized enrollees*. Assuming that Covered California can find a way to include covered pediatric dental costs for households with children in the 2nd lowest priced Silver plan, then excluding those costs for adult-only households would further the objective of controlling premiums and enrolling the uninsured. Under CMS' standard age rating curve, children (< 21) are rated at 0.635 of the index rate for the youngest adults. Embedding or bundling pediatric dental coverage spreads the costs of this benefit accordingly – in a ratio of 0.635 for children to 1-to-3 for adult rates. Thus, most of the cost for embedded or bundled pediatric dental coverage is baked into adult rates, even if the adults do not have children. (Of course, it is also true that excluding this cross-subsidy would raise premiums for unsubsidized households with children i.e., those above 400% of FPL, but they are generally insured, under employer-sponsored coverage.)

   The minimization of cross subsidies is sought to avoid loss of enrollment of price-sensitive adults in households without children – both younger and older adults. Most of the young households without children represent relatively healthy individuals. A premium increase that disproportionally affects adult-only households will likely cause lower enrollment rates in the healthier adult households without children. Over time, this selection effect could generate higher premiums for everyone.

   The following example depicts what the magnitude of the cross subsidy might look like, were pediatric dental to be embedded into the benefits for all participants on the individual exchange.

Table 5

Cross Subsidization of Pediatric Dental			
		Premium	
Age	Factor	DHMO	DPPO
0-20	0.635	$8	$25
21 - 24	1.000	$13	$39
40	1.278	$17	$50
50	1.786	$24	$70
60	2.714	$36	$106
64	3.000	$40	$117
Average	1.455	$19	$57

   Assumptions –

   i. Approximately 15% of enrollees are children eligible for dental coverage
   ii. Using 2014 median .5 dental premium in San Francisco for DHMO and DPPO

The actual increase in premium will depend actual cost coverage embedded. However, the relationship depicted above where a 64 year old will pay approximately 5 times the price for a benefit that they will not use as someone who will be using it will hold.

Avoiding the cross-subsidy from adult-only households can be achieved in one of two ways. One is to offer 9.5 QHPs that adult-only households can purchase. This argues for options 5, 6, and 8.

A second way to avoid the cross-subsidy from households without children would be to "bake" the full cost of embedded pediatric dental services into the age-rating scale for children.[29] Under CMS rules, states can adopt their own unique age-rating curves. California could develop an age-rating curve which increases the 0.635 age index for children under 21 sufficiently to "transfer" the full cost of pediatric dental services to the premiums for children. Doing so would allow Covered California to embed pediatric dental coverage in 10.0 QHPs, without costing childless families anything. Clearly, this approach would address a shortcoming of embedded options 1, 2, and 3.

However, this approach would not work for bundled plans because the two premiums are separate. They would have to be rated using CMS' age rating curve, and there is no way around charging adults without children for pediatric dental benefits.

Option 10 explicitly contemplates both 9.5 and 10.0 plans being offered by Covered California. Unless two different rating curves were used for the 9.5 and 10.0 plans, the age-rating curve would "unfairly" penalize or reward households without children. (On the other hand, this is the case now for states which offer both 9.5 and 10.0 plans across the market, on- or off-exchange, under the same rating curve.)

Assuming that the current age-rating factors reflect only medical relativities between ages, Wakely calculated how much the 0-18 age factor may need to increase were it to reflect the cost of pediatric dental. Were Covered California to consider this option, it would need to perform its own calculations, as the numbers provided in this paper are illustrative and should be used for directional purposes only.

Table 6 illustrates the impact of doing so on children's rates. In Wakely's example below, transferring the cost of pediatric dental services into the age rate for children would increase their rate between 7% and 17%, depending on whether a DHMO plan or a PPO plan was built into the rates.

[29] This option assumes that the current age factors correspond with 9.5 (medical only) plan designs.

Table 6

Changes to 0-18 Age Factors w/ Pediatric Dental

	Estimated Enrollment	Age Factors		
		Standard	w/ Ped Dental	
			PPO	DHMO
0-18	14.8%	0.635	0.741	0.678
19-20	2.6%	0.635	0.635	0.635
21+	82.7%	1.627	1.627	1.627
Total	100.0%	1.455	1.471	1.462
	Increase in 0-18 rates		16.6%	6.7%

Assumptions: *The three major assumptions involved in Wakely's estimate were the distribution of ages expected to enroll in the exchange population, the cost of medical services, and the cost of pediatric dental services. For the projected exchange enrollment, Wakely utilized the California census data[30] and publically available enrollment projections enclosed in the actuarial memoranda which issuers are required to file with the exchange. The cost estimate for medical services was based on the claim continuance tables contained within the federal actuarial value calculator. For the estimated cost of pediatric dental services, allowed costs were estimated for PPO and DHMO products using averages of the rates filed by the SADP carriers.*

As noted above, while these results are a realistic representation of the required increase in the 0-18 age factor, Covered California would need to do further research before making any changes to their age factors.

Options 5, 6, and 8 fully meet this criterion; by giving households a choice of 9.5 plans for all levels except Silver, option 10 largely meets this criterion; options 1-4 and 9 would require a complex calculation to alter California's age-rating index in order to fulfill this criterion, and even then would raise practical issues about filing rates in CalHEERs and SERFF for children aged 19 and 20. (See discussion below under criterion 6 addressing the discrepancy in the cut-off ages for pediatric dental coverage (19) and for the child premium rate (21).)

	Options								
Criteria	1	2	3	4	5	6	8	9	10
Minimize premiums for unsubsidized enrollees	◗	◗	◗	◗	●	●	●	◗	●

[30] 2011 census data was used and only people flagged as "without insurance" were considered

3. *Assure dental coverage for children.* One of the problems with SADPs is that, even when the APTC calculation includes pediatric dental costs, both subsidized and unsubsidized families may decide to save monthly contributions by foregoing this coverage. One solution is to bundle or embed pediatric dental coverage, thereby avoiding the choice of only 9.5 coverage. This solution favors Options 1-4 and 9, assuming that 9.5 plans are not offered as well. However, it also runs counter to criterion 2 -- unless the cost of pediatric dental coverage is built entirely into the child rate under a new age-rating curve, as described above.

   An alternate approach for assuring dental coverage for children is to offer 9.5 QHPs (with or without embedded and /or bundled plans), but create a "mechanical" fix that effectively bars families with children from "checking out" of Covered California without 0.5 coverage. This is option 6, which the states of Washington and Nevada have implemented. Although apparently compliant with CMS' regulations, it would of course have to comply with California's as well.

	Options								
Criteria	1	2	3	4	5	6	8	9	10
Assure dental coverage for children	●	●	●	●	○	●	●	●	●

4. *Moderate pediatric dental premiums and out-of-pocket spending.* As the actuarial analysis in Section III indicates, the embedded options, with an integrated dental OOPM and a separate dental deductible, satisfy this criterion better than the other configurations. The separate deductible comports with all options, but the integrated OOPM differentiates option 2 from the others. While a case can be made for flexibility to allow different configurations of OOPMs at different metal levels, if Covered California prefers a standard cost-sharing design, then the two integrated OOPMs (Option 2), along with a separate, low dental deductible, offers the best protection against high out of pocket cost-sharing. (However, a single high deductible and OOPM appear to be required for catastrophic and HDHP coverage.) Option 9 and embedded plans in option 10 should also be configured with this cost-sharing formula.

	Options								
Criteria	1	2	3	4	5	6	8	9	10
Moderate out-of-pocket spending and monthly premiums	◗	●	◗	○	○	○	○	●	●

5. *Promote consumer protection, network access, continuity of care, choice of plans, product flexibility, and simplicity.* The embedded options "automatically" apply all of the ACA's consumer protections for pediatric dental coverage, but Covered California has imposed many of the same consumer protections on SADPs. However, two consumer protection mechanisms that Covered California may not be able to impose contractually on SADPs are rate review and medical loss ratio requirements. Even were State legislation to give California regulators the authority to do so, applying these protections separately to SADPs on a much smaller premium base than 10.0 or 9.5 plans, requires careful analysis to determine appropriate levels. (See comparison below of retention for SADP versus 10.0 plans.)

   By packaging pediatric dental with QHPs, options 1-4, and 9 offer the simplicity of bundling the 10 EHBs together in one package, while retaining choice among different dental networks as a factor in selecting QHPs. The ability under options 5, 6, 8 to mix-and-match SADPs with different 9.5 QHPs—or go without pediatric dental coverage—clearly offers more consumer choice. Option 10 offers the most choice, but may overwhelm consumers with so much complexity over just one .5 benefit.

   On the other hand, Options 5, 6, and 8 entail separate enrollment and monthly billing and collections for SADPs, and these are non-trivial costs in the context of SADP premiums that can be as low as $8 per month. Wakely estimates that that billing and collection costs range from $1.50 to $2.50 per household, or about 10% - 15% of the median SADP premium ($15.75) for one child in Covered California.[31] By offering both embedded and SADPs, option 10 only compounds the cost and complexity for issuers.

   Moreover, the evidence from Massachusetts is that individual enrollment will be fairly short-term—median tenure has been less than one year in both the subsidized and non-subsidized exchanges—so two enrollment and set-up expenses instead of one is also material. Duplicate billing and collections not only increases administrative costs, but doubles the number of hand-offs and possibilities for "glitches."

[31] Estimate for the costs of printing, mailing, postage, lock box, and other collection functions is $2 PSPM from the Massachusetts Health Connector, for 200,000 enrollees, which is consistent with responses to other procurements done by state-based marketplaces.

By contrast with SADPs, the embedded and bundled options largely avoid the duplicate billing and collection expenses of options 5, 6, 8 and 10, even if one premium payment is divided between two partnering carriers. However, Option 8 may generate offsetting administrative savings and ease hand-offs, by concentrating all the SADP coverage in one specialty carrier. If so, option 9 may yield even more administrative savings than options 1-4 by eliminating dual policies *and* concentrating all (or most) pediatric dental coverage with one specialty carrier.

Wakely compared non-claims retention projections from the same carrier for comparable pediatric dental coverage offered as stand-alone and in 10.0 plans, in an attempt to quantify the administrative costs for different options. Thus, Wakely has used the carriers' own estimates to compare retention rates. Unfortunately, Wakely could not access such filings for California, but we have tracked down 2014 rate filings for the same pediatric dental benefits, embedded and stand-alone, from a few carriers in Colorado and Tennessee.

They show considerably higher retention as a percentage of premium for stand-alone dental coverage than for comprehensive 10.0 plans. The available same-issuer rate filings in Colorado show a difference in retention of 8 – 9%. Notable differences in components of the retention for these SADPs versus 10.0 plans are in commissions (8% vs 5%) and profits (6% vs 4.1%). The one available set of rate filings from the same issuer in Tennessee shows a difference in retention rate of 16.3% for SADP versus the 10.0 plan. This filing does not break down administrative costs, but profit and contingencies for the 10.0 plan is 2.5% ($3.51 PMPM) vs. 8.9%, ($3.13 PMPM) for the SADP.

While it is theoretically possible that the lower retention percentages for 10.0 benefits are composed of (a) higher claims processing, customer service, medical management and corporate overhead costs for dental benefits, and (b) lower for 9.5 benefits, this hypothesis would not explain the difference in profit and commission rates. Very likely, these differences reflect the relative costs and risks of selling and installing small-premium, specialty products compared with those of comprehensive coverage with a larger premium base. Table 6 summarizes the increased retention for stand-alone compared to comprehensive plans, from the available same-issuer rate filings for Colorado and Tennessee.

Table 7: Retention Comparison 10.0 plans vs. SADP

10.0 Plan			Pedi-dental SADP		
Plan Name	**Retention %**	**Retention PMPM (child rate)**	**SADP Plan Name**	**Retention %**	**Retention PMPM (child rate)**
Colorado (rating area 3)					
Rocky Mountain View PPO Silver - Deductible $1500/Copay $40 (w/Child Dental)	21.60%	$39.62	Rocky Mountain View - Anthem Low AV (70%)	29.46%	$5.28
Humana Connect Silver 4600/6300 Plan Silver	25.10%	$31.23	Humana Dental Smart Choice (Low AV 70%)	34.00%	$11.39
Tennessee (rating area 4)					
Humana Preferred Silver 3650/3650 Plan with Children's Dental	27.50%	$36.06	Humana Dental Smart Choice (Low AV 70%)	43.80%	$15.42

Dental specialty carriers argue that they do a better job at arranging, reimbursing and managing dental coverage than comprehensive health plans. While this may well be true, it may not be relevant, at least in the foreseeable future, since most of California's 12 QHP issuers indicate that they intend to use a specialty carrier for pediatric dental coverage, under either embedded and bundled options.

Another variable of concern is provider choice and continuity of care. While there is currently very limited choice of stand-alone dental coverage in California's non-group market, children in households, whether formerly covered or not, have relationships with dentists that should be preserved if possible. Providing a choice of various DHMOs and DPPOs on the exchange probably eased these transitions for 2014, but will increase the disruptive potential of a change for 2015. If children have to change dentists to stay in network, this is personally disruptive and leads to duplicate x-rays, administrative costs, even loss of continuity of care and missing routine, preventive visits.

Dental plans package and price access to networks of dentists for various covered benefits and cost-sharing. Covered California has already defined a standard set of benefits and cost-sharing, so the main difference among SADPs is network, premium and service. Based on the bidding for 2014, Covered California may be in the fortunate position of offering its customers the best of all worlds—more choice of dentists at lower premiums--without offering the choice of different dental carriers.

Table 8 compares the number of dentists statewide in each product and their relative premiums across California's 19 rating areas. Not surprisingly, DHMO premiums are considerably less than DPPO premiums, so we have divided the premium ranking into two product groupings. We rank the DHMO and DPPO plans 1-4 by price (1 for lowest) across 19 regions, and then calculate an unweighted mean of the 19 rankings. (For example, Blue Shield's DPPO has the lowest premium in all 19 rating regions relative to the other DPPO plans, hence its average rank is 1; the Blue Shield DHMO ranked lowest

in 14 regions and second lowest in 5, relative to the other DHMO plans, hence its average ranking if 1.26.)

Table 8: Comparative Premium Position and Breadth of Dental Networks across California

	Average Premium Rank Across CA Pricing Regions	Number of Network Dentists
HMOs		
Blue Shield (DHMO)*	1.26	8,841 dentists
Delta (DHMO)	2.53	5,347 facilities
LIBERTY (DEPO/DHMO)*	2.63	10,123 dentists
Premier Access (DHMO)	3.58	3,662 dentists
PPOs		
Blue Shield (DPPO)*	1.00	13,926 dentists
Anthem (DPPO)	2.42	12,861 dentists
Premier Access (DPPO)	2.58	9,972 dentists
Delta (DPPO)	4.00	14,673 dentists

*Network figures shown sourced from Covered California "Children Dental Insurance Plan Rates 2014." Wakely is still awaiting confirmation of these figures fr Blue Shield and Liberty.

There is considerable variation in price and network size among the SADPs currently offered in Covered California. Surprisingly, however, the lower priced plans within each product category offer as many or more dentists than several higher-priced competitors, and almost as many dentists as the highest-priced dental plan in both product categories.

This pattern suggests the possibility of *optimizing,* rather than simply trading off price and access. By offering the entire volume of Covered California's non-group pediatric dental enrollment to the "best in class" dental carrier, Options 8 and 9 might offer a better value to all families—more dentists at lower monthly cost. For example, best-in-class contracts might be awarded on the basis of price, network and service, but only to dental carriers which meet a threshold minimum network size, such as 95% of Medi-Cal participating dentists and 80% of the number of dentists in the largest DHMO and DPPO networks currently offered by Covered California.

Although consumers can take account of dental access in selecting a bundled or embedded QHP, the bundled and embedded options (1-4) are less flexible and offer less choice of plans and networks than other options. SADP options (5 and 6) offer lots of choice and flexibility. Options 8 and 9 simplify the consumer shopping experience and could provide a very large choice of dentists. Option 10 offers the most choice and complexity, except at the Silver level.

	Options								
Criteria	1	2	3	4	5	6	8	9	10
Protections, access, choice, flexibility, continuity, & simplicity									

6. *Feasible for CalHEERs and issuers.* Covered California was constrained in what it could offer in 2014 because of operational challenges. There are a number of such concerns about options other than the current SADP+9.5. One is that CalHEERs could not handle bundled policies, whereby two policies and premiums are tied together and presented to the enrollee as one. Another is that SERFF may be unable to break out rates separately for children (aged 19 & 20) who are too old for pediatric dental benefits. (Unlike many other exchanges, however, Covered California does not use SERFF for obtaining rates.) As this problem is specific to bundling, and pertains to other exchanges as well, we presume that it can be addressed, but not without considerable time and effort devoted to systems changes; and exchange systems are already quite challenged. We assume that the pressure on IT and related systems will not abate any time soon.

   Another concern is that some issuers will be challenged to integrate claims tracking with a specialty dental carrier to accumulate dental claims along with medical claims toward one OOPM or two integrated OOPMs. While two integrated OOPMs is more challenging operationally than one (10.0) OOPM, the "extra work" of also accumulating dental claims against a lower dental OOPM should fall mainly on the specialty carriers. Specialty carriers have indicated that, if given sufficient lead time, they can accommodate this extra challenge. Indeed, the key for every issuer and specialty carrier is clear direction and sufficient time. We address these implementation challenges further in section V, for the four options that we recommend for further consideration by Covered California.

   To maintain and track both SADP+9.5 and embedded 10.0 plans increases the operational challenges, for both the specialty dental carriers and the medical issuers. As this is explicitly contemplated in option 10, that challenge is reflected in its scoring below. However, we note that under options 5 and 6, issuers would be required to support both bundled/embedded plans outside Covered California and 9.5 plans on the exchange, so the feasibility differences among these options may be less than the

scoring below suggests. (Wakely cannot independently confirm carriers' feedback on some of the questions that relate to feasibility.

	Options								
Criteria	1	2	3	4	5	6	8	9	10
Feasible for CalHEERs, SERFF, and issuers	◗	◗	◗	◗	●	●	●	○	○

V. Recommended Options and Stakeholder Perspectives

Four options merit serious consideration and legal review. We provide further assessment in this section of the four options, concluding with a recommendation that two of them be dismissed at this point, and that the Board proceed with option 2, holding option 10 in reserve. This recommendation benefited from input of an advisory committee and was worked through with staff of Covered California.

- Embed pediatric dental coverage in 10.0 QHPs, with a small dental deductible and two integrated OOPMs (except for catastrophic), and consider adopting an age-factor curve that effectively re-allocates the cost of pediatric dental coverage to the child-specific premium rate. (Option 2)

- Continue to offer the current arrangement, but require households with children under 19 to purchase SADPs (option 6), if federal rules governing the calculation of APTCs change to include SADP coverage

- Select a best-in-class specialty dental carrier to develop embedded pediatric dental coverage for all (or most) medical issuers, and adopt the same configuration of deductibles, OOPMs and age-rating curve as in Option 2. (Option 9)

- Solicit embedded pediatric dental coverage for the four AV metal levels, and 9.5 plans for catastrophic, Bronze, Gold and Platinum levels. (Option 10)

Table 9: Nine Options Assessed on Six Criteria

Options			Criteria					
			1 Include pedi-dental costs in subsidy calculation	2 Minimize premiums for un-subsidized enrollees	3 Assure dental coverage for children	4 Moderate out-of-pocket spending and monthly premiums	5 Protection, access, choice, flexibility, continuity, & simplicity	6 2015 Feasibility for CalHEERs, and issuers
Embed-ded	1	Single OOPM (8)	●	◗	●	◗	◗	◗
	2	Integrated OOPMs (9)	●	◗	●	●	◗	◗
	3	Separate OOPMs for Medical and Dental (8)	●	◗	●	◗	◗	◗
Bundled	4	Separate 9.5 and 0.5 policies & OOPMs (5)	○	◗	●	○	◗	◗
Multiple SADPs & QHPs	5	Mix-and-match 9.5 and 0.5 plans (6)	○	●	○	○	●	●
	6	Children required to have 0.5 plan at checkout (8)	○	●	●	○	●	●
Best-in-Class Dental Carrier	8	Stand-alone or bundled (8)	○	●	●	○	●	●
	9	Embedded in 10.0 plans (9)	●	◗	●	●	●	○
Hybrid	10	10.0 Silver; 10.0 + 9.5 on other AVs (10)	●	●	●	●	●	○

Option 2: Embedded Pediatric Dental Coverage and Consider Revising Age-Rating Curve

As discussed in Section IV, this option partially or fully meets all criteria. Most importantly, it would guarantee that APTCs are calculated on the basis of 10.0 benefits, that they apply to the purchase of pediatric dental coverage, that families with children are covered for pediatric dental services, and that households without children do not pay for it (if the age curve is changed). By comparison with the other embedded options (1 and 3), a separate, integrated (or protective) pediatric dental OOPM, combined with a small dental deductible maximizes financial access and protection for pediatric dental benefits without unduly increasing overall premiums. An illustrative analysis of the impact of option 2 (recommended option) to the option 5 (default option) on families and single adults can be found in Appendix B.

The issues for further exploration, other than compliance, include the following:

a. Is it reasonably feasible for all QHP issuers to develop integrated OOPMs by 2015, and to drop 9.5 plans?

b. Should California develop a separate rating curve for the entire non-group market (in and out of the exchange) to shift the cost of pediatric dental benefits from adults to the rates for covered children and, if so, what problems might arise from doing so?

c. Is there value in requiring issuers to partner with a dental specialty carrier or otherwise meet a special set of dental-specific criteria for dental coverage?

d. Is there any reason to preserve SADP coverage as an option on the exchange, in the absence of 9.5 plans?

e. Should California consider revising the dental design, given additional flexibility of not having specific SADP AV requirements under embedding?

Is it feasible for all QHP issuers to develop integrated OOPMs by 2015 and discontinue 9.5 plans?

In order to integrate OOPMs, the claims processing systems for both dental and the other 9.5 EHBs must track claims paid, and aggregate enrollee cost-sharing separately for the 9.5 and the .5 benefits. (Typically, two different claims adjudication systems are used to process dental and other claims, even by one insurer.) In addition, if two systems are involved, they must routinely communicate this aggregation to each other, so that both "know" when the 0.5 and 10.0 OOPMs have been reached. In fact, there will be lag times and retroactive adjustments even with only one claims processing system, since multiple services and providers can be used within a short period of time, but claims for these encounters may be submitted at quite disparate times—and vice versa.

Therefore, communication among "partnering" claims systems needs to be frequent and regular (e.g., end of each day), not "real-time," and some retroactive adjustments are inevitable. Nevertheless, this is not easy. Given that "delegation" of claims processing to medical groups is far more common in California than elsewhere, the challenge of integrating a dental claims processing system with multiple medical claims processing systems for any one issuer is probably more complex in California than elsewhere.

Not surprisingly, preliminary discussion with specialty dental carriers and participating issuers on the feasibility of embedding for 2015 generated a range of responses. Generally, specialty but special attention should be paid to the capabilities of this group, if Covered California wants to encourage their entry.)

Carriers generally believe that they can build the interfaces with dental carriers, if given enough time. Issuers have to build the capacity to interface with prescription benefit managers, vision and other specialty claims processing systems, so dental is not a unique challenge, but embedding dental adds to already stressed systems and IT priorities. Of course, issuers in California dental carriers indicate that they can track out-of-pocket spending dental coverage, and all issuers can track OOPMs for their own covered claims. (Some Medi-Cal plans anticipating participating in Covered California after 2014 may see building the systems capabilities for just one OOPM across 10.0 benefits as a challenge. Wakely has not attempted to contact new entrants, have a host of other IT priorities as well. What is still in doubt is whether all issuers can embed for 2015. A few issuers have already built this capability for their own, subsidiary dental carrier; and most began to prepare to build this capacity with a "partnering" dental carrier early in 2013.

This is not an isolated challenge for any issuer, but one that must be prioritized against many other major systems projects, which have only multiplied because of the ACA. While all issuers agree that with time and clarity of direction, they can respond, they cite different requirements for adequate advance notice. At a minimum, to build this capability afresh, such efforts must stand in line with other priorities and compete (internally) for limited IT resources. For example, one issuer is piloting an embedded benefit for 2014 on one of its systems, but not the one used for QHPs on the exchange. This issuer suggested a bundled approach for 2015, as an interim solution, until it can integrate OOPMs in its QHPs on covered California for 2016.

However, most issuers that Wakely asked said that they could embed for 2015, if given sufficient notice and clear direction. The sooner the Board can specify and vote on exactly what it wants issuers to develop for 2015, the better their chances of being able to respond. This is an important consideration in moving forward with one option as soon as possible.

As to whether those same issuers would desist from proposing 9.5 plans, that is a matter to be worked out between Covered California and issuers, in light of guidance from HHS that seems to prohibit an outright ban on such plans. To this point, it is worth noting that we asked a couple of issuers about the difficulty of maintaining both 9.5 and 10.0 plans. And were told that

it would be easier to offer just the 10.0 than to support both plan designs in the same market segment.

Should California modify age rating and, if so, what problems might arise from adjusting California's age rating?

Changing the age rating curve only works as a way of avoiding the cross-subsidy problem between adults and children in a 10.0 plan. In addition, if 9.5 plans continue to be sold in California (with or without .5 plans), the existing age rating curve must be maintained for them. Using age curves in 9.5 plans that have been adjusted to eliminate adult subsidies of pediatric overage in 10.0 plans would result in over-pricing medical coverage for children, relative to adults, in 9.5 plans. Moreover, this change in age curve must also apply to individual plans in the off-exchange market, for the same reason.

In order to calculate the appropriate age factors, the current age rating curve would need to be evaluated for appropriate relationships between children and adults for various scenarios of benefits: with and without dental, as well as for various levels of medical and dental benefits. Since these factors will vary based on the level of medical and dental benefits, an average age factor curve will need to be determined based on the distribution of membership in various metal tiers and dental coverage levels.

Another issue worth noting is that the age cut-off for rating children (<21) is different than the age cut-off for pediatric dental coverage (<19). Ideally, a fix for the child rates would also differentiate between children under 19, so that children 19 and 20 do not bear the cost of dental coverage for which they do not qualify. Adding another child rating step, however, may strain the capabilities of CalHEERs. SERFF is not currently configured to accept two different rates for children, but California uses SERFF for rate review only, so the SERFF problem may be less determinative than CalHEERs.

Another issue for separately rating children 19 and 20 is compliance with federal regulations. Although the applicable guidance authorizes states to develop their own rating curves, the language is unclear as to whether this flexibility extends to replacing one with two childrens' rates. For States intending to submit their own rating curves for 2014, the deadline was March 29, 2013, but no deadline has been given for 2015.[32]

Given the difficulty in finding a "perfect" solution, it is important to keep this issue in perspective: Wakely suggests that the inequity in age-rating for two years may be tolerable. After all, by 2016, most children aged 19 and 20 would have recently qualified (in 2014 and 2015) for pediatric dental benefits, and their rates would no longer reflect this cost when they turn 21. To put this in perspective, insurance is pooling, not prepayment, and there are far

[32] Sub-Regulatory Guidance Regarding Age Curves, Geographical Rating Areas and State Reporting," February 25, 2013.

fewer 19 and 20 year-olds that would pay for this benefit than men who pay for gynecology or women who pay for prostate exams.

Further, the Board may well consider the entire issue of cross-subsidies and age rating a detail to be further analyzed for 2016, rather than a major issue for immediate resolution. Given the relatively small number of children eligible for this benefit, the premium impact on households without children is modest.

Is there value in issuers partnering with dental specialty carriers?

Specialty dental carriers argue that their expertise and the specialized nature of dental claims processing allow them to offer a superior product and consumer experience. In fact, the health plans in California seem to agree, and most, if not all, issuers expect to "partner" for the foreseeable future with a specialty carrier—their own subsidiary or an external party—to arrange for pediatric dental benefits. This expectation holds for both embedded and bundled arrangements.

Therefore, the real point of differentiation for SADP+9.5 is the choice that it gives consumers to select their own SADP, rather than have the issuer of an embedded or bundled benefit do so for them. There may be value to this choice, but it is not clear that it is any more valuable than being able to mix-and-match networks for other major specialties—pediatrics, obstetrics, oncology, etc—separately from each 10.0 QHP. Rather, it reflects the development of dental insurance in the U.S. as an employee benefit separately and later that medical insurance. (In many other economically advanced countries, dental is part of medical coverage.)

Is there any reason to preserve SADP coverage as an option on the exchange?

Even with embedded coverage, SADPs may serve an important niche: large employers are not required to offer all 10 EHBs, so access by their employees to non-group dental coverage could be very beneficial. Indeed, there may be a market for stand-alone dental coverage that applies to adults as well as children. Moreover, under current rules, CMS requires exchanges to offer SADPs, if proposed. Therefore, it probably does not make sense for California to seek a change in this rule.

Should California consider revising the dental design, given additional flexibility of not having specific SADP AV requirements under embedding?

SADPs must meet specific actuarial value requirements to be certified by the exchange (70% AV for low option and 85% for high option). When the pediatric dental benefits are embedded in the medical plan (10.0 option), there are no similar constraints with respect to the dental cost sharing. This allows for additional flexibility in designing the cost sharing features of the plan. For example, under the current low option SADP, the $60 deductible applies to all services,

including preventive/diagnostic services. Covered California may want to consider not applying any deductible to preventive services to align with the treatment of other preventive services covered under the medical plan, and eliminate financial barriers for preventive dental services. This change would have an additional cost which could be modeled upon request.

Option 6: SADP+9.5 QHPs, with Mandatory Purchase for Children <19

As discussed in Section IV, this option would partially or fully meet all the criteria if, and only if, federal rules for calculating APTCs are revised to include the cost of SADP coverage. If this condition were met, this option would offer the advantage of continuity from 2014, rather than the disruption that another change for 2015 inevitably entails. Even with the systems changes in Covered California to block "check out" for households with eligible children who have not selected an SADP, option 6 is relatively easy to implement and would provide consumers with a broad choice of stand-alone dental plans, premiums and networks.

The issues for further exploration under this option include the following:

a. By when should Covered California make its determination, and will the required changes in federal policy being made prior to that point.

b. Are there any difficulties in mandating purchase of SADPs for children <19?

c. Should standard plan designs be revisited to mitigate impact of SB639?

Timing & probability of federal policy changes on APTCs

The sooner that Covered California makes a decision, the more feasible it will be for carriers to implement any of the other options (2, 9 or 10) that require embedding for 2015. Delaying this decision long enough would effectively force a default to option 6.

Obviously, changing the calculation and applicability of APTCs is prerequisite for option 6. This represents a major policy shift. The change would have to be made immediately and draft regulations published soon thereafter to avoid missing the issuers' timetable for embedding pediatric dental coverage. Wakely cannot comment definitively on the prospects for this change, but there is presently no indication that it is forthcoming, and obviously CCIIO's current focus is on some more pressing problems with a higher political and practical urgency.

Are there any difficulties in mandating purchase of SADPs for children <19?

All four options recommended for further consideration effectively mandate purchase of pediatric dental coverage for children. As a result, this option avoids the need to consider altering California's age rating curve to assign the costs for pediatric dental coverage to

children's rates. Therefore, this option ought *not* to raise more concern than options 2 and 9 about another mandate. However, given the strength of political opposition to the ACA and sensitivity to government intrusion, an explicit mandate that households *with* children buy SADPs may raise concerns about the agency's statutory authority and role in the market.

Moreover, option 6 perpetuates an inequality between the purchase of pediatric dental coverage on and off the exchange. Because under option 6, Covered California would not require childless households to purchase SADPs, but 9.5 QHPs must be bundled with SADPs outside the exchange, adult-only households would find it materially less expensive to buy their coverage on exchange. This difference maintains a price advantage for (unsubsidized) childless households to use Covered California. Childless families include many young "invincibles," but also older "empty-nesters," so this inequity may or may not drive better risk selection for Covered California.

As a practical matter, Nevada and Washington have put in the mechanical "fix," so that families with children cannot check out a QHP without also buying SADP coverage. However, CalHEERs is under considerable stress, so however easy it might have been originally to add a screen to Covered California's check-out process, its feasibility may be more uncertain at this point.

Should standard plan designs be revisited to mitigate impact of SB639?

Under the SADP+9.5 QHP scenario, SB639 has the impact of forcing the medical plans to have a lower out-of-pocket maximum, so as to not breech the required maximum total of $6,350/$12,700 (individuals/families). The current low option SADP design includes a $1,000 per child OOPM, which requires a reduction in the maximum medical OOPM from $6,350/$12,700 to $5,350/$10,700. This change in the medical OOPM will result in either increased premiums for both children and adults or increases in other cost sharing features. This impact could be mitigated if the standard low SADP design had a lower OOPM, for example $700, allowing for a higher medical OOPM. In order to maintain the 70% required AV for the low plan option, the dental plan would need to have an increased deductible. This variation is modeled in column 3 of Table 3.

Option 9: Best-in-Class pediatric dental Embedded, with a Revised Age-Rating Curve

As discussed in Section IV, this option partially or fully meets all criteria, if an aggressively priced, relatively broad network, "best-in-class" pediatric dental coverage can be embedded in most QHPs. It offers several other advantages as well, but raises unique challenges:

a. Would a "best-in-class" bidding process likely encourage at least as good, if not better, proposals than the current arrangement in terms of premium, choice of dentists, and service?

b. What would be lost in not offering different specialty carriers in the exchange?

c. Is it reasonable to expect all QHP issuers to integrate with Covered California's selected pediatric dental carrier in time for 2015?

d. Can this bidding process be coordinated with Medi-Cal so as to eliminate the disruption in coverage and provider access for children who move from Medi-Cal (under 250% of FPL) to Covered California and vice versa?

Would "best-in-class" improve value (access, cost and service) for consumers?

Clearly, option 9 reduces consumer choice of dental carriers, but Table 8 suggests that it might actually increase choice of dentists, at a reasonably low price, compared with option 2. If the best-in-class SADPs in 2014 were embedded in all QHPs, they would present all consumers with lower premiums and more dentists than almost any other combination. By contrast, under option 2, were various issuers to pair up with the various specialty dental carriers, it is quite likely that many consumers who want one or another 9.5 QHP would be forced to accept a less than optimal pediatric dental network. (Interviews with issuers indicate that no single specialty dental carrier is the first choice of all issuers.)

Moreover, it is reasonable to expect that a "winner-take-all" bidding process might attract an even more aggressive proposal for pediatric dental coverage, if only because the scale economies and purchasing power of that dental carrier would enable it to attract more dentists at existing reimbursement rates. (Given the relatively low MLR of dental versus medical carriers, scale economies should be especially relevant.) In this case, option 9 might offer better pediatric dental coverage than any of the SADPs available in 2014. Of course, no such result can be guaranteed, and any observations about bids for 2014 should be heavily caveated because so little experience and information was available to carriers in setting initial premiums.

What is lost by not offering different specialty carriers in the exchange?

If the exchange represented most of California's dental market, so that denying a specialty carrier the opportunity to participate would threaten its viability, this option might threaten dental carriers and ongoing competition among them. However, there is robust competition among dental carriers in California, and the exchange represents an increase in volume, rather than a shift of existing volume from one to another. Therefore, awarding the bid to a single carrier would not necessarily reduce the competitive field. Nor would it necessarily reduce choice of products: both a DHMO (or DEPO) and a DPPO proposal at the 70% and 85% levels should be solicited, thereby assuring the choice of at least two different networks in combination with two different benefit configurations from one issuer. In fact, four is much more choice of dental plans than many large employers offer.

However, this option is higher risk because a failure of the selected dental carrier to perform, either initially or over time, would affect all enrollees and issuers. Because of the initial disruption in existing relationships of some issuers and some consumers with dental carriers, and the set-up efforts required for all issuers to integrate with a single dental carrier, a multi-year contract would make sense. Even so, re-bidding and replacing that one dental carrier after 3-5 years could prove administratively expensive and disruptive, yet again. Finally, complaints from enrollees about pediatric dental coverage would reflect on Covered California's selection, and might enhance political opposition toward public exchanges.

Moreover, it would certainly trigger resistance from some issuers and specialty carriers, which could further delay the decision or cast uncertainty on its credibility.

Is it reasonable to expect all issuers to integrate with one pediatric dental carrier?

It is not unusual for a large employer to select one carve-out vendor for such benefits as dental, vision, behavioral health or even prescription drug coverage, but the level of integration may not be comparable. On the one hand, health plans have long argued that behavioral and medical health services are so related that it is awkward to split them between different carriers or TPAs. In fact, some carve-out vendors set up shop in the medical plan's offices to foster communication between nurses and other personnel from the two firms. Nothing like that degree of clinical integration would be required for option 9. Rather, the required integration is largely related to the exchange of data for two OOPMs.

On the other hand, no issuer wants to be pushed into a partnership with another vendor, especially not a competitor's. For the participating issuers which own specialty dental carriers (Blue Shield, Health Net and Anthem), and for Kaiser, which has a longstanding partnership with Delta Dental and expects to work with Delta Dental if embedding is required, potentially forcing them to integrate OOPMs with a competing dental specialty carrier entails a level of re-work, re-branding, trust building, and data exchange that may simply be too disruptive. Moreover, if the relationships do not work smoothly, then meeting the requisite deadlines for testing and operationalizing these arrangements by 2015 would be put at risk.

Certainly, one of the key criterion for selecting a dental carrier must be its ability and commitment to adequately resource and work flexibly at such integration with all participating medical issuers. Other ways to anticipate and ameliorate this concern would be to phase-in integration, for example, by allowing a bundled arrangement between issuers and the single dental carrier as an interim step in 2015. Allowing exceptions for medical issuers to work with their own, wholly-owned specialty carriers, if they can embed by 2015 and meet the network criteria for best-in-class dental carrier, would also be prudent.

However, the most problematic feature of this approach may be timing. Even if the process were to go forward very smoothly, Covered California would require months to develop the

RFP, receive proposals, evaluate them and contract with a "best-in-class" specialty dental carrier. Then each issuer would have to work with that single carrier in a compressed timeframe. Especially if issuers are required by Covered California to partner with a different dental carrier than they control or have traditionally partnered with outside Covered California—and this includes at least Anthem, Blue Shield, HealthNet and Kaiser—then meeting a 2015 deadline for embedding will raise strong concerns. Even with exceptions for existing relationships between medical plans and specialty carriers, were this option considered worthwhile it may well be simply impractical for 2015.

Can this bidding process be coordinated with Medi-Cal?

In most of California, a single specialty carrier arranges all dental coverage for Medi-Cal. Medi-Cal is scheduled to go out to bid for dental coverage next year (2014). This alignment of timing raises the prospect of Covered California and Medi-Cal coordinating their procurements to address the important problem of churn between the two programs. Enrollees' incomes are expected to fluctuate, leading to considerable "churn" as enrollees lose eligibility for one program and gain eligibility for another. Nationally, Somers and Rosenbaum projected that in one year, 50 percent of all adults with family incomes below 200 percent of the federal poverty level will experience a shift in eligibility from Medicaid to an insurance exchange, or the reverse. While the rate may be somewhat different for children of families below 250%, (the income cut-off for children in Healthy Families), there is no reason to expect it to be significantly lower.[33]

As children churn between one program and another, they would not be able to keep their dentists, unless those dentists participate in the networks for both Medi-Cal and their QHPs. Under option 2, dentists will be in some 10.0 QHPs, but not others, so when selecting a health plan, the family may have to choose between the child's dentist, pediatrician or behavioral health specialist. Option 6 presumably allows the children to retain their dentists under either Medi-Cal or an SADP, but that SADP may require a high premium, and some dentists will simply not participate in both programs.

Of course, changing dentists may disrupt geographic access, can make childrens' dental visits that much more difficult, and generate duplicate x-ray films, the expense of transferring dental records, etc. To avoid all this disruption and expense, ideally, Covered California and Medi-Cal could find a way to coordinate their upcoming procurements to the extent of insisting that, at least for the exchange's DHMO, the specialty carrier's dental networks would be similar for both coverage programs. (Greater choice of dentists could be available in the higher-priced DPPO, which is more likely to appeal to unsubsidized enrollees.) Exceptions granted for dental

[33] Sommers BD, Rosenbaum S. Issues in health reform: how changes in eligibility may move millions back and forth between medicaid and insurance exchanges. Health Affairs (February 2011); 30 (2): 228-36.

carriers that are owned by issuers, or have long-standing relationships, could carry a requirement that the exempt arrangements offer all Medi-Cal participating dentists that meet that specialty carrier's dental quality and fraud prevention criteria.

Option 10: Hybrid

As discussed in Section IV, this option offers more choice of specialty carriers and flexibility to integrate OOPMs than the other options, except at the Silver level, where the offering of embedded only mirrors option 2. So long as households with children under 19 can be required to select pediatric coverage, this option seems to offer many of the same advantages as options 2 and 6 combined. Most of the issues relating to this option have been raised under options 2 and 6. Two additional questions are worth considering:

a. Can two age curves be developed for 9.5 and 10.0 plans?

b. Does maintaining both 9.5 and 10.0 plans increase administrative costs and burden on issuers?

Can two age curves be developed for 9.5 and 10.0 plans?

Since the existing age rating curve seems to have been developed without reference to pediatric dental costs, it should fit 9.5 plans. Only the additional effort to modify and test the standard age-rating curve to load all the pediatric dental claims costs of 10.0 plans into child rates would be required to have distinct age rating curves for both 9.5 and 10.0 plans. Maintaining two age-rating curves over time should be fairly straight-forward. The greater unknown is whether CMS would approve two age rating curves in these circumstances: the language in its regulation and guidance speaks to a "uniform age rating curve," not two:

> "Section 147.102(e) requires that, for age rating purposes…, health insurance issuers use a uniform age rating curve established by the state for the individual market, small group market, or both markets…"[34]

Does maintaining both 9.5 and 10.0 plans increase administrative costs and burden?

Interviews with issuers suggest a range of burden here. When asked, some responded that the need to track benefits, premiums, collateral materials, separately for each, the potential confusion among enrollees and providers, and so forth definitely drives complexity and cost. However, this reaction also reflects the existing burden on carriers—to which this duplication would be added—rather than a monumental challenge. In fact, the current issuers have all developed 9.5 plans. The larger challenge, by far, would be to embed pediatric dental coverage for 10.0. It is only that maintaining a second set of similar benefits, on top of the challenge of

[34] Sub-Regulatory Guidance Regarding Age Curves, Geographical Rating Areas and State Reporting," February 25, 2013.

embedding, adds to the total burden. Most issuers indicate that they have already begun planning for bundling or embedding, and they know which dental carrier they will partner with. Disrupting their plans under option 9 would undo and complicate efforts already made to get ready for 2015.

Based on discussions with Covered California's staff, Wakely recommends not dismissing this option, but holding it in reserve in the event that issuers insist on offering 9.5 plans, and HHS will not allow the California regulatory authorities the flexibility to proscribe this design in Covered California, as it has outside Covered California.

VI. Transition Challenges for Option 2

- For all options, a very important transition issue is the timing for getting clear-cut federal guidance: without such guidance by the end of 2013 or very early in 2014, most issuers have indicated that embedding cannot be done for 2015.

- Under option 2, substantial numbers of children with established pediatric dental relationships will face disruption, and some medical carriers will be challenged to integrate with specialty dental carriers in time for 2015.

A critical challenge for option 2 is the potential disruption in patient-dentist relationships that would result from removing free choice of dental plans and networks. Wakely has not performed an analysis of the overlap among the four DHMO and four DPPO networks currently offered, nor a geo-access assessment of each, but the disparities in network size (3,300 to 14,000) are huge, even within each product category. And none offers more than about 60% of California's practicing dentists.[35] Therefore, a transition issue of particular concern is to ease discontinuity of access, consequent harm to patients, and business disruption for dentists and dental carriers.

For patients, the disruption in access could be substantially ameliorated by Covered California insisting that all dental plans meet high network size and geographic access standards.

[35] "Children's Dental Insurance Plan Rates 2014" Covered California. 6 Sept 2013.
Based on interviews with stakeholders, we are assuming that there are about 25,000 practicing dentists in California.

Nevertheless, additional transitional efforts might be required, such as allowing 18-year olds to stay with their existing dentist (for the last year of coverage) at in-network rates, special efforts to contract with high-volume dental practices, and so forth.

Most of the accommodations to broaden choice of dentists and maintain existing patient relationships impose burdens on the carriers. Dental carriers may resist (a) directives to substantially broaden their networks, at the cost of raising reimbursement rates and premiums, (b) transitional accommodations for out-of-network dentists, and (c) being required to embed pediatric dental benefits for 2015. This might even be a legitimate rationale for raising premiums in 2015.

Option 2 also poses a challenge to each medical issuer, to partner with a dental carrier to integrate their separate systems. Based on interviews with most of the issuers, all expect to use a specialty carrier for the foreseeable future. Finding the right partner, negotiating the arrangements, including price, and then actually integrating the systems will take time, so the sooner Covered California announces its decision for 2015, the more feasible this option is.

Appendix A: Impact of Pediatric Dental Regulations

Summary

Current regulations may prevent pediatric dental coverage from being included in the calculation of the value of enrollees' Advance Premium Tax Credits (APTC), QHPs are offered at the Silver level without the pediatric dental benefit. As a result, low-income enrollees may not receive enough financial assistance to purchase pediatric dental coverage, and they may choose to forego purchasing such coverage. This paper provides an overview of regulations that impact the value of APTC and examines the possibility of changing such regulations.

Advance Premium Tax Credits (APTC)

APTC provide federal financial assistance, or subsidies, to exchange enrollees with income levels up to 400% FPL. The formula to calculate the value of an enrollee's APTC is summarized below:

Premium of second lowest Silver plan that would cover the enrollee's tax household
\- Enrollee contribution toward 2nd lowest Silver, based on their income (Magi)
= APTC value

Current regulations do allow enrollees to use their APTC towards the purchase of pediatric dental coverage, however their tax credit must first apply to QHP premiums and then any remaining tax credits can be used to purchase pediatric stand-alone dental coverage[36]. Since the tax credit is always less than the premium of the 2nd lowest priced Silver plan, it could only be used for stand-alone pediatric dental coverage if the enrollee buys the least expensive Silver plan or a Bronze plan priced below the APTC. This paper focuses on the impact regulations have on determining the value of the benchmark plan (second lowest priced Silver plan on the exchange), which in turn affects the value of an enrollee's APTC.

Regulations that impact the value of second lowest priced Silver plan and APTC value

45 C.F.R. § 155.1065 regulates how exchanges offer the pediatric dental essential health benefit. The regulation is copied below:

§ 155.1065

(a) General requirements. The Exchange must allow the offering of a limited scope dental benefits plan through the Exchange, if—

(1) The plan meets the requirements of section 9832(c)(2)(A) of the Code and 2791(c)(2)(A) of the PHS Act; and

(2) The plan covers at least the pediatric dental essential health benefit as defined in section 1302(b)(1)(J) of the Affordable Care Act, provided that, with respect to this benefit, the plan satisfies the requirements of section 2711 of the PHS Act; and

(3) The plan and issuer of such plan meets QHP certification standards, including §155.1020(c), except for any certification requirement that cannot be met because the

[36] 45 C.F.R. § 155.340(e) and 26 CFR § 1.36B-3(k)

plan covers only the benefits described in paragraph (a)(2) of this section.

(b) Offering options. The Exchange may allow the dental plan to be offered—

(1) As a stand-alone dental plan; or

(2) In conjunction with a QHP.

(c) Sufficient capacity. An Exchange must consider the collective capacity of stand-alone dental plans during certification to ensure sufficient access to pediatric dental coverage.

(d) QHP Certification standards. If a plan described in paragraph (a) of this section is offered through an Exchange, another health plan offered through such Exchange must not fail to be treated as a QHP solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under section 1302(b)(1)(J) of the Affordable Care Act.

For purposes of this discussion, there are two main takeaways from 45 C.F.R. § 155.1065:

1. An exchange must allow pediatric SADP (0.5 plans) to be offered
2. If there is at least one SADP offered, then the exchange must also allow issuers to offer medical plans without pediatric dental coverage (9.5 plans)

IRS regulation 26 CFR § 1.36B-3 determines how exchanges calculate the value of an enrollee's APTC, and it states that the benchmark plan calculation is based on the premium of the second-lowest priced silver plan, regardless of whether the plan includes pediatric dental coverage.

According to § 155.1065, an exchange cannot prevent 9.5 plans from being offered (if SADPs are also offered). If only 9.5 plans are offered on the Silver level in the exchange, then the APTC is based on a premium that does not cover the pediatric dental benefit; and even if both 9.5 and 10.0 plans are offered, the 9.5 plans are likely be priced lower than 10.0 plans, and will therefore likely be the second lowest priced silver plan used to determine the value of an enrollee's tax credit. IRS regulation 26 CFR § 1.36B-3 clarifies that if a 9.5 plan is the second-lowest priced silver plan, then the value of pediatric dental coverage cannot be included in the APTC value calculation.

On a separate but related note, 45 C.F.R. § 155.1065 also states that exchanges must offer pediatric dental coverage, but do not have to require enrollees to purchase the coverage. While this aspect of the regulation does not directly impact the value of APTC, it allows enrollees to forego purchasing pediatric dental coverage. It is reasonable to assume that if enrollees receive a lower-valued APTC, which does not incorporate the value of pediatric dental in its calculation, they are less likely to purchase stand-alone pediatric dental coverage.

Possibility of Changing Regulations

Altering regulations to increase the value of APTC may not be feasible for 2014, and CMS plans to issue guidance on this possibility for 2015. Overall, there are two potential regulation changes that can increase the value of APTC to include pediatric dental:

1. Change 45 C.F.R. § 155.1065 so that exchanges are not required to allow 9.5 plans, if SADPs are also offered. This would give exchanges the authority to solicit 10.0 plans only, or 10.0 and .5 SADPs, but to exclude 9.5 plans, thereby assuring the inclusion of the pediatric dental benefit in the second lowest priced silver plan.
2. Change IRS regulation 26 CFR § 1.36B-3 so that if a 9.5 plan is the second-lowest priced silver plan, then the premium of a pediatric SADP is added ti the premium of the second-lowest price silver plan for purposes of calculating APTC.

The American Dental Association (ADA), Children's Dental Health Project, Delta Dental Plans Association, and the National Association of Dental Plans (NADP) have issued a joint letter to Secretary Lew of the U.S. Department of Treasury requesting a change to the interpretation of APTC calculation to include pediatric dental (option 2 above).[37] The letter notes that pediatric dental is defined as an essential health benefit by the ACA and the law intended that the purchase of the entire essential health benefit package would be supported by tax credits. In addition the organizations believe that there will be very limited circumstances in which actual premiums will be less than the tax credit amount and enrollees will not have left over tax credits to purchase pediatric dental coverage from a SADP, thereby leaving many children without essential dental coverage. The letter suggests that the Treasury Department has broad authority to revise the regulation, and that is it appropriate for the department to re-open the regulation comment period for this issue.

CMS plans to issue guidance on the possibility of changing regulations, and it is unclear yet whether any changes will be made for 2014 or 2015. Connecticut's Access Health CT was given a 1-year waiver from the requirement to offer SADPs and 9.5 plans. In Vermont and Washington DC, most issuers chose to offer only 10.0 plans, and therefore pediatric dental is included in the second lowest Silver plan and is included in APTC calculations.

[37] American Dental Association (ADA), Children's Dental Health Project, Delta Dental Plans Association, and the National Association of Dental Plans (NADP). Letter to The Honorable Jack Lew, Secretary, U.S. Department of the Treasury. 23 Sept. 2013.

Appendix B: Illustrative Impact of Recommended Option (#2) on Families and Single Adults

Summary

The following provides an illustration of the impact of the recommended option (#2) relative to the default option (#5) given either a DHMO or a DPPO as noted below.

DHMO ***	Impact of recommended option vs. default					
	Unsubsidized			APTC Subsidized		
	Helped	Hurt	Total	Helped	Hurt	Total
Family of Four (per year)						
% of Families	85.5%	14.5%	100.0%	85.5%	14.5%	100.0%
Average (Savings)/Cost	($320)	$721	($169)	($247)	$792	($96)
Range of (Savings)/Cost	($320) - $0	$0 - $1,680	($320) - $1,680	($247) - $0	$0 - $1,753	($247) - $1,753
Single Adult (per year)						
% of Single Adults	93.8%	6.2%	100.0%	Unaffected	6.2%	100.0%
Average (Savings)/Cost	($40)	$960	$22		$1,000	$62
Range of (Savings)/Cost	($40) - $0	$0 - $960	($40) - $960		$0 - $1,000	$0 - $1,000

DPPO ***	Impact of recommended option vs. default					
	Unsubsidized			APTC Subsidized		
	Helped	Hurt	Total	Helped	Hurt	Total
Family of Four (per year)						
% of Families	85.7%	14.3%	100.0%	85.9%	14.1%	100.0%
Average (Savings)/Cost	($665)	$383	($516)	($753)	$297	($604)
Range of (Savings)/Cost	($666) - $0	$0 - $1,334	($666) - $1,334	($755) - $0	$0 - $1,245	($755) - $1,245
Single Adult (per year)						
% of Single Adults	None Helped	100.0%	100.0%	Unaffected	6.2%	100.0%
Average (Savings)/Cost		$64	$64		$1,000	$62
Range of (Savings)/Cost		$2 - $1,002	$2 - $1,002		$0 - $1,000	$0 - $1,000

Key takeaways for families of four include:

- Under both the DHMO and DPPO scenarios, more than 85% of unsubsidized families are helped under the recommended option compared to the default option, generally as a result of lower premium due to:
  - Higher out-of-pocket maximum (OOPM) on medical services ($6,350 vs. $5,350), and
  - The cost of pediatric dental is spread across the entire population, including adults without dependent children.
- The 14% - 15% of families that are hurt under the recommended option compared to the default are those with out-of-pocket costs higher than $5,350 / $10,700 (individual/family) that are not offset by the premium decrease described above.
- Families of four that are eligible for the tax credits benefit from the inclusion of dental premiums in their subsidy calculation, though some are hurt by the increase in the OOPM.

Key takeaways for single adults include:

- On average, unsubsidized adults pay more as a result of embedding dental (without a change in the age curve). Because of the age curve, older adults subsidize a greater amount of the cost of pediatric dental than younger adults
- Subsidized adults that select the 2nd lowest cost silver plan are not affected by the premium increase resulting from embedding pediatric dental into the medical plan.
- Some subsidized adults are hurt under the recommended option relative to the default option due to the higher OOPM ($6,350 vs. $5,350).

Key Assumptions

The analysis was based on the following assumptions:

- Modeled Plan Design for Recommended Option
    - Proxies a silver medical plan (~70% AV)and low dental plan option (~70% AV)
    - 10.0 plan with embedded pediatric dental
    - $60 dental deductible, $900 medical deductible per person (2x stacked deductible for families)
    - $1,000 dental out-of-pocket maximum (OOPM), $6,350 integrated OOPM for medical and dental combined (2x stacked OOPM for families)
    - 30% coinsurance for medical and dental services
- Modeled Plan Design for Default Option
    - Proxies a silver medical plan (~70% AV) and low dental plan option (~70% AV)
    - Separate 9.5 medical and 0.5 pediatric dental
    - Medical plan has $900 deductible (2x stacked deductible for families), $5,350 OOPM (2x stacked OOPM for families), and 30% coinsurance
    - Dental plan has $60 deductible (2x stacked deductible for families), $1,000 OOPM (2x stacked OOPM for families), and 30% coinsurance
- Families purchase 2nd lowest cost medical plan (for both recommended and default options) and second lowest cost dental plan (default option only)
- Though 0.5 pediatric dental coverage is voluntary under default option, analysis assumes all families purchase 0.5 pediatric dental coverage
- Premiums for 2nd lowest cost 70% DHMO and 2nd lowest cost 70% DPPO for the San Francisco area used for illustration
- 2014 cost levels
- No change in age curve

Methodology

The following methodology was used to perform the analysis.

1. Medical and dental annual claim amounts trended to 2014 and simulated 10,000 times for each member of a family of four and a single adult
2. For each of option, the resulting claim costs and out-of-pocket expenses were determined
3. The net total annual impact (including out-of-pocket costs, premiums, and advanced premium tax credits) of selecting the recommended option was determined
4. The comparison is displayed separately for a family of four and a single adult (≥21) and for those eligible for advanced premium tax credits
5. The resulting net impacts on a household's premium and out-of-pocket costs are separated into those who were "helped" or "hurt" by the recommended option - including by how much (average and range of "help" or "hurt").