DATE: **APRIL 14, 2014**

TO: **AHCT STAFF**

RE: **RESPONSE TO SADP DISCUSSION ON APRIL7, 2014**

Background

NADP is responding to various questions as raised by the AHCT staff during the 4/7/14 "SADP Kick-Off Meeting." We traditionally ask member dental plans to respond to specific plan design questions as each carrier has a dental officer or consultants who continuously review clinical processes and develop their policies according to ongoing guidance. Following are general perspectives and recommendations on issues impacting the dental beneifts industry and our member plans.

Standard Plan Design:

- It will be difficult to meet the lower 70% Actuarial Value (AV) level with the plan design as outlined. Included is a Milliman study which illustrates the impact of lowering the maximum out-of-pocket (MOOP) limit on premiums. The Milliman memo is not specific to the proposed AHCT plan design but offers the relation between the MOOP and the premium when placed on a typical dental product under the ACA.
    - To reach the 70% AV level with the lower MOOP, you must increase the deductible, but with a zero deductible as outlined in the plan design, there is not a reasonable way to meet the lower AV level without pricing the premium out of reach of most consumers. This should be reviewed closely by an actuary familiar AHCT's proposed plan design and dental products in the commercial market.
    - Allowing for additional, non-prescribed plan designs would parallel other Marketplaces and provide consumers more affordable options that are likely to parallel the employer market.
    - AHCT should allow for additional types of network products. Attached is an outline of the dental market in Connecticut, which illustrates the vast majority of policies are DPPOs. To limit Exchange offerings to Indemnity plans will certainly drive up costs as discounted provider networks are not part of Indemnity products as they are with DPPOs.
- NADP recommends AHCT increase slightly the out-of-pocket limits to $350/$700 for the higher 85% AV level to parallel federal guidelines. The modification would allow additional flexibility in plan design and assure lower premiums. The increased MOOP still offers similar consumer protection and brings down administrative costs for the carriers so they can have more standardized policies across the company and across products being offered on Marketplaces.
- Currently under ACA regulations, coverage of medical necessity orthodontia is required but carriers have some flexibility as to how to define medically necessity within their policies. As CCIIO will be reviewing the EHB policies in 2016, NADP recommends AHCT to allow carriers to continue contracting orthodontia as they are now, and review this policy once CCIIO provides new guidance in 2016.

Display:

- NADP recommends viewing Kynect, Kentucky's Exchange, as they have made a decision to require the purchase of pediatric dental for children and also utilize Deloitte as a vendor. Currently, they have QHP enrollment of 77k which is similar to Connecticut's 76k, while Kentucky also has an additional dental enrollment of 20k. They allow for all types of dental benefit offerings, whether embedded in a medical plan or purchased via a standalone dental policy.
- While Nevada Health Link has experienced some technical issues during open enrollment, the Exchange has achieved 40k for QHP enrollment and over 20k for dental enrollment. This impressive dental enrollment has been credited to a requirement that children enrolling in health coverage also have

pediatric dental benefits, but also to the allowance of purchasing dental without the purchase of medical, similar to Connecticut. This is another Exchange AHCT should review as their enrollment numbers are promising.

- HealthSource RI, Rhode Island's Exchange, has been creative in their dental design by allowing family dental policies to be offered with the pediatric portion rated at zero. In other words, they use the question asked in the beginning "Are you wanting to cover any dependents?" and if the response is no then they are offered family dental plans but rated financially for adults only. This is a direct cost savings for their adult consumers.
- While NADP is certain AHCT will be required to allow medical carriers to offer QHPs without dental, the dental plan design differs between embedded and standalone. It should be transparent to consumers what dental benefits are included in the medical policy they purchased and the choices available from separate dental policies so they are not purchasing duplicative coverage.

In Addition:

- Medical Without Dental: The ACA statute and corresponding guidance requires Marketplaces to allow for QHPs not to include pediatric dental benefits. Upon further discussion, there is not an AHCT or CDI policy that in any way conflicts with this guidance.
    - NADP recommends AHCT to provide a QHP plan design that does not require embedded dental.
- Off Exchange Certification: ACA Guidance requires medical carriers to be reasonably assured an enrollee in the private small group and individual market has "exchange certified" dental policies or the QHP must include pediatric dental. CMS guidance indicates the method of obtaining assurance is at the discretion of the issuer and some states have taken various approaches to clarify this requirement, which NADP is providing to AHCT separately. In most cases, to become "exchange certified," a standalone dental plan must complete the certification process of the Exchange, up until the point of signing an agreement. Therefore, the plan designs adopted by the AHCT have a direct impact on the Connecticut dental commercial market and must be considered during these deliberations.

CONTACT: KRIS HATHAWAY, NADP Director of Government Relations
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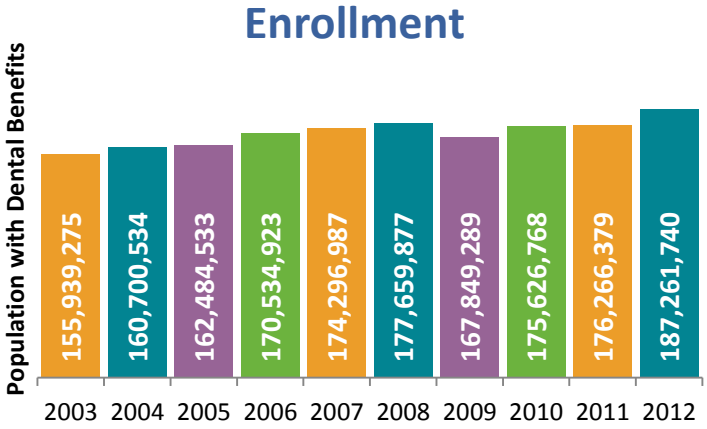
Connecticut

Dental Benefits Fact Sheet

National Enrollment Trends



Source: 2013 NADP/DDPA Joint Dental Benefits Report on Enrollment

State Enrollment

An estimated 1,862,985 people are enrolled in a private dental plan from Connecticut.

Private Plan Enrollment

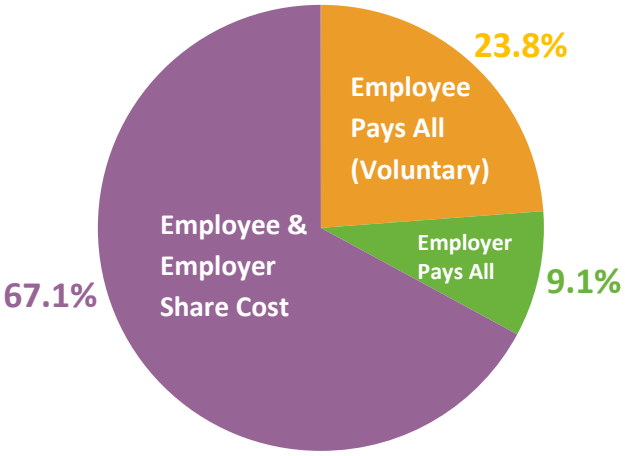
Plan Type	Enrollment
DHMO	82,806
DPPO	1,690,251
Indemnity	51,371
Other Private	38,555

Public Plan Enrollment

Medicaid/CHIP[1]	6,286
Other Public[2]	299,470

Source: 2013 NADP/DDPA Joint Dental Benefits Report on Enrollment

Group Policy Funding

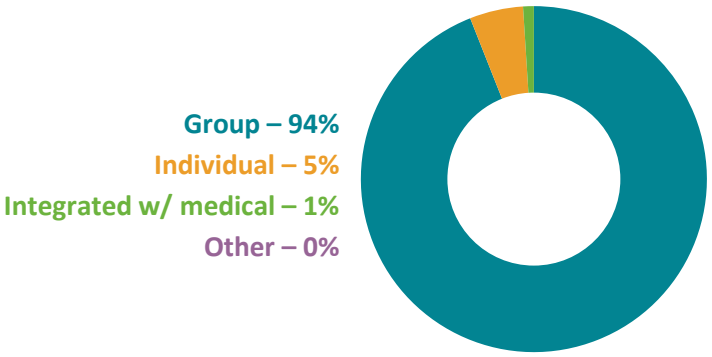


Source: 2013 NADP/DDPA Joint Dental Benefits Report on Enrollment

Distribution of Commercial Benefits: State vs National

	DHMO	DPPO	Indemnity	Other
Connecticut	4.4%	90.7%	2.8%	2.1%
National	8.4%	77.2%	9.0%	5.4%

Sources of Private Dental Coverage



Source: 2013 NADP/DDPA Joint Dental Benefits Report on Enrollment

Premium Facts

Nationally, premium increases ranged for existing group coverage from 0.2% for DHMO products to 1.5% for DPPO products

Average monthly dental premium per member per month in Connecticut: DPPO: $46.02

[1] Data from the Center for Medicare and Medicaid Services. If 0, then CMS data is not available.
[2] "Other Public": Includes enrollment in federal and state programs not part of Medicaid

Source: NADP 2013 Dental Benefits Report: Premium and Benefit Utilization Trends, Dec 2013

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Connecticut Dental Benefits Fact Sheet

Workforce

The federal standard for an adequate supply of dentists is 3.33 practicing dentists per 10,000 population.[2]

According to the American Dental Association 2,629 dentists are actively practicing in Connecticut or 7.32 dentists per 10,000 population.[3]

Network Type	Total Dentists	General Dentists	Pediatric Dentists	Specialists
DHMO	440	248	23	61
DPPO	2,487	1,798	101	153
Discount	1,770	1,354	54	99

Source: 2013 NADP/DDPA Joint Dental Benefits Report on Network Statistics

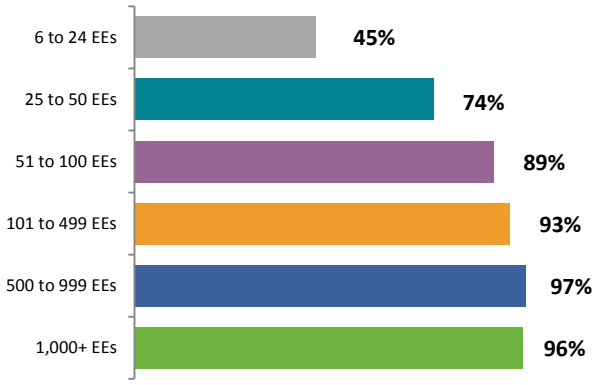
NADP Members

Plan Types Offered by NADP Members

Source: 2013 NADP Membership Directory

Where do Consumers Get Dental Benefits

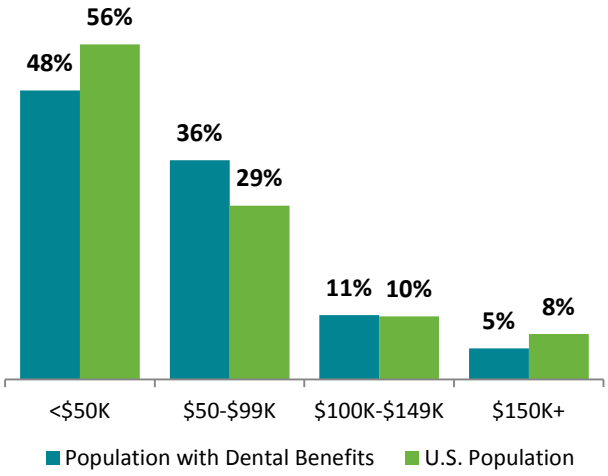
Employers Offering Dental Benefits by Employer Size



Source: 2013 NADP Purchaser Behavior Survey

Who Has Dental Benefits

Consumers with Dental Benefits by Household Income compared to General Population



Source: 2013 NADP Survey of Consumers

About

The National Association of Dental Plans (NADP), a nonprofit corporation with headquarters in Dallas, Texas, is the "representative and recognized resource of the dental benefits industry." NADP is the only national trade organization that includes the full spectrum of dental benefits companies operating in the United States. NADP's members provide dental benefits to approximately 90 percent of the 187 million Americans with dental benefits.

[2] U.S. Department of Health and Human Services

[3] American Dental Association

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MEMO

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TO: Evelyn Ireland, CAE
Executive Director
National Association of Dental Plans

FROM: Joanne Fontana

DATE: March 14, 2014

RE: Actuarial Value, Benefit Plan Design, and Consumer Cost-Sharing Ramifications of Lowering Standalone Pediatric Dental Out-of-Pocket Maximum to $350/$700

BACKGROUND AND PURPOSE

On December 27, 2013, Milliman produced a memo for the National Association of Dental Plans (NADP) providing analysis on the actuarial value, benefit plan design, and consumer cost-sharing ramifications of the draft Notice of Benefit and Payment Parameters for 2015 released by the Center for Consumer Information and Insurance Oversight (CCIIO) earlier that month. Included in that draft was a revised national annual out-of-pocket maximum (OOPM) requirement for standalone dental plan pediatric essential health benefits of $300 for a single child and $400 for two or more covered children. It also proposed removing the actuarial value (AV) requirements on these standalone dental plans.

The final Notice of Benefit and Payment Parameters for 2015 was released by CCIIO on March 6, 2014. The final version sets the national annual OOPM requirement for standalone dental plan pediatric essential health benefits at $350 for a single child and $700 for two or more covered children. This requirement will be applied in all states, not just states with federally facilitated marketplaces. It also reversed the draft's removal of AV requirements and instead imposed the same 85% (High) and 70% (Low) AV standards as were used for the 2014 plan year.

The National Association of Dental Plans (NADP) has asked Milliman to perform some calculations for standalone pediatric dental essential benefit plans illustrating premium levels, AV, and consumer cost sharing levels for various plan designs. The information will be used by NADP to demonstrate the impact on plan design and on consumer out-of-pocket costs of moving from the rule for the 2014 plan year ($700 OOPM single child/$1,400 OOPM two or more children) to the new requirements, as well as comparing to other alternative plan designs. We have performed premium, AV, and consumer cost sharing calculations for several illustrative plans, all based on the scope of services contained in the Federal Employee Dental and Vision Plan (FEDVIP) dental benefit including orthodontia only when medically necessary.

SUMMARY OF KEY RESULTS

Premium and AV Impact of Reduced OOPM

Table I shows the annual premium per child and the actuarial value of various pediatric dental plans. The first and second rows show results for typical employer plans pre-ACA. The third row shows the calculated results for a "status quo" plan with a $700/$1,400 OOPM, and the fourth row shows results for the $350/$700 OOPM. Other illustrative plan designs are also shown for comparison. All plan designs in Table I assume the FEDVIP benefit structure ($50 deductible waived for Class I services, plan coinsurance of 100%/70%/50%/50%) and the ACA plans shown fall in the High AV (83 – 87%) range. A full description of the calculation methodology is contained in a later section of this report.

TABLE I. Impact on Per Child Per Month Premiums and Plan AVs of Lowering OOP Maximum

OOP Maximum	Combined Dental/Ortho Premium Per Child Per Year (2015)	Actuarial Value	Percentage Price Increase on Combined Dental/Ortho Rate Over $700/$1,400 OOPM Plan	Percentage Price Increase on Combined Dental/Ortho Rate Over $1,500 Annual Max Plan
No OOPM; $1,500 Annual Benefit Maximum	$592.49	75.8%	-14.7%	0.0%
No OOPM	628.25	75.9%	-9.6%	6.0%
$700/$1,400	$694.75	84.0%	0.0%	17.3%
$350/$700	$708.79	85.7%	**2.0%**	**19.6%**
$500/$750	$702.15	84.9%	1.1%	18.5%
$500/$1,000	$700.03	84.6%	0.8%	18.2%
$1,000/$2,000	$688.96	83.3%	-0.8%	16.3%

If no other adjustments are made to the benefit plan structure, a change in the annual OOPM from the current $700/$1400 to $350/$700 for a High AV level plan is estimated to result in an approximate 2.0% increase in premiums, and represents a 19.6% increase over a typical employer plan pre-ACA.

The table above illustrates the impact on price due to a change in OOPM for a sample dental PPO benefit construct with moderate provider discounts. For plans such as DHMOs with much lower premium levels, or for plans with less rich benefits or lower AV, the impact of a change in OOPM will be larger. Plans with lower AV levels require a higher amount of cost-sharing by the consumer, which makes a given OOPM relatively easier to reach. For example, we calculated the impact of moving from a $700/$1,400 OOPM to a $350/$700 OOPM on an illustrative Low (68 – 72%) AV plan to be 3.3%, as compared to 2.0% for the High AV plan shown in Table I.

In order to mitigate premium increases, carriers could elect to adjust other components of the benefit plan design by increasing the deductible, increasing the types of services to which the deductible applies, or lowering plan coinsurance levels, while still maintaining the AV within the required range. Some illustrative High AV level plan design changes are shown in Table II.

TABLE II. Impact on Per Child Per Month Premiums and Plan AVs of Lowering OOP Maximum

OOP Maximum and Benefit Changes	Combined Dental/Ortho Premium Per Child Per Year (2015)	Actuarial Value	Percentage Price Increase on Combined Dental/Ortho Rate Over $700/$1,400 OOPM Plan
$700/$1,400	$ 694.75	84.0%	0.0%
$350/$700	$708.79	85.7%	2.0%
$350/$700; Deductible Changed to $75	$693.91	84.2%	-0.1%

Table II shows that, as one example, increasing the deductible (waived for Class I) from $50 to $75 would offset the premium increase.

Again, results depend on the assumptions used in pricing the benefit. For a Low AV plan, for example, the deductible would need to be increased even more in order to offset the premium increase due to lowering the OOPM.

Based on our claim cost modeling, we estimate that approximately 3% of the pediatric population would reach $700/$1,400 in OOP costs, and we estimate that, depending on the underlying benefit plan, an additional 2 to 3% of the population would reach the $350/$700 level in OOP costs. As such, lowering the OOPM to $350/$700 largely serves to provide even greater financial protection to very few children. Any benefit plan shift designed to lessen the premium increase due to the lower OOPM – one example being the increased deductible -- would have the effect of creating higher member cost sharing for routine services which most children incur, thereby shifting costs away from the small percentage of children with the highest claims and toward the majority of children.

Impact of Plan Design on Consumer Out-of-Pocket Cost

We were also asked to illustrate the financial impact to consumers at the point of service under various plan designs. To do this, we created three sample children who undergo the following dental procedures during the policy year:

- Child A incurs preventive and diagnostic services (assumed to include two cleanings, two oral exams, one set of x-rays, and one fluoride application) as well as one filling during the policy year. Child A is meant to represent a typical covered child.
- Child B incurs the same preventive and diagnostic services as well as a surgical extraction.
- Child C incurs the same preventive and diagnostic services, a filling, and medically necessary orthodontia. Child C is meant to represent the estimated 3% of children with catastrophic needs.

We calculated the total out-of-pocket costs for each child, as well as for illustrative families comprised of varying combinations of children A, B, and C. We also calculated the insurance plan payment for each child and family. Table III below illustrates the out-of-pocket costs for each child or family, followed by the insurance company payment, under the following benefit plans:

- The ACA “status quo” plan with $700/$1400 OOPM and FEDVIP cost-sharing as described earlier
- The $350/$700 OOPM plan, with FEDVIP cost sharing

- Plans with $500/$750 and $500/$1,000 OOPMs, with FEDVIP cost sharing
- A $350/$700 OOPM plan with FEDVIP cost sharing except that deductible is raised to $75

A full description of the calculation methodology is described in a later section of this report.

TABLE III

2015 Estimated Consumer Cost Sharing and 2015 Estimated Plan Payments for Illustrative Children Under Various Plan Designs (in $)

(first number represents consumer payment/second number represents insurance plan payment)

	Status Quo $700/$1400 OOPM	**$350/$700 OOPM**	**$500/$750 OOPM**	**$500/$1,000 OOPM**	**$350/$700 with $75 Deductible**
Child A	$68.19/ $244.66	$68.19/ $244.66	$68.19/ $244.66	$68.19/ $244.66	$85.69/ $227.16
Child B	$107.17/ $335.62	$107.17/ $335.62	$107.17/ $335.62	$107.17/ $335.62	$124.67/ $318.12
Child C	$700/ $1,787.85	$350/ $2,137.85	$500/ $1,987.85	$500/ $1,987.85	$350/ $2,137.85
Family with 2 Children: A, A	$136.37/ $489.33	$136.37/ $489.33	$136.37/ $489.33	$136.37/ $489.33	$171.37/ $454.33
Family with 3 Children: A, A, A	$204.56/ $733.99	$204.56/ $733.99	$204.56/ $733.99	$204.56/ $733.99	$257.06/ $681.49
Family with 2 Children: A, B	$175.35/ $580.29	$175.35/ $580.29	$175.35/ $580.29	$175.35/ $580.29	$210.35/ $545.29
Family with 3 Children: A, A, B	$243.54/ $824.95	$243.54/ $824.95	$243.54/ $824.95	$243.54/ $824.95	$296.04/ $772.45
Family with 2 Children: B, C	$807.17/ $2,123.47	$457.17/ $2,473.47	$607.17/ $2,323.47	$607.17/ $2,323.47	$474.67/ $2,455.97
Family with 3 Children: A, B, C	$875.35/ $2,368.14	$525.35/ $2,718.14	$675.35/ $2,568.14	$675.35/ $2,568.14	$560.35/ $2,683.14

**Child C orthodontia costs are shown as the average total cost to the consumer and to the insurer over a two year treatment period, assuming the cost of treatment is evenly spread over the two years.*

As is evident from Table III, adjusting the OOPM from $700/$1,400 to $350/$700 provides no additional insurance benefit for Child A, Child B, or 2- or 3-children families comprised of A and B. The only children benefiting from the change in this example are those requiring medically necessary orthodontia, who we have previously indicated are expected to comprise fewer than 3% of the total pediatric population.

We looked at alternative OOPM levels between the $350/$700 and $700/$1,400 and found the same result; the only children whose cost is impacted are those requiring medically necessary orthodontia.

If carriers attempt to mitigate the cost increase associated with a lower OOPM by, for example, increasing the deductible to $75 as shown in Table II, then out-of-pocket costs for Child A and B would increase, as would the out-of-pocket costs for families with some combination of children A and B. Such a plan reduces the insurance benefit for most children while giving a high level of cost protection to the few highest cost children.

In general, the $350/$700 OOPM continues to move the standalone pediatric dental essential benefit further away from standard employer dental offerings, which generally have no OOPM and instead utilize annual benefit maximums above which the consumer is fully responsible for the cost of care. This has the effect of making ACA-compliant standalone pediatric dental plans more catastrophic in nature than typical employer plans; that is, while typical employer plans on average provide richer benefits for the vast majority of children not requiring significant costly dental or orthodontic services, the ACA-compliant plans provide richer coverage for the small proportion of children with catastrophic dental or orthodontic expenditures. To mitigate the premium increase associated with a lower OOPM, carriers would have to increase member cost sharing on more routine services, shifting the balance of coverage away from common preventive and diagnostic procedures and toward higher cost but infrequently sought procedures. The decision regarding the right balance between catastrophic coverage and coverage of the majority of the population's routine needs is a philosophical one and is beyond the scope of this report.

We also believe that the potential for overutilization of pediatric dental services increases as the OOPM decreases, since, once the OOPM has been achieved, the insurer fully covers all further dental costs for the year. A family that achieves the OOPM via orthodontia or other significant dental services for one child may be incentivized to obtain additional dental services for the rest of their children, and dental providers may be more prone to recommend such services knowing that the costs are borne by the insurer. Since we modeled specific children each with a fixed assumed number of services, our modeling of cost sharing does not directly capture the pricing impact of this potential increase in utilization. Should such activity occur, the cost of pediatric dental coverage will increase.

METHODOLOGY

Per Child Per Month Premium Calculation Methodology

We used the Milliman 2013 Health Cost Guidelines – Dental® model, developed from a national dental claims database, with Milliman's standard national pediatric population through age 18 to calculate per child per month premium rates for various plan designs. Specific pricing assumptions inherent in all the premiums shown in this report include:

- January 1, 2015 premium effective date
- 25% provider discount
- 100% in-network utilization
- 70% loss ratio
- Selection loads commensurate with voluntary individual dental policies
- The calculated premiums make no explicit provision for additional fees or taxes related to the ACA, such as exchange fees or assessment fees

Results are sensitive to these assumptions and could differ if different assumptions are chosen. For example, claim costs and premiums may vary by geography or by provider discount level.

Actuarial Value Methodology

For medical plans, the calculation of AV has been standardized; a single standard calculator distributed by the Department of Health and Human Services is to be used for all medical EHB. The AV calculation for the standalone pediatric dental essential benefit, however, is not standardized; carriers must calculate AV using a reasonable methodology and must have the calculation certified by an actuary. The actuarial value calculation we utilized mimics the methodology promulgated for medical plans under the ACA. It takes the ratio of the anticipated allowed charges paid by the plan for the pediatric oral care essential benefit for a standard population to the anticipated total allowed charges for the same benefit and population. This ratio is calculated for in-network benefits only; out-of-network benefit levels are not

considered. Utilization levels are assumed to be constant in the numerator and denominator of the calculation; that is, the AV calculation looks only at cost-sharing, not any decrease in utilization resulting from member out of pocket costs. We used cost and utilization assumptions from Milliman's 2013 Health Cost Guidelines – Dental® model and the same pricing assumptions as shown above to generate AVs for each plan design.

Medical necessity requirements for orthodontia are not directly modeled in the Health Cost Guidelines – Dental®, as they are based on commercial dental cost and utilization for which medical necessity has not historically been applied. For the medically necessary orthodontia benefit, we assumed that on average, 30% of commercial orthodontia claims would be considered medically necessary, but higher cost claim levels were more likely to be medically necessary than lower ones. Based on prior studies conducted by Milliman, we believe this to be consistent with fairly stringent application of medical necessity.

Consumer Cost Sharing Calculation Methodology

To illustrate the total expected out of pocket costs for sample consumers, we created three sample children who undergo the following dental procedures during the policy year:

- Child A incurs preventive and diagnostic services (assumed to include two cleanings, two oral exams, one set of x-rays, and one fluoride application) as well as one filling during the policy year. Child A is meant to represent a typical covered child.
- Child B incurs the same preventive and diagnostic services as well as a surgical extraction.
- Child C incurs the same preventive and diagnostic services, a filling, and medically necessary orthodontia.

We developed cost estimates for each of these procedures using Milliman's 2013 Health Cost Guidelines – Dental® model, assumed a 25% provider discount would be applied, and then applied the cost sharing elements inherent in each benefit plan to determine the consumer's cost of each procedure. We then calculated the total cost sharing for each child in a given policy year based on the services the child is assumed to incur, as well as the amount the insurance company would pay on behalf of each child for the same procedures during the policy year. We did the same for sample families comprised of varying combinations of children A, B, and C.

For orthodontia, we assumed that the services would be provided over the course of two years, as is common for an orthodontia treatment plan. We applied cost sharing components to the orthodontia procedure costs assuming that half the children receiving orthodontia would be in their first year of treatment and half would be in their second year of treatment, and that the cost of treatment would be equally distributed over the two years. That allowed us to see the true expected differential in consumer outlay over the full course of treatment. For example, for a benefit plan with an annual OOP maximum, the child incurring orthodontia might hit that maximum in both years, moderating the cost in both years. On the other hand, for a plan with an orthodontia benefit maximum, the entire benefit might be depleted in the first year, making the consumer outlay for that year quite low or zero, but in the second year the consumer would bear the most or all the burden for any remaining orthodontia costs. The actual timing of orthodontia claims incurred during a two year course of treatment can affect the consumer and insurer payment levels; the assumption that the claim cost will be spread equally over the two year period is illustrative.

Children A, B, and C are illustrative and are not meant to represent the full range of potential out of pocket cost scenarios that could be seen.

CAVEATS AND LIMITATIONS

I, Joanne Fontana, am a Consulting Actuary for Milliman. I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

Milliman has prepared this report for the specific purpose of providing actuarial value, premium, and cost sharing estimates for various illustrative pediatric dental benefit plans. This information may not be appropriate, and should not be used, for any other purpose. This report has been prepared solely for the internal business use of, and is only to be relied upon by, the management of NADP. We understand that this report may be shared with representatives of the Center for Consumer Information and Insurance Oversight (CCIIO) and other third parties. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work even if we permit the distribution of our work product to such third party.

The results presented herein are estimates based on carefully constructed actuarial models. Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

In performing this analysis, we relied on data and other information provided by NADP. We have not audited or verified this data and other information but reviewed it for general reasonableness. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

Milliman does not provide legal advice, and recommends that NADP consult with its legal advisors regarding legal matters.

The terms of Milliman's Consulting Services Agreement with NADP dated March 17, 2011 and signed March 24, 2011 apply to this letter and its use.