REPORT ON

THE COST OF MANDATING DENTAL AND VISION BENEFITS IN QUALIFIED HEALTH PLANS

STATE OF ARKANSAS
Department of Insurance
Health Connector Division

Lewis and Ellis, Inc. – Actuaries & Consultants

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Chapter 1
Introduction

PURPOSE AND SCOPE

The Arkansas Health Connector Division (AHCD) of the Arkansas Insurance Department (AID) is engaged in establishing and managing a State Partnership Exchange for the state of Arkansas. Lewis & Ellis, Inc. (L&E) was engaged to assist the AHCD with issues of an actuarial nature.

Sections 1302(a) and (b) of the Affordable Care Act (ACA) provide information on the Essential Health Benefits (EHBs) that must be covered by a Qualified Health Plan (QHP). In addition, Section 1311(d) (3) (B) specifies that states can mandate other benefits; however, the state must assume this additional cost of covering those benefits if they were not included in the originally designated EHB benchmark plan.

This report evaluates dental and vision benefits for adults and the potential costs the State of Arkansas would incur if these were mandated to be included in the QHP benefit package.

KEY ISSUES FOR ANALYSIS

The key issues L&E analyzed were:

- The level of dental and vision coverage to be covered;
- Claim cost and demographic information specific to an Arkansas population;
- The impact of the Health Care Independence Program (Private Option) and potential cost offsets due to Federal Medicaid waivers.

LIMITATIONS OF THIS STUDY

This report has been prepared for the use of the state of Arkansas with regard to the implementation and management of an Exchange. The AHCD should use this report to understand the actuarial implications of mandating dental and vision benefits for adults who purchase Individual or Small Group QHPs and adults covered via the Medicaid Private Option.

The authors of this report are aware that it may be distributed to third parties; however, any users of this report must possess a certain level of expertise in health insurance, healthcare, or actuarial science so as not to misinterpret the data presented. Any distribution of this report must be made in its entirety. In addition, any third party with access to this report acknowledges, as a condition of receipt, that L&E makes no representations or warranties as to the accuracy or completeness of the material. Any third party with access to these materials cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.

Reliances

In performing this study, L&E relied on data and information from many sources, including the Arkansas Insurance Department and multiple Arkansas health insurance issuers. L&E did not audit the data sources for accuracy, although they were reviewed for reasonableness. If the data or information provided was inaccurate or incomplete, then any resultant projections or guidance could also be inaccurate or incomplete.

Confidentiality

L&E recognizes that in the performance of the work, L&E acquired or had access to records and information considered confidential by the health insurance issuers and the Arkansas Insurance Department. L&E took steps to comply with confidentiality and privacy issues.

Limitations

Much uncertainty surrounds many of the projections in this report, primarily due to the dynamic nature of Federal and State regulatory requirements. The guidance provided in this report is based on modeling a specific set of assumptions and should be used to evaluate a range of potential outcomes. Actual experience will deviate from these projections.

The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing this analysis. The guidance and analysis expressed in this report are those of the authors only and do not necessarily represent the opinions of other L&E consultants.

The authors of this report are not attorneys and are not qualified to give legal advice. Users of this report should consult legal counsel for interpreting legislation and administrative rules, specific Exchange features, and other issues related to implementing an Exchange.

Chapter 2
Executive Summary

Lewis & Ellis, Inc. was engaged by the Arkansas Health Connector Division of the Arkansas Insurance Department to perform actuarial analysis and prepare guidance related to establishing and managing a Health Insurance Marketplace.

One of the reforms enacted in the Affordable Care Act is a mandatory requirement to cover Essential Health Benefits (EHBs) as defined by the law for Individual and Small Group markets. Section 1302(a) defines the EHBs package, while Section 1302(b) (1) lists the categories under which the services are considered as EHBs. Arkansas specific guidance regarding EHBs are detailed in Arkansas Bulletin 9-2014 and Arkansas Directive 2-2012.

Section 1311(d)(3)(B) of the ACA also states that additional benefits can be mandated by every state but the state must assume the costs for the additional benefits unless those benefits are covered under the benchmark plan. Key considerations in defining the cost of the additional benefits include the net cost of the actual benefits provided and the specific characteristics of the Arkansas population.

The Arkansas benchmark plan does not cover basic dental and vision benefits for adults. L&E analyzed the cost of providing these benefits, which included various basic dental and comprehensive dental services, routine eye exams, and frames and contacts[1]. The claims data used accounts for various demographic and health status characteristics of the Arkansas population. An estimate of the final cost the State would incur was then determined if these additional mandated benefits were included in the QHP benefit package.

Since the State of Arkansas chose to expand the Medicaid program to include those under 138% of the Federal Poverty Level (FPL) via the Private Option, L&E also analyzed the cost of the new benefits for this population after accounting for the potential impact of Federal Medicaid waivers.

RESULTS

A few key results of L&E's analysis include:

- Table 2-1 summarizes the projected 2015 population (with ranges) which would likely be impacted by the mandate.

Table 2-1 2015 Projected Arkansas Marketplace Enrollment

	Over 138% FPL	Private Option	Total
Children 0-18	19,117 (13,521 - 29,059)	0 0	19,117 (13,521-29,059)
Adults 19-64	68,326 (48,598 - 102,696)	167,446 (160,718 - 192,024)	235,772 (209,316 - 294,720)
Total	87,443 (62,119 - 131,755)	167,446 (160,718 - 192,024)	254,889 (222,837 - 323,779)

- Table 2-2 summarizes the projected additional premium on a per member per month (pmpm) basis for mandating the dental and vision benefits to the adult population. This estimates the average premium increase which would need to be added to a health insurance policy to cover these benefits.

Table 2-2 Projected 2015 Additional Premium Per Member Per Month

Total
$19.65 pmpm ($17.40 - $21.82)

- Table 2-3 summarizes the expected aggregate premium required by mandating dental and vision benefits. This additional premium that would ultimately be charged is assumed to be the potential "cost" to the State for mandating the coverage of these benefits.

Table 2-3 Projected 2015 Aggregate State Cost

	Over 138% FPL	Private Option	Total
Members 0-64	$17.42 mil ($10.80 - $37.90)	$42.68 mil ($35.77 - $55.23)	$60.10 mil ($46.53 - $93.13)

- The pmpm cost experience for the Private Option through June 2014 is currently higher than the Federal Waiver cap of $477.63. As a result, the

State would be fully liable for any dental & vision costs that are also in excess of the cap (as illustrated in Table 2-3). If the early Private Option cost experience stabilizes around original expectations and is ultimately lower than the cap amount, then the state would not be liable for the majority of the dental and visions costs (if any).

Table 2-4 summarizes multiple scenarios under which the Medicaid waiver partially offsets the cost for mandated benefits (note that the results assume that waiver cannot offset the Non-Medicaid costs).

Table 2-4 Analysis of Costs if Current Private Option Costs Reduce

Scenario	Over 138% FPL	Private Option	Total
Base Case	$17.42 mil	$42.68 mil	$60.10 mil
Costs Equal Waiver Amount	$17.42 mil	$42.68 mil	$60.10 mil
Costs are 99% of Waiver	$17.42 mil	$33.51 mil	$50.92 mil
Costs are 98% of Waiver	$17.42 mil	$15.35 mil	$32.77 mil
Costs are 97% of Waiver or Less	$17.42 mil	$0.00 mil	$17.42 mil

Chapter 3
Background

Federal Context of State Mandated Benefits

The Patient Protection and Affordable Care Act, Public Law 111-148, was enacted on March 23, 2010. The Health Care and Education Reconciliation Act, Public Law 111-152, was enacted on March 30, 2010. These laws are collectively referred to as the Affordable Care Act (ACA).

The ACA established rules for health plans to be classified as Qualified Health Plans (QHPs). One of those rules is a requirement to cover Essential Health Benefits (EHBs). Sections 1302(a) and (b) of the ACA specify EHBs that must be covered by each QHP.

Prior to the implementation of the ACA, State governments had the freedom to mandate any benefit they deemed appropriate. Section 1311(d)(3)(B) of the current law still allows states to mandate benefits in addition to EHBs; however, states must assume the cost for these benefits unless they were included in the originally designated benchmark plan.

Under the ACA, states also had the option to expand the Medicaid program with the federal government assuming the expansion costs. Arkansas, with approval by the Centers for Medicare and Medicaid Services (CMS), implemented this Medicaid expansion by using Medicaid funds as a premium assistance mechanism for eligible persons to purchase Qualified Health Plans[2] in the Arkansas Marketplace. Under this scenario, the State of Arkansas would pay the premiums for the eligible individual and receive a waiver payment from CMS to cover those premiums.

Marketplace Characteristics

Arkansas Coverage Under the ACA

On May 1, 2014, the Office of The Assistant Secretary for Planning and Evaluation (ASPE) within the U.S. Department of Health & Human Services (HHS) released state-level coverage expansion data[3]. This report summarized the number of new enrollees in each state's Marketplace and the change in Medicaid enrollment as a result of expansion.

Table 3-1 provides the profile of Arkansas's ACA coverage expansion enrollment for Medicaid and the Health Insurance Marketplace.

Table 3-1 ASPE 2014 ACA Enrollment Totals

Source of Coverage	Members
Exchange	43,446
Medicaid/CHIP	124,865

Table 3-3 illustrates the enrollment in Arkansas's Private Option through June 2014.

Table 3-2 AR DHS 2014 Private Option Enrollment Total

Source of Coverage	Members
Private Option	167,446

In March 2013, the Society of Actuaries (SOA) produced a report *Cost of the Future Newly Insured under the Affordable Care Act (ACA)*[4]. In its report, the SOA estimated the impact of the ACA on the future sources of coverage, morbidity, and cost of health insurance in each state.

Table 3-3 provides the estimated ultimate enrollment for the new sources of coverage: the Employer and Individual Exchanges. For Medicaid, the value is the expected change in enrollment as a result of expansion. These projected ultimate enrollments will be used in modeling the range of expected costs.

Table 3-3 SOA Projected Ultimate Enrollment by Source of Coverage

Source of Coverage	Members
Employer Exchange	116,475
Individual Exchange	193,232
Medicaid	214,161

PROPOSED MANDATED BENEFITS IN ADDITION TO EHBS

Arkansas Proposed Additional Benefits

For calendar year 2014, one health insurance issuer, Ambetter of Arkansas, offered adult dental and vision coverage as optional benefits to their Qualified Health Plan that only offered the EHB benefit package. However, Ambetter only

sold health insurance policies in three regions of the State: North West, West Central, and Central. These three regions account for 29 of the 75 counties in the state.

Since dental and vision benefits were only offered by one issuer and only available in approximately 40% of the State, the AID was asked to evaluate the impact of mandating these benefits in future time periods so every adult with a Qualified Health Plan would have coverage for basic Dental and Vision services.

The covered procedures and services that were analyzed are provided in Appendix A.

Chapter 4
Cost Analysis of Adult Dental and Vision Benefits

For our analysis, L&E used proprietary client information and the Towers Watson HealthMAPS® Dental Rate and Vision Rate Manuals (Towers Watson) to estimate the dental and vision claim costs.

Exposure projections were based on:

- Current Private Option enrollment as provided by Arkansas DHS;
- Health insurance issuers projected 2015 enrollment based on submitted filings (which are currently being reviewed by the AID and not yet publicly available); and
- The 2013 Society of Actuaries ACA cost report.

DENTAL CLAIM COST

HealthMAPS® was used as a manual rate (starting point) for estimating the costs of covered dental services. The following adjustments were made to the HealthMAPS® starting cost:

- Benefit maximums;
- Consumer cost-sharing assumptions;
- Projected age/gender demographics
- Projected population by geography;
- Claim cost trend;
- Tobacco user impact;
- Pent-up demand for services; and
- L&E client experience in Arkansas.

The dental PMPM claim cost was estimated to be $12.50 per adult per month.

The Affordable Care Act requires health insurance issuers in the Individual and Small Group markets to spend at least 80% of premium revenues on clinical services and quality improvement. This requirement is known as the Medical Loss Ratio (MLR). Actual MLR for each health insurance issuer will vary; however, for our analysis we assumed 80%.

Therefore, based on a projected claim cost estimate of $12.50, this produces a premium estimate of $15.63 per adult per month ($12.50 divided by 80%) for covering dental benefits.

VISION CLAIM COST

HealthMAPS® was used as the starting point for estimating the costs of covered vision services. The following adjustments were made to the HealthMAPS® starting cost:

- Benefit maximums;
- Consumer cost-sharing assumptions;
- Claim cost trend; and
- Pent-up demand for services.

The vision PMPM claim cost was estimated to be $4.49 per adult per month.

Based on an assumed 80% MLR, a premium of $5.61 per adult per month was estimated to cover vision benefits.

PROJECTED ENROLLMENT

Enrollment projections were based on:

- The 2015 rate filings submitted by each health insurance issuer;
- Current Private Option enrollment as provided by Arkansas DHS;
- The 2013 Society of Actuaries ACA cost report.

TRADITIONAL MARKET (OVER 138% FPL)

The starting point for the estimated number of persons, whose income is over 138% FPL, purchasing coverage in the Exchange via a traditional Small Group or Individual policy was based on the 2015 rate filings submitted by the Arkansas health insurance issuers offering health insurance coverage.

These filings include the premium rates that each issuer is proposing to use for policies sold in 2015. These filings also include each insurer's best estimate of the number of persons they expect to cover in 2015. It should be noted these submitted filings are currently being reviewed by the AID for appropriateness and are not yet publicly available. L&E assumed that the enrollment projections provided by each issuer was the best source of data to use even though the premium rates are not yet finalized.

While the rate filings were used as the base case for enrollment projections, the SOA report was used to develop a range of estimates. The SOA report estimated

the ultimate Arkansas enrollment by source of coverage (e.g., employer exchange, private non-group, uninsured, etc.) once all the ACA reforms are implemented through 2016.

Based on the projected base enrollment for 2015 and the projected ultimate enrollment, L&E simulated 100,000 possible enrollment scenarios. These simulations produced the likely range of enrollment, which when multiplied by the expected per policy premium costs, produced the range of aggregate costs the State may be liable for if dental and vision benefits are to be covered.

PRIVATE OPTION

The starting point for the estimated number of persons purchasing coverage via the Private Option was based on current enrollment as of June 30, 2014.

The SOA report was used to develop a range of estimates for the number of adults who could ultimately purchase Medicaid coverage via the Private Option.

Based on current Private Option enrollment and the projected ultimate enrollment, L&E simulated 100,000 possible enrollment scenarios. These simulations produced the likely range of enrollment, which when multiplied by the expected per person premium costs, produced the range of aggregate costs the State may be liable for if dental and vision benefits are to be covered.

MEDICAID WAIVER IMPACT

The state of Arkansas decided to participate in ACA Medicaid expansion. Arkansas implemented Medicaid expansion by using Medicaid funds as premium assistance to allow eligible individuals to purchase a QHP via the Arkansas Exchange. Under this Private Option, the State would pay the premiums for the eligible individuals and the State would in return receive a waiver payment from the federal government to cover those premiums.

The federal waiver payment was determined to be $477.63 per person per month. At establishment, the actual cost of the covered Private Option population was expected to be $437.00 per person per month. Therefore, if cost expectations are ultimately achieved, the State could theoretically include extra benefits in the Private Option benefit package at no additional cost.

Through June 2014, the actual cost of providing Private Option coverage is approximately $495 per month. If costs continue to exceed the federal waiver payment amount, the State would have to absorb the costs of any additional mandated benefits.

Our base case, which is included in Table 2-3 above, assumes that costs continue at levels similar to what is currently being experienced.

L&E performed sensitivity tests to calculate the impact of the Medicaid waiver on the overall costs to the State if the cost of providing Private Option stabilizes and ultimately reaches levels below the federal waiver payment amount. These sensitivity tests are provided in Table 2-4 above.

Due to the size of the Private Option enrollment relative to the size of the over 138% FPL market, the ultimate cost of mandating dental and vision coverage for adults is significantly impacted by the future cost of providing EHB coverage to persons with Private Option coverage.

Appendix A
Vision and Dental Benefits Included in the Analysis

Table A-1 Vision Benefits Assumed

Vision Services for Adults ages 19 and older		
Benefits	In-Network	Out-of-Network
Copayment for Exams	$10	$20
Copayment for Eyewear	$10	$20
Routine Eye Exam (1 visit per year)	100% after copay	Up to $38.50 after copay
Eyeglasses (frames) and contacts (1 item per year)	Up to $130 after copay	Up to $50 after copay
Lenses (per pair)		
Single	100% after copay	Up to $37.50 after copay
Bifocal	100% after copay	Up to $55 after copay
Trifocal and Lenticular	100% after copay	Up to $75 after copay
Contact Lenses		
Contact Lenses (in lieu of glasses)	Up to $130 after copay	Up to $91 after copay

Table A-2 Dental Benefits Included

Dental Services for Adults ages 19 and older		
Benefits	In-Network	Out-of-Network
Annual Maximum	$1,000 per person per CY	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam (1 per 6 months)	No charge, subjection to annual maximum	Not Covered
Routine Cleaning (1 per 6 months		
Bite-wing X-ray (1 per 12 months)		
Full Mount X-ray (1 per 60 months)		
Panoramic Film (1 per 60 months)		
Topical Fluoride Application (2 per 12 months)		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services	50% coinsurance, subject to annual maximum	Not Covered
Silver Fillings (1 per 2 years)		
Tooth Colored Fillings (1 per 2 years, front teeth only)		
Endodontics		
Therapeutic Pulpotmy on Permanent Teeth (1 per lifetime per tooth)		
Periodontics		
Scaling and Root Planning (1 per 24 months)		
Periodontal Maintenance (4 in 12 months)		
Oral Surgery		
Simple Extractions		
Surgical Extractions		
Removal of Impacted Teeth		
Alveoloplasty		
Prosthodontics		
Relines (1 per 36 months)		
Rebase (1 per 36 months)		
Adjustments		
Repairs		

Appendix B
Endnotes

[1] Full list of benefits is included in Appendix A.
[2] http://kff.org/health-reform/fact-sheet/medicaid-expansion-through-premium-assistance-arkansas-and-iowas-section-1115-demonstration-waiver-applications-compared/
[3] http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/Marketplace_StateSum.cfm

[4] http://www.soa.org/newlyinsured/