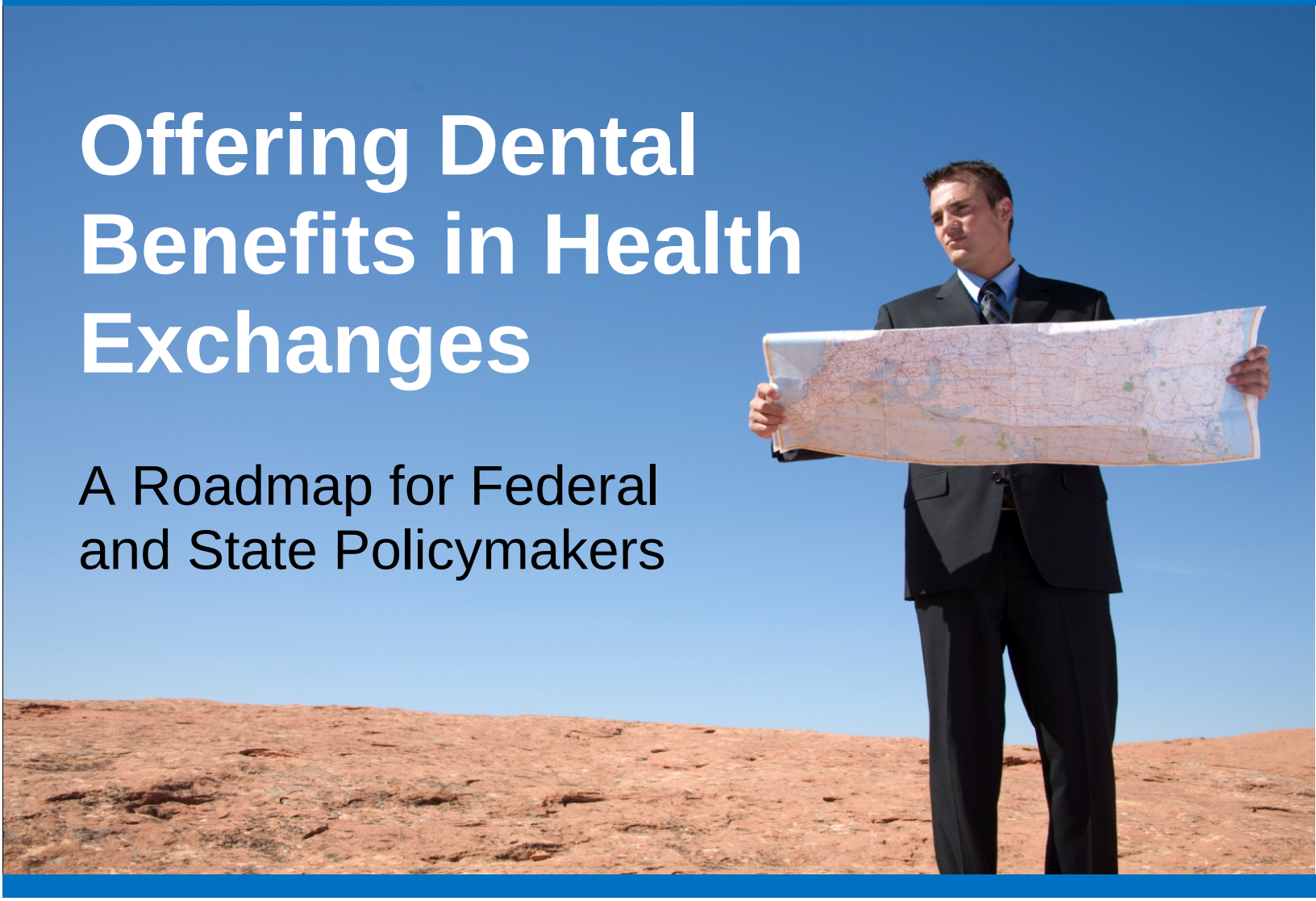
# Offering Dental Benefits in Health Exchanges



## A Roadmap for Federal and State Policymakers

## EXECUTIVE SUMMARY

*September 2011*

*Presented by the National Association of Dental Plans (NADP)*
*and the Delta Dental Plans Association (DDPA)*

Complete white paper linked on NADP and DDPA home pages.

**National Association of Dental Plans (NADP),** a Texas 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 HMO, Dental PPO, Dental Indemnity and Discount Dental products to 143 million Americans, over 85% of all Americans with dental benefits.

NADP
12700 Park Central Drive
Suite 400
Dallas, Texas 75251
Phone: 972-458-6998
Web: www.nadp.org

**Delta Dental Plans Association (DDPA),** based in Oak Brook, IL, is a national network of 39 independently operated not-for-profit dental service corporations specializing in providing dental benefits in all 50 states, the District of Columbia and Puerto Rico; covering more than 56 million people in over 95,000 groups across the country.

DDPA
1515 West 22nd Street
Suite 450
Oak Brook, Illinois 60523
Phone: 630-574-6001
Web: www.deltadental.com

The recommendations contained herein are solely those of NADP and DDPA. NADP and DDPA acknowledge the firms of **McKenna Long & Aldridge, LLP** and **Milliman Inc** for their assistance in the development of issues and alternatives on which our organizations' analysis and recommendations are based.

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# Executive Summary

*In this White Paper the term "policy" is used for the contract or certificate of coverage and the term "plan" is used for the carrier or company issuing the contract or certificate.*

This White Paper addresses issues raised by the requirement of "pediatric oral services" as part of the Essential Health Benefits Package (EHBP) offered through Exchanges. The Affordable Care Act (ACA) requires the scope of benefits in EHBP be equal to the "typical employer plan." Employer plans usually consist of separate medical and dental policies that deliver "pediatric oral services." ACA provides that "pediatric oral services," as defined by the U.S. Department of Health and Human Services (HHS) , may be offered in Exchanges either as part of a medical policy or as a separate dental policy. This White Paper:

1. Frames the issues related to dental offerings in Exchanges;
2. Explains the unique characteristics of the dental marketplace for consideration on each issue;
3. Defines and analyzes the operational challenges inherent in offering dental plans through both AHBE and SHOP Exchanges;
4. Offers common-sense options for state and federal policymakers engaged in Exchange design.

The White Paper is presented by the National Association of Dental Plans (NADP) and the Delta Dental Plans Association (DDPA) as the two associations representing virtually all of the dental benefits industry in the United States. It is based on issues and alternatives developed by the firms of McKenna Long & Aldridge and Milliman, Inc. Specific references to Milliman's work are noted in this document, with their full report attached as a technical appendix in the White Paper.

**EXCHANGES:** Exchanges are the new insurance marketplaces for both individuals and small businesses to access health insurance coverage required by the ACA. The American Health Benefits Exchange (AHBE) is the individual coverage market where federal subsidies of premium are available to qualified consumers. States must also provide a separate Small Business Health Options Program (SHOP) Exchange where employers with 100 employees or less can provide insurance to their full-time workforce. In some instances states can merge these Exchanges.

**ESSENTIAL HEALTH BENEFITS PACKAGE:** ACA establishes a specific benefit package to be offered in the Exchanges. This "essential health benefits package[1]" (EHBP) includes ten categories of services; one of these is "pediatric services including oral and vision care". EHBP is to be defined by the Secretary of the U.S. Department of Health and Human Services (HHS) as equivalent in scope to a "typical employer plan" i.e. health benefits offered by employers. For oral care today, most medical policies cover oral health assessments performed by pediatricians as part of well child visits and

[1] As consumers purchasing coverage in Exchanges are only offered EHBP, it becomes their "Minimum Essential Coverage (MEC)" under ACA.

provide some coverage for oral care connected to medical conditions.[2] However, as medical policies do not typically cover services to prevent or treat the two dental diseases (decay and periodontal disease), most employers supplement their medical plan by offering a separate policy of dental benefits. These separate policies of dental benefits are most often provided by standalone dental plans or carriers and often on an "employee-pay-all basis."

**OFFER OF SEPARATE DENTAL POLICIES:** To provide consumers access to the same policies and expertise of a typical employer plan available in the commercial marketplace, ACA provides states shall allow the offer of standalone dental policies in Exchanges. When a standalone dental policy is offered, state Exchanges must also allow a medical carrier to offer the EHBP without "pediatric oral services".[1] Medical carriers can also offer the full EHBP in Exchanges as well.

The Secretary has yet to promulgate regulations detailing the requirements for EHBP; however, the possibility of including some of the specialized oral services typically covered by separate dental policies necessitates a more detailed look at dental coverage. Specialized dental coverage, and the dental benefits industry, possesses unique characteristics that must be considered as states and the federal government establish Exchanges and the products offered on those Exchanges.

**ISSUES, KEY POINTS AND RECOMMENDATIONS:** Six issues are explored with regard to the offer of separate dental plans in Exchanges as required by ACA. The key points and recommendations offered by the National Association of Dental Plans (NADP) and the Delta Dental Plans Association (DDPA) are outlined for each issue below.

**More detailed recommendations and background information to support key points and summaries highlighted in this Executive Summary are contained in each of the detailed Issue Briefs of the White Paper. The full White Paper can be found on nadp.org and deltadental.com.**

## ISSUE 1: WHAT SHOULD CONSTITUTE "PEDIATRIC ORAL SERVICES" REQUIRED AS PART OF THE EHBP?

This is the most critical issue to all the options and recommendations outlined in this White Paper. The decision on this definition impacts the breadth of coverage offered as separate dental policies in Exchanges. It also impacts administrative requirements of Exchanges and carriers including the flow of federal subsidies and coordination of consumer out-of-pocket maximums, as well as the application of consumer protections. However, as HHS's proposal on the EHBP may be one of the last regulations issued to implement ACA, all options for HHS's definition of EHBP must be examined. Some options result in complex coordination of subsidies and out-of-pocket cost-sharing maximums to consumers selecting coverage through the ABHE Exchange. These options must be examined by states prior to design of Exchange IT systems to assure the offer of standalone dental policies in the Exchanges is a viable option for Exchange consumers.

[2] Oral treatment for medical conditions includes reconstruction for cleft lip and palate or sequelae of trauma and cancer treatment or prophylaxis for kidney failure/dialysis and organ transplants or palliative and/or emergency treatment.

While this paper does not recommend a specific benefit option for adoption, there are basic considerations for defining "pediatric oral services" which are described. Issue #1 in the White Paper arrays the options which could meet these considerations along with their impacts and costs. The funding available for subsidies and clinical appropriateness of care being provided to children under the EHBP will be important factors to weigh in determining the path for defining "pediatric oral services" as part of the EHBP.

***Key Points:***

- Federal or State: The federal government should take the lead in defining the EHBP. States will make the decision whether to allow additional coverage and apply state requirements to the package at their cost. The benefit defined for "pediatric oral services" will be applicable to both AHBE and SHOP Exchanges, as well as for the individual and small group market outside Exchanges.

- The design and cost of EHBP and particularly the "pediatric oral services" holds broad implications for continuity of coverage for those who currently have both public and private dental coverage, and access for children who do not currently have coverage.

- The age range covered by the term "pediatric" must be defined for benefits to be modeled and priced.

- ACA calls for the EHBP to have the scope of a "typical employer plan." Most employer plans, i.e. commercial plans, provide coverage to the employee who may add family coverage through a range of benefit options. Both medical policies and dental policies offered by most employers cover pediatric oral services but usually only dental plans cover services to prevent and treat dental disease. Potential interpretations of "typical employer plan" include:
    1. an oral health assessment now covered in medical policies;
    2. preventive and diagnostic dental services with emergency treatment;
    3. a typical employer dental plan as described by the U.S. Department of Labor;
    4. a Medicaid or Children's Health Insurance Program (CHIP) style benefit—with or without orthodontia; or
    5. a next generation employer-type dental plan with the application of risk assessment and medical necessity.

  The additional cost of this range of options is from a low of no change in cost to medical policies to a high of $48.25 per child per month or $579 per child annually in addition to medical coverage.

- Metal levels, representing specific actuarial values of coverage, should not be applied to "pediatric oral services" when offered as separate dental policies in Exchanges.

***Recommendation:***

HHS should define a core benefit level for "pediatric oral services" including the age encompassed by the term "pediatric" to create a consistent base for states to make both separate dental policies and dental services integrated with medical coverage available to consumers in Exchanges. This core or "essential" benefit for "pediatric oral services" should be affordable for consumers and administratively simple for Exchanges to administer.

## ISSUE 2: HOW SHOULD "DENTAL PLANS" BE QUALIFIED TO OFFER COVERAGE THROUGH THE EXCHANGES?

ACA provides states allow dental plans, i.e. carriers that provide standalone dental policies, to offer these policies in the Exchanges provided the policies cover the benefit defined by HHS for "pediatric oral services" as part of the EHBP. The National Association of Insurance Commissioners (NAIC) Model Act on Exchanges provides for dental carriers to become "qualified dental plans" to operate on Exchanges. Whatever the definition of "pediatric oral services" as part of EHBP, standalone dental policies are allowed to be offered in Exchanges. The definition will simply determine what dental coverage is offered and subsidized and what is optional for consumers to purchase at their own cost. The elements for qualification as a "qualified health plan" (QHP) are examined for their application to dental carriers in becoming "qualified dental plans" (QDP).

***Key Points:***

- Federal or State: the states have the primary responsibility for identifying and implementing criteria to qualify dental plans within Exchanges.

- Criteria developed for certifying QHPs are not necessarily applicable to dental plans when offering "pediatric oral services" as separate dental policies, particularly when the required benefit is pediatric only. States differentiate in regulations applied to medical plans and plans offering a single benefit like dental today. While dental policies offered on Exchanges should be licensed and compliant with relevant state statutes for solvency, market conduct and other standards, there are marked differences between medical and dental coverage to consider when determining the applicability of QHP criteria to QDPs.

- Plans offered on both the AHBE and SHOP Exchanges are required by ACA to be certified as QHPs. Therefore, criteria for dental plans – whether it be through the QHP or a separate QDP process – will be applicable to both Exchanges.

***Recommendations:***

1. **Should criteria for qualification be established at the federal or state level?**

   As ACA provides for HHS to establish qualifications for health plans, it also directs states to allow separate dental policies to make offerings in the Exchanges, the establishment of criteria for standalone dental plans to qualify to offer coverage in the Exchanges appears to be the responsibility of the states. However, HHS may use its broad authority to apply or waive health plan standards to dental plans to establish a threshold of qualification standards for the states.

2. **Should criteria created for certification of "qualified health plans" be applied to dental plans?**

   QHP criteria should not be indiscriminately applied to dental plans to be eligible to offer coverage in the Exchanges. The differences in medical and dental coverage must be considered in applying any of the QHP criteria to dental plans. As well, policymakers should weigh the value of the criteria and cost of implementation given the limited scope of the "pediatric oral services." It will also be useful for each state to compare the criteria to existing state requirements for licensure.

3. **If not, what criteria should be used?**

   Of the reviewed criteria:

   - Accreditation is inapplicable to dental plans;
   - The local nature of networks and uneven geographic distribution of dentists make a single, national network adequacy standard inappropriate for dental plans. States without network adequacy standards for dental plans that determine they are needed should apply them only to general dentists and allow the dental plan to specify a target appropriate to their coverage for approval;
   - Relevant quality and performance measures are limited and may be difficult to narrowly apply to children. If utilization data for children's services is required, it should be consistent with Medicaid measures now reported;
   - Marketing limitations and disclosure requirements should follow existing state regulation;
   - Metal levels, representing specific actuarial values of coverage, should not be applied to separate dental policies covering "pediatric oral services;"
   - If standard disclosures are required to qualify dental plans, a separate form or requirements appropriate to the limited scope dental product offering should be developed.

## ISSUE 3: HOW SHOULD THE OFFER OF CHILD, ADULT AND FAMILY DENTAL COVERAGE BE STRUCTURED IN THE EXCHANGE TO ENSURE CONSUMERS HAVE APPROPRIATE INFORMATION TO MAKE INFORMED CHOICES?

There are three options for providing "pediatric oral services" examined in this section. These options should be combined by an Exchange to mirror the options now available to consumers in the commercial market. The options include:

- Separate dental policy and separate medical policy;
- Co-offered dental and medical policies;
- "Pediatric oral services" integrated with a medical policy.

Providing all three of the above configurations of medical and dental policies, with information about the dental-only element within each, allows Exchanges to maximize transparency and choice for consumers. By emulating today's marketplace, Exchanges can promote the conditions under which medical-only, dental-only and full service plans can compete and thrive in Exchanges while consumers choose what's best for them.

***Key Points:***

- Federal or State: the federal government will provide guidance regarding consumer choices through Exchanges by both defining "pediatric oral services" and providing guidance for consumer information. States will design and implement the consumer interface which provides the information to make informed choices.

- If the definition of "pediatric oral services" in EHBP includes services typically covered by dental policies, recognition of existing coverage under a dental policy outside the Exchange is easily achieved and necessary to ensure consumers are allowed to keep the coverage they have and aren't required to purchase duplicative coverage.

- Dental and medical benefits today are purchased in one of three configurations: separately from two different carriers; co-offered by a carrier and its affiliate, subsidiary or partner as separate medical and dental policies; or dental services integrated in a medical policy.[2] All three configurations should be allowed in Exchanges to ensure robust competition and consumer choice.

- Transparency with respect to cost can be achieved when a separate dental plan is offered in a state Exchange by requiring medical plans that integrate dental services in their medical policies to also offer a medical policy without dental services, and requiring any carrier, medical or dental, that chooses to offer dental policies also offers a separately priced "child-only" dental policy covering just the required "pediatric oral services."

- Supplemental dental coverage for adults and non-essential pediatric dental benefits should be offered alongside the essential "pediatric oral services" so parents or guardians have

access to family coverage, can access covered care from the same family dentist as their children/dependents, and are not discouraged from obtaining such coverage.

- Purchasers, both employers and consumers, generally make decisions about dental policies based on cost, benefits and access to dentists within a network. This information must be presented effectively to ensure tools are available to make an informed and educated choice regarding dental coverage.

- Presentation of consumer choices and related information will be relevant to both the AHBE and SHOP Exchanges. Employers in SHOP exchanges should also be allowed to specify the coverage offered to employees.

***Recommendations:***

1. **How should the essential "pediatric oral services" be presented to consumers?**

   HHS should allow separate dental policies purchased outside Exchanges to meet the "pediatric oral services" required in EHBP when medical coverage is purchased through an Exchange meeting the balance of required services in EHBP.

   If "pediatric oral services" is defined to include services normally covered by separate dental policies, this benefit should be offered and separately priced on the Exchange as a "child only" policy by all carriers choosing to offer dental policies.

   ACA provides for medical carriers to offer policies in Exchanges which include all EHBP benefits, but medical carriers should also be required to provide a medical policy without "pediatric oral services" when a QDP is also offered in the Exchange to allow:
   - Adults without children to purchase coverage without "pediatric oral services" and
   - Consumers who have dental or medical policies covering "pediatric oral services" outside of Exchanges to keep their coverage and purchase medical coverage that is not duplicative

   When consumers in a household with children fail to select a policy covering "pediatric oral services" and evidence of other dental coverage is not presented, Exchanges should apply automatic enrollment in the lowest cost dental "child-only" policy to assure required coverage is met.

2. **How should supplemental dental products be presented to consumers?**

   Much like the required "pediatric oral services," supplemental dental benefits should be presented as a separate policy option. Exchanges must take steps to both:
   a) Ensure consumers understand "pediatric oral services" as defined by HHS as part of the EHBP are subsidized and supplemental dental coverage is not; and

b) Recognize separate family coverage which includes "pediatric oral services" meeting the HHS definition can meet the EHBP whether purchased inside or outside the Exchange, allowing parents and children to remain on or be covered under the same dental policy.

3. **How can an Exchange uphold its responsibility for providing "standardized, comparative information" on plan options among QHP and standalone dental policies offering "pediatric oral services"?**

   While information presented to consumers should be manageable in scope, it should also provide enough detail for them to make educated choices about insurance options, including the availability of dental as a standalone option. Beyond that, Exchanges should maintain in-depth information about all plan choices and consumers should be able to access progressively more in-depth information on a proactive basis.

## ISSUE 4: HOW CAN PREMIUM SUBSIDIES BE APPLIED TO "PEDIATRIC ORAL SERVICES" PURCHASED IN A STANDALONE DENTAL POLICY?

ACA specifically provides premiums allocable to the purchase of "pediatric oral services," under a separate dental policy, to be considered for the calculation of premium subsidies. ACA does not address whether the premium tax credit subsidy should be allocated between medical insurance and dental insurance or paid first to one or the other.

***Key Points:***

- Federal or State: the federal government has control over tax credits that subsidize the purchase of the EHBP, while states will determine how subsidies are distributed and premiums are collected and distributed.

- Relatively small dental policy premiums and a lack of infrastructure to collect premiums from individuals (as opposed to employers) make the premium collection from Exchange participants challenging for standalone dental plans. This scenario is further complicated by the limitation of the subsidized benefit to only "pediatric oral services," which is expected to be a low dollar benefit compared to medical coverage. Exchanges must consider how to build on existing systems to keep costs low for carriers and ultimately consumers.

- Tax credit for subsidies are relevant only to the AHBE while premium payment issues are relevant to both the AHBE and SHOP Exchange.

***Recommendations:***

**1. Should the applicable subsidy be split between the dental and medical carrier?**

When a separate dental policy is selected covering "pediatric oral services," the federal government should split the value of the tax credit on a basis proportionate to the premium for the "pediatric oral services" in the dental policy and the medical policy. The subsidy should be paid directly to the dental plan and medical plan as required by ACA. Where an aggregator is used by the state Exchange, the subsidy should be paid to the aggregator for distribution on the same basis as required for subsidies paid directly to the dental plan and medical plan.

**2. Will the collection of the unsubsidized portion of the premium be centralized for distribution or the responsibility of the dental plan providing the separate policy?**

States should provide for premium collection through a central location – either the Exchange or an aggregator in addition to ACA required consumer option for direct payment to the QHP. Centralized collection and aggregation with subsidies where appropriate will reduce administrative costs for plans, particularly standalone dental plans collecting small premium amounts. It also allows Exchanges to answer consumers' questions on payment status in a real-time basis.

## ISSUE 5: HOW SHOULD COST-SHARING AND OUT-OF-POCKET MAXIMUMS BE APPLIED TO MEDICAL AND DENTAL COVERAGE?

ACA includes additional provisions which protect subsidized consumers, i.e. those between 133% and 400% of poverty, from excessive out-of-pocket cost due to health care expenses. Out-of pocket expense for these consumers purchasing the EHBP in the AHBE is limited to the out-of-pocket maximum for a High Deductible Health Plan (HDHP) which is currently $5,950 for an individual and $11,900 for a family.

ACA also provides for a reduction in these out-of-pocket limits for consumers purchasing a silver level of coverage (70 percent actuarial value) to ensure subsidized consumers are not required to spend more than a specified threshold "out-of-pocket" on health care. However, when a subsidized individual enrolls in both a QHP and a separate dental policy to meet EHBP, the portion of the cost-sharing reduction properly allocable to "pediatric oral services" is not applied to the reduction in cost-sharing by the qualified health plan for the consumer's out-of-pocket expense.[3]

So while reductions in out-of-pocket maximums do not apply to "pediatric oral services" purchased as a separate dental policy, some coordination must occur to provide subsidized consumers purchasing EHBP through the combination of a medical plan and a dental plan relief from additional out-of-pocket (OOP) costs when the maximum is reached.

***Key Points:***

- Federal or State: cost-sharing reductions and out-of pocket maximum issues are largely federal, although states could play a role through Exchanges in the collection and tracking of information that triggers their application.

- ACA includes cost-sharing maximums on EHBP designed to limit consumers' out-of-pocket spending on health care. These maximums apply to consumers who receive subsidies in Exchanges to purchase the EHBP, including both medical and "pediatric oral services" components.

- In today's environment, medical and dental claims are processed separately, most often using different claim systems, even when offered by the same carrier. Therefore, coordinating out-of-pocket limits among medical and dental carriers offering the benefits required for the EHBP for subsidized consumers in the Exchange should be addressed carefully.

- Methods for addressing the splitting of cost-sharing limitations across separate medical and dental coverage include:
  - Designing "pediatric oral services" in a way that requires no cost-sharing;
  - Apportioning the total OOP maximum between medical and dental;
  - Developing individual carrier systems to administer a shared OOP maximum;
  - Setting up the Exchange to serve the function of claims aggregator.

- Cost-sharing and OOP maximum issues will apply only to the AHBE Exchange, not the SHOP Exchange. While ACA exempts dental policies from reductions in out-of-pocket cost-sharing limits, coordination between medical plans and dental plans to eliminate consumer OOP cost-sharing once consumers reach the standard out-of-pocket cost limit should occur.

***Recommendations:***

In summary, the key methods to manage the determination of achievement of OOP maximums by subsidized consumers, given the meshing "pediatric oral services" in the EHBP through separately purchased medical and dental policies are:

- Managing the process through the design of the "pediatric oral services", covering specified procedures only, at 100 percent, such that no portion of the OOP maximum needs to be attributed to dental;
- Managing the process via a separate pediatric dental-specific OOP maximum;
- Providing carriers the responsibility of determining when the OOP maximum has been achieved, potentially using an exception process to handle any pediatric dental claim payment issues that could arise after a person has achieved their OOP maximum;

- Giving the Exchange the responsibility to build, maintain, and administer a process to aggregate claims for determination of OOP maximum achievement.

The appropriate option depends on HHS's determination of the scope of "pediatric oral services" in the EHBP or splitting the OOP maximum when a consumer selects a separate dental policy and potentially, the sophistication of the Exchange's IT systems.

## Issue 6: Which of ACA's consumer protections should be applied to "pediatric oral services" when provided under separate dental policies?

Dental plans are primarily regulated at the state level where many consumer protections exist today including summary of benefits, plain language requirements, as well as timely claims processing and appeals processes.

While in general the Health Insurance Portability and Accountability Act (HIPAA) "excepted" benefits remain outside the scope of most major medical market reform provisions of ACA, relevant consumer protections required for participation in the Exchanges can be applied to QDPs offering the "pediatric oral services" through standalone or separate dental policies. Under ACA, requirements for dental plans are deferred to states, but the federal government may establish requirements related to other ACA provisions.

In its Exchange Notice of Proposed Rule-making (NPRM),[4] HHS notes some QHP certification requirements and consumer protections the state Exchange itself may determine to be relevant and necessary for standalone dental plans. This paper considers the standards HHS identifies in the NPRM, including:

- quality reporting;
- transparency measures;
- summary of coverage information;
- provider network standard;
- standards regarding the consumer's experience in comparing and purchasing dental plans.

The White Paper focuses on applicability to "pediatric oral services" required as part of the EHBP when offered by a dental plan as a separate dental policy only.

***Key Points:***

- Federal or State: the federal government may establish or defer to the states' development of consumer protections under ACA to be applied to dental policies offered through both the AHBE and SHOP Exchanges.

- ACA implemented several insurance market reforms designed to protect consumers and require medical carriers to offer fairly valued coverage in a non-discriminatory manner. These requirements apply broadly to all group health plans and health insurance issuers as defined under HIPAA. Separate dental policies are "excepted benefits" under HIPAA and not subject to the insurance market reforms for medical coverage.

- An Exchange may apply relevant consumer protections to QDPs offering coverage in the Exchanges. NPRM identified these potential consumer protections as quality reporting, transparency measures, summary of coverage information, provider network standards, and standards regarding the consumer's experience in comparing and purchasing coverage.

***Recommendations:***

Any relevant ACA consumer protections should only be applied to separate dental policies covering "pediatric oral services" required as part of the EHBP.

Given existing state requirements for dental plans, the following consumer protections should be deferred to the states for conformance with current requirements specific to separate dental policies:

- provider network standards;
- plain language requirements.

Transparency requirements for the following areas could be established at the federal or state level taking into account the differences appropriate for separate dental policies covering a limited scope benefit for "pediatric oral services":

- cost-sharing disclosures;
- plan performance;
- summary of benefits.

The NAIC's expertise should be utilized in developing templates and standards appropriate to separate, non-integral dental policies.

**More detailed recommendations and background information to support key points and summaries highlighted in this Executive Summary are contained in each of the detailed Issue Briefs of the White Paper. The full White Paper can be found on nadp.org and deltadental.com.**

# Acknowledgements

## McKenna Long & Aldridge

McKenna Long & Aldridge LLP provides business solutions in the areas of health care, complex litigation, government contracts, public policy and regulatory affairs, corporate law, political law, intellectual property and technology, real estate, energy, finance, environmental regulation and international law. Our clients are a mix of Fortune 500 and mid-size companies, major government contractors and non-profit organizations of all types. In addition, MLA offers clients a first-in-the-nation Health Insurance Exchange Team, a unique cross-practice initiative designed to help companies prepare strategically for the impact of health insurance exchanges on their business; specifically how Exchanges will affect providers, suppliers, insurers and employers.

## Milliman, Inc. Caveats and Limitations

Milliman prepared the client report in Appendix D of the full White Paper for the specific use of NADP & DDPA. This report is footnoted where it is used in the body of the White Paper. The terms and limitations of the report and data provided by Milliman are noted in the client report in Appendix D.

## Endnotes

[1] ACA Section 1302(b)(4)(F)
[2] NADP research reports show that about 2/3 of dental enrollment is through a carrier other than the medical carrier; just under 1/3 is through a medical carrier but under a separate dental policy and a very small percentage is dental services covered under a medical policy.
[3] ACA Section 1402(c)(5) of ACA
[4] "Establishment of Exchanges and Qualified Health Plans", Federal Register, Vol. 76 No. 136, July 15, 2011

## NOTES

## NOTES