



## President's Report

Bryan Geremia

► The Board recently convened for our annual Strategic Planning session. As we all have some very critical issues ahead for our industry, this session proved to be very productive and addresses the Association's priorities for the upcoming calendar year.

Members of your Board have been working very closely with the National Association of Dental Plans and other groups to develop and influence how dental benefits will be defined within the Essential Benefits Package currently in development by HHS as part of the implementation of the Affordable Care Act (ACA). One of our major priorities will be to develop a message with talking points that we can all use as we interact with California leadership and staff that will be developing the state exchange. It is critical that we develop a clear agenda with respect to certification for participation in the exchange, access to adult dental, a full competitive environment with transparency and choice. Dental benefits will need to be affordable and friendly both within the exchange and outside the

exchange. We will be partnering with CAHP and building ties with consumer groups and the CDA to further these causes in the coming months and year.

With the appointment of a new DMHC Director, it is critical that the Association once again present our value as the "go to" resource for all things related to dental benefits and the marketplace in California. We will have a group of Board members scheduling a meeting with Director Brent Barnhart to present our story.

Communication and ease of access to information are important to all of our plan members. For this reason, another priority will be optimizing the use of the CADP website. We will be focused on improving both content and functionality in the near future.

So, a lot going on. The Board appreciates your support and volunteer efforts in all the initiatives critical to the success of our industry. Now is a good time to also plan to attend our annual Legislative and Regulatory Conference scheduled in mid-January 2012.

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The CADP News is published quarterly. Your suggestions and/or comments are encouraged. Please write or call:

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# CADP Board of Directors

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# Dots and Dashes

Charles D. Stewart, DMD  
Chair, Quality Management Committee

► Fall 2011 is proving to be a season of change. Some things, however, remain a constant. One is the uncertainty of what is included as a core benefit, as well as whether one plan qualifies to participate in one of the exchanges involved in the Patient Protection and Affordable Care Act (PPACA). The anticipated March 2011 release of the medical and dental core benefits remains elusive, and speculation of a fall release is just that – speculation.

One area of change is with the Code revision process (run by the ADA.) The members of the Code Revision Committee were recently informed that the committee was being abolished, and all were thanked for their participation. The ADA stated that the process was under review and disclosure of the new process would be made after the November Council meeting. Once the changes are clear, we will communicate to the CADP membership. In spite of this change, the ADA has publicly commented that all planned dates and deadlines will remain valid.

The recent Quality Management Committee Meeting hosted by CIGNA was well attended, and many items were discussed that deserve coverage here. The recent appointments to the DMHC were discussed, with Brent Barnhart appointed as the Director and Shelly Rouillard as Chief Deputy Director. The Dental Board of California updated section 1005, infection control guidelines, and we updated the shared assessment program and tool to reflect these changes. Some of the highlighted changes are the requirement to date and identify the sterilizer used for all sterilizer bags, use of utility gloves when handling instruments as well as when handling germicides or hazardous chemicals, and new, more detailed hand washing and care protocols. This material was distributed in the meeting and provided the basis for our CE credits. I was very pleased to report that the Shared Assessment Warehouse now has a total of 9,735 assessments in the warehouse, currently representing data on 4,905 separate provider offices, many with multiple assessments, therefore allowing some trending and analysis of provider offices. There will be a meeting of those Plans that desire to coordinate their schedules for 2012 later this year. If you are interested in participating in this process, please contact Dr. Cary Sun (CIGNA), who is the champion of this process.

Another long-awaited change that has occurred is the requirement for fingerprinting via live-scan technology. Effective July 1, 2011, all license renewals require the fingerprints; cost is the responsibility of the applicant. And yet another change: the California Department of Public Health has proposed rules regarding X-ray quality assurance. These rules establish requirements to take control radiographs at the start of each work day in order to minimize the need for re-takes. This law is in the comment period process and, coincidentally, a recent CNN study explored the safety of dental radiography. This may incite public outcry and almost assure the new regulation will be approved.

The ADA Code Revision Committee actions on Batch 2 (held in August 2011) were discussed and debated by the QMC, with agreement not to disclose publicly, understanding they do not become final until the publication of the CDT 2013-2014 due out in July 2012.

In 2012, three QA Consultant Courses will be held. The first takes place February 27-28, at the LAX Marriott. The second will be in conjunction with the CADP Annual Conference, June 1- 2 at the Esmeralda Resort in Indian Wells, and the third in the Fall hosted by Western Dental, in Orange – date and time to be determined.

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# Legislative Update

Pamela Loomis, Nossaman LLP

▶ Friday, October 9th, is the last day for the Governor to sign or veto any bills that were passed by the Legislature before it adjourned on September 9th. And true to form, Governor Brown has been varied, unpredictable and colorful in his approach to signing or vetoing bills. At the time of writing this update, Brown has not acted on most of the bills being tracked by CADP that have made it to his desk. The clock is ticking down.

Below, I outline a handful of bills that are either a top priority for CADP or warrant specific mention.

CADP originally **opposed AB 1059 (Huffman)** because it would have required the imposition of administrative penalties on health care service plans for late or under-paid claims. The bill has since been narrowed to require the director of DMHC to require the timely payment of claims and the payment of interest on late or under-paid claims, which is essentially a restatement of current law. CADP has requested that dental plans be exempted from this bill, but to no avail. However, since the bill has been amended to be of almost no consequence, CADP has not actively opposed the bill. Status: To Governor 9/9/11; no action taken yet.

**AB 52 (Feuer)** would require health care service plans and health insurers to apply for prior approval of proposed rate increases, and impose on the California Department of Insurance and Department of Managed Health Care specific rate regulation criteria, timelines, and hearing requirements. Fortunately, specialized health care service plans were exempted from the requirements of the bill back in March. The Senate Appropriations Committee passed this bill 6 to 3 on a strict party-line vote with Democrats voting in favor and Republicans voting against. The lobbying efforts against this bill kicked in to high gear to stop its passage by the Senate. Their efforts paid off. Insurance Commissioner Jones was unable to get the requisite 21 votes due to the opposition of the moderate members of the Democratic Caucus (aka the Mod Squad), so the bill was placed on the Inactive File in order to live to fight another day in 2012. Status: To Senate Inactive File on 9/1/11; two-year bill.

**AB 792 (Bonilla)** would require health plans and insurers, among other entities, to notify individuals who are ceasing to be enrolled due to loss of employment or other "life events" of health care coverage through the California Health Benefits Exchange and begin "pre-enrollment" activities on behalf of these individuals. Specialized health care service plans are exempted from this bill and dental insurance is not included in the bill. *However, CADP member dental plans as employers may have an interest in the bill's notice requirements on employers.* Status: Held in Senate Appropriations Committee on 8/25/11.

**AB 922 (Monning)**, which would move the Office of the Patient Advocate from the Department of Managed Health Care to the Health & Human Services Agency, was amended late in the session and currently awaits action by the Governor. As amended, AB 922 also transfers authority of the DMHC from the Business, Transportation and Housing Agency to the Health and Human Services Agency. Both provisions would be effective July 1, 2012. According to Mr. Monning, the HHS Agency, which is focused on consumers and implementation of PPACA, is the appropriate place for the Patient Advocate and the DMHC rather than the BTH Agency, which has no expertise in federal health care and its requirements. He also argues that PPACA implementation necessitates collaboration and a robust federal-state relationship that already exists within HHS. Concerns have been expressed that this change has the negative effect of placing under the same agency both the regulation of health plans and their reimbursement (through health plan purchasers such as the Department of Health Care Services). Status: To the Governor on 9/20/11; no action taken yet.

**AB 1296 (Bonilla)** would enact the Health Care Reform Eligibility, Enrollment, and Retention Planning Act, which would require the California Health and Human Services Agency to establish standardized single, accessible application forms and related renewal procedures for state health subsidy programs. According to the author, the PPACA requires a seamless "no wrong door" application system so that wherever consumers apply they are enrolled into the program for which they are eligible. Although there was no registered opposition to the bill, it passed on a strict party line vote with Democrats voting in favor and Republicans voting against it. Status: To the Governor on 9/20/11; no action taken yet.

**ABX1 21 (Blumenfeld)**, which was signed by the Governor on September 16, extends the managed care plan tax, which had been scheduled to sunset on July 1, 2011, to July 1, 2012, in order to fund the Healthy Families Program. Many organizations, including CADP, raised concerns that eliminating the tax could cause 300,000 children in the HFP to be disenrolled. In his signing message, the Governor stated: "Extending the tax on health care service managed care plans for an additional year will raise more than \$200 million in new revenue, bring in an additional \$300 million in federal funds, and save the General Fund \$103 million this fiscal year... This will help maintain funding for the Healthy Families low-cost health insurance program for children and teens." Status: Chaptered into law on 9/16/11.

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▶ **SB 51 (Alquist)** would require annual rebates to customers when the actual medical loss ratio (MLR) exceeds the standard MLR pursuant to a formula set out in the bill. The California Department of Insurance, the sponsor of this bill, states that this bill incorporates the federal loss ratio requirements into California law so that CDI can enforce these additional requirements. Specialized health insurance and specialized health care service plan contracts are exempted from this bill. Although there was no registered opposition to the bill, it passed on a strict party line vote with Democrats voting in favor and Republicans voting against it. Status: To the Governor on 9/13/11; no action taken yet.

**SB 703 (Hernandez)** would establish in state government a Basic Health Program, to be administered by MRMIB, to provide health plan coverage to individuals under age 65 with family incomes between 133 percent and 200 percent of the federal poverty level (FPL), and legal immigrants with family incomes at or below 133 percent of the FPL who are not eligible for Medicaid, rather than providing these two groups of individuals with federal premium tax credits and cost-sharing subsidies through the California Health Benefits Exchange. The Board was not interested in taking a position on this bill since it did not include dental plans. *However, SB 703 has since been amended to allow MRMIB to consider including specialized health care plans. No dental plans or other specialized health care plans have taken a position on the bill.* Status: the bill was held in the Assembly Appropriations Committee; two-year bill.

**SB 615 (Calderon)** was amended to require the DMHC to train solicitors of health care service plan contracts (and requires solicitors to complete the training) regarding the federal Patient Protection and Affordable Care Act and the CA Health Benefits Exchange, as well as the Knox-Keene Act and ethics. The initial goal of this bill was to ensure that navigators in the CA Health Benefits Exchange were licensed. *Since the bill was watered down from its original purpose, the sponsors did not move the bill out of the Senate before the legislative deadline, so it is a two-year bill.*

**Will the Governor and Legislature soon be singing the budget blues?** As you may recall, Governor Brown vetoed the Legislature's first attempt at a budget because it was not balanced. The Legislature then passed a second budget that the Governor signed. So it must have been balanced, right? Wrong! The budget optimistically assumed that \$4 billion of additional revenues would materialize before the end of 2011 due to an up-tick in the economy. As we now know, the hoped for up-tick has actually been a down-tick, and a significant revenue shortfall is predicted. The Legislature cleverly planned for this eventuality by building into the budget automatic spending cuts to adjust for a potential shortfall in revenues. In reality, they were just kicking the proverbial can of tough decisions down the proverbial road. The Department of Finance will have a good handle on the revenue forecast for the remainder of 2011 in October, which will determine whether the Legislature must come back from its recess for a special session or whether it can wait until January. No one believes that the Legislature will sit back and let spending cuts automatically occur to programs important to the constituencies that elected them. Before that happens, they will be back in session to craft a stop-gap budget measure that will most likely be out of balance within another few short months.

Should you have any questions or require additional information regarding this report, please feel free to contact me.

# Regulatory Update

Mary Powers Antoine, Nossaman LLC

▶ On August 11, 2011, Governor Brown appointed Brent Barnhart as director of the Department of Managed Health Care. I have known Mr. Barnhart for many years and have worked closely with him on legislative and health plan issues. He is a very smart, affable person. Mr. Barnhart has long standing ties to the health plan and insurance industry and is well-known in Capitol circles, both as an Assembly staffer and as a lobbyist. As the Governor's press release noted, Mr. Barnhart was senior counsel at Kaiser Foundation Health Plan from 1996 to 2009 and a policy committee consultant to the California State Assembly from 1993 to 1996. He was the legislative affairs director at Blue Cross of California from 1991 to 1993 and senior attorney and legislative advocate from 1983 to 1987. He also served as counsel and secretary at the Association of California Life and Health Insurance Companies from 1987 to 1991 and was the California legislative director of the American Civil Liberties Union from 1975 to 1983. This position requires Senate confirmation. Mr. Barnhart is registered decline-to-state. He assumed the position of Director immediately upon announcement of his appointment. Ed Heidig, now former interim director, will be remaining with the Department at least for a transition period.

Simultaneously with the appointment of the new Director, Governor Brown also appointed Shelley Rouillard as chief deputy director of the Department of Managed Health Care. Ms. Rouillard has strong credentials as a consumer advocate. Ms. Rouillard previously served as deputy director of the Benefits and Quality Monitoring Division at the Managed Risk Medical Insurance Board. She was program director at the Health Rights Hotline for Legal Services of Northern California from 2006 to 2007 and from 1996 to 2004. In 2005, Ms. Rouillard served as chief of health policy at the Office of Health Policy and Plan Administration at the California Public Employee Retirement System. Before that, she was the principal at Rouillard Consulting from 2001 to 2004 and served as director of Network Operations at HealthCare Compare Corporation from 1991 to 1996. She was a legislative advocate at the California Rural Legal Assistance Foundation from 1987 to 1991. This position does not require Senate confirmation. Ms. Rouillard is a Democrat.

Others currently on the DMHC leadership include Lynne Andersen Randolph, Deputy Director, Communications and Planning; Holly Pearson, Deputy Director and General Counsel; Andrew George, Assistant Deputy Director, Help Center; Maureen McKennan, Acting Deputy Director, Plan and Provider Relations; Tim LeBas, Assistant Deputy Director, Office of Legal Services; and Debra L. Denton, Acting Assistant Deputy Director, Office of Enforcement.

## ▶ REGULATIONS UPDATE

Below is a chart updating the latest information on the Department of Managed Health Care's currently pending regulations and regulations under consideration.

CURRENTLY PENDING REGULATIONS		
Regulation	Status	Remarks
Discount Plan Regulations (Adds T28 CCR § 1300.49.1.1, et seq.)	On December 28, 2010, the OAL issued its Decision of Disapproval of Regulatory Action. The Department has chosen not to appeal this Decision.	The Department remains steadfast in its position that it has the authority to require unlicensed discount plans to be licensed in order to operate in the state, and will continue to enforce this position against unlicensed entities.  At present, the Department has no stated plans to resurrect the discount plan regulations. That said, the new Director may take an opportunity to issue some sort of policy statement regarding these regulations.

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**REGULATIONS CURRENTLY UNDER CONSIDERATION**

<b>Regulation</b>	<b>Status</b>	<b>Remarks</b>
Conflict of Interest (T28 CCR § 1000)	Draft regulations under development.	Statute being implemented: Government Code § 87300
Enrollee Notices	Draft regulations under development.	Statutes being implemented: Health and Safety Code §§ 1344(b), 1389.4, 1368.015; 1363.02; 1363.5; 1363.06; 1363; 1364.5; 1367.10; 1368.02; 1373.19; 1373.65; 1389.1
Clarifying Changes to Various Rules (T28 CCR §§ 1300.43.3, 1300.67, 1300.80.10, among others)	This proposed rulemaking package will be used to make various clarifying and conforming changes including, but not limited to, areas such as ambulance plans, health care services, and medical surveys. The rulemaking package is currently under research and development.	Statute(s) being implemented: Health and Safety Code §§ 1343, 1367, 1373.18, and 1380, among others
License Application Revisions (T28 CCR §§ 1300.51; 1300.52)	Draft regulations under research and development.	Statute(s) being implemented: Health and Safety Code §§ 1351; and 1352
Cancellation of Enrollment (T28 CCR §§ 1300.65, 1300.67.4)	Due to federal and/or state law changes, the Department has determined that there will be no separate rulemaking at this time. Any future changes in this area may be consolidated with other rulemaking referenced above.	Statute(s) being implemented: Health and Safety Code § 1365
Centers of Excellence	Due to federal and/or state law changes, the Department has determined that there will be no separate rulemaking at this time. Any future changes in this area may be consolidated with other rulemaking referenced above.	Statute(s) being implemented: Health and Safety Code § 1367(d), (e), and (g)
Post-Claims Underwriting	Due to federal and/or state law changes, the Department has determined that there will be no separate rulemaking at this time. Any future changes in this area may be consolidated with other rulemaking referenced above.	Statute(s) being implemented: TBD

► The Task Force formed with representatives of the California Dental Association (CDA) and CADP to address common issues, as well as situations that may influence legislative and regulatory functions, has had a routine year. A key accomplishment of the task force was the development of a course for the spring and fall CDA Presents, where Dr. Gary Dougan of MetLife and I presented a three-hour lecture to assist dentists and staff on filing a claim and the potential pitfalls that may occur in that process. This helped to transmit an understanding that many of the issues CDA member dentists may have are individual ones, and are not indicative of a systemic situation with the dental benefits industry. The task force met on October 5, 2011, with an agenda intended to reinforce the mutual agreement that discussion will precede any legislative solution. One issue is the continued frustration by CDA members with the implementation of the non-covered services legislation by some plans. The CDA has indicated that it may seek clean-up legislation to assure that the law is properly interpreted and applied without obstacles, or opt-in, opt-out options. I would like to acknowledge Jeff Album (Delta Dental) and Courtney Barnes-Ransom (MetLife) who join me on this Task Force. I also would like to thank Dr. Gary Dougan for his devotion and input in the CDA Presents presentations.

During 2011, CADP QMC members have been very active in outreach projects, which directly support many of our strategic plan initiatives. Current examples of some of these projects include: OHAC, Give Kids a Smile, Remote Area Medical, National Children's Dental Health Month, the ADA Code Revision Committee, and the ADA Council on Dental Benefits. These activities demonstrate that the members of CADP are striving to be part of the solution in providing a means to help serve the underserved and underinsured populations in California. The validity of this strategic initiative was demonstrated in the ADA report, "Breaking Down Barriers to Oral Health for all Americans." For those interested, registration for the 2012 Give Kids a Smile Program opened on October 3, 2011, at the ADA website [www.ada.org](http://www.ada.org). All dental Plans are encouraged to register and participate in the 2012 program, scheduled for February 3.

Our next QMC meeting is scheduled for November 1, 2011 to be held at Western Dental in Orange. I hope to see you there!

## Save the Date!

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CADP's 22nd Annual Legislative & Regulatory Conference

January 17-18, 2012

Sheraton Grand, Sacramento

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The latest on the California Exchange, budget picture,  
2012 election, and more!

# In the News . . .

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**Survey Indicates Employees Will Pick Up Larger Share of Health Care Insurance Costs in 2012**—With health care costs continuing to rise, employers are expected to pass on more of these costs to their employees in 2012, according to a survey by the National Business Group on Health (NBGH). Of the 83 large employers surveyed in the NBGH report, a majority of respondents admitted that they will adopt increased cost-sharing in their approach to budgeting for rising health care costs. For instance, 53 percent of employers will require their workers to pay a higher percentage of health care premiums. Additionally, 39 percent of employers are expected to increase in-network deductibles while 33 percent will increase out-of-network deductibles. Employers are expecting an average increase of 7.2 percent in health care costs in 2012, whereas in 2011, they expected an average increase of 7.4 percent. Employers anticipate higher health care costs due to key provisions in the new health care bill: the requirement to extend dependent coverage to children up to the age of 26 and the removal of annual benefits caps.

**Peter V. Lee Named Executive Director, California Health Benefit Exchange**—The California Health Benefit Exchange Board recently named Peter V. Lee as its first Executive Director. As Executive Director, Lee will oversee the planning, development and ongoing administration and evaluation of the California Health Benefit Exchange. He will join the Health Benefit Exchange on October 17, 2011. Lee currently serves as the Deputy Director for the Center for Medicare and Medicaid Innovation at the Centers for Medicare and Medicaid Services (CMS) in Washington, DC, where he helped shape initiatives to identify, test, and support new models of care in Medicare and Medicaid. Previously he served as the Director of Delivery System Reform at the federal Health and Human Services' Office of Health Reform. From 2000-2008, he served as the Executive Director and Chief Executive Officer of the Pacific Business Group on Health (PBGH) in San Francisco. From 1995-2000, Lee served as the Executive Director of the Center for Health Care Rights and from 1993-1995, he practiced law at Tuttle and Taylor in Los Angeles. From 1984-1993, he served in a variety of leadership positions in Washington, DC, including the Director of Programs for the National AIDS Network. He holds a Juris Doctorate from the University of Southern California and a Bachelor of Arts from the University of California at Berkeley.

**More Californians Lack Health Insurance, Live in Poverty**—According to a Census Bureau report, the rate of Californians living in poverty continues to rise, and nearly one in five state residents lacked health insurance last year. According to the report, 7.2 million California residents, or 19.4%, lacked insurance in 2010. California ranked eighth among states for having the highest rate of residents who are not insured. Texas had the highest rate of uninsured residents at 24.6%. In addition, the census data showed that the state's poverty rate rose to 16.3% last year, its highest level in more than 10 years, and that household incomes fell by 5%.

The report also found that the number of covered individuals who obtain their insurance through public programs increased for the fourth consecutive year. The percentage of U.S. residents covered by private health insurance declined from 64.5% in 2009 to 64% in 2010, while the percentage of residents covered by public plans increased from 30.6% in 2009 to 31% in 2010. About 55.3% of U.S. residents had employer-sponsored coverage, down from 56.1% in 2009 and 64% in 1999. The data also showed that the number of U.S. residents covered by Medicaid rose by about 1.5%, to 48.6 million, and Medicare enrollment increased by 2.1%, to 44.3 million.

**Mercer Survey: Workers Face Smallest Hike in Health Care Costs since 1997**—U.S. workers will pay 5.4% more for their health care in 2012, down from a 6.4% increase in 2011 and the smallest increase in health care costs since 1997, according to a recent survey published by Mercer. Mercer surveyed nearly 1,600 employers from across the U.S. for the analysis. The report found that many employers expect to offset increases in insurance costs by raising deductibles or copayments or by switching insurers. About one-third of employers surveyed said they plan to increase the amount their employees pay for insurance next year. Without cutting any benefits or costs, employers estimated that their average health benefit costs would increase by about 7% in 2012, down from 9% each of the previous five years. The analysis also found that the slowed increase could be attributed to consumers scaling back their health care use. The survey also noted that corporate health programs could be contributing to lower employees' health care costs.

**White House Petitions Supreme Court to Review Reform Law**—In late September, the Obama Administration filed a formal request to the U.S. Supreme Court to review a decision by a three-judge panel of the 11th Circuit Court of Appeals that declared the individual mandate in the federal health reform law unconstitutional. In August, the three-judge panel reviewed the multistate lawsuit against the overhaul and became the first appellate court to rule against any part of the law. However, the court upheld the remainder of the law. The plaintiffs, 26 states and the National Federation of Independent Business, also requested that the high court review the case and said the entire law should be struck down. NFIB said the panel's ruling creates uncertainty for businesses regarding the overhaul's costs and requirements. The Supreme Court is not required to hear the case. However, disparate rulings in three separate appellate courts and the petitions from both sides of the lawsuit make it "all but certain" the Court will accept the case, according to the New York Times. If it accepts the case, the Court could issue a ruling as early as June 2012.