MILLIMAN REPORT

Adult dental coverage analysis

Prepared for the Colorado Division of Insurance

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Introduction

Under Colo. Rev. Stat. § 10-16-155, the Colorado Division of Insurance (DOI) under the Colorado Department of Regulatory Agencies (DORA) has retained Milliman, Inc. (Milliman), a global actuarial consulting firm, to perform actuarial reviews of legislative proposals that may impose a new health benefit coverage requirement on health benefit plans or reduce or eliminate coverage required under a health benefit plan. The legislative requirements may impact the individual, small group, and large group health insurance markets. The actuarial review must consider the predicted effects of the legislative proposal on the affected markets during the one, five, and 10 years immediately following the effective date of the legislative proposal, or during another time period following the effective date of the legislative proposal if such consideration is more actuarially feasible, including:

- An estimate of the number of Colorado residents who will be directly affected by the legislative proposal
- Estimates of changes in the rates of utilization of specific healthcare services that may result from the legislative proposal
- Estimates of changes in consumer cost sharing that would result from the legislative proposal
- Estimates of changes in health benefit plan premiums charged to covered persons or employers, in individual, small group, and large group markets that would result from the legislative proposal
- An estimate of the out-of-pocket healthcare cost changes associated with the legislative proposal
- An estimate of the potential long-term healthcare cost changes associated with the legislative proposal
- Identification of any potential health benefits for individuals or communities that would result from the legislative proposal
- Information concerning who would benefit from any cost changes and benefit expansions and any disproportionate effects it may have on protected classes, as available
- To the extent practicable, the social and economic impacts of the legislative proposal including information concerning who would benefit from cost changes, and any disproportionate effects and a qualitative analysis of the impacts of the legislative proposal

At the request of the Colorado DOI, Milliman was asked to provide an analysis of a legislative proposal that would require all individual and small group commercial health benefit plans regulated by the state of Colorado to include coverage for adult dental services as a part of the medical plan. As part of our analysis, we have considered the impact on individual and small group market medical plan premiums, cost sharing for members of individual and small group market medical plans, and reduced out-of-pocket costs for those who newly take up a plan. We have included the premium decrease associated with any current enrollees in a standalone dental insurance plan no longer enrolling in those plans post-mandate; this impact is shown as a change in the total out-of-pocket costs.

At present, the Affordable Care Act (ACA) mandates the offer of dental coverage for children in the individual and small group markets, either via health insurance policies or separate standalone dental policies, as part of the pediatric dental essential health benefit (EHB); this requirement does not extend to adults. This legislative proposal in Colorado would represent a change from the status quo, as many dental benefits in today's insurance market are provided as a separate dental insurance policy, as opposed to being covered benefits in a medical plan. However, the legislative proposal does not call for inclusion of these adult dental benefits as EHBs.

Executive summary

The Colorado Division of Insurance (DOI) commissioned Milliman, Inc., a global actuarial consulting firm, to review a legislative proposal that would impose a new health benefit coverage requirement on individual and small group commercial health plans. The proposal requires all commercial health benefit plans in the individual and small group markets to cover dental care for adults as part of the health benefit plan.

Currently, the Affordable Care Act (ACA) mandates the offer of dental coverage for children in the individual and small group markets as an essential health benefit (EHB). Such coverage may be provided as part of a health benefit plan or as a separate standalone dental policy. The same rules do not extend to adults. The proposed change would expand access to dental services for adults who currently do not have coverage by requiring health benefit plans to cover adult dental services. However, the proposal does not establish adult dental services as EHBs in Colorado.

The actuarial review estimates the effects of the legislative proposal on the individual and small group markets regulated by the DOI over one, five, and 10 years following the effective date of the proposal. Factors considered include the number of Colorado residents affected, changes in healthcare service utilization rates, consumer cost sharing, health benefit plan premiums, out-of-pocket healthcare cost changes, potential long-term healthcare cost changes, potential health benefits for individuals or communities, and the social and economic impacts of the proposal. All values presented in this report are for non-HSA qualified plans only based on discussions with the potential bill sponsors around potential cost-sharing limitations on the proposed covered benefits.

As shown in **Exhibit 1**, the estimated one-year, five-year cumulative, and 10-year cumulative impact on premiums in the fully insured commercial market is $112.7 million, $618.1 million, and $1,392.5 million respectively, or $17.32, $18.63, and $20.46 per member per month (PMPM) respectively. This represents a 2.93%, 2.73%, and 2.49% increase in premium over the timeframes analyzed.

EXHIBIT 1: ESTIMATED PREMIUM IMPACT OF ADULT DENTAL COVERAGE

	1-Year impact	5-Year impact	10-year impact
Individual - Total Dollars	$53,582,000	$293,967,000	$662,211,000
Individual - PMPM	$16.19	$17.42	$19.12
Individual - Percent Change	3.2%	3.0%	2.7%
Small Group - Total Dollars	$59,074,000	$324,138,000	$730,244,000
Small Group - PMPM	$18.49	$19.90	$21.85
Small Group - Percent Change	2.7%	2.5%	2.3%
Combined Individual and Small Group - Total Dollars	**$112,656,000**	**$618,105,000**	**$1,392,455,000**
Combined Individual and Small Group - PMPM	**$17.32**	**$18.63**	**$20.46**
Combined Individual and Small Group - Percentage Change	**2.9%**	**2.7%**	**2.5%**

Background

PROPOSED LEGISLATION

The proposed legislation would require all commercial market individual and small group health plans regulated by the State of Colorado to embed dental services for adults into their benefit offerings. Plans would be required to offer preventive and diagnostic care without cost sharing and to offer restorative care services at cost-sharing levels as applied to similar medical benefits. Plans would be allowed to specify a separate deductible for dental benefits but would not be allowed to specify annual or lifetime benefit dollar limits.

For the purpose of our analysis, we assumed that new adult dental coverage through health benefit plans would be similar to what is currently provided under commercial dental policies. These and other assumptions related to our analysis are presented in the Methodology and Assumptions section of this report.

Because preventive services would be covered before the deductible, we have excluded HSA-plan enrollees from the analysis, as they cannot cover these services before the deductible and maintain their HSA status.

LANDSCAPE OF ADULT DENTAL BENEFIT COVERAGE

Colorado residents seek dental services for a variety of reasons including preventive and restorative care. Currently, dental services for children and emergency dental care are offered under either health benefit plans or via ACA-compliant standalone dental plans, in the individual and small group commercial markets as an essential health benefit (EHB). Routine dental services for adults are not considered to be an EHB under the ACA. A small portion of the commercial market currently embeds dental care for adults into their benefit offerings; however, is it more common for people to have dental care covered through separate dental policies.

Over 2.6 million individuals in Colorado (44% of the state population in July 2023) had a dental insurance plan in 2023.[1] These plans are primarily provided through employers. Dental plans are also offered on the ACA marketplace, which may provide non-EHB adult dental benefits as well as the pediatric dental EHB.

Dental insurance premiums are paid to dental insurers by enrollees or their employers. A portion of insurance premiums are retained by insurers for administrative expenses and profit margin. The rest of the premium is used to pay for dental services. Under the legislative proposal, individual and small group commercial health insurance plans would be required to cover similar benefits to what is currently covered by standalone commercial dental insurance plans as part of the covered benefits for the medical plan. Based on a review of historical rate filings in Colorado in 2023, the average premium for individual market dental plans was approximately $47 per member per month (PMPM) and the average premium for small group dental plans was approximately $39 PMPM. By paying this monthly premium, enrollees gain access to the dental insurer's network, discounts, and covered plan benefits.

POTENTIAL HEALTH BENEFITS

It is commonly recommended that people visit a dentist for a cleaning every six months to prevent gum disease, tooth decay, and other oral health issues, though recommended frequency may vary depending on other risk factors.

Poor oral health can lead to infections such as gingivitis and periodontitis, which are two of the most common infections in humans.[2] Over 100 systemic diseases have oral manifestations, including cardiovascular disease, stroke, respiratory infections, pancreatic cancer, diabetes, and nutritional problems.[3]

Oral health is also linked to mental health. People with severe mental illness are 2.7 times more likely to lose all their teeth when compared to the general population. People with missing teeth have a harder time eating and therefore may suffer from poor nutrition. Missing teeth may also cause some people to struggle with speech and other social and psychological areas of life.[4]

Pregnancy outcomes have also been found to be associated with oral health. Periodontal disease and dental caries in pregnant individuals may increase their risk of atherosclerosis and rheumatoid arthritis.[5] Moderate to severe maternal periodontal disease is associated with increased risk for preterm birth and preeclampsia.[6] Dental caries in pregnant individuals is also linked to greater risk of early and severe dental caries in their offspring.[7]

In a systematic literature and meta-analysis of the rate of emergency department visits related to nontraumatic dental conditions in the United States through 2020, the authors found that around 2.2% of emergency department visits were due to nontraumatic dental conditions.[8] This rate is around 2.8% for uninsured patients.[9] For individuals who visited the emergency department for any dental condition and who were not admitted (approximately 88% of visits), the top three diagnoses reported are loss of teeth, diseases of pulp and periapical tissues, and dental caries.[10]

More research is needed to confirm the bidirectional impacts of oral health and systemic disease, but there is evidence that inflammation from periodontal disease can increase the risk of diabetes and cardiovascular disease.[11] Regular dental care prevents tooth loss and decay,[12] and leads to healthier outcomes for pregnant individuals and their offspring. Expanded access to dental care and earlier treatment may reduce emergency department utilization for nontraumatic dental conditions by preventing the progression of oral diseases.[13,14]

Insurance coverage is associated with higher rates of dental care utilization and better oral health. Untreated cavities are twice as likely among uninsured adults aged 20 to 64 compared to adults with private health insurance.[15] Dental coverage has been found to increase the probability of using preventive and restorative dental services. In an adult Medicaid population, introducing dental benefits was shown to increase the probability of a dental visit within 12 months by 16.4% to 22%.[16] A study comparing privately insured and uninsured U.S. adults under 65 years old found that dental coverage increased the probability of preventive care by 19% and restorative care by 11% to 16%.[17]

PUBLIC DEMAND, DISPARITY, AND AVAILABILITY OF SERVICES

Demand for dental services

Based on the 2021 Medical Expenditure Panel Survey (MEPS), it is estimated that 43% of the U.S. population and 39% of adults ages 19 to 64 saw a dentist within the prior 12 months.[18]

There are disparities in dental care utilization across socioeconomic and geographic characteristics, including race and ethnicity, income, and geography. Among different racial and ethnic groups, 51.2% of non-Hispanic whites reported receiving dental care within the last 12 months, whereas 37.6% of Asian, 32.3% of Black, and 28.9% of Hispanic individuals reported receiving care.[19] Similar patterns have been observed in other nationally representative survey data.[20] Higher rates of dental care utilization have been found to be associated with higher household income.[21,22] There have also been found to be higher rates of dental care utilization in urban areas relative to rural areas.[23,24] For example, the 2019 National Health Interview Survey results showed that 66.7% adults living in urban areas had a dental visit in the past 12 months compared to 57.6% of adults living in rural areas.[25]

As described in the Health Benefits section, insurance coverage has been shown to increase the utilization of dental services, suggesting that cost can be a barrier to utilization care. [26, 27,28]

Dental insurance market

In an analysis of 2021 MEPS data by the Health Policy Institute for the American Dental Association, 61.4% of U.S. adults ages 19 to 64 had private insurance, 15.7% had public insurance, and 22.8% were uninsured.[29]

According to the March 2024 Bureau of Labor Statistics (BLS) report, nationally, dental benefits are currently offered to 30% of private industry workers employed by businesses with less than 100 workers, and 73% of workers who have access to the benefit enroll.[30] Colorado currently considers entities with between two and 100 employees to be small employers.

Nationally, access to dental benefits varies by wage category. Sixteen percent of workers in the bottom 25th percentile of wages have access to benefits, whereas 69% of workers in the top 25th percentile of wages have access to benefits. There is less variation in the take-up rate of benefits between wage categories. Sixty-three percent of workers in the bottom 25th percentile of wages enrolled in a dental benefit when offered, and 75% of workers in the top 25th percentile of wages enrolled.[31]

Embedded dental plans (where dental benefits are part of the same plan as medical benefits) are much less common than standalone dental plans, and enrollment in these plans has been declining. A study of MEPS data from 2005 to 2018 found that the number of employer-sponsored embedded dental benefit plans has decreased from 14.1 million

plans to 9.3 million plans, and the percentage of employees enrolled in employer-sponsored insurance health plans with dental coverage has decreased from 23.2% of enrollees to 15.0%.[32]

Dental benefits are being utilized by the majority of plan enrollees. The 2023 National Health Interview Survey (NHIS) data show that among insured individuals, 72.4% of individuals with private insurance saw a dentist within the last 12 months as compared with 39.2% of uninsured individuals.[33]

Surveys have identified affordability as a primary barrier to dental care.[34] In a 2023 Kaiser Family Foundation consumer survey in both the marketplace and employer markets, about a quarter of people surveyed cited delaying or forgoing dental care due to cost barriers.[35]

Availability of services

According to a survey of commercial medical carriers in Colorado, 12% of small group health plans offer embedded dental coverage. The text of this survey is presented in **Appendix A**. Nationally, 9% of health plans on the marketplace offered embedded dental plans across 36 states in 2023.[36] The majority of marketplace dental coverage for both children and adults is via standalone dental carriers.

Dental provider shortages are recognized as a national challenge. Colorado has 884,783 people living in designated health provider shortage areas (HPSA), and 58.12% of the state's need is met through current dental providers as of December 31, 2024. An additional 85 dental providers would be needed to remove the HPSA designation statewide in Colorado. Colorado has the third-highest percentage of need met out of the 50 states. Rural and other non-metro areas are relatively more negatively impacted by the availability of dental services.[37]

Financial analysis

The proposal would require all individual and small group non-HSA health plans to cover dental services for their adult enrollees. The estimated number of enrollees impacted by this proposal in the first year is shown in **Exhibit 2**. In 2026, the estimated number of people affected by the proposal is 198,000, representing 72% of the individual health plan market and 207,000 or 78% of the small group health plan market in the state. Those not affected are individuals in an HSA plan or under age 18.

EXHIBIT 2 – ESTIMATED POPULATION IMPACTED BY MANDATE, 2026

	INDIVIDUAL	SMALL GROUP
Total enrollment subject to state benefit requirements	276,000	266,000
Total enrollment in non-HSA plans, over the age of 17	198,000	207,000
% of enrollment affected by proposal	**72%**	**78%**

Our evaluation projects the population, cost of benefits to the plan and enrollees, and premium for calendar years 2026 through 2035 under the following two scenarios:

1. Baseline – The proposal **does not** go into effect.
2. Post-benefit requirement – The proposal **does** go into effect.

The difference between the baseline and the post-benefit requirement values is the impact of the benefit requirement.

The exact list of dental services to be covered and cost-sharing requirements per service are not explicitly specified by the proposal. It is our understanding that the intent of this proposal is that dental benefits should be similar to existing offerings by independent dental plans with the following major modifications:

- Plans may not implement annual or lifetime dollar benefit maximums.
- Covered preventive and diagnostic dental care must be offered without cost sharing.

Under the proposal, health plans are allowed to impose a separate deductible for dental benefits. For the purpose of our analysis, we assumed that dental care under the proposal would be subject to the existing out-of-pocket maximum for each health plan.

In addition, we relied upon a list of proposed covered benefits and corresponding cost sharing for dental services provided to us by the bill sponsor. This list is shown below in **Exhibit 3**. If cost-sharing requirements are defined differently in future legislation, the projected utilization and financial results will be very different from what is presented in this report.

EXHIBIT 3 – DENTAL BENEFIT DESIGN USED FOR FINANCIAL ANALYSIS

Class I	Covered Before Deductible ($50)	Allowed Member Cost Sharing	Comments
Oral Exams	Yes	0%	2 per year
Prophylaxis	Yes	0%	2 per year
Fluoride	Yes	0%	2 per year
X-rays	Yes	0%	1 per year
Lab and Other Tests	No		
Other Preventive	No		

Class II	Covered Before Deductible ($50)	Allowed Member Cost Sharing	Comments
Emergency (Palliative)	No	50%	Paid as a separate benefit only if no other service, except X-rays, is rendered during the visit
Space Maintainers	No	0%	Limited to non-orthodontic treatment for prematurely removed
Simple Extractions	No	50%	
Surgical Extractions	No	50%	
Oral Surgery	No	50%	
Anesthesia	No	50%	
Restorations	No	50%	
Periodontics	No	50%	
Endodontics	No	50%	

Class III	Covered Before Deductible ($50)	Allowed Member Cost Sharing	Comments
Inlays/Onlays/Crowns	No	50%	
Dentures	No	50%	
Bridges	No	50%	
Repair (Simple)	No	50%	
Other Prosthetics	No	50%	
Occlusal Guards	No	20%	
Occlusal Adjustments	No	50%	
Implants	No	50%	

DENTAL BENEFIT UTILIZERS

Individuals can access dental insurance through standalone dental plans, through benefits offered under a medical plan, or by paying for services directly without insurance. At present, relatively few medical plans embed dental services into their benefit offerings; coverage is usually offered via separate dental plans. For the purposes of our analysis, we grouped people with medical coverage into one of three categories of dental care access:

1. Members with embedded dental coverage – These members receive dental care coverage through their medical plan.
2. Members with standalone dental coverage (not embedded) – These members have a standalone private dental plan, separate from a medical plan. These plans can be for individuals or for groups.
3. Uninsured utilizers (self-pay) – These members do not have dental coverage through insurance and instead pay for services directly.

The number of people with a given type of dental access is shown below in **Exhibit 4**. Not everyone with dental coverage will utilize their benefits. The number of people assumed to utilize dental services given their type of access is shown in **Exhibit 5**.

The proportion of people who receive dental care under their medical plan was estimated using information provided by medical carriers and through a review of research. The total number of people with coverage was estimated using data from the National Association of Insurance Commissioners and the BLS, and through a review of research. Additional detail on the development of these estimates can be found in the Methodology and Assumptions section of this report. We estimate that for members with an individual market health plan, 112,000 (57%) do not have dental benefits provided by insurance, 69,000 (35%) have coverage through a standalone dental plan, and 17,000 (9%) have dental benefits offered by their medical plan. We estimate that for members with a small group market health plan, 104,000 (50%) do not have dental benefits provided by insurance, 91,000 (44%) have a standalone dental plan, and 12,000 (6%) have dental benefits offered by their medical plan.

EXHIBIT 4 – ESTIMATED MEDICAL ENROLLEES BY DENTAL ACCESS, 2026

	INDIVIDUAL	SMALL GROUP
Members With Embedded Dental Coverage	17,000	12,000
Members With Standalone Dental Coverage (not embedded)	69,000	91,000
Uninsured Utilizers (self-pay)	112,000	104,000
Total Members	**198,000**	**207,000**
Proportion of affected enrollment		
Members With Embedded Dental Coverage	9%	6%
Members With Standalone Dental Coverage (not embedded)	35%	44%
Uninsured Utilizers (self-pay)	57%	50%

The member counts and proportions in **Exhibit 4** show the breakdown of dental access before implementation of the proposed legislation. Should the proposal be implemented, 100% of affected membership would have dental care access via their medical plans.

Not every person will access dental care in a given year. We estimated the proportion of people who access dental services in a given year by type of access using Milliman's proprietary Dental Rating Model (DRM) and a review of research. Based on the DRM, we estimate that 65% of individuals with a standalone dental plan in the small group market will access dental services of any kind in a given year. In the individual market, due to the anti-selective nature of those purchasing benefits, we have assumed that 90% of those with a standalone dental plan will access services during the year. We assumed that 18% of individuals who have no dental insurance and self-pay for services and 42% of individuals with embedded dental benefits through their medical plan utilize services, reflecting the elective nature of purchasing a standalone plan compared to dental benefits being automatically included in embedded plans and lower expected utilization among individuals with no insurance due to cost barriers.

EXHIBIT 5 – ESTIMATED MEDICAL ENROLLEES UTILIZING DENTAL SERVICES, 2026

	INDIVIDUAL	SMALL GROUP
Members Utilizing Dental Services		
Members With Embedded Dental Coverage	7,000	5,000
Members With Standalone Dental Coverage (not embedded)	62,000	59,000
Uninsured Utilizers (self-pay)	20,000	19,000
Total Utilizers	**89,000**	**83,000**
Percentage of Members Utilizing Dental Services		
Members With Embedded Dental Coverage	42%	42%
Members With Standalone Dental Coverage (not embedded)	90%	65%
Uninsured Utilizers (self-pay)	18%	18%

Should the proposal be implemented, we assumed changes in expected utilization patterns depending on the category of individuals in the baseline. Specifically, we assumed that the utilization pattern for those affected would change as follows based on their prior source of access to dental care:

- Previously uninsured - More people would have dental benefits after the mandate. Utilization would be consistent with members who currently have embedded dental coverage. That is, we assumed that 42% of those who previously did not have previously have dental insurance would utilize services post-mandate, compared to 18% at baseline.
- Previously had embedded coverage – No impact on utilization would be observed. These members would continue to utilize services at the same rate (i.e., 42% of individuals would utilize services in both the baseline and post-mandate periods).
- Previously had standalone dental coverage – No impact on utilization would be observed. These members would utilize care at rates consistent with utilization under their standalone plan (i.e., 90% of those in the individual market and 65% of those in the small group market would utilize services in both the baseline and post-mandate periods).

The number of estimated utilizers before and after implementation of the proposal is shown in **Exhibit 6**. The proposal is expected to increase the number of members with an individual market health plan who utilize dental services by 27,000 (14% of affected population) and those with a small group market health plan by 25,000 (12% of affected population).

EXHIBIT 6 – ESTIMATED TOTAL NUMBER OF UTILIZERS PRE- AND POST- PROPOSAL IMPLEMENTATION, 2026

	INDIVIDUAL	SMALL GROUP
Members Utilizing Dental Services - Baseline	89,000	83,000
Members Utilizing Dental Services - Post-benefit Requirement	116,000	1208,000
Impact of Proposal	**27,000**	**25,000**
Percent of Members Utilizing Dental Services - Baseline	45%	40%
Percent of Members Utilizing Dental Services - Post-benefit Requirement	59%	52%
Impact of Proposal (percentage point increase)	**14%**	**12%**

ENROLLEE OUT-OF-POCKET AND NON-COVERED COSTS

Most members today pay for dental services themselves or receive coverage through a standalone dental plan. As such, medical insurers are currently not responsible for the majority of dental care expenditures. While there are insurers who are responsible for some of the overall dental care expenditures, standard dental services are generally considered a “non-covered” expenditure from the medical insurer perspective. The proposal would shift responsibility for dental expenditures away from standalone dental plans and into medical plans. The impact of the proposal on the medical plan non-covered amount after accounting for cost-sharing requirements is shown in **Exhibit 7**. Both

changes to member cost sharing and changes to out-of-pocket costs for previously uninsured members are included in these estimates. We have included the reduction in cost associated with no longer paying a premium for standalone dental insurance in these estimates.

- For individual insurance, we estimate a one-year patient out-of-pocket impact of -$40,411,000, a five-year patient out-of-pocket impact of -$221,706,000, and a 10-year patient out-of-pocket impact of -$499,430,000 or -$12.21, -$13.13, and -$14.42 per member per month respectively.
- For small group insurance, we estimate a one-year patient out-of-pocket impact of -$45,832,000, a five-year patient out-of-pocket impact of -$251,482,000, and a 10-year patient out-of-pocket impact of -$566,561,000 or -$14.34, -$15,44, and -$16.95 per member per month respectively.

EXHIBIT 7 – ESTIMATED ENROLLEE OUT-OF-POCKET AND NON-COVERED COST IMPACT

	1-Year impact	5-Year impact	10-year impact
Individual - Total Dollars	($40,411,000)	($221,706,000)	($499,430,000)
Individual - PMPM	($12.21)	($13.13)	($14.42)
Small Group - Total Dollars	($45,832,000)	($251,482,000)	($566,561,000)
Small Group - PMPM	($14.34)	($15.44)	($16.95)
Combined Individual and Small Group - Total Dollars	**($86,243,000)**	**($473,188,000)**	**($1,065,991,000)**
Combined Individual and Small Group - PMPM	**($13.26)**	**($14.26)**	**($15.66)**

PREMIUM IMPACT

The estimated health insurance premium impact due to the proposal is shown in **Exhibit 8**.

- For individual insurance, we estimate a one-year premium impact of $53,582,000, a five-year premium impact of $293,967,000, and a 10-year premium impact of $662,211,000, or $16.19, $17.42, and $19.12 per member per month respectively, or 3.2%, 3.0%, and 2.7% change over baseline premium respectively.
- For small group insurance, we estimate a one-year premium impact of $59,074,000, a five-year premium impact of $324,138,000, and a 10-year premium impact of $730,244,000, or $18.49, $19.90, and $21.85 per member per month respectively, or 2.7%, 2.5%, and 2.3% change over baseline premium respectively.

EXHIBIT 8 – ESTIMATED HEALTH INSURANCE PREMIUM IMPACT

	1-Year impact	5-Year impact	10-year impact
Individual - Total Dollars	$53,582,000	$293,967,000	$662,211,000
Individual - PMPM	$16.19	$17.42	$19.12
Individual - Percent Change	3.2%	3.0%	2.7%
Small Group - Total Dollars	$59,074,000	$324,138,000	$730,244,000
Small Group - PMPM	$18.49	$19.90	$21.85
Small Group - Percent Change	2.7%	2.5%	2.3%
Combined Individual and Small Group - Total Dollars	**$112,656,000**	**$618,105,000**	**$1,392,455,000**
Combined Individual and Small Group - PMPM	**$17.32**	**$18.63**	**$20.46**
Combined Individual and Small Group - Percentage Change	**2.9%**	**2.7%**	**2.5%**

STATE DEFRAYAL OF MANDATED BENEFITS IN EXCESS OF ESSENTIAL HEALTH BENEFITS

Under federal law, states must defray the premium cost of mandated benefits in excess of EHB for qualified health plans (QHPs) offered in the individual and small group markets. Because adult dental care is not considered an EHB, the State would likely be required to defray the premium costs of mandating coverage for adult dental care. **Exhibit 8** shows the estimated average change to premiums associated with the inclusion of the proposed benefits and an estimate of what the state would be required to defray.

Note that since we have no way of distinguishing QHPs from non-QHPs, we have presented our results assuming that all individual and small group market enrollees are enrolled in a QHP.

TOTAL COST OF CARE IMPACT

The estimated impact of the proposal on total cost of care is shown in **Exhibit 9**. The total cost of care is the sum of the costs covered by the medical plan, the cost sharing paid by the enrollee, and any non-covered services paid by the enrollee. Because all members will receive coverage after the implementation of the proposal, the cost of non-covered services is assumed to be eliminated by the proposal. In addition, the dental premium that was paid by individuals or small groups who purchased commercial insurance previously would not be paid if these individuals and groups instead purchase embedded coverage moving forward.

- For individual insurance, we estimate a one-year total cost of care impact of $13,171,000, a five-year total cost of care impact of $72,261,000, and a 10-year total cost of care impact of $162,781,000 or $3.98, $4.28, and $4.70 per member per month respectively.
- For small group insurance, we estimate a one-year total cost of care impact of $13,242,000, a five-year total cost of care impact of $72,656,000, and a 10-year total cost of care impact of $163,683,000 or $4.14, $4.46, and $4.90 per member per month respectively.

EXHIBIT 9 – ESTIMATED TOTAL COST OF CARE IMPACT

	1-Year impact	5-Year impact	10-year impact
Individual - Total Dollars	$13,171,000	$72,261,000	$162,781,000
Individual - PMPM	$3.98	$4.28	$4.70
Small Group - Total Dollars	$13,242,000	$72,656,000	$163,683,000
Small Group - PMPM	$4.14	$4.46	$4.90
Combined Individual and Small Group - Total Dollars	**$26,413,000**	**$144,917,000**	**$326,464,000**
Combined Individual and Small Group - PMPM	**$4.06**	**$4.37**	**$4.80**

Please see **Appendices B through D** for more detailed information regarding the impact of this proposal.

LONG-TERM HEALTHCARE COST IMPACT

Our financial analysis concluded that there would be small aggregate increases in healthcare costs due to requiring commercial individual and small group health insurers to cover dental benefits for adults. The increase in costs is due to more people having access to dental benefits and the corresponding increase in utilization of services. As noted in the Background section *Potential Health Benefits*, regular dental care has the potential to minimize the severity of oral health conditions, reduce emergency department visits, prevent tooth loss and decay, and improve health outcomes for pregnant individuals and their offspring, and is also associated with lower risk of certain systemic health conditions. More research is needed to prove whether the lack of dental care causes or exacerbates certain systemic health conditions or simply shares the same underlying risk factors. We did not quantify any potential offsets due to improved health outcomes on the cost of providing dental care as part of this analysis. Developing estimates of long-term medical cost offsets is complex and requires modeling the interactions between improved oral health and other comorbidities.

Social and economic impact

As discussed under the Public Demand, Disparity, and Availability of Services section, cost is the leading barrier to dental care.[38] This proposed legislation would likely have the greatest benefit for individuals enrolled in medical plans offered by individual and small group carriers with low deductibles and/or individuals who will meet their out-of-pocket maximum through medical costs alone. Individuals who are eligible for income-based financial assistance through the marketplace may also benefit from this legislation. Under the ACA, standalone dental plans are not eligible for the same federal premium subsidies as health plans and are not required to limit out-of-pocket spending. Additionally, an adult dental benefit included as part of a medical plan is not an EHB, so premium subsidies cannot be applied to that portion of premium cost. Depending on an individual's deductible and out-of-pocket maximum, they may benefit from having a single, subsidized premium that covers both medical and dental care.[39]

Out-of-pocket costs may be higher for individuals if deductibles or out-of-pocket maximums will not be met through medical costs alone. Individuals with high out-of-pocket costs may still find dental care to be cost-prohibitive.

Disparities in dental care may persist even with expanded dental insurance coverage. Individuals living in dental health professional shortage areas (HPSAs) may not have access to dental care regardless of insurance benefits. HPSAs tend to be in rural areas. In a study of racial and ethnic disparities to dental care after Medicaid expansion of dental benefits, disparities in care were reduced but not eliminated after expansion.[40]

Currently, most pediatric dental coverage in the individual and small group markets is provided by dental plans rather than through embedding dental coverage in medical plans. This is similar to the market for adult dental coverage. The requirement to embed adult dental coverage in medical plans may cause changes in how pediatric dental benefits are covered in these markets, as insurers may decide to embed both pediatric and adult dental coverage into their policies. This has potential implications for pediatric dental coverage since there are benefit differences between a qualified standalone dental plan and a pediatric dental benefit embedded in a medical plan. We have not modeled the impact of any of these potential changes to carriers' approach to coverage of pediatric dental benefits as part of this work.

Methodology and assumptions

The financial analysis projects the population, cost of benefits, premium, and enrollee cost sharing for calendar year 2026, calendar years 2026 through 2023, and calendar years 2026 through 2035 under the following two scenarios:

1. Baseline – The proposal **does not** go into effect.
2. Post-benefit requirement – The proposal **does** go into effect.

The difference between the baseline and post-benefit requirement values is the impact of the proposed legislation.

COLORADO POPULATION

We used 2023 enrollment data from the Colorado All Payer Claims Database (APCD) to identify fully insured commercial enrollment in preferred provider organization plans (PPO), point of service plans (POS), exclusive provider organization plans (EPO), and health maintenance organization plans (HMO). We limited the data to enrollment months with both medical and pharmacy coverage and placed each enrollment month into individual or small group based on their plan size. We then used Colorado population projections from the Department of Local Affairs to trend the 2023 enrollment data to 2026 through 2035. We did not separately account for the potential expiration of enhanced subsidies in the ACA market for 2026, or other potential future changes that could dramatically impact the number of individuals enrolled by market.

ADULT DENTAL COHORTS

As noted above, we allocated all Colorado adult individual and small group commercial members into one of three cohorts. These cohorts are:

1. Members with embedded dental coverage – These members receive dental care coverage through their medical plan.
2. Members with private dental coverage (not embedded) – These members have a standalone private dental plan. These plans can be for individuals or for groups.
3. Uninsured utilizers (self-pay) – These members do not have dental coverage through insurance and instead pay for services directly.

We utilized the March 2024 BLS report on employee benefits to determine the nationwide average proportion of percentage of total adults with dental coverage, given that they have medical coverage. This proportion was applied to the total non-HSA population over the age of 17 in the small and large group markets to estimate the total number of people with employee-sponsored dental insurance.

We estimated the number of people with individual dental plans based on dental filings in Colorado for 2023. We assumed that the remainder of individuals and groups did not have dental insurance.

Finally, we used information provided through carrier surveys as well as a review of dental filings and a review of literature to obtain a proportion of employer-sponsored dental plans that are embedded in the medical plan.

We relied on industry utilization data to determine the portion of dental insurance enrollees that utilize their benefits. We relied on values from literature review and from Milliman's proprietary Dental Rating Manual to estimate the proportion of people without dental insurance who receive dental care.

DENTAL CLAIMS, PREMIUM, AND COST SHARING

After categorizing all adult commercial market members into the three cohorts, we applied cost per utilizing member assumptions to these cohorts to determine dental service claim costs under the baseline and post-benefit requirement scenarios. Dental claim costs were estimated using a combination of implied costs for private insurance based on commercial dental rate filings in the Colorado market and modeling using Milliman's 2023 Dental Rating

Model. This model is designed to price dental plans based on many inputs including plan benefit design and member geography and demographics. The model utilizes commercial dental industry data and research to estimate cost and utilization patterns for each dental service. We adjusted this model to account for the differences in utilization patterns for each cohort. Uninsured individuals are less likely to utilize Class I services (preventive and diagnostic) and are more likely to use more expensive Class II and Class III services. Members with embedded benefits are less likely to use dental benefits due to less awareness of their coverage. In modeling claim costs, we uniformly decreased embedded plan utilization by 20% compared to a standalone plan.

We assumed that cost sharing for dental benefits would align with the plan design shown in **Exhibit 2** – Class I services covered with no cost sharing, primarily in front of the deductible, and Class II and III services covered with a 50% coinsurance for the member after the deductible. Class IV (Orthodontia) services were not included as a covered benefit.

COLORADO MEDICAL/PHARMACY CLAIMS AND PREMIUM

Using the data provided in the Colorado APCD, we summarized medical and pharmacy claims by individual, small group, and large group incurred during calendar year 2023 and paid through April 2024. Claims were adjusted to account for claims incurred but not paid using completion factors calculated using the development method. The resulting completion factors are in **Exhibit 10**. The medical completion factors range from 0.968 to 0.976 by market and the pharmacy completion factors range from 0.983 to 0.999.

EXHIBIT 10: 2023 COMPLETION FACTORS

	INDIVIDUAL	SMALL GROUP	LARGE GROUP
Medical Completion Factor	0.968	0.976	0.975
Pharmacy Completion Factor	0.984	0.999	0.983

ADMINISTRATIVE COSTS

We applied administration expense ratios separately for individual and small group medical plans from the 2022 and 2023 Colorado Department of Regulatory Agencies Health Insurance Cost Reports to the projected claims to develop premiums for 2026 through 2035. **Exhibit 11** shows the assumed administration expenses as a percentage of total premium.

EXHIBIT 11: ADMINISTRATION EXPENSES AS A PERCENTAGE OF TOTAL PREMIUM INCLUDING PROFIT

	INDIVIDUAL	SMALL GROUP
Administration Ratio	15.0%	20.0%

We assumed no undue burden from administering this additional benefit. Administrative costs will increase in proportion to the cost of additional mandated benefits. Loss ratios for standalone dental insurance are often lower than in traditional medical plans. In development of the estimated premium impact of this proposed legislation, we have assumed that standard medical plan loss ratios will apply as noted in the Considerations and Limitations section of this report.

APPLICABILITY TO HEALTH SAVINGS ACCOUNT (HSA) PLANS

For a health plan to be health savings account (HSA) eligible, all services aside from certain defined preventive services must be subject to the deductible. HSA-eligible health plans would not be able to fully comply with the proposed benefit requirement without losing their HSA status. For this reason, we assumed that HSA-eligible plans would not be subject to the proposed legislation.

We assumed that individuals who currently have dental insurance will continue to utilize dental services at the same level as today. For those who currently do not have dental insurance, we assume that some number of them will begin to utilize services once they are covered.

Considerations and limitations

As noted above in the Methodology and Assumptions section, we assumed that cost sharing for newly covered dental services would be similar to those currently applied in the dental insurance market, except that annual dollar maximums on covered benefits common in dental insurance would not be allowed. To the extent that health insurers deviate from the cost sharing assumed in this analysis, the actual impact on both premiums and cost sharing will vary from what we have estimated.

We estimated the impact to health plan premiums based on dental insurance claim costs and observed health insurance administrative retention loads. This approach assumes that administrative costs to health insurers for administering dental services will be similar to the costs of administering other health services. If health insurers were to contract with current dental insurers to administer dental services, the administrative costs would likely differ from those estimated in this analysis.

We observe in the dental insurance market that plans have negotiated substantial discounts with providers. It is our expectation that health insurers will eventually negotiate similar discounts to those currently obtained by the dental offerors, but it is likely that health insurers will not immediately reach the dental insurance market level of discounts upon offering these benefits unless they work through existing relationships (i.e., there may be a transition phase where health insurer discounts are less material than current dental market discounts). Given the unpredictability of new discount negotiations, we chose to simplify the analysis to assume that health insurers would achieve similar discounts to current dental insurance offerors. This might be achieved in the short or long term through partnering with current dental insurance providers to offer this benefit as part of a health benefit plan.

We assumed that under the new health benefit coverage, members that currently purchase dental insurance (whether by themselves or through their employers) would end their dental insurance coverage, given that similar services would now be provided under their health insurance plan. However, in practice there may be many reasons for members to continue their separate dental insurance coverage, including employer sponsorship, network differences, and cost-sharing differences. If many members retain and utilize their current insurance dental coverage, we expect a reduction in the estimated impact on health insurer premiums and expect that out-of-pocket costs will not decrease by as much as shown in this report, as these members would continue to incur the cost of premiums for dental insurance.

Our analysis did not consider the downstream impacts of the proposed legislation. Post-benefit requirement, enrollees with a fully insured individual or group policy may decide to not purchase dental coverage through traditional dental insurers. Uninsured Coloradans or Coloradans enrolled in HSA-qualified plans, Medicaid, or a self-funded health plan would need to purchase a standalone policy if they wanted insurance for dental services post-benefit requirement. Having fewer people enrolled in standalone dental policies may increase the administration costs per policy for the enrollees who purchase standalone dental service polices post-benefit mandate. Depending on the price sensitivity of these enrollees, these enrollees may opt to not purchase dental insurance. It is also possible that with a smaller pool of enrollees, dental insurance companies may consolidate with each other or with health insurers. Modeling these impacts is considered beyond the scope of this analysis.

Variability of results

Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made in this model. It is certain that actual experience will not conform exactly to the assumptions used in this model. Actual amounts will differ from projected amounts to the extent that actual experience is different than expected.

Model and data reliance

Milliman has developed certain models to estimate the values included in this report. The intent of the model was to estimate the impact of the proposed dental requirements for commercial market insurers. We have reviewed this model, including its inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We have relied upon certain data and information for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete.

Milliman's data and information reliance includes:

- Data from Colorado's All Payer Claims Database
- Colorado census data and projections
- All other sources mentioned inline and in references.
- Carrier survey responses

The models, including all input, calculations, and output, may not be appropriate for any other purpose.

We have performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our investigation.

Qualifications to perform analysis

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. T.J. Gray is a member of the American Academy of Actuaries and meets the qualification standards for performing the analyses supported by this model.

Distribution and usage

Milliman's work is prepared solely for the use and benefit of the Colorado Department of Regulatory Agencies in accordance with its statutory and regulatory requirements. Milliman recognizes that this report will be a public record subject to disclosure to third parties. To the extent that the information contained in this report is provided to any third party, the report should be distributed in its entirety. We do not intend this information to benefit, or create a legal liability to, any third party, even if Milliman consents to the release of its work product to such third party. Similarly, third parties are instructed to place no reliance upon this report prepared by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. It is the responsibility of any recipient of this report to make an independent determination as to the adequacy of the proposed results for their organization.

Appendix A: Carrier coverage survey

COVERAGE SURVEY FOR ADULT DENTAL COVERAGE IN HEALTH BENEFIT PLANS

Colorado Revised Statute § 10-16-155 calls for the Colorado Division of Insurance (the division) to retain by contract one or more entities that have experience in actuarial reviews, healthcare policy, and health equity for the purpose of performing actuarial reviews of legislative proposals that may impose a new health benefit coverage mandate on health benefit plans or reduce or eliminate coverage mandated under health benefit plans. The entities, under the direction of the division, shall conduct actuarial reviews of up to six legislative proposals, regardless of the number of legislative proposals that are requested for each regular legislative session by members of the general assembly.

The sponsors of a potential bill related to the coverage of dental care in individual and small group health benefit plans have requested an actuarial review of the benefits included in the legislation.

The potential bill requires coverage of dental care under the medical benefit for individual and small group health benefit plans with a similar benefit design to existing standard dental plans.

Please return this survey to Riley De Valois (riley.devalois@state.co.us) and Tara Smith (tara.smith@state.co.us) by December 22, 2024.

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1. What is the name of the insurance carrier?

2. Please complete the following table with how many people are enrolled in the following lines of business as of October 31, 2024? Please exclude all self-insured or administrative services only plans in your responses. Please also exclude all HSA-qualified plans.

Age	**Individual Market (non-HSA)**	**Small Group Market (non-HSA)**

19 and Older	#	#

3. What percentage of adult enrollees (age 19 or older) **currently have coverage** for comprehensive non-emergency dental care attached to their medical benefit:

Age	**Individual Market (non-HSA)**	**Small Group Market (non-HSA)**
19 and Older	%	%

4. If you currently offer comprehensive dental benefits in any health benefit plans in the individual or small group market, do you currently implement a maximum annual or lifetime benefit? What is the most common annual/lifetime benefit you apply?

5. If you currently offer comprehensive dental benefits in health benefit plans in the individual or small group market, do you have a separate deductible for dental services? What is the most common deductible you apply?

6. Do you expect any additional administrative burden resulting from coverage for dental care in health benefit plans? If so, please describe the additional complexity you expect.

7. Is there any additional information you would like to share?

Appendix B: Individual enrollee PMPM

Individual Market	1-Year	5-Year	10-Year
Total enrollment subject to state benefit requirements	275,720	1,406,660	2,886,402
Total population affected	197,629	1,010,212	2,075,770
Baseline PMPM			
Insurer premium	$500.96	$577.74	$697.65
Patient out-of-pocket	$0.32	$0.34	$0.38
Patient non-covered	$17.29	$18.59	$20.41
Total Baseline PMPM	**$518.57**	**$596.67**	**$718.44**
Post benefit requirement PMPM			
Insurer premium	$517.16	$595.15	$716.77
Patient out-of-pocket	$5.39	$5.80	$6.37
Patient non-covered	$0.00	$0.00	$0.00
Total post-benefit requirement PMPM	**$522.55**	**$600.95**	**$723.14**
Change attributable to proposed benefits			
Insurer premium	$16.19	$17.42	$19.12
Patient out-of-pocket	$5.07	$5.46	$5.99
Patient non-covered	-$17.29	-$18.59	-$20.41
Total change PMPM	**$3.98**	**$4.28**	**$4.70**
Percent change attributable to proposed benefits			
Insurer premium	3.2%	3.0%	2.7%
Patient out-of-pocket	1587.6%	1587.6%	1587.6%
Patient non-covered	-100.0%	-100.0%	-100.0%
Total percent change	**0.8%**	**0.7%**	**0.7%**

Appendix B: Small Group Enrollee PMPM

Small Group Market	1-Year	5-Year	10-Year
Total enrollment subject to state benefit requirements	266,268	1,357,664	2,784,744
Total population affected	207,143	1,058,974	2,176,160
Baseline PMPM			
Insurer premium	$684.10	$789.24	$953.32
Patient out-of-pocket	$0.23	$0.25	$0.28
Patient non-covered	$19.73	$21.23	$23.32
Total Baseline PMPM	**$704.06**	**$810.72**	**$976.91**
Post-benefit Requirement PMPM			
Insurer premium	$702.59	$809.14	$975.17
Patient out-of-pocket	$5.62	$6.04	$6.64
Patient non-covered	$0.00	$0.00	$0.00
Total Post-benefit Requirement PMPM	**$708.20**	**$815.18**	**$981.81**
Change Attributable to Proposed Benefits			
Insurer premium	$18.49	$19.90	$21.85
Patient out-of-pocket	$5.38	$5.79	$6.36
Patient non-covered	-$19.73	-$21.23	-$23.32
Total Change PMPM	**$4.14**	**$4.46**	**$4.90**
Percent Change Attributable to Proposed Benefits			
Insurer premium	2.7%	2.5%	2.3%
Patient out-of-pocket	2297.8%	2297.8%	2297.8%
Patient non-covered	-100.0%	-100.0%	-100.0%
Total Percent Change	**0.6%**	**0.6%**	**0.5%**

Appendix C: Individual enrollee total dollars

Individual Market	1-Year	5-Year	10-Year
Total enrollment subject to state benefit requirements	275,720	1,406,660	2,886,402
Total population affected	197,629	1,010,212	2,075,770
Baseline Total Dollars			
Insurer premium	$1,657,501,000	$9,752,134,000	$24,164,513,000
Patient out-of-pocket	$1,057,000	$5,801,000	$13,069,000
Patient non-covered	$57,199,000	$313,811,000	$706,911,000
Total Baseline Dollars	**$1,715,757,000**	**$10,071,746,000**	**$24,884,493,000**
Post-benefit Requirement Total Dollars			
Insurer premium	$1,711,083,000	$10,046,101,000	$24,826,724,000
Patient out-of-pocket	$17,845,000	$97,906,000	$220,550,000
Patient non-covered	$0	$0	$0
Total Post-benefit Requirement Dollars	**$1,728,928,000**	**$10,144,007,000**	**$25,047,274,000**
Change Attributable to Proposed Benefits			
Insurer premium	$53,582,000	$293,967,000	$662,211,000
Patient out-of-pocket	$16,788,000	$92,105,000	$207,481,000
Patient non-covered	-$57,199,000	-$313,811,000	-$706,911,000
Total Change	**$13,171,000**	**$72,261,000**	**$162,781,000**
Percent Change Attributable to Proposed Benefits			
Insurer premium	3.2%	3.0%	2.7%
Patient out-of-pocket	1588.3%	1587.7%	1587.6%
Patient non-covered	-100.0%	-100.0%	-100.0%
Total Percent Change	**0.8%**	**0.7%**	**0.7%**

Appendix D Small group enrollee total dollars

Small Group Market	1-Year	5-Year	10-Year
Total enrollment subject to state benefit requirements	266,268	1,357,664	2,784,744
Total population affected	207,143	1,058,974	2,176,160
Baseline Total Dollars			
Insurer premium	$2,185,847,000	$12,858,288,000	$31,856,996,000
Patient out-of-pocket	$748,000	$4,106,000	$9,251,000
Patient non-covered	$63,029,000	$345,841,000	$779,140,000
Total Baseline Dollars	**$2,249,624,000**	**$13,208,235,000**	**$32,645,387,000**
Post-benefit Requirement Total Dollars			
Insurer premium	$2,244,921,000	$13,182,426,000	$32,587,240,000
Patient out-of-pocket	$17,945,000	$98,465,000	$221,830,000
Patient non-covered	$0	$0	$0
Total Post-benefit Requirement Dollars	**$2,262,866,000**	**$13,280,891,000**	**$32,809,070,000**
Change Attributable to Proposed Benefits			
Insurer premium	$59,074,000	$324,138,000	$730,244,000
Patient out-of-pocket	$17,197,000	$94,359,000	$212,579,000
Patient non-covered	-$63,029,000	-$345,841,000	-$779,140,000
Total Change	**$13,242,000**	**$72,656,000**	**$163,683,000**
Percent Change Attributable to Proposed Benefits			
Insurer premium	2.7%	2.5%	2.3%
Patient out-of-pocket	2299.1%	2298.1%	2297.9%
Patient non-covered	-100.0%	-100.0%	-100.0%
Total Percent Change	**0.6%**	**0.6%**	**0.5%**

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