SOCIETY OF ACTUARIES

Article from:

Health Watch

May 2012 – Issue 69

Dental Coverage and the ACA

By Laurence Weissbrot

Laurence R Weissbrot, FSA, MAAA is director, Actuarial & Underwriting at Northeast Delta Dental in Concord, N.H. He can be reached at *lweissbrot@nedelta.com*.

Some readers may be concerned about the effect of the Affordable Care Act (ACA) on dental benefits. Under the ACA, Dental is an "excepted benefit." The Act doesn't apply to Dental. Well, not so fast!

How important is one person's life? In the grand scheme of things, what difference can one person make? If that person is 12-year-old Diamonte Driver, he can make a lot of difference. Diamonte had an abscessed tooth, but he did not have dental insurance, and his family had lost their Medicaid coverage. His mother could not find a dentist to see her children. By the time emergency room doctors saw Diamonte for headaches it was too late, and the Prince Georges County, Md. boy died after two brain surgeries.

When Congress was debating health care reform, stories such as this one were part of the decision to make pediatric dental benefits one of the essential benefits that any medical plan sold on the new health insurance exchanges must cover. The problem for the stand-alone dental benefits industry (Delta Dental, Guardian, etc.) is that in the private market (not including public programs), roughly 98 percent of Americans with dental coverage today have a dental benefit policy separate from their medical policy. Only about 2 percent of Americans get their medical and dental policies integrated (or embedded) into one policy from the same carrier or benefits administrator. If families (individuals and small groups) begin purchasing their medical from public exchanges, and if the medical already contains the mandatory pediatric dental benefits, these families might not venture outside the exchanges to buy dental coverage for the adults, or they might not look further for adult coverage on the exchange.

The National Association of Dental Plans (NADP) and the Delta Dental Plans Association (DDPA) approached Senator Debbie Stabenow of Michigan to propose an amendment to the ACA that would allow dental benefits plans to be sold on health care exchanges on a stand-alone basis, i.e., not bundled into a medical plan.

Under the ACA, states will have the power and authority to form their own exchanges, band together in a regional exchange, or do nothing and have the federal government provide the exchange for them. So it is up to each state to decide whether stand-alone dental will be:

1) not allowed to be sold on its exchange,
2) allowed to be sold on its exchange, or
3) not allowed to be sold anywhere but on its exchange.

Furthermore, as long as there is at least one carrier selling dental on the exchange, medical carriers can sell plans that do not include the pediatric dental benefit—as long as the person visiting the exchange to buy medical also buys a dental plan that covers at least the essential pediatric dental benefits.

Also, where customers may buy dental either separately from medical or bundled with the medical, it is up to the state to determine whether the pricing of the bundled dental must be transparent to the purchaser, allowing the purchaser to compare benefits and costs when purchasing the products separately or together.

Finally, the ACA contains a definition of "small group" for purposes of being allowed or required to purchase health insurance from exchanges. In 2014, it may be groups either under 50 employees or under 100 employees. In 2016 a "small" group will be under 100 employees. Beginning in 2017, states will have the option to extend exchanges to large employers. Current surveys of large employers reveal no plans to drop medical and dental as employee benefits, but things could change (such as the tax treatment of such benefits to the employer and the employee.)

This brings me back to the importance of Diamonte Driver's life, or death. Under several of the exchange scenarios listed above, the stand-alone dental benefits industry could simply cease to exist. If dental had truly remained an "excepted benefit," there would be no concerns to dental from the ACA.

My company, Northeast Delta Dental, operates in three states: Maine, Vermont and New Hampshire. These three states probably represent the full range of what states are doing about health care reform. We are in close touch with the legislatures in all three states, and are closely following the debates.

In Maine, both versions of proposed legislation currently being considered in a legislative committee would allow citizens to buy dental on the exchange by itself or as part of a medical plan. Those concerned with consumer rights are advocating that bundled plans be priced separately to allow consumers to make apples to apples comparisons of the available products. This would allow the market to continue the current situation, previously cited, that 98 percent of dental plans are sold separately now. If part of a medical plan, the benefits and costs must be broken out to be transparent to the purchaser. A medical plan that does not include dental still meets the requirements of providing the essential benefit if a buyer can purchase a dental plan separately to cover the essential pediatric dental benefit. The bill is silent as to whether consumers may purchase the separate dental on or off the exchange.

In Vermont, they don't believe the federal government has gone far enough; they passed a law last year to create an exchange en route to universal, single-payer health care to become effective in 2017. In the mean time, they are moving forward with their exchange, which will allow dental to be provided either as part of a medical plan or as a stand-alone benefit plan, as long as it covers the essential pediatric benefit. Existing law and pending legislation are silent as to whether carriers can offer the separate dental benefit off the exchange. The administration is proposing that individuals and small groups may purchase medical ONLY through the exchange. Here is where the definition of "small group" becomes important. The entire population of Vermont is under 650,000, and if they define "small employer" as groups up to 100 employees, beginning in 2014, 98 percent of the employers in the state will have only one source of purchasing health insurance: the exchange. Since they plan to limit the number of health carriers that may sell on the exchange, this goes a long way toward implementing the single payer idea.

That brings us to New Hampshire. Various medical, dental and consumers' rights stakeholders, plus the Department of Insurance, crafted an exchange bill in the Senate that would have allowed carriers to sell stand-alone dental on the exchange. That bill has been tabled and will probably never see the light of day. At the same time, the New Hampshire House of Representatives has proposed a bill that would bar the state from having anything to do with creating a health exchange under the federal health care reform law. If New Hampshire does not pass a law setting up an exchange and does not take other significant steps by Jan. 1, 2013, New Hampshire will default to a state exchange run by the federal government. Unless the Supreme Court finds the ACA (or at least the provisions that require each state to establish an exchange) unconstitutional, the federal government will run New Hampshire's health exchange. The Supreme Court is hearing arguments by the end of March, with decisions due by end of June, so some of the uncertainty may be resolved by July.

Throughout this article I have referred to "dental benefits" not "dental insurance." To be insurable, a risk must be of low frequency, high economic impact, and out of the control of the insured. Dental fails all three criteria. It works as "insurance" in the group benefits market because it enjoys the double tax exemption of health benefits: the employer can

CONTINUED ON **PAGE 12**

Carriers will face a challenge designing products that control antiselection, provide a meaningful benefit, and help promote good oral health.

deduct the premium as a business expense and the employee does not have to report the value as a taxable income item. Individuals buying pre-paid dental benefits on exchanges will not have these same advantages. The question becomes whether the expense load is greater than or less than the network discount available from the carrier. There is another benefit to being "insured" for dental: 75 percent or more of the people who have dental coverage see their dentists on a regular basis. Fewer than 50 percent of people without dental coverage do so. So part of the challenge in selling dental benefits to individuals will be in making them understand it is important to see a dentist regularly (it is!) and without the benefit, they probably won't do so.

What about benefit design? Group dental benefits most commonly sold include varying coinsurance percentages, an annual deductible, and a maximum benefit. The deductible is a cost sharing mechanism between the employer and the employee. Does a deductible make sense when the insured is paying the entire premium? Typical coinsurance levels might be 100 percent for preventive and diagnostic services (cleanings, radiographs, evaluations), 80 percent for basic restorative services (fillings, endodontics, periodontics, oral surgery), and 50 percent for major restorative services (crowns, bridges, dentures). Coinsurance levels also share cost, but more importantly they provide an incentive for the patient to see the dentist at least once a year for preventive services. This helps find problems before they become major expenses.

Another problem is price. Group dental offered by employers helps attract and retain employees, and is a valued employee benefit. When offered on a voluntary basis (the employee pays the whole cost) it suddenly loses some of its importance, and only 25 percent or less of the employee population buys it. We are about to enter a world where purchasers will buy some or much or most or all of our products on a website modeled after Priceline. Will they—can they—differentiate based on brand, quality, customer service, network, exclusions and limitations, etc., or will they simply look at price? To sell to individuals may require a product price at or below $50 per month per person. A typical group dental plan that covers 100 percent preventive, 80 percent basic, 50 percent major, 50 percent orthodontia, with a $50 deductible and a $1,500 calendar year maximum costs more than $50 per month per person. That means products sold on exchanges must provide benefits that cover less than the average group plan, through lower coinsurances, higher deductibles, service exclusions, or some combination. This brings us back to the "insurance" question. Because the timing of receipt of dental benefits is so much under the control of the insured, the antiselection associated with dental is a serious problem when sold in the individual market. Carriers will face a challenge designing products that control antiselection, provide a meaningful benefit, and help promote good oral health.

We are facing interesting times! ■