Session 26IF, The Affordable Care Act and Dental: Past, Present, and Future

Moderator/Presenter:
Thomas Daniel Murawski, ASA, MAAA

Presenter:
Anne L. Treankler, FSA, MAAA
The ACA and Dental: Past, Present, and Future

Thomas Murawski, ASA, MAAA, Milliman
Anne Treankler, FSA, MAAA, Delta Dental of Wisconsin
Agenda

• Why this topic is important
• Dental past
• Dental present
  – The foundation
  – Unique challenges for standalone dental within the ACA
  – Standalone vs. embedded dental
• Dental future
  – Anti-selection
  – Trend
  – Network
  – The group market on- vs. off-exchange
  – Emerging issues
WHY
is this important?
All markets are evolving.
Consumers are CONFUSED
Pre-ACA - Common Plan Design Features

• Coinsurance
  – Common Plan Coinsurance Structure by class-100%/80%/50%/50%

• Deductible
  – May be waived for certain services (e.g. Class I)

• Annual Benefit Maximum
  – Industry standard on employer-sponsored plans
  – Often separate annual or lifetime max for orthodontia

• OOP Maximums – Rarely found in dental policies
Pre-ACA – How Dental Insurance Is Purchased

• Only 1% of dental policies are individual policies
• Virtually all dental policies obtained via employer, union, or public program
• Usually a family policy covering employees and dependents
• 98% of Americans with dental coverage have dental as a separate policy from medical coverage
• Only 2% have dental coverage embedded in medical plan

Source: Offering Dental Benefits in Health Exchanges. NADP/DDPA September 2011.
Pre-ACA – Waiting Periods

- Not common for Small Group policies
- Very common for Individual policies
- Waiting periods may be waived by meeting prior coverage requirements
- Waiting periods often vary by benefit class
  - Class I – typically no waiting period (immediate coverage of preventive services)
  - Class II – no waiting or 3, 6, 12 month waiting periods
  - Class III – no waiting or 3, 6, 12, 18 month waiting periods
- Orthodontia – 12 months typical, FEDVIP up to 24 months
- Some states have restrictions, for ACA and/or non-ACA plans
ACA Basics – Essential Health Benefits

- Emergency Services
- Hospitalization
- Outpatient or Ambulatory
- Various Therapy Services
- Preventive and Wellness
- Prescription Drugs
- Maternity and Newborn
- Laboratory Services
- Mental Health and Substance Abuse
- Pediatric Services
ACA Basics – Essential Health Benefits

- Emergency Services
- Hospitalization
- Outpatient or Ambulatory
- Various Therapy Services
- Preventive and Wellness
- Prescription Drugs
- Maternity and Newborn
- Laboratory Services
- Mental Health and Substance Abuse
- Pediatric Services
ACA Basics – Pediatric Dental Services

States Choose a Benchmark Plan
ACA Basics – Pediatric Dental OOP Maximum

Stand-Alone pediatric dental plans must have “reasonable” annual OOP maximum (45 CFR 156.150) for in-network services

- $350/$700 national OOP maximum for 2016

- OOP max not common in dental plans pre-ACA
- Increases price point, affects Actuarial Value
- Few children hit OOP maximum

If pediatric dental is embedded in a medical plan, then subject to medical OOP maximum.

Disjoint between pediatric dental benefits stand-alone v. embedded
ACA Basics – Medically Necessary Orthodontia

- Little to no MN criteria in pre-ACA commercial policies
- Most states’ EHBs include MNO
- MN criteria will vary by state and/or carrier
  - List of qualifying conditions
  - Score on malocclusion index
- Price impact is not negligible, especially with no benefit maximum and with an OOP maximum
ACA Basics – New Expenses and Fees

Health Insurance Tax (HIT)  Exchange Fees
ACA Basics – New Expenses and Fees

Expenses applicable to SADP

- Health Insurance Tax (HIT)

<table>
<thead>
<tr>
<th>($B)</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Industry Tax</td>
<td>$8.0</td>
<td>$11.3</td>
<td>$11.3</td>
<td>$13.9</td>
<td>$14.3</td>
</tr>
</tbody>
</table>

- Exchange Fees
  - 3.5% of premium for FFE
ACA Basics - Exchanges

Exchange

FFM / SPM / State-Based

Small Business Health Options Program

Individual
WHAT IS THE IMPACT TO SADP?
SADP can provide a waiver for medical plans to **exclude** pediatric oral EHB.
Pediatric Oral EHB and SADP

On-exchange

Off-exchange
Exchange-certified dental plans

The basics:

- Filed and approved by the exchange
- Covers pediatric oral EHB
- Available on-exchange, off-exchange, or both
Guaranteed vs...

Estimated Rating
Different benefits: Pediatric vs. Adult

<table>
<thead>
<tr>
<th></th>
<th>Pediatric (EHB) Coverage</th>
<th>Adult (Non-EHB) Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Out-of-Pocket Limit (MOOP)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Annual Maximum</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Waiting Periods</td>
<td>No*</td>
<td>Yes</td>
</tr>
<tr>
<td>Medically Necessary Orthodontia</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Actuarial Value</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

*Except medically necessary orthodontia if FEDVIP benchmark plan
## Actuarial Value

A few notes on actuarial value (AV)

- Under the ACA, AV Plan A = AV Plan B

<table>
<thead>
<tr>
<th></th>
<th>Plan A</th>
<th>Plan B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adult</td>
<td>Pediatric</td>
</tr>
<tr>
<td><strong>D &amp; W</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Basic</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Major</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>$25</td>
<td>$25</td>
</tr>
<tr>
<td><strong>MOOP</strong></td>
<td>N/A</td>
<td>$350</td>
</tr>
<tr>
<td><strong>Annual Max</strong></td>
<td>$1,000</td>
<td>N/A</td>
</tr>
</tbody>
</table>
**Actuarial Value**

A few notes on actuarial value (AV)

- Under the ACA, AV Plan A = AV Plan B

<table>
<thead>
<tr>
<th></th>
<th>Plan A</th>
<th></th>
<th>Plan B</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adult</td>
<td>Pediatric</td>
<td>Adult</td>
<td>Pediatric</td>
</tr>
<tr>
<td>D &amp; W</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Basic</td>
<td>80%</td>
<td>80%</td>
<td>50%</td>
<td>80%</td>
</tr>
<tr>
<td>Major</td>
<td>50%</td>
<td>50%</td>
<td>0%</td>
<td>50%</td>
</tr>
<tr>
<td>Deductible</td>
<td>$25</td>
<td>$25</td>
<td>$50</td>
<td>$25</td>
</tr>
<tr>
<td>MOOP</td>
<td>N/A</td>
<td>$350</td>
<td>N/A</td>
<td>$350</td>
</tr>
<tr>
<td>Annual Max</td>
<td>$1,000</td>
<td>N/A</td>
<td>$1,000</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Plan Selection Statistics

- Total FFM SADP selections: 1,377,874

<table>
<thead>
<tr>
<th>SADP Selections by Age</th>
<th>% of SADP Total</th>
<th>% of QHP Age Group Enrolling in SADP</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 18</td>
<td>7%</td>
<td>14%</td>
</tr>
<tr>
<td>18-25</td>
<td>12%</td>
<td>16%</td>
</tr>
<tr>
<td>26-34</td>
<td>22%</td>
<td>20%</td>
</tr>
<tr>
<td>35-44</td>
<td>19%</td>
<td>18%</td>
</tr>
<tr>
<td>45-54</td>
<td>20%</td>
<td>15%</td>
</tr>
<tr>
<td>55-64</td>
<td>20%</td>
<td>12%</td>
</tr>
<tr>
<td>&gt;= 65</td>
<td>0%</td>
<td>12%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Source: ASPE Issue Brief March 10, 2015; data through 2/22/15
SADP Age Distribution

Age distribution of individual members on-exchange vs. off-exchange

Percent of Enrollment

- 0-18
- 19-25
- 26-34
- 35-49
- 50-64

On-exchange vs. Off-exchange
SADP Members per Policy

Individual members per policyholder

on-exchange vs. off-exchange

Ratio

On-exchange  Off-exchange  Small group
Embedded vs. Standalone Dental

2014 26.8%  2015 35.7%

## Embedded vs. Standalone Dental

<table>
<thead>
<tr>
<th>Cost sharing on preventive care</th>
<th>Embedded</th>
<th>SADP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible waived</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separate dental deductible</td>
<td>4.7%</td>
<td>39.6%</td>
</tr>
<tr>
<td>Medical deductible</td>
<td>65.5%</td>
<td>43.1%</td>
</tr>
<tr>
<td><strong>Deductible not waived</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separate dental deductible</td>
<td>0%</td>
<td>43.1%</td>
</tr>
<tr>
<td>Medical deductible</td>
<td>23.8%</td>
<td></td>
</tr>
<tr>
<td><strong>No deductible, no other cost share</strong></td>
<td>5.5%</td>
<td>4.3%</td>
</tr>
<tr>
<td><strong>No deductible, but other cost share</strong></td>
<td>0.5%</td>
<td>13.0%</td>
</tr>
</tbody>
</table>

Embedded vs. Standalone Dental

“Shadow Premiums”

$0  $10  $20  $30  $40

Embedded  SADP 70% AV  SADP 85% AV
WHY

“Better” coverage at “lower” cost?
Actuarial value

Base for spreading cost of care

Member out-of-pocket limit

Benefit plan impacts
Dental Past

Dental Present

Dental Future
Future Considerations - Pricing

• What does the insured pediatric population look like?
  – Pent up demand, adverse selection
  – Little credible experience

• Balancing AV, OOP maximum, no annual/lifetime maximums while maintaining preventive coverage and affordability

• Separation of child and adult coverage purchase decision

• Adult/buy-up plans: affordable, attractive benefit structures to encourage purchase while limiting risk
Future Considerations – Adverse Selection

• A concern in adult dental policies
• Fully voluntary coverage
  – Not tied to purchase of benefits for dependents
• Many dental benefits are elective
  – E.g. Class II and III
• Immediate coverage of benefits
• Use plan design to mitigate adverse selection
Future Considerations – Avoid Adverse Selection

- **Waiting Periods**
  - Amount of time after coverage effective date when plan does not reimburse for services

- **Service Class Assignment**
  - Endodontics, Periodontics, Oral Surgery
  - Can be covered as Class II or III

- **Progressive Benefits**
  - Increase coinsurance in future years

- **Annual Benefit Maximums**
  - Limit plan liability on expensive benefits
  - e.g. implants and dentures
Selection and Durational Loss Ratios

- Only a mature block of stand-alone dental business will have stable loss ratios

- New policy form with waiting periods
  - 1st year claims lower than lifetime target loss ratio
  - 2nd year claims might be higher than lifetime target loss ratio
    - Example: Pent-up demand with a 12 month Class III waiting period

- New policy form without waiting periods
  - 1st year claims much higher than lifetime target loss ratio due to adverse selection
  - Cumulative loss ratio higher than lifetime loss ratio for several years depending upon multi-year pricing model
  - Could present cash flow issues for insurer
Future Considerations – Durational Loss Ratios

New policy form - with waiting periods
• 1st year claims lower than lifetime target loss ratio
• 2nd year claims might be higher than lifetime target loss ratio

New policy form - without waiting periods
• 1st year claims much higher than lifetime target loss ratio due to adverse selection
• Cumulative loss ratio higher than lifetime loss ratio for several years depending upon multi-year pricing model
• Could present cash flow issues for insurer
Future Considerations - Trend

Prior coverage vs. no prior coverage

Impact on intensity and utilization
Future Considerations – Network Scope

Broad access

“My dentist”
Small Group Market

SHOP exchange

- Single carrier vs. employee choice
Small Group Market

SHOP exchange

- Group size definition

Current 2-50  Exchange 1-50  Effective 1/1/2016 1-100
WILL NON-MEDICALLY NECESSARY ORTHODONTIA BE SUSTAINABLE?
Emerging Dental Industry Issues

- King v. Burwell
- Medicaid dental coverage for children and adults
- Use of mid-level providers/dental hygienists
- Improvement in diagnostic coding
- What else?
CONCLUSION
Even though dental is an excepted benefit, the ACA has impacted and will continue to impact SADP in many ways.
QUESTIONS?
Caveats and Limitations

I, Thomas Murawski, am an Associate Actuary for Milliman. I am a member of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

Milliman has prepared this presentation for the specific purpose of providing commentary on the impact of the Affordable Care Act on the dental benefits industry. This information may not be appropriate, and should not be used, for any other purpose. This presentation has been prepared solely for the SOA. No portion of this presentation may be provided to any other party without Milliman's prior written consent. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work even if we permit the distribution of our work product to such third party.

Milliman does not provide legal advice, and recommends that the SOA consult with its legal advisors regarding legal matters.
Caveats and Limitations

I, Anne L. Treankler, am Director, Actuarial Services for Delta Dental of Wisconsin. I am a member of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

This presentation has been prepared for the specific purpose of providing commentary on the impact of the Affordable Care Act on the dental benefits industry and has been prepared solely for the SOA. This information may not be appropriate, and should not be used, for any other purpose. Delta Dental does not intend to benefit or create a legal duty to any third party recipient of its work even if this presentation is distributed to such a third party.

Delta Dental does not provide legal advice, and recommends that the SOA consult with its legal advisors regarding legal matters.