Healthcare reform: What about dental?

Joanne Fontana, FSA, MAAA

While many of the tenets of the Patient Protection and Affordable Care Act (PPACA) focus on medical insurance, its implementation will also have a major impact on how dental insurance is offered, what services are covered, and the cost of dental coverage. The inclusion of "pediatric services, including oral and vision care" as a required coverage in the essential health benefit (EHB) package creates an interweaving of medical and oral health services rarely seen prior to healthcare reform, causing new complexities in selling and administering dental insurance. As the PPACA is implemented, it will be critical to consider the inclusion of dental insurance thoughtfully in order to prevent unintended consequences to the dental insurance marketplace affecting insurers, consumers, and providers alike. This briefing paper explores issues for the dental insurance market arising from the PPACA.

PEDIATRIC ORAL CARE AS PART OF EHB PACKAGE

In Section 1302 of the PPACA, the Department of Health and Human Services (HHS) defined services comprising an essential health benefit (EHB) package, all of which must be included in individual or small group benefit plans offered on or off an exchange. One of the required benefits is "pediatric services, including oral and vision care." While HHS's December 2011 bulletin clarified the method states should use to define their EHB, there is still a wide array of potential outcomes for the construct, covered services, and cost of each state's pediatric oral care benefit. The simple inclusion of oral care for children as a required benefit raises complex issues on how that and other dental benefits should be constructed and sold in the post-reform environment.

HOW WILL DENTAL INSURANCE BE SOLD ON EXCHANGES?

Today, dental insurance is generally not embedded in medical coverage, but rather sold as a separate policy. People usually purchase a dental policy to cover themselves and any family members. Once exchanges are operational, consumers purchasing medical insurance on the exchange will be required to buy coverage that includes pediatric oral care services, raising important questions on the offer of dental insurance.

- **Will pediatric dental policies need to be sold separately from adult or family policies?** If the services contained in the pediatric oral care essential benefit go beyond a simple oral check done by a pediatrician to include procedures normally covered under a dental plan, then the consumer may need to choose a medical plan and a dental plan to comprise the EHB. The required pediatric coverage could come as part of a traditional family dental policy, or it could come as a child-only policy that may cover only the minimum required benefits.

- **If child-only dental policies are offered, what coverage will consumers choose for themselves?** People purchasing individual or small group insurance policies will be required to purchase pediatric oral care as part of the EHB, but have no obligation to purchase additional dental insurance. The uptake rate on additional coverage will depend on many factors, including (1) whether the prices of child-only policies are transparent to the consumer or bundled with either medical coverage or family dental policies, (2) the coverage scope and the cost of the child dental policy, and (3) how easy it is for the consumer to navigate the exchange's portal to purchase both medical and dental coverages. Importantly, many consumers purchasing on the individual, or American

Health Benefits (AHB) Exchange will receive considerable federal subsidies toward the purchase of insurance. Those subsidies apply only to the EHB; as such, the consumer would bear the full cost of any additional family dental coverage, adult-only dental coverage, or pediatric supplemental dental coverage not included in the essential health benefit package. Might some consumers forgo dental insurance for themselves, or supplemental dental insurance for their children, if given the option to do so?

- **Who will purchase insurance on exchanges?** A study by the Kaiser Family Foundation[1] suggests that the majority of AHB Exchange enrollees will be prior uninsureds, with the balance made up of people losing employer-sponsored insurance, people transitioning from Medicaid, and people who previously purchased insurance on the individual market. The study indicates that these people are likely to be more racially diverse, older, lower-income, and less healthy overall than the average population in today's commercial marketplace. First-time insureds purchasing coverage on the exchange represent a new market for dental insurance, but one with different needs than a commercial customer. Pent-up demand for services and unmet dental needs, along with affordability of dental options, will be key concerns for this population.

  Even less is known about how many small employer groups, and large employer groups once they become eligible in 2017, will migrate to the small employer exchange—or Small Business Health Options Program (SHOP) Exchange—or stop offering benefits altogether and send their employees to the AHB Exchange to shop for individual coverage. Employer groups are modeling the impact of healthcare reform on their employee benefit programs, weighing the cost of offering benefits and implementing the required administrative and compliance processes against paying the penalty for not offering coverage and sending individuals to the AHB Exchange for their insurance needs. Employer-based coverage is dental's bread and butter; only about 1% of Americans access dental insurance through an individual policy today.[2] As such, it will be important to have affordable and attractive dental options on the exchange in order to maintain dental insurance enrollment as well as the population's oral health.

WHAT EXACTLY IS CONSIDERED "PEDIATRIC ORAL CARE"?

In December 2011, HHS released a bulletin providing more context on the EHB, allowing each state to tie the scope of services in its EHB to a selected benchmark plan. Broadly, the benchmark plan may be chosen from a typical small group plan in the state, the largest HMO in the state, the state employee health benefit plan, or the national Federal Employees Health Benefits (FEHB) plan. The bulletin acknowledged that dental insurance today, while sometimes provided as part of a comprehensive medical plan, is often provided separately from medical coverage as a standalone dental policy. It is possible that the state's chosen benchmark plan may not include pediatric oral services as part of medical coverage. In that situation, the bulletin allows the state to supplement the benchmark plan with the pediatric oral care coverage contained in another benchmark, or the state's Children's Health Insurance Program (CHIP), or the Federal Employee Dental and Vision Insurance Program (FEDVIP). Each state applies these rules to define its own benchmark plan for EHB. This leaves several open questions with respect to pediatric dental coverage:

- The **covered services for the pediatric oral care essential benefit** can vary quite widely depending on the benchmark chosen by each state. For example, the FEHB Blue Cross Blue Shield Basic plan includes preventive, diagnostic, and emergency dental procedures embedded in its medical plan. Should a state choose this benchmark, the pediatric oral care essential benefit might be limited to those common, relatively low-cost procedures. Meanwhile, state CHIP programs often cover a much wider range of dental services, including medically necessary orthodontia; that benchmark would provide a broader base of required pediatric oral care coverage.

- The **price point for the pediatric oral care benefit** can also differ considerably depending on both the covered services and the consumer cost-sharing associated with those services. While CHIP programs offer a wide array of child dental benefits, costs are kept in check via strict benefit limitations and stringent medical necessity criteria for certain procedures such as orthodontia. Those same benefits provided in employer-sponsored dental plans, with more traditional coinsurance structures and few if any medical necessity requirements, result in a higher cost basis. Importantly, EHB guidance only concerns itself with covered services, not with cost-sharing levels. Thus, even states with very similar EHB could see different premium levels for the pediatric oral care benefit depending on the cost-sharing or medical necessity requirements applied.

- As the guidance released by HHS in December 2011 largely deferred to the states to create their own EHB definitions, the **composition of the pediatric oral care essential benefit will likely differ, maybe by quite a bit, from state to state**. Dental carriers wishing to offer insurance on exchanges may need to create targeted state-level strategies to ensure that the plans they offer are both compliant and attractive.

HOW IS "PEDIATRIC" DEFINED?

An even more basic question, how "pediatric" is defined, can affect the cost of the essential benefit and the importance of including various services. Clinically, children are thought to transition from child dental care to adult dental care at age 12.[3] But state CHIP programs generally cover children through age 19, and state Medicaid programs through age 21. Further, the PPACA extended "dependent" coverage to age 26, creating another potential

1 Kaiser Family Foundation (March 2011). *A Profile of Health Insurance Exchange Enrollees*. Focus on Health Reform.
2 National Association of Dental Plans and Delta Dental Plans Association (September 2011). *Offering Dental Benefits in Health Exchanges: A Roadmap for Federal and State Policymakers*.
3 *Offering Dental Benefits*, ibid.

Joanne Fontana

definition. The per-child cost of oral care coverage will depend on the age limit of the benefit, as older children utilize a different mix of services than younger ones. It remains to be seen whether HHS will specify the definition of pediatric or whether states will be at liberty to define it as they see fit.

HOW IS PLAN ADMINISTRATION AFFECTED WHEN THE EHB CROSSES MEDICAL AND DENTAL PLANS?

Another requirement of the PPACA is that, for the set of benefits comprising the EHB, cost-sharing must be limited to individual/family deductible limits of $2,000/$4,000 and out-of-pocket maximum limits of $5,950/$11,900 in 2014, and indexed thereafter. Pediatric oral health services are part of the EHB plan and hence subject to these overall limits, but the benefit may be offered by a stand-alone dental insurance carrier separate from the medical plan. Somehow, the overall EHB cost-sharing and out-of-pocket limits must be administered even when separate medical and dental insurance companies, each with its own claim systems and processes, are involved. Creative solutions need to be explored to make this feasible.

CONSIDERATIONS IN THOUGHTFULLY INCLUDING DENTAL IN PPACA IMPLEMENTATION

The issues associated with ensuring that dental is appropriately included when implementing exchanges and other aspects of the PPACA are many and complex. Dental insurers need to be ready to position themselves with innovative products designed to meet the needs of the exchange marketplace and to work with employer groups to ensure that group dental insurance remains a value-added employee benefit. It will also be important for them to understand how pediatric dental benefits have become linked with medical benefits via the EHB and to hash out the ramifications on marketing, claims administration, pricing, and product design, likely on a state-by-state basis. Understanding the changing environment in advance will ensure that we are ready for 2014's challenges and opportunities.

Joanne Fontana, FSA, MAAA, is an actuary in the Hartford, Connecticut, office of Milliman. Contact her at joanne.fontana@milliman.com.

The materials in this document represent the opinion of the authors and are not representative of the views of Milliman, Inc. Milliman does not certify the information, nor does it guarantee the accuracy and completeness of such information. Use of such information is voluntary and should not be relied upon unless an independent review of its accuracy and completeness has been performed. Materials may not be reproduced without the express consent of Milliman.

Copyright © 2012 Milliman, Inc.

FOR MORE ON MILLIMAN'S HEALTHCARE REFORM PERSPECTIVE

Visit our reform library at www.milliman.com/hcr
Visit our blog at www.healthcaretownhall.com
Or follow us on Twitter at www.twitter.com/millimanhealth