Here we go again: Potential impact of healthcare reform on dental insurance

Joanne Fontana, FSA, MAAA

Milliman

The passage of the Patient Protection and Affordable Care Act (ACA) in 2010 caused sweeping changes in the dental insurance industry, affecting the construct of dental benefits, the pricing of those benefits, and the availability of dental coverage. Now, as changes to the ACA or elimination of some of its provisions could potentially be enacted in the coming months, the dental benefits industry again must determine how to succeed in this evolving environment. In this article, we explore several key aspects of the ACA that, if amended or removed, would affect dental benefits, and we discuss considerations for dental insurers to turn change into opportunity.

Exchanges and essential health benefits

Arguably, the most notable dental-related change brought about by the ACA was the inclusion of pediatric oral care as an essential health benefit (EHB). Broadly, according to the ACA, pediatric oral care benefits must be offered in the individual and small group markets both on and off state exchanges. The benefit may be embedded within a medical plan or offered as a standalone dental plan (SADP), either as a child-only dental policy or as part of family dental coverage. Only pediatric dental coverage was deemed an EHB; there is no required dental benefit for adults.

For the 2017 open enrollment period, 9% or approximately 173,000 of the 1,924,059 SADP selections on state exchanges were for children under age 18;[1] this number includes all states except Colorado but excludes both children who obtained standalone dental coverage off exchange and those who received dental benefits embedded in medical coverage either on or off exchange. So, while this isn't a vast increase in coverage, the actual number of children gaining some level of dental insurance via the pediatric dental EHB is likely at least slightly greater than the number cited. Also, notably, although there is no mandate for adults to purchase dental insurance, the vast majority of 2017 plan SADP selections were for adults; this has been the case since the advent of the state exchanges in 2014.

What if the next iteration of health reform alters EHB, allows each state to define its own set of EHB, or does away with the concept of EHB entirely such that pediatric dental is no longer included? Dental insurers can build on the experience gained since ACA enactment to develop a winning strategy going forward.

Partnerships with health plans. Prior to the ACA, approximately 98% of Americans with dental coverage had dental policies separate from their medical policy,[2] and the policy generally covered the entire family, including adults and children. The inclusion of pediatric dental benefits in EHB upended this norm, spurring medical and dental carriers to compete as well as collaborate in new ways. While medical carriers generally had not included dental benefits in their policies, the ACA propelled some to offer embedded pediatric dental EHB to provide consumers with one-stop shopping for the full set of EHB, including medical and dental. Some health insurers had in-house dental products to embed; others sought partnerships with dental carriers. If EHB rules are altered, medical and dental carriers alike will have to re-evaluate these relationships. If the individual market has valued the inclusion of pediatric dental benefits within medical plans, it could be beneficial to keep or even expand these new connections between medical and dental carriers to offer consumers a wider range of medical plus dental options, potentially including adult dental coverage within a medical plan as well. Could one-stop shopping for medical and dental benefits in a combined package incentivize more employers to offer dental benefits and provide a growth opportunity for dental insurers? Also, with an increasing number of clinical studies linking oral health to physical health, connections between medical and dental insurers to better manage patients' total body health may prove valuable. Or, if the potential benefits of combining medical and dental coverage under a single policy are outweighed by administrative costs, hassle, or other barriers such that medical and/or dental carriers do not expect such collaborations to be mutually beneficial, a move back toward the pre-ACA norm of separate medical and dental policies may resume.

Right-sizing pediatric dental benefits. While child-only dental plans had been rare prior to the ACA, dental carriers were impelled to design EHB-compliant dental plans for children that could be purchased on a standalone basis to supplement medical EHB purchased from a health insurer. If EHBs are eliminated or if child dental is no longer considered an EHB,

1 From OE2017_STATE_PUF_FINAL.xlsx, available at **https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan_Selection_ZIP.html**

2 National Association of Dental Plans and Delta Dental Plans Association. *Offering Dental Benefits in Health Exchanges*. September 2011.

are child-only dental plans still desirable and marketable? Or would it be more beneficial to consumers and carriers alike to resume the family coverage model that prevailed prior to the ACA? The pediatric EHB SADP plans did not see significant uptake on exchanges: Was that due to lack of need for such coverage, or was it due to the required construct of the benefit per the ACA, which, if altered, could allow for more flexibility in benefit design? The pediatric dental EHB scope of benefits includes comprehensive dental coverage for children covering all classes of dental services as well as, in most states, medically necessary orthodontics. Such inclusive coverage comes with a price tag higher than for leaner plans. This, coupled with other ACA rules related to cost-sharing levels in standalone pediatric dental EHB plans, created a standalone pediatric dental EHB plan that was generally more expensive than traditional dental plans. If EHB were amended to exclude pediatric oral care, or dismantled entirely, dental insurers would have the opportunity to re-evaluate the pediatric dental benefit to determine whether a change in the balance between benefit richness and premium could entice greater pediatric membership. Could lean pediatric plans covering key preventive and diagnostic services enhance affordability for a wider swath of the child population? Would plans with innovative orthodontic benefits be appealing? How could child-only plans be fine-tuned to provide the optimal benefit? These are all questions that dental insurers should evaluate in light of any changes to the pediatric dental mandate.

Individual dental coverage for adults. As for adult dental coverage, even though the ACA set no requirements for carriers to offer or for consumers to purchase, more than 90% of dental plans purchased on exchanges have been for adults. In the years leading up to the ACA, virtually all private market dental policies were obtained via group coverage; only 1% of dental policies were purchased by individuals.[3] When carriers developed pediatric EHB dental policies to offer on exchanges, they generally also offered individual adult dental policies so that a family looking for dental coverage could find plans for all family members. In doing so, they uncovered an unmet need for individual dental coverage for adults. While many dental carriers had focused on group sales prior to the ACA, the uptake of adult dental coverage on exchanges indicates that individual coverage is marketable as well. In fact, the number of family dental plans offered on exchanges increased from 2014 to 2015 as carriers reacted to the demand for adult dental benefits.[4] Regardless of the direction that exchanges and EHBs take, carriers can capitalize on this individual market growth by assessing that population's dental needs and developing valuable, affordable, and easy-to-purchase individual dental insurance for adults across the age spectrum.

Premium subsidies and dental coverage gains

The uptake of dental benefits on state exchanges may be due in part to the premium subsidies available to consumers purchasing health insurance on state exchanges. While subsidy dollars could not be used to purchase non-EHB adult dental coverage, the reduction in the cost of health coverage due to subsidies could provide extra "found money" to put toward purchase of other coverages such as dental. A reduction in subsidies from the level provided under the ACA could reduce the likelihood that people purchase dental coverage for their children or for themselves.[5] The impact of a change in the premium subsidy program on segments of the individual market—people of differing ages or income levels—will depend on the structure of the subsidies. For dental insurers, understanding the dental needs of each population cohort, along with what is likely to happen to the cost of healthcare for that cohort, will be critical to help keep people insured or even expand dental penetration. For people better off under a new subsidy program, targeted products may entice purchase of dental insurance. For those worse off, pared-down dental benefits or other innovations might help keep them insured. It is also important for dental insurers to anticipate the adverse selection impact of dental coverage changes; new dental enrollees who were previously uninsured may exhibit initially high utilization, while those losing coverage may utilize services heavily before the coverage expires.

People also gained government-subsidized dental coverage under the ACA via the expansion of Medicaid. Adult Medicaid dental coverage varies widely by state, with benefits ranging from minimal mandated emergency care only in some states to comprehensive dental coverage in others. Medicaid expansion provided some level of dental coverage to an additional 5 million adults—those living in the expansion states that offer non-negligible adult dental services under Medicaid.[6] Proposals to change the level of Medicaid funding, convert to block grant or per capita cap programs, or otherwise roll back ACA's Medicaid expansion could put that dental coverage at risk. If states take on more of the Medicaid funding burden and must mitigate budget concerns, eliminating optional benefits like adult dental is one common method to reduce costs.[7] Are there ways for dental insurers to creatively structure affordable benefit programs aimed at this expansion population to keep them insured if they lose their Medicaid dental benefit?

3 National Association of Dental Plans and Delta Dental Plans Association. *Offering Dental Benefits in Health Exchanges*. September 2011.

4 Yarbrough C, Vujicic M, Nasseh K. More dental benefits options in 2015 Health Insurance Marketplaces. Health Policy Institute Research Brief. American Dental Association. February 2015. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0215_1.ashx.

5 Reusch, Colin. The future of dental coverage: Will Congress pull out the rug? DentistryIQ, February 27, 2017.

6 Grant, John. In Dental Care, 3 Issues to Watch in 2017. The Pew Charitable Trusts, January 30, 2017.

7 Birrell C, Gerstorff J, Johnson N, and Armstrong B. Building blocks: Block grants, per capita caps, and Medicaid reform. Milliman, Inc. January 2017.

Actuarial value and pediatric EHB cost-sharing requirements

As mentioned earlier, the standalone pediatric dental EHB is subject to several benefit and cost-sharing requirements. The ACA prohibits all essential health benefits, including pediatric dental, from using annual or lifetime dollar maximums. Traditional commercially sold dental plans rely on dollar maximums to keep premiums affordable while still providing a comprehensive benefit; as excepted benefits under the ACA, dental plans other than the pediatric EHB have continued to utilize them. The standalone pediatric dental EHB, however, not only is prohibited from such maximums but also must include a $350 annual out-of-pocket maximum; after a child incurs $350 in out-of-pocket costs, the remainder of all claim costs are the responsibility of the dental plan. In addition, standalone pediatric dental EHB plans must meet actuarial value (AV) requirements of 68% to 72% for low plans or 83% to 87% for high plans. The interaction of the benefit requirements and the actuarial value requirements causes the standalone pediatric dental EHB plan to look quite different from traditional commercial dental plans and, notably, from pediatric dental EHB embedded in medical plans. For medical plans that embed pediatric dental, no separate dental AV is required, nor is a separate dental out-of-pocket maximum, allowing for more flexibility in dental benefit design. A research brief by the American Dental Association's Health Policy Institute compared embedded versus standalone pediatric dental EHB and found that 1) embedded pediatric dental benefits were more likely to offer first-dollar coverage of preventive dental services, and 2) embedded pediatric dental benefits were less expensive.[8] This is partly due to the required benefit construct of the standalone plan. In order for standalone plans to balance the AV requirements for overall cost sharing while supporting a $350 out-of-pocket maximum that limits cost sharing for relatively rare high-cost dental issues, consumer cost sharing for common procedures such as preventive care is sometimes the only solution.

If pediatric dental AV ranges are expanded or AV requirements are eliminated, dental carriers can develop and market a broader range of standalone pediatric benefit options, allowing for more variety in the balance between preventive benefits and catastrophic cost relief and for closer alignment between standalone and embedded pediatric dental coverage. Similarly, if the prohibition on dollar maximums is lifted and/or the out-of-pocket maximum requirement for standalone pediatric dental EHB plans is removed, carriers could get more creative with pediatric dental plan design. The price tag associated with high-cost dental procedures is still just a fraction of high-cost medical care, allowing dental insurers to creatively produce alternate benefit structures without taking on too much risk.

8 Yarbrough C, Vujicic M, Nasseh K. More dental benefits options in 2015 Health Insurance Marketplaces. Health Policy Institute Research Brief. American Dental Association. February 2015. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0215_1.ashx.

Medicare

The ACA did not address coverage of dental under Medicare. Medicare continues to exclude "most dental care, dental procedures, or supplies, like cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices."[9] That said, Medicare has been a topic of discussion in health reform recently, with ideas ranging from privatizing the program[10] to enhancing benefits to include dental, hearing, and vision care.[11] For dental issuers, Medicare enrollees represent a potential market. Tailoring individual dental policies to the needs of different types of Medicare enrollees—those who had group dental coverage while they were employed, those without historical dental coverage, and dually eligible Medicare/Medicaid beneficiaries—could fill a coverage gap. Partnering with Medicare Advantage issuers to include dental benefits in those plans is another way to reach that population.

Other aspects of the ACA affect dental insurers as well: network adequacy requirements, exchange fees, the health insurer tax, essential community provider standards, and many more. Oftentimes regulatory and legislative changes made in the health insurance space affect dental insurers differently or in unintended ways. By staying on top of emerging proposals, dental insurers can work to promote the best outcome for the industry and transform uncertainty into opportunity.

9 https://www.medicare.gov/coverage/dental-services.html

10 Paul Ryan's "A Better Way" campaign included privatization of Medicare.

11 "Seniors Have Eyes, Ears, and Teeth Act of 2017" (H.R. 508) aims to expand Medicare coverage to include eyeglasses, hearing aids, and dental care.

FOR MORE ON MILLIMAN'S HEALTHCARE REFORM PERSPECTIVE:

Visit our reform library at milliman.com/hcr
Visit our blog at healthcaretownhall.com
Follow us at twitter.com/millimanhealth

CONTACT

Joanne Fontana
joanne.fontana@milliman.com