Dental Insurance Today

Actuaries Club of Hartford and Springfield

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Overview

- **How Dental Insurance differs from Medical Insurance**
  - Plan Design
  - Rating Considerations
  - Nature of the Risk
  - Data
- **Market Overview**
  - Enrollment Trends
  - Funding Trends
- **ACA/Medicaid**
- **Current/Future Key Issues**

HOW DENTAL DIFFERS FROM MEDICAL

Basic Components of Dental Plan Design

Dental insurance is **different** from medical insurance:

- Designed to **emphasize preventive care** over catastrophic coverage
- **Elective** nature of many dental benefits compared to medical
- Often sold on **voluntary** basis
- **Cost sharing** designed to limit adverse selection
- Substantial **out-of-pocket cost** and **benefit limits** to control utilization
- Benefits divided into **class structure**

Classes of Dental Benefits

- **Class I – Preventive and Diagnostic**
  - Oral Exams, X-Rays, Cleanings, Fluoride, Sealants
- **Class II – Basic**
  - Fillings, Endodontics, Periodontics, Extractions
- **Class III – Major**
  - Inlays, Onlays, Crowns, Bridges, Dentures
- **Class IV – Orthodontics**
  - Sometimes excluded, or included just for children

Common Commercial Dental Plan Designs

- **Coinsurance**
  - Common Plan Coinsurance Structure by class- 100%/80%/50%/50%
  - Or copays
- **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

Adverse Selection in Dental

By Patient:

- Relationship between risk and purchasing behavior
- Many dental benefits are elective, especially Class II and Class III benefits
- Immediate coverage of these benefits creates large opportunity for adverse selection
- Important to construct product design to mitigate adverse selection

Adverse Selection in Dental

By Provider:

- Lack of diagnosis-driven treatment standards
- Treat according to benefit plan specifications (e.g. # covered cleanings per year)
- Multiple ways to treat the same dental problem
  - Different materials
  - Extract versus repair

Avoiding Patient Adverse Selection

- Waiting periods
  - The amount of time immediately following the member's effective date for which the plan does not reimburse expenses for specified services
- Placement of certain services in Class II versus Class III
  - Endodontics, Periodontics and Oral Surgery may be covered as Class II or Class III services
- Progressive Benefits
  - Increase in coinsurance levels in years 2+
- Annual Benefit Maximums
  - Limits coverage of expensive benefits such as implants and dentures
- Benefit Exclusions
  - Missing tooth

Waiting Periods

- Not common for large group policies
- Common for individual and small group 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

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

Avoiding Provider Adverse Selection

- Provider Reimbursement Structure and Covered Codes
  - Align provider incentives with insurer
  - Example – restoration materials
  - Example – emergency-only dental coverage

- Align benefit plan structure with clinical guidelines
  - Example – x-ray frequency limitations

- Next frontier
  - Diagnosis codes
  - Movement away from FFS
  - Medical/dental integration

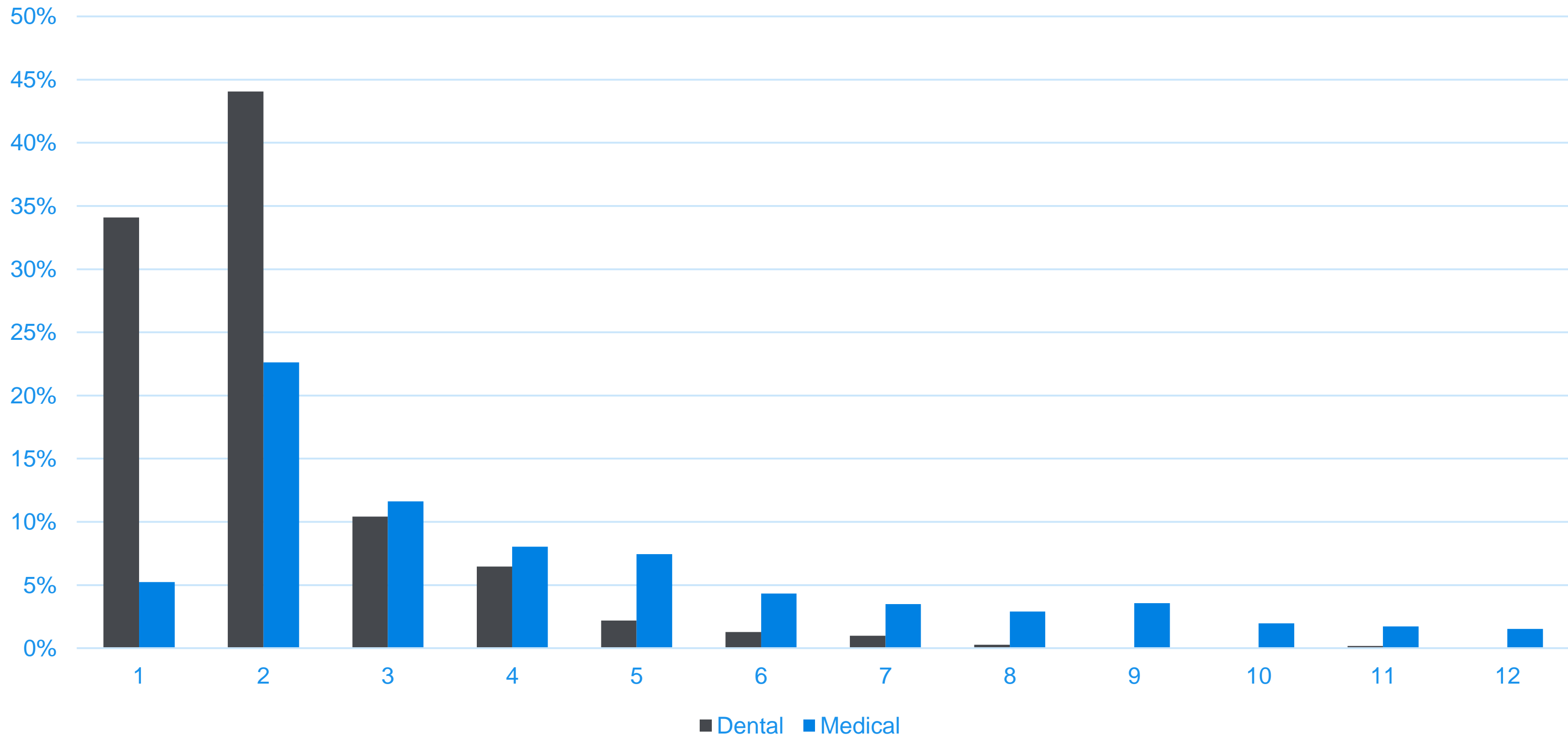
Claims Cost Differences – Distribution of Charges

- **Dental claims have much lower volatility than medical claims**

- **“Zero Bucket”**
  - Dental ~ 33%
  - Medical ~ 5%
- **“High Claimant”**
  - Dental ~ $3,000-$10,000
  - Medical ~ $50,000 - >$1,000,000

Source: Milliman’s Health Cost Guidelines

Claims Cost Differences – Distribution of Charges



*Only 75% of medical distribution shown

Source: Milliman's Health Cost Guidelines - Dental

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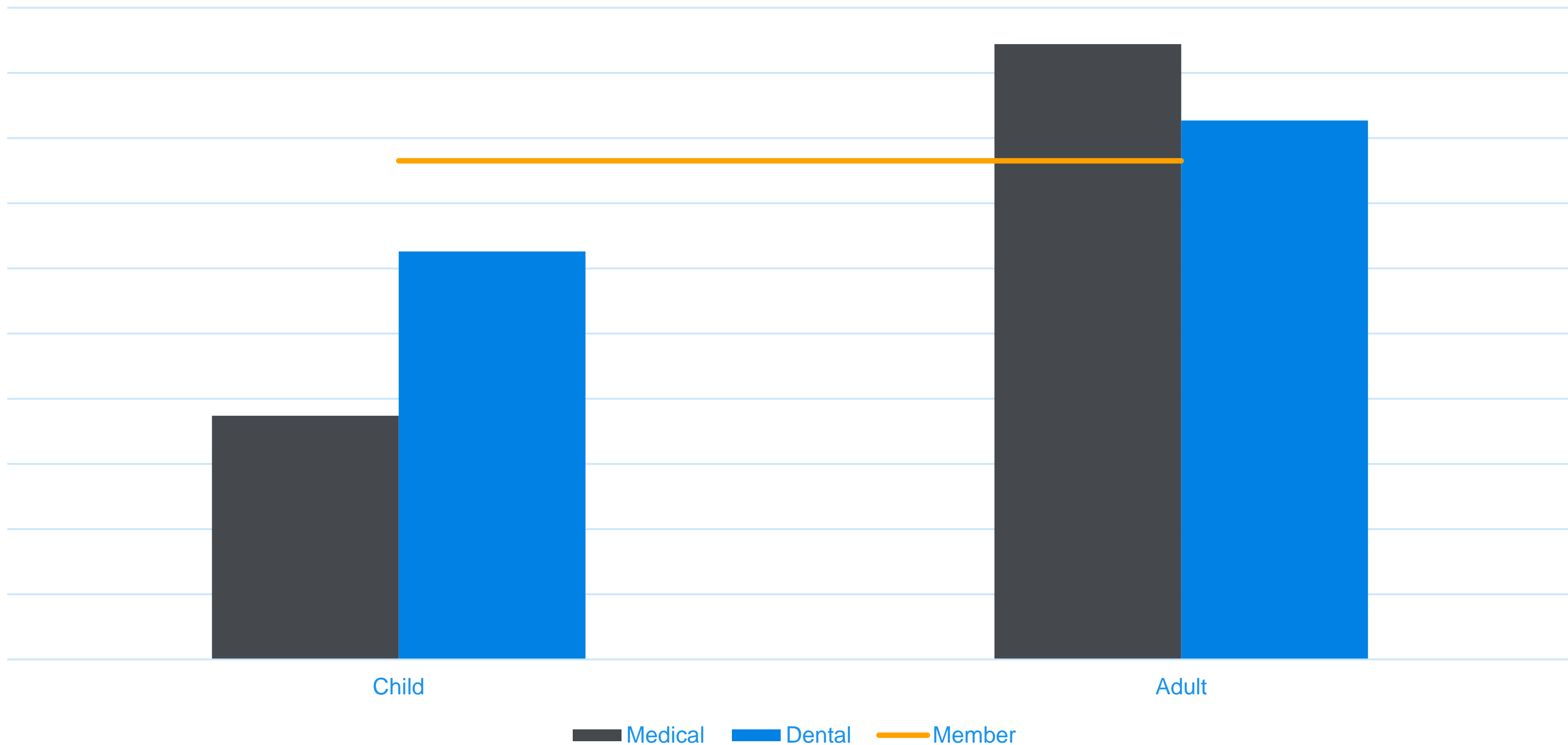
Claims Cost Differences – Medical vs Dental, Adult vs Child



- Dental Child Claims – High Frequency, Low Severity
- Dental Adult Claims – Low Frequency, High Severity
- Ortho could change the relationship shown

Source: Milliman's Health Cost Guidelines - Dental

Dental Data

Dental Data - Composition

- **Dental procedure codes follow a uniform code type**
  - ADA Codes – CDT Codes - “D” Codes
  - DXXXX
  - Hundreds of different codes

% Of Total Cost	Number of Codes
50%	
90%	
95%	

Source: Milliman’s Health Cost Guidelines - Dental

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- **Dental procedure codes follow a uniform code type**
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  - Hundreds of different codes

% Of Total Cost	Number of Codes
50%	10
90%	
95%	

Source: Milliman’s Health Cost Guidelines - Dental

Dental Data - Composition

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% Of Total Cost	Number of Codes
50%	10
90%	40
95%	

Source: Milliman’s Health Cost Guidelines - Dental

Dental Data - Composition

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  - ADA Codes – CDT Codes - “D” Codes
  - DXXXX
  - Hundreds of different codes

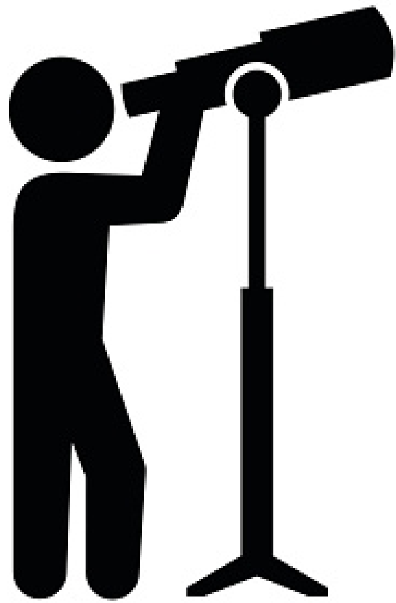
% Of Total Cost	Number of Codes
50%	10
90%	40
95%	60

Source: Milliman’s Health Cost Guidelines - Dental

Dental Data – Top 20 Codes

By Billed Charges PMPM, Sorted by Code

Description	Category
Periodic oral evaluation - established patient	I-Oral Evaluations
Limited oral evaluation - problem focused	I-Oral Evaluations
Comprehensive oral evaluation - new or established patient	I-Oral Evaluations
Intraoral - complete series of radiographic images	I-X-Rays
Bitewings - four radiographic images	I-X-Rays
Panoramic radiographic image	I-X-Rays
Prophylaxis - adult	I-Prophylaxis (Cleanings)
Prophylaxis - child	I-Prophylaxis (Cleanings)
Resin-based composite - one surface, posterior	II-Restorations
Resin-based composite - two surfaces, posterior	II-Restorations
Resin-based composite - three surfaces, posterior	II-Restorations
Crown - porcelain/ceramic substrate	III-Inlays/Onlays/Crowns
Crown - porcelain fused to high noble metal	III-Inlays/Onlays/Crowns
Crown - porcelain fused to predominantly base metal	III-Inlays/Onlays/Crowns
Crown - porcelain fused to noble metal	III-Inlays/Onlays/Crowns
Endodontic therapy, molar (excluding final restoration)	II-Endodontics
Periodontal scaling and root planing - four or more teeth per quadrant	II-Periodontics
Periodontal maintenance	II-Periodontics
Extraction, erupted tooth or exposed root	II-Simple Extractions
Surgical removal of erupted tooth	II-Surgical Extractions



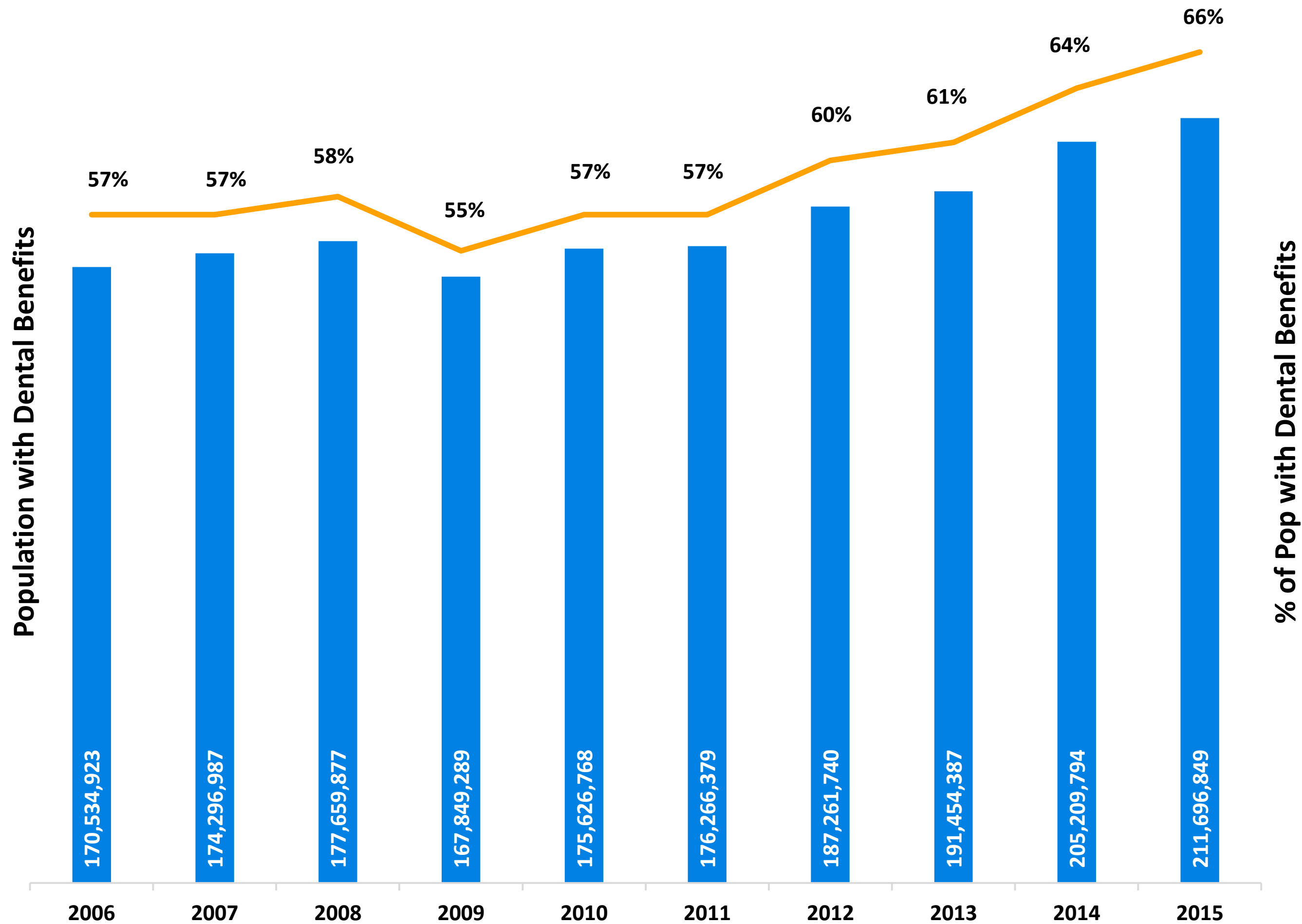
INDUSTRY OVERVIEW

Major Large Group Dental Insurers

Company	2016 Premium (in millions)
Met Life	$1,364
Delta Dental of California	$1,089
Aetna	$529
Cigna	$312
Guardian	$294
United Concordia	$245
Delta Dental of Michigan	$219
Delta Dental of New Jersey	$172
Blue Cross Blue Shield of MA	$163
Delta Dental of Washington	$147

Source: https://www.benefitnews.com/top-10-large-group-dental-carriers-ebn

Enrollment Trends



Source: NADP 2016

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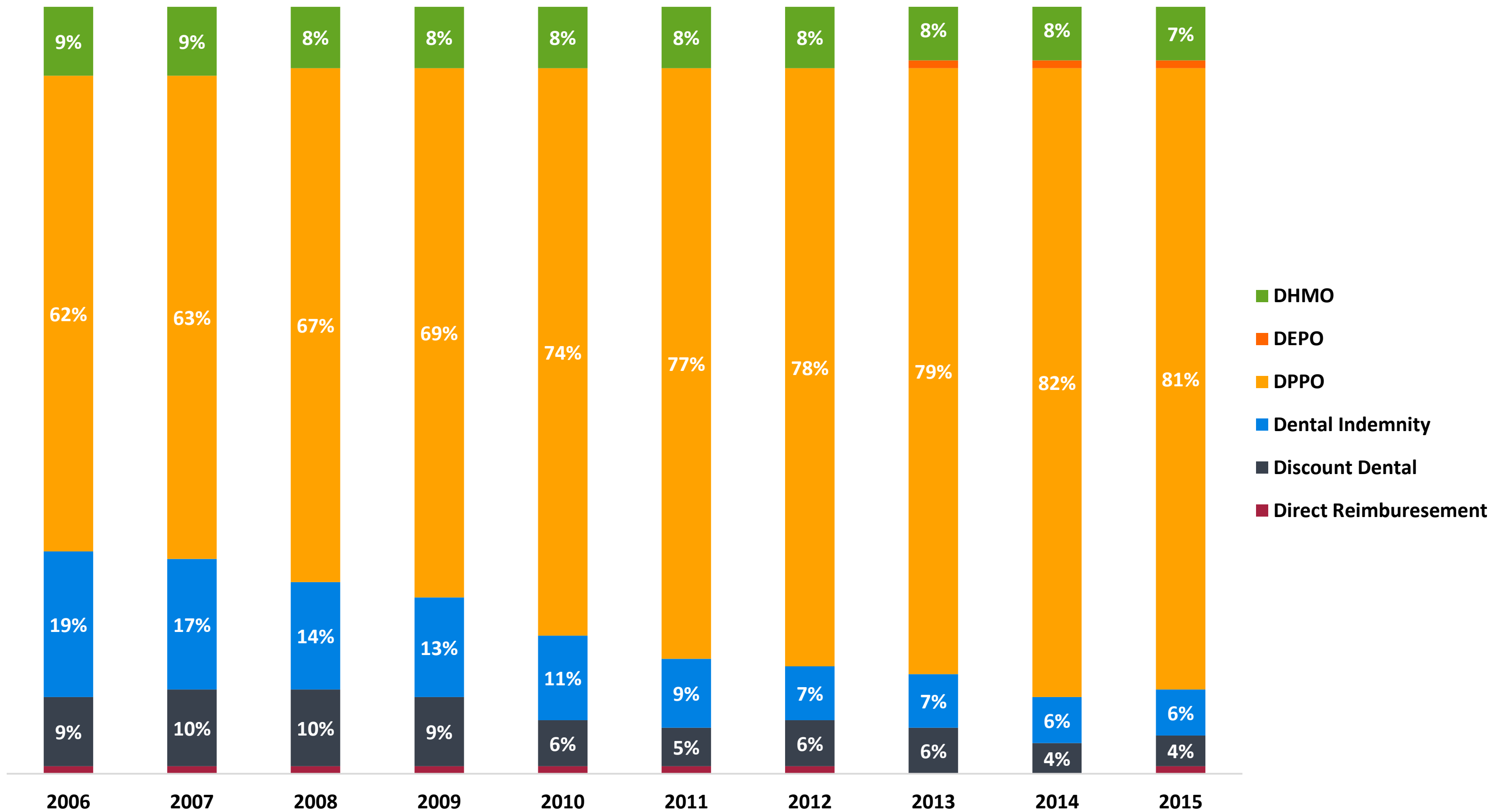
Enrollment Trends - Commercial



Source: NADP 2016

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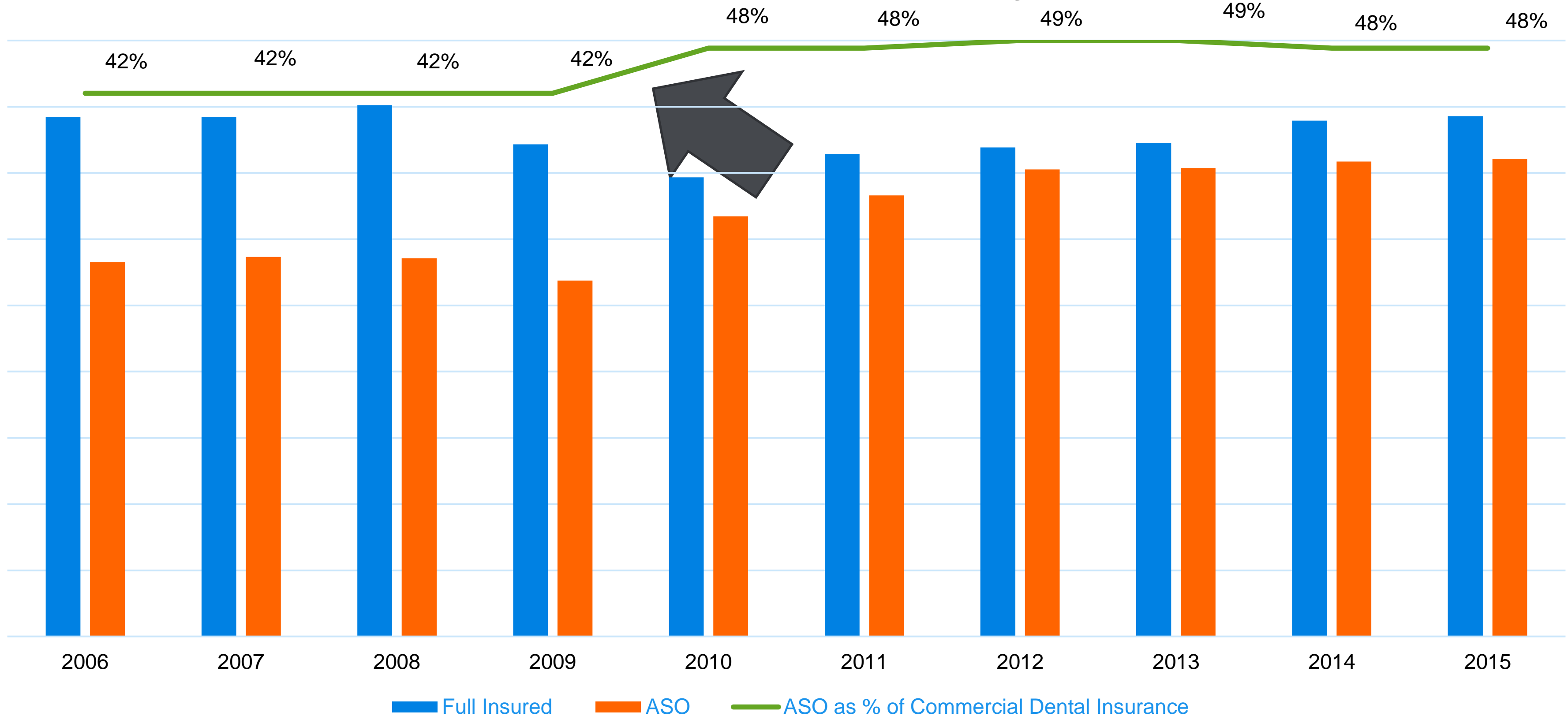
Enrollment Trends – ASO vs Fully Insured



Source: NADP 2016

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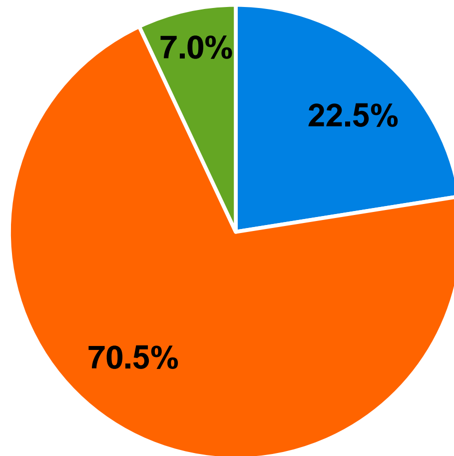
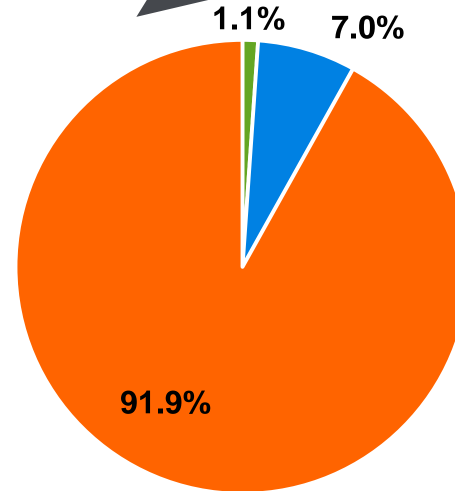
Enrollment Trends – Benefit Sources and Funding

WAS SMALLER PRE-ACA

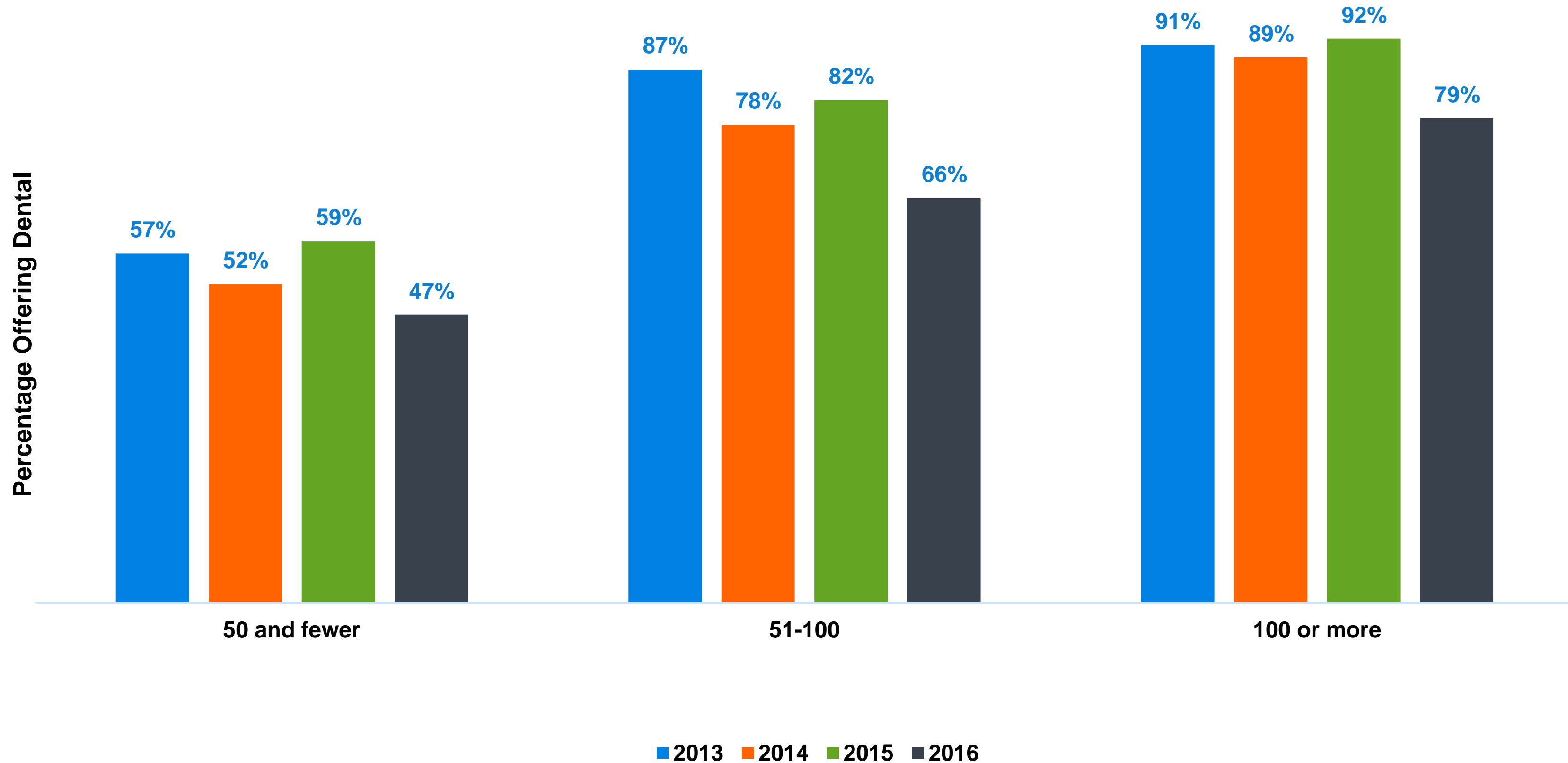
Source of Premium Funding



Policy Structure



Enrollment Trends – Likelihood of Dental Benefit Offering by Group Size



Source: NADP 2016

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AFFORDABLE
CARE ACT

CURRENT KEY ISSUES: ACA

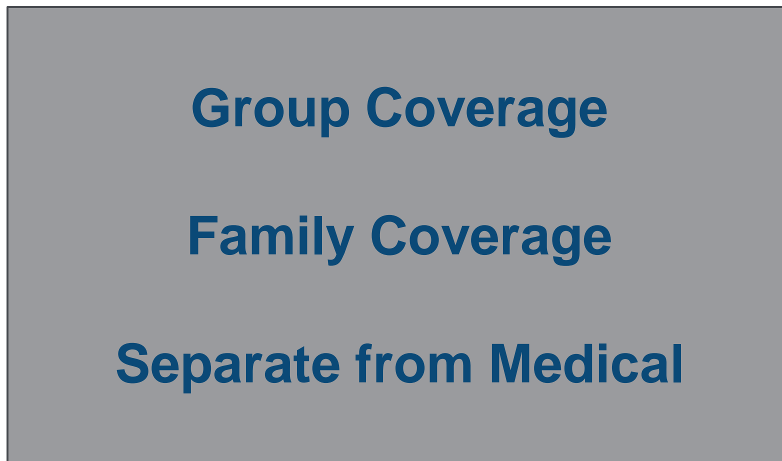
How Dental Insurance Is Purchased (Pre-ACA)

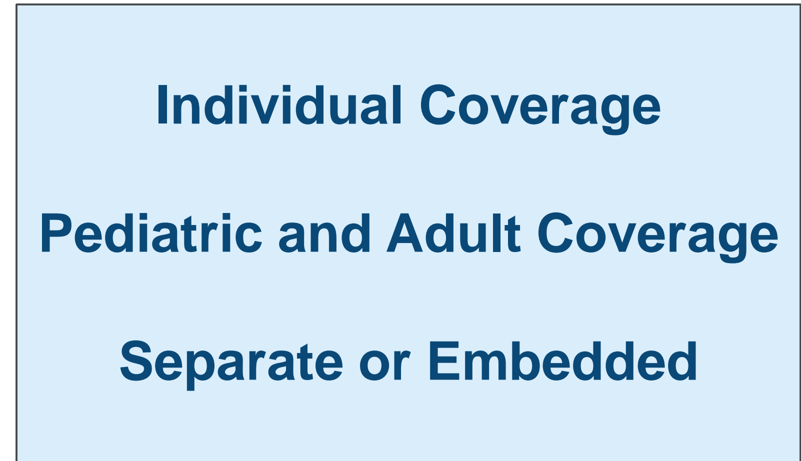
- Only **1%** of dental policies are **individual** policies
- Virtually all dental policies obtained via **employer**, union, or public program
- Usually a **family policy** covering employees and dependents
- 98% of Americans with dental coverage have dental as a **separate policy from medical coverage**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

Source: Offering Dental Benefits in Health Exchanges. NADP/DDPA September 2011.

ACA: Pediatric Dental Essential Health Benefit

- ACA defined minimum essential health benefit package (EHBP) required in individual and small group markets
- **“Pediatric oral health services” is one of the named EHBs**
- Adult dental is NOT an EHB





Pediatric Dental EHB on Exchanges

- **May be embedded in medical or sold by standalone dental plan (SADP)**

  2015 exceptions:

  - Alaska, Connecticut, Vermont, West Virginia, Washington DC – all QHPs embedded

- **Standalone dental product could be a pediatric EHB-only plan or a family dental plan with EHB included**
- **Generally required “offer”, not required “purchase”**

Pediatric Dental EHB Product/Pricing

Pre-ACA		ACA
Group Coverage		Individual Coverage
Family Coverage		Pediatric and Adult Purchase May Be Separate
Annual Benefit Maximum		No Annual Benefit Maximum
Orthodontia with Lifetime Maximum		Medically Necessary Orthodontia
Standalone Dental from Medical		Actuarial Value
		Out-of-Pocket Maximum
		Standalone v. Embedded

Enrollment Statistics (March 2017)

1.5M SADP selections in the 39 states using healthcare.gov

434K SADP selections in 11 SBMs

Age breakdown for healthcare.gov states:

SADP Selections by Age	% of SADP Total	% of QHP Total
Age < 18	9%	10 %
Age 18-25	10%	11%
Age 26-34	22%	16%
Age 35-44	18%	16%
Age 45-54	19%	20%
Age 55-64	21%	26%
Age ≥ 65	1%	1%
Total	100%	100 %

Source: Health Insurance Marketplaces 2017 Open Enrollment Period: March Enrollment Report. Department of Health and Human Services.

Pediatric Dental Pricing: A Balancing Act

- Actuarial Value requirements
- Low OOP maximum
- No annual or lifetime maximums
- Maintain preventive coverage
- Affordability
- Embedded versus standalone plans
- Adverse selection
- Rules still changing!

ACA Application to SADPs

Standalone dental is “excepted benefit” under the ACA

- 3 Rs -- Do not apply
- Advance Premium Tax Credit
  - If $ left over after purchasing QHP, remaining funds can be used for standalone pediatric dental EHB
  - APTC calculation includes pediatric dental ONLY if 2nd lowest cost Silver plan has embedded dental
  - No subsidy for adult dental
- Cost Sharing Reductions
  - Only apply for embedded pediatric dental with combined cost-sharing (deductible, OOP maximum)

ACA Application to SADPs, cont.

- Health Insurer Fee (HIT/Section 9010 Tax)
  - **Does** apply; dental insurers are "issuers"
- Rating Rules
  - 156.470(b): "standalone dental issuers not subject to fair health insurance premium rules, not required to develop rates under same limitations as QHPs"
  - However, it makes sense to align standalone dental plan rates with the structure of medical rates
    - Exchange systems for data collection from carriers
    - Exchange user portals
    - Consumer understanding

CURRENT KEY ISSUES: MEDICAID

Medicaid Dental Landscape

Dental Coverage by Medicaid Population

- Children / CHIP –
  - Mandatory Comprehensive Benefit
- Traditional Adult Medicaid Populations
  - No minimum requirements
  - Dental benefits for adults range from no coverage to emergency only to comprehensive
  - 46 states and Washington DC offer some level of dental benefit to Medicaid-enrolled adults
  - Adult dental benefits can vary by population type such as pregnant women, disabled, elderly and all other

Source: http://www.chcs.org/media/Adult-Oral-Health-Fact-Sheet-_070615.pdf

Medicaid Dental Landscape

Medicaid Adult Dental Benefits

Emergency Only

Relief of pain under defined emergency situations (e.g., uncontrolled bleeding, traumatic injury, etc.)

Limited

Fewer than 100 diagnostic, preventive, and minor restorative procedures recognized by the American Dental Association (ADA); per-person annual expenditure cap is $1,000 or less

Comprehensive

A mix of services, including more than 100 diagnostic, preventive, and minor and major restorative procedures approved by the ADA; per-person annual expenditure cap is at least $1,000

Source: http://www.chcs.org/media/Adult-Oral-Health-Fact-Sheet-_070615.pdf

Medicaid Dental Landscape

Dental Coverage by State for Traditional Adult Medicaid Population

13 states cover emergency dental only

FL, GA, HI, ME, MD, MS, NV,
NH, OK, TX, UT, WV, ID

17 states cover limited dental benefits

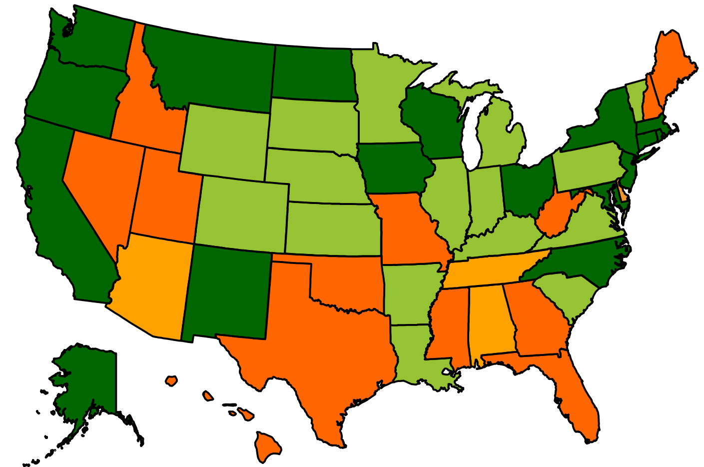
AR, CO, IL, IN, KS, KY, LA, MI, MO
MN, NE, PA, SC, SD, VT, VA, WY

17 states offer comprehensive dental

AK, CA, CT, DC, IA, MA, MT, NJ, NM, NY,
NC, ND, OH, OR, RI, WA, WI

No adult dental benefits

AL, AZ, DE, TN



Source: http://www.chcs.org/media/Adult-Oral-Health-Fact-Sheet_051617_updated.pdf

Medicaid Dental Landscape

Adult Medicaid dental benefits are frequently changing on a state by state basis

- **Coverage decisions tend to be significantly tied to financial conditions of the state and correspond to budget cycles**
- **In the years following 2008, with the recession, several states began to reduce or eliminate adult dental benefits**
- **Recently, many states are moving to enhance or reintroduce dental coverage for Medicaid adults**

Medicaid Expansion

Enrollment Observations

- **Among states that had implemented Medicaid expansion and were covering newly eligible adults in June 2015, Medicaid and CHIP enrollment rose by approximately 29.7% compared to the July-September 2013 baseline period. [1]**
- **States that have not, to date, expanded Medicaid reported an increase of approximately 9.8% over the same period. [1]**
- **The potential coverage expansion is significant, with up to 8.3 million adults gaining some form of dental benefits coverage through Medicaid. [2]**

1. *http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/june-2015-enrollment-report.pdf*
2. *http://jada.ada.org/article/S0002-8177%2815%2900644-3/pdf*

Concerns and Considerations

Access Issues

- **A limited % of dentists nationwide accept Medicaid**
  - Administrative requirements
  - Missed appointments
  - Long payment wait times
  - Low reimbursement rates
- **In most states that cover adult Medicaid dental services, Medicaid reimbursement rates are less than half of commercial reimbursement rates**
- **Both Medicaid expansion and low cost exchange products have exacerbated access issues**

CURRENT/FUTURE KEY ISSUES

Dental Industry Emerging Issues

- **ACA Changes**
- **Loss Ratio Requirements**
- **Connections between oral health and overall health**
- **Potential for innovation**
  - Use of mid-level providers/dental hygienists
  - Embedded plans
  - Narrow networks
  - Dental diagnosis codes
  - New provider payment mechanisms
  - Tele-dentistry
- **What else?**

Caveats and Limitations

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Questions?

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