# ISSUE BRIEF:
# EHB DENTAL BENCHMARKS

## Premiums & AVs for
## Pediatric Dental within State Benchmarks

**PURPOSE:** NADP's *Issue Brief: EHB Dental Benchmark* is to provide background and cost information for state and federal policymakers developing the pediatric dental portion of the EHB benchmarks. This Issue Brief includes a brief summary of how pediatric dental is included within current HHS EHB guidance, the costs and actuarial value levels of those dental benchmarks, and recommendations from the dental benefits industry.

**ACA BACKGROUND:** The Patient Protection and Affordable Care Act's (ACA) inclusion of "pediatric services, oral and vision care" (pediatric dental) in the Essential Health Benefits Package[1] (EHB) is an important achievement for the oral health of children. These services will be a required component in policies sold in the small group and individual market beginning in 2014. The Pew Center on the States estimates that 5.3 million children will be added to dental coverage by the ACA primarily in public programs[2].

**DENTAL IN BENCHMARKS:** On December 16, 2011 HHS released the *Essential Health Benefits Bulletin* followed on February 17, 2012 by the *Frequently Asked Questions Essential Health Benefits Bulletin*. These documents provided guidance to states on what the EHB should parallel in the current marketplace. HHS outlines four distinct health benefit benchmarks for states to use in defining their EHB's. In short they include policies from small employers, state employees, the Federal Employees Health Benefits Program (FEHBP) and non-Medicaid HMOs. HHS also adds two specific benchmarks for dental when pediatric dental is "missing" from these health specific benchmarks; they include the Federal Employees Dental & Vision Program (FEDVIP), and the state's Children's Health Insurance Plan (CHIP). In addition, HHS notes that it is considering adding "medically necessary" orthodontia as part of the EHB package.

Of the four health options above, the FEHBP is the only benchmark which consistently includes pediatric dental coverage. The FEHBP two largest health plans have a schedule of preventive and restorative dental procedures with greater cost sharing (higher out of pocket costs) on the consumer than typical employer dental coverage[3]. The two additional dental specific benchmarks, FEDVIP and

[1] ACA Section 1302, "Essential Health Benefits Requirements" March 2010.
[2] The Pew Center on the States: "The State of Children's Dental Health: Making Coverage Matter," Gehshan, Shelly, et al. May 2011.
[3] One interpretation of the Bulletin's language suggests if pediatric oral services is missing from all the selected medical benchmarks, a state should utilize the additional dental benchmarks included in the Bulletin. However, as one of the medical benchmarks, i.e. the FEHBP most common policy, includes dental coverage, another interpretation is that states would always use FEHBP and be precluded from using the two specific dental benchmarks.

CHIP cover similar services; however, FEDVIP has high annual maximums while CHIP has no[4] consumer cost sharing so neither benchmark parallels typical private market dental plans. HHS has not specifically included a benchmark that reflects pediatric dental in a typical employer policy per ACA Sec. 1302(b)(2)(A).

With the inclusion of the dental specific benchmarks, HHS implies that "pediatric oral services" are tied to typical dental plans. However, since the benchmarks that are used are atypical, NADP has requested that HHS allow states to utilize small employer dental coverage as a benchmark for pediatric dental just as the default for health coverage is small employer medical coverage. For full descriptions on dental in HHS benchmarks, please review Attachment 1 of NADP Comments to HHS on the *Essential Health Benefits Bulletin.* [Please see NADP Recommendation #1].

**PREMIUMS**: NADP commissioned Milliman (an independent actuarial firm) to develop monthly premium costs for the pediatric dental benchmarks outlined in HHS guidance. The core parameters for these premium cost estimates included no annual or lifetime limits, coverage of child related services for ages up to 21, and no deductible applied to Class I (preventive services). The estimated premiums reflect national average costs from Milliman's dental database. Costs are displayed on a per child basis since policies will have to be offered as 'child-only' per HHS guidance, and the benefit is only required for 'pediatric' age children within ACA.

To be able to compare the current EHB benchmarks to a typical employer plan as it exists today, Milliman also estimated premiums for a small employer dental plan. And while that plan includes procedures and services similar to the dental specific benchmarks, the deductibles, cost sharing and annual limits differ significantly.

Premiums were also calculated on three levels of orthodontia services since no guidance is given for "medical necessity" and states vary widely in their parameters for orthodontia in public programs. The most restrictive level calculated provides coverage only for treatment of cleft palate, the mid-range level provides coverage for treatment of "severe or handicapping malocclusion," and the high range level allows treatment whenever indicated by a dentist. The definition used for medically necessary orthodontia results in a substantial range of costs. The cost illustrated in the chart represents the mid-range "medically necessary" orthodontia coverage with 50% coinsurance. Without coinsurance the cost would double.

**ACTUARIAL VALUE (AV):** The HHS February Bulletin proposing a methodology for standard calculation of actuarial value of health plans did not include a factor for dental coverage. As such the AV level of the dental portion of the Essential Health Benefit package **will not affect** the AV level of a health plan. In the NADP/DDPA White Paper on Exchanges, we proposed that AV levels not be applied to dental as it is only a small portion of the overall EHB. However, some state and federal regulators have raised questions about the actuarial values of dental plans which suggest that they may require dental policies on Exchanges to meet AV levels separately or in combination with a medical plan.

To determine the AV levels of today's typical dental plans and how the proposed dental benchmarks fall within the ACA required AV benchmarks for Exchanges, NADP again commissioned Milliman.

[4] While our calculation of the state CHIP benchmark does not include cost sharing, most states utilize a variety of limits to contain costs within this public program.

Milliman developed AV for the benchmarks as they exist today with annual and lifetime limits as well as without annual and lifetime limits for comparison purposes. Milliman's calculations reflect the HHS proposed methodology of using in network claim values only and the waiver of the typical $50 deduction on Class I (preventive services) as is often done in today's dental benefit market. The AV levels illustrated below would be slightly lower if in network claims are blended with out of network claims (see footnote 7).

The chart shows that typical dental plans and the proposed benchmarks will approximate the gold or platinum level of coverage outlined in the ACA. Milliman also calculated AV levels with the common $50 deductible applied to all dental services which brought the AV levels of the typical small employer plan and the benchmarks down to the silver range. While dental benefits do not explicitly impact the AV level of the EHB, whether offered embedded or stand-alone, with appropriate cost sharing dental benefits can be developed within the range required for Exchange participation. Please see NADP Recommendation #4.

States must weigh the limited dental benchmarks carefully to find the right balance for their state and to allow pediatric dental coverage to be consistent with the required silver and gold actuarial values for Exchange participation. While medically necessary orthodontia raises the overall premium cost of dental coverage, it **could lower** the actuarial value. A state must decide what the parameters are for medical necessity if HHS includes it as part of the pediatric dental benefit. Please see NADP Recommendation #3.

**CONSUMERS & COSTS**: In considering benchmark options for pediatric dental, states should consider the impact of the cost of these services on families purchasing coverage. Through 2008, 57% of the U.S. population had dental coverage—a percentage that had been relatively stable for several years. In 2009, enrollment in dental plans dropped to 54% with 10 million fewer Americans having dental coverage, a decrease for the first time since the industry has been tracking enrollment. The lower enrollment reflected both decreased employment and employees choosing not to purchase coverage for which they pay all or a substantial portion of the cost due to other economic pressures as during this period both new and in-force premiums rose only by 1% to 4% depending on the type of product. NADP consumer survey data confirms there is high price sensitivity to increases in the premiums for dental coverage among consumers.

Requiring coverage for children's dental within the EHB changes the dynamic of coverage. Currently, employers offer dental benefits to their employees with the election to have their families covered. Now, the policy is issued on the child with the adults as additional coverage. Therefore if the cost of the children's coverage is excessive, parents may not continue dental coverage for themselves. Based on consumer surveys, NADP has projected half of adults with employer-provided dental coverage in the small group market today, i.e. 11 million, would drop coverage if their dental coverage is separated from their children's coverage and the cost of the children's coverage is substantial. With Pew Institutes estimate that 5.3 million children will be added to programs providing dental coverage -- most in public not commercial dental plans--the net loss in coverage and reduction in access to dental care could be significant.

With the Surgeon General's finding that dental coverage results in more dental visits by both adults and children and the more recent linkages of oral and overall health, any degradation of dental coverage will have an overall negative impact on oral health, overall health and ultimately the costs of

medical conditions like diabetes, cardiovascular disease and low birth weight babies. Therefore, allowing families to stay together while providing high quality dental policy options with affordable costs is critical for consumers.

**RECOMMENDATIONS:**

1. To best approximate current small group coverage, states should be given an option to use a small employer dental policy as a benchmark for "pediatric oral services" with the typical cost sharing and other limits of that plan (keeping in place the exclusion of annual and lifetime maximums). Employer plans are able to balance appropriate services needed for children while staying affordable by utilizing cost containment structures such as frequency limits and Least Expensive Alternative Treatment (LEAT) provision.
2. Allow dental coverage, both stand-alone and embedded, to apply the common $50[5] deductible to pediatric oral services and reduce the deductible of any medical policy without dental by $50[6]. This eliminates both the potential that any consumer will have to meet the full ACA deductible before accessing dental benefits and the complexity of coordinating between the medical and dental deductibles. Anyone using dental benefits during the year will easily satisfy the $50 deductible.
3. If "medically necessary orthodontia" is included in the final EHB rules as part of "pediatric dental services," HHS or the states should provide guidance for medical necessity as the application of "medical necessity criteria" for orthodontic coverage is not common in commercial dental plans today and public programs vary widely in their coverage of orthodontia for children.
4. Pediatric dental coverage offered separately or included in a medical plan should provide benefits consistent with the silver and gold actuarial value levels required for Exchange participation. This recommendation is contingent on the adoption of the $50 deductible for dental outlined above as without this deductible dental coverage would exceed the gold AV level[7]. Since HHS does not include pediatric dental services in the standard calculation of AV levels for health plans, a separate standard calculator for dental should be developed.
5. When a consumer selects a medical plan without pediatric dental services and a separate dental plan covering these services, the subsidy, which is set on the 2nd lowest silver health plan with dental included, can either be distributed in one of 3 ways:
    a. paid entirely to the medical plan;
    b. distributed proportionately to the medical and the dental plan based on the ratio of the two premiums to the total premium; or
    c. paying the full dental premium with the balance to the medical plan.

    Given geographic differences in premiums, NADP recommends that the subsidy be calculated on a state-by-state basis and proportionately distributed (see b above) when consumers select separate dental coverage[8]. If HHS or the state determines that the full subsidy should be paid to the medical plan, processes should be adopted to reduce the disproportionate risk that dental plans would assume in the collection of all dental premium from the consumer. These processes could be the provision of EFT or credit card payment or payment of the annual premium or some portion of premium in advance.

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[5] Any amount that is set as the initial standard for a dental deductible may need to be indexed for inflation over time.
[6] The split deductible should not be applied to a High Deductible Health Plan offered in the Exchanges.
[7] Milliman June 11th memo on AV of dental coverage.
[8] Based on currently available information NADP estimated the portion of the subsidy to be distributed to dental will average approximately 3.6% nationally. The calculation is available on request.

# 2014 Dental Benchmark Premium & AV Levels per Child up to Age 21[i]

| Benchmark Dental Plan Description | Without Orthodontia | | | | | With Mid-Level Medically Necessary Ortho @ 50% Coinsurance | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Per Child Per Month As Exists Today | AV as Plan Exists Today | Per Child Per Month without Limits | AV No Limits[ii] & $50 Deductible on Class II & III Only | AV No Limits w/$50 Deductible on All Services | Per Child Per Month | AV as Plan Exists Today with Ortho | Per Child Per Month without Limits with Ortho | AV No Limits & $50 Deductible on Class II & III Only | AV No Limits w/$50 Deductible on All Services |
| **Typical Small Employer DPPO Dental Plan without Ortho**<br>*(currently not allowed as a dental benchmark)*<br>**$1,000 Annual Maximum**[iii]; In Network: 100/80/50, Out-of-network: 80/60/40, $50 deductible applied only to Class II & III services[iv]. | $21.00 | 76% | $24.50 | 81% | 73% | $23.80 | 72% | $27.30 | 77% | 74% |
| **FEHBP Plan with Largest Enrollment --BCBS Standard**<br>*(BCBS Standard and BCBS Basic are the only EHB health benchmarks that include dental)*<br>Schedule of covered dental procedures includes diagnosis, prevention, emergency, restorative & extractions with scheduled payment based on age. Any services not listed are not covered. | $4.50 | 21% | no change | no change | no change | $7.30 | 26% | no change | no change | no change |
| **FEDVIP Dental with Largest Enrollment--MetLife DPPO**[v]<br>*(dental specific benchmark)*<br>$10,000 annual maximum[vi]; In network 100/70/50, Out-of-network 90/60/40 with $50 deductible on Class II & III services. | $24.50 | 77% | $24.50 | 77% | 73% | $27.30 | 73% | $27.30 | 73% | 70% |
| **State CHIP Program Without**[vii] **Ortho**<br>*(dental specific benchmark)*<br>No annual maximums or cost-sharing | $29.25 | 100% | same | n/a | n/a | $32.05 | 93% | same | n/a | n/a |

| **Cost for Addition of Orthodontic Coverage**<br>*Cost depends on definition of "medical necessity*[viii]*."* | **Cleft Palate Only** | **Severe or Handicapping Malocclusion** | **As Administered Today** |
|---|---|---|---|
| Medically Necessary (MN) Ortho* with 50% coinsurance[ix] | $ 0.40 | $2.80 | $9.40 |
| Medically Necessary (MN) Ortho with no coinsurance[x] | $0.80 | $5.60 | $18.75 |

*NOTE: Premiums are estimated based on currently available information. They do not include the impact of the ACA's insurer assessment or fees that will be levied for Exchange operation.*

## Chart Footnotes

[i] Costs were developed by Milliman for NADP as a national average with in-network utilization as proposed in HHS's AV calculation. Costs will vary by geographic area. Assumptions included that the age of pediatric services to be 21. NOTE: If utilization is blended between in and out of network, AV levels drop by 7% to 10% in the typical small employer plan, by 4% in the FEDVIP plan, and 1% in the CHIP plan with MN orthodontia.

[ii] No lifetime or annual limits are applied.

[iii] The data presented to HHS by the Secretary of Labor indicates small employer plans have a $1000 annual maximum while overall employer plans currently have a $1500 annual maximum.

[iv] The deductible is waived for Class I preventive services. If the standard dental deductible is not utilized and the $2000 ACA annual deductible is coordinated with a medical plan, the cost of coverage could be decreased by as much as half. However, a consumer would incur significant expense before receiving any dental services other than prevention which usually consists of periodic office visits, cleanings, sealants and topical fluoride.

[v] The MetLife plan also includes 50% coinsurance on orthodontia (ortho) up to age 19 with a 24 month waiting period and $3500 lifetime limit. This provision was not priced since HHS indicated that what was being considered is *medically necessary* ortho.

[vi] Actual annual limit of the MetLife DPPO for 2012 is $10,000. For purposes of the analysis of children's benefits, a $10,000 maximum is essentially equal to no annual maximum.

[vii] The MEPS Chartbook 17 shows the average annual expense for children from birth to 20 with a dental visit in 2004 was $635 for children with private dental coverage and $272 for children with public dental coverage. Public programs have put in place limits for receiving care that are substantial even without the annual limits commonly used by private coverage. The cost of a CHIP equivalent program is substantial because private insurers will not be able to impose the limits that states do now in CHIP programs—like lower provider reimbursement.

[viii] The range of costs for orthodontia was based on the following alternatives derived from state CHIP programs. Lowest estimate is based on coverage for ortho for cases of cleft palate only. The middle estimate is based approximates the application of a mid-range Salzman index to reflect a National Center for Health Statistics study that found 29% of pediatric population had a handicapping to severe malocclusion. The high range is the provision of an ortho benefit as it is administered today without regard to medical necessity.

[ix] As administered today ortho claims are subject to 50% coinsurance and a separate annual limit. Although the full lifetime limit is usually paid on each claim, there is significant cost sharing for the procedure. Since it is unclear whether cost sharing will be allowed for "medically necessary" ortho treatment, Milliman developed estimated premium for no coinsurance as well.

[x] Ibid

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**NADP DESCRIPTION:**

NADP is the largest non-profit trade association focused exclusively on the dental benefits industry, i.e. dental PPOs, dental HMOs, discount dental plans and dental indemnity products. NADP's members provide dental benefits to over 90% percent of the 176 million Americans with dental benefits Our members include the entire spectrum of dental carriers: companies that provide both medical and dental coverage, companies that provide only dental coverage, major national carriers, regional and single state companies, as well as companies organized as non-profit plans.

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