DATE: **MAY 9, 2013**

TO: **STATE POLICY MAKERS & INTERESTED STAKEHOLDERS**

FROM: **EVELYN IRELAND, NADP EXECUTIVE DIRECTOR**

RE: **DENTAL COSTS WITHIN THE ACA**

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As the trade association for the dental plan industry, NADP has received multiple inquiries from legislators, regulators and interested stakeholders on how the various measures within the Patient Protection and Affordable Care Act (ACA) will impact pediatric dental benefit costs as part of the essential health benefits package.

NADP is a strong proponent of every child having access to quality, affordable oral health coverage and is therefore concerned about the affordability of the dental benefit as cost is a consumers' number one factor when deciding whether to purchase dental coverage[1]. An unaffordable benefit could result in fewer children being covered when the decision to purchase is optional, the opposite of the ACA's intention.

NADP retained Milliman to provide an impartial actuarial analysis of dental out-of-pocket (OOP) costs, premiums, and actuarial value, which follows this overview.

KEY STATISTICS

- OOP maximums do not exist today in dental plan designs. Including a $1,000 OOP maximum increases the premium of a child-only policy that complies with other ACA cost sharing provisions by 23% in comparison to today's benefits.
- Reducing the OOP maximum from $1,000 to $700 increases a child-only premium by 2% more while also increasing other consumer cost sharing such as deductibles and potentially reducing coinsurance levels for all children.
- Lowering OOP maximums from $1,000 to $700 on a dental policy meeting the 70% actuarial value (AV) level requires the benefit design to change significantly from today's typical small group coverage. For example, deductibles could increase from today's typical $50 to as much as $150, and for some plan designs deductibles may need to be applied to preventive services, or coinsurance may need to be reduced from 70% to 50% for some classes of services. These changes would increase the upfront OOP costs for all children.
- Pediatric dental premiums on a national basis will average between $45 and $50 monthly per child for a 70% AV plan and around $55 per month for an 85% AV plan without any taxes or fees included in the rates. The monthly premium for a typical dental PPO premium today is $35 per child. Premium increases of $10 to $20 per month per child are significant especially when coupled with greater cost-sharing on common dental procedures.
- Medically necessary orthodontia is the primary reason a child would reach the dental OOP maximum in any year.
- Of the 22.9 million children with separate dental coverage today that will be subject to the ACA's new EHB provisions in 2014, only the half million that get treatment for medically necessary orthodontia or other catastrophic dental needs - and just the portion of those who choose a standalone dental plan in 2014 - will experience lower out-of-pocket costs under a $700 OOP maximum verses a $1000 OOP maximum. The catastrophic dental expenses of children obtaining dental coverage through a medical plan will be subject to the medical OOP maximums of $6350 for an individual and $12,700 for a family.
- Most children (97.75%) will experience higher out-of-pocket costs under a $700 OOP maximum verses a $1000 dental OOP maximum in a stand-alone dental plan due to increased deductibles and coinsurance required to meet dental actuarial value levels.

RECOMMENDATION: NADP recommends states should set the 2014 threshold for a "reasonable" out-of-pocket (OOP) maximum for separate pediatric dental plans at $1,000 for a single child and $2,000 for a family. Lowering the pediatric dental OOP maximum increases up-front out-of-pocket costs for most children covered under a pediatric dental policy. In addition, NADP surveys show that new cost pressures may result in parents dropping their own coverage under a 'family' policy and purchasing child-only coverage leaving fewer adults with dental coverage.

BACKGROUND

PURPOSE OF MEMO

There are many firsts in the ACA for dental policy requirements, including: elimination of annual and lifetime limits, addition of actuarial value (AV) levels and out of pocket (OOP) maximums, and the addition of child-only policies leading to the separation of child coverage from family coverage. As well, in some state Marketplaces and in the Federally-facilitated Marketplaces (FFM), pediatric dental is a voluntary benefit rather than a required part of the essential health benefit package purchased by consumers. NADP is a strong proponent of every child having access to quality, affordable oral health coverage and believes it is therefore important to consider how costs may impact efforts to expand access.

On April 5, 2013, HHS released "Affordable Exchanges Guidance"[2] which provided information to medical and dental issuers on how HHS would include pediatric dental within Federally-facilitated and State Partnership Exchanges/Marketplaces (FFM). The letter provides guidance on multiple issues, including specific OOP maximum limits on dental policies offered on FFMs. "For the 2014 coverage year in the FFE, CMS interprets the word 'reasonable' to mean any annual limit on cost sharing that is at or below $700 for a plan with one child enrollee or $1,400 for a plan with two or more child enrollees." State Marketplaces have the ability to define "reasonable" dental OOP maximums.

NADP has been providing actuarial and industry specific data to HHS for better understanding of the dental benefits industry as it differs greatly from medical insurance. As state policymakers must make decisions on what constitutes a "reasonable" out of pocket limit for dental, NADP commissioned Milliman, an independent actuarial firm, to provide an analysis of the relationship between OOP limits, premiums and other cost sharing elements in dental policies.

EXPLANATION OF OOP MAXIMUMS & ACA

One of the core elements of the ACA is to contain families and individual's health expenses so those underinsured or who do not have insurance coverage would not have to face catastrophic costs that could cause financial burdens. One of several new cost containment features of the ACA was the inclusion of an OOP maximum for consumers[3].

An OOP maximum is the full amount a consumer would pay annually "out of their pocket," and is also referred to as "annual limitation on cost sharing" within the ACA. Insurance has other typical cost sharing elements that consumers currently pay either up front or through their health visits, such as deductibles, co-payments and coinsurance. With an OOP maximum, all those costs are added up annually and if a consumer reaches their OOP maximum, the insurer would pay 100% of all remaining dental health costs. The OOP maximum excludes premium payments.

Starting in 2014, all health policies (with minor exceptions) offered to the small group[4] and individual market (on and off Exchanges) must include specific benefits and cost sharing components and is defined as the Essential Health Benefit (EHB) package. The EHB package is not required to be in policies sold to the large group market. Part of the EHB package includes an OOP maximum benchmarked to the IRS definition of Health Savings Accounts (HSA).[5] In 2013, the OOP limit is $6,250 for self-only and $12,500 for family and is adjusted annually for inflation. This OOP maximum is applied to health coverage but not to separate dental coverage by the ACA.

DENTAL OOP MAXIMUM IN ACA

The ACA allows for the pediatric dental component of the EHB package to be offered from a stand-alone dental carrier or a medical carrier offering a separate dental policy from the medical policy[6]. The ACA does not address separate cost limitations on these dental policies offered independently from medical policies.[7] HHS has implemented dental-specific cost sharing mandates to protect children's families from catastrophic dental costs, which include:

- No annual limits on pediatric dental policies (a carrier cannot place an annual 'cap' on the financial amount they will cover for the enrollee)[8];
- No lifetime limits on pediatric dental policies[9]; and
- Annual limits on cost-sharing[10] (a "reasonable" dental specific out of pocket maximum).

Outlined in recent CMS guidance[11], the Federally-facilitated Marketplace has stated that for 2014, any annual limit on cost sharing that is $700 or below will be considered reasonable for the pediatric dental EHB package. Any limit above that number will need additional review. State based Marketplaces can choose their own 'reasonable' OOP limit for dental, and pediatric dental policies offered off Exchanges in the small group and individual market must adhere to the dental OOP limit chosen by the state. The $700 OOP maximum is included in CMS guidance rather than formal regulations and therefore the amount can change with new guidance.

Within HHS guidance, there are additional requirements for dental policies offered in state and federal Marketplaces, including specific certification standards[12] and dental high/low actuarial values. NADP is uncertain whether these are applied to "Exchange certified" separate dental policies including pediatric dental services offered in the small group and individual market *outside* Exchanges.

DENTAL & MEDICAL INSURANCE

Dental and medical policies are different due to their policy design[13], cost implications, types of coverage, provider networks, diagnostic and procedure codes, electronic claims, quality measures, etc. Due to these factors, dental along with other ancillary benefits are considered 'excepted benefits'[14] under the Health Insurance Portability and Accountability Act (HIPAA). As such, within the ACA, market reforms designed for medical insurance are not applied to dental policies. However, HHS has applied in regulations certain market reforms to dental policies as outlined below. Following is a simplified list of how cost related market reforms are applied to a dental benefit embedded in a medical policy, and a dental benefit offered separately from a medical policy (when defined as a HIPAA excepted benefit).

Dental Embedded in Medical Policy	Separate Dental Policy
All market reforms applied	Specific market reforms: No annual or lifetime limits and separate OOP maximum
Included in AV metal levels: 60, 70, 80, 90 (+/-2%)	AV high/low levels: 70, 85 (+/-2%)
OOP annual maximum ($6,350 Individual/$12,700 Family in 2014)	"Reasonable" OOP max set by states; FFM = $700 per child; $1,400 per 2 or more children
Medical deductibles cannot exceed $2,000 Individual/ $6,000 Family	No limit on deductibles; typical deductible is $50
Cost sharing reductions apply (OOP max is lessened by income status)	Cost sharing reduction is not applied[15]

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[1] NADP 2012 Consumer Survey, May 2012, Dallas, Texas. Ordering information at www.nadp.org

[2] HHS, CCIIO's "Affordable Exchanges Guidance", *Letter to Issuers on Federally-facilitated and State Partnership Exchanges*, April 5, 2013; http://cciio.cms.gov/resources/regulations/Files/2014_Letter_to_Issuers_04052013.pdf.

[3] ACA Section 1032 (c).

[4] ACA Section 1304 (a)(3) defines "large and small group markets" as the markets under which individuals obtain health insurance coverage through a group health plan maintained by a large employer or by a small employer. ACA Section 1304 (b)(2)defines "small employer" as an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. For plan years beginning before 1/1/2016, states have the option to substitute "50 employees" for "100 employees" in the preceding definition.

[5] ACA Section 1302 (c)(1).

[6] ACA Section 1311 (d)(2)(B)(ii).

[7] ACA Section 1402 (c)(5) exempts separate dental policies from receiving cost sharing reductions. NADP is unaware of the reasoning behind this exemption. HHS states in Grandfather Rules that HIPAA excepted benefits (separate dental policies) are exempt from market reforms; FR Vol. 75, No. 116, 6/17/10 pg.34539.

[8] HHS Exchange Interim Final Rule, FR Vol. 77, No. 59, 3/27/12 pg. 18411.

[9] Ibid.

[10] HHS Standards Related to EHB, AV & Accreditation Final Rule, FR Vol. 78, No. 37 2/25/13 pg. 12852; for both medical and dental carriers, OOP maximums are applicable to in-network services only.

[11] HHS, CCIIO's DRAFT "Affordable Exchanges Guidance", *Letter to Issuers on Federally-facilitated and State Partnership Exchanges*, March 1, 2013.

[12] HHS Exchange Interim Final Rule, FR Vol. 77, No. 59, 3/27/12 pg. 18412 states relevant QHP certification standards should be applied to dental plans. In CMS Letter to Issuers 3/1/13 the relevant certification standards are listed.

[13] The Milliman memo utilizes a common dental PPO plan design which includes coinsurance of various classes. Plan designs vary greatly due to cost and client requests; in general, classes could include the following procedures:

Class I – Prevention & Diagnostic: exams, cleanings, sealants, x-rays, etc.
Class II – Basic Restorative: fillings, single root canals, etc.
Class III – Major Restorative: crowns, surgical extractions, etc.

[14] "Limited scope dental and vision coverage are considered to be "Excepted benefits" provided they are (1) offered as separate benefit policy, certificate, or contract of insurance; or (2) not an integral part of the plan. To be considered not an integral part of the plan, in general, participants must have the right to elect not to receive coverage; and if a participant elects to receive coverage, the participant must pay an additional premium or contribution for that coverage…" HHS Secretary Sebelius letter to Hogan Lovells on behalf of NADP requesting clarification on ACA's market reforms applicability to dental. All letters are linked on http://www.nadp.org/Advocacy/HealthCareReform.aspx.

[15] ACA Section 1402 (c)(5). NADP is unaware of the reasoning behind this exemption.

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MEMO

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TO: Evelyn Ireland, CAE
Executive Director
National Association of Dental Plans

FROM: Joanne Fontana

DATE: April 26, 2013

RE: Actuarial Value, Benefit Plan Design, and Consumer Cost-Sharing Ramifications of Lowering Standalone Pediatric Dental Out-of-Pocket Maximum to $700

BACKGROUND AND PURPOSE

The National Association of Dental Plans (NADP) has asked Milliman to perform some illustrative calculations for standalone pediatric dental essential benefit plans illustrating actuarial value (AV), premium levels, and consumer cost sharing levels for various plan designs. This information will be used by NADP to demonstrate the trade-off in consumer out-of-pocket costs between the out-of-pocket (OOP) maximum of a given plan design and other member cost sharing mechanisms such as deductible and coinsurance. I have performed AV, premium, and consumer cost sharing calculations for several illustrative High plans (AV of 85% plus or minus 2%) and Low plans (AV of 70% plus or minus 2%). All plans are based on the scope of services contained in the Federal Employee Dental and Vision Plan (FEDVIP) dental benefit including medically necessary orthodontia.

METHODOLOGY

Actuarial Value Methodology

For medical plans, the calculation of AV has been standardized; a single standard calculator distributed by the Department of Health and Human Services is to be used for all medical EHB. The AV calculation for the standalone pediatric dental essential benefit, however, is not standardized; carriers must calculate AV using a reasonable methodology and must have the calculation certified by an actuary. The actuarial value calculation we utilized mimics the methodology promulgated for medical plans under the ACA. It takes the ratio of the anticipated allowed charges paid by the plan for the pediatric oral care essential benefit for a standard population to the anticipated total allowed charges for the same benefit and population. This ratio is calculated for in-network benefits only; out-of-network benefit levels are not considered. Utilization levels are assumed to be constant in the numerator and denominator of the calculation; that is, the AV calculation looks only at cost-sharing, not any decrease in utilization resulting from member out of pocket costs. We used cost and utilization assumptions from Milliman's 2013 Health Cost Guidelines – Dental® model, developed from a national dental claims database. The demographics underlying the calculation are Milliman's standard pediatric population distribution. We assumed a 25% nationwide average provider discount.

Medical necessity requirements for orthodontia are not directly modeled in the Health Cost Guidelines – Dental®, as they are based on commercial dental cost and utilization for which medical necessity has not historically been applied. For the medically necessary orthodontia benefit, we assumed that on average, 30% of commercial orthodontia claims would be considered medically necessary, but higher cost claim levels were more likely to be medically necessary than lower ones. Based on prior studies conducted by Milliman, we believe this to be consistent with fairly stringent application of medical necessity.

This work product was prepared solely to provide assistance to the National Association of Dental Plans. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. Milliman recommends Recipient be aided by its own actuary or other qualified professional when reviewing the Milliman work product.

Per Child Per Month Premium Calculation Methodology

We also used the Milliman 2013 Health Cost Guidelines – Dental® model with Milliman's standard pediatric population through age 18 to calculate per child per month premium rates for various plan designs. Specific pricing assumptions inherent in all the premiums shown in this report include:

- January 1, 2014 premium effective date
- 25% provider discount
- Assumes in-network utilization only
- 70% loss ratio
- Selection loads commensurate with voluntary individual dental policies. In prior analyses that we have performed for you, our premium development reflected lower selection loads, as it was assumed that, since pediatric dental is an essential health benefit, most people would purchase it for their children. As it has become clearer that pediatric dental is truly only a "required offer" rather than a "required purchase" within the federally facilitated marketplaces (exchanges), we have revised our selection loads to reflect the voluntary nature of the purchase.
- The calculated premiums make no explicit provision for additional fees or taxes related to the ACA, such as exchange fees or assessment fees.

Consumer Cost Sharing Calculation Methodology

To illustrate the total expected out of pocket costs for sample consumers, we created three sample children who undergo the following dental procedures during the policy year:

- Child A incurs preventive and diagnostic services (assumed to include two cleanings, two oral exams, one set of x-rays, and one fluoride application) as well as one filling during the policy year. Child A is meant to represent a typical covered child.
- Child B incurs the same preventive and diagnostic services as well as a surgical extraction.
- Child C incurs the same preventive and diagnostic services, a filling, and medically necessary orthodontia.

We developed cost estimates for each of these procedures using Milliman's 2013 Health Cost Guidelines – Dental® model, assumed a 25% provider discount would be applied, and then applied the cost sharing elements inherent in each benefit plan to determine the consumer's cost of each procedure. We then calculated the total cost sharing for each child in a given policy year based on the services he is assumed to incur, as well as the amount the insurance company would pay on behalf of each child for the same procedures during the policy year.

For orthodontia, we assumed that the services would be provided over the course of two years, as is common for an orthodontia treatment plan. We applied cost sharing components to the orthodontia procedure costs assuming that half the children receiving orthodontia would be in their first year of treatment and half would be in their second year of treatment. That allowed us to see the true expected differential in consumer outlay over the full course of treatment. For example, for a benefit plan with an annual OOP maximum, the child incurring orthodontia might hit that maximum in both years, moderating the cost in both years. On the other hand, for a plan with an orthodontia benefit maximum, the entire benefit might be depleted in the first year, making the consumer outlay for that year quite low or zero, but in the second year the consumer would bear the most or all the burden for the remaining orthodontia costs.

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RESULTS

Premium Impact of Reducing OOP Maximum

Table I illustrates the impact on per child per month premiums of decreasing the OOP maximum on a given benefit plan while holding all other cost sharing elements constant. The actuarial values of the benefit plans in this table are not considered; we have simply taken an illustrative benefit plan design and calculated the premium differentials associated with moving to lower and lower OOP maximum levels. Also shown is the percentile of the claim distribution, which represents the proportion of children expected to incur annual claims below the OOP maximum.

TABLE I. Impact on Per Child Per Month Premiums of Lowering OOP Maximum

OOP Maximum	Approximate Percentile of Claim Distribution	Resulting Combined Dental/Ortho Premium Per Child Per Month (2014)	Percentage Price Increase on Combined Dental/Ortho Rate Over No OOP Maximum Plan
None	100th	$49.70	0%
$2,850	99th	$53.67	8%
$2,000	98.6th	$56.70	14%
$1,500	98.3th	$58.70	18%
$1,000	98th	$60.91	23%
$900	98th	$61.37	23%
$700	97.75th	$62.33	25%

This chart illustrates that, to go from a plan with no out-of-pocket maximum to a plan with a $700 OOP maximum, rates could be expected to increase by 25%. It also shows that the move from a $1000 OOP maximum plan to a $700 OOP maximum plan adds 2% to consumer premiums.

It should also be noted that almost the entire proportion of children expected to incur claims over the OOP maximum are those requiring medically necessary orthodontia treatment. Without orthodontia costs, virtually no children would incur claims high enough to trigger the OOP maximum.

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Premium Impact of Moving from Typical Plan Pre-ACA to ACA Plan with $700 OOP Maximum

Importantly, pre-ACA marketplace dental products not only have no OOP max, they also commonly utilize annual benefit maximums on dental services and lifetime benefit maximums on orthodontia. Dollar benefit maximums are not permitted for essential health benefits under ACA. Table II below shows illustrative per child per month premium changes relative to a typical dental plan of today, with no OOP maximum, a $1500 annual benefit maximum on dental, and a $1500 lifetime benefit maximum on orthodontia. The first row represents this typical dental plan, and the premium increases shown are relative to that base.

Table II also includes the calculated premium for the Federal Employees Dental and Vision Program (FEDVIP) dental benefits, which has been chosen as the default benchmark for the pediatric dental essential health benefit.
For the typical pre-ACA plan as well as the FEDVIP plan, we have shown the premiums assuming pre-ACA adverse selection levels. As we described earlier in this memo, the exchange environment will allow people to make separate purchase decisions for their children versus themselves, which is different from the pre-ACA marketplace in which an individual would purchase a policy on behalf of his family.

As with Table I, only OOP maximums and lifetime maximums were altered in creating these scenarios; no adjustments were made to normalize actuarial values.

TABLE II. Impact on Per Child Per Month Premiums of Plans with OOP Maximums Compared to Typical Pre-ACA Plan

OOP Maximum	Benefit Maximums	Resulting Combined Dental/Ortho Premium Per Child Per Month (2014)	Percentage Price Increase on Combined Dental/Ortho Rate Versus Today's Market Plan
None	Typical Pre-ACA Plan: $1500 Annual Dental Max/$1500 Lifetime Ortho Max	$34.89	0%
None	FEDVIP Plan: $10,000 Annual Dental Max/$3500 Lifetime Ortho Max	$42.15	21%
None	Not Allowed in ACA	$49.70	42%
$1,000	Not Allowed in ACA	$60.91	75%
$700	Not Allowed in ACA	$62.33	79%

This chart illustrates that the removal of annual and lifetime maximums from dental coverage has a significant impact on the premium charged. Moving from a typical dental plan in today's environment, with benefit maximums and with the adverse selection impact of a typical dental plan sold in today's individual marketplace, to a plan under ACA with no benefit maximums, a $700 OOP maximum, and the adverse selection inherent in the exchange marketplace in which the purchase of a child dental policy is fully voluntary, would be expected to increase premiums by 79%.

This chart also shows the premium differential between the typical plan and the FEDVIP plan. FEDVIP is a voluntary program designed to provide wrap coverage over basic dental coverage that is contained in federal employees' medical plans; its annual and lifetime limits are more generous than the typical plan of today.

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Balancing Premiums, Consumer Out of Pocket Costs, and Actuarial Value

Under ACA, standalone pediatric dental essential health benefit plans must meet either a 70% plus or minus 2% AV (Low option) or an 85% plus or minus 2% AV (High option). As the OOP maximum on a given plan is lowered, other cost sharing components must be adjusted upward in order to maintain the plan's AV.

Table III below shows how two illustrative plan designs would need to be adjusted in order to move from $1000 OOP maximum to $700 OOP maximum while maintaining a Low AV. Table IV illustrates the same concept for illustrative plans at the High AV. For example, for Plan I, when the OOP maximum is changed from $1000 to $700, the annual deductible could be increased from $75 to $90 to maintain the 70% AV. As the OOP maximum affects very few children, while deductibles and coinsurance affect most children, the design of the benefit plan becomes a balancing act between moderating costs for the vast majority of children who would not hit the OOP maximum versus protecting the very small proportion of children who require significant out of pocket expenditures.

For the Low AV plans, it is difficult to achieve the required AV range without applying the deductible to all services (rather than waiving it for preventive and diagnostic procedures), introducing coinsurance to Class I services, and/or reducing plan coinsurance levels below 50%. We have limited our illustrative designs to plans that do not apply coinsurance to Class I services and maintain plan coinsurance of 50% or more for all classes of service, but Plan I does apply the deductible to preventive and diagnostic services.

TABLE III. Illustrative Pediatric Dental Essential Health Benefit Plans With Approximate 1/1/2014 Actuarial Values of 70% Plus or Minus 2%

	Illustrative Plan I		Illustrative Plan II	
	$1000 OOP Max	$700 OOP Max	$1000 OOP Max	$700 OOP Max
Out-of-Pocket Maximum	$1000	$700	$1000	$700
Annual Deductible	$75	**$90**	$110	**$150**
Deductible Applies to Class I?	Yes	Yes	No	No
Class I - Plan Coinsurance	100%	100%	100%	100%
Class II - Plan Coinsurance	70%	70%	50%	50%
Class III – Plan Coinsurance	50%	50%	50%	50%
Medically Necessary Orthodontia – Plan Coinsurance	50%	50%	50%	50%
Annual Prem Per Child	$607.23	$599.29	$538.96	$533.44

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TABLE IV. Illustrative Pediatric Dental Essential Health Benefit Plans With Approximate 1/1/2014 Actuarial Values of 85% Plus or Minus 2%

	Illustrative Plan III		Illustrative Plan IV	
	$1000 OOP Max	$700 OOP Max	$1000 OOP Max	$700 OOP Max
Out-of-Pocket Maximum	$1000	$700	$1000	$700
Annual Deductible	$50	**$65**	$75	**$90**
Deductible Applies to Class I?	No	No	No	No
Class I - Plan Coinsurance	100%	100%	100%	100%
Class II - Plan Coinsurance	70%	70%	80%	80%
Class III – Plan Coinsurance	50%	50%	50%	50%
Medically Necessary Orthodontia – Plan Coinsurance	50%	50%	50%	50%
Annual Prem Per Child	$653.25	$648.24	$682.92	$678.92

As you can see from Tables III and IV, in order to support a lower OOP maximum, other features of the plan's cost-sharing must be adjusted. The more the OOP maximum is lowered, the more cost sharing is applied in the form of deductibles and coinsurance in order to maintain AV. In Table I of this memo, we showed that 97.75% of children are expected to have OOP costs of $700 or less. Most children will incur services subject to deductibles and coinsurance, while fewer than 2.25% of children's claims would likely to hit a $700 OOP maximum. A relatively lower OOP maximum generally has the effect of giving greater protection to the children with very high dental costs while increasing cost-sharing for most other children.

This work product was prepared solely to provide assistance to the National Association of Dental Plans. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. Milliman recommends Recipient be aided by its own actuary or other qualified professional when reviewing the Milliman work product.

Total Annual OOP Expenses for Sample Children Under Various Benefit Plan Designs

Finally, we used the illustrative plan designs shown in Tables III and IV, as well as the pre-ACA typical plan design and the FEDVIP plan, to develop total annual OOP costs (member cost sharing) for children incurring varying levels and types of dental services. Children A, B, and C were described in the Methodology section of this memo.

Table V illustrates the expected total out of pocket expenses for the three sample children under the pre-ACA typical plan design, the pre-ACA FEDVIP plan, and Plans I and II from Table III above. It also illustrates the insurance plan payment for each child under each plan design.

Table VI illustrates the same values for the 85% AV plans.

Table V

2014 Estimated Consumer Cost Sharing and 2014 Estimated Plan Payments for Illustrative Children Under Various Plan Designs (in $)						
(first number represents consumer payment/second number represents insurance plan payment)			70% AV			
			Plan I		Plan II	
	Typical DPPO Plan Pre-ACA	FEDVIP Plan Pre-ACA	$1000 OOP Max, $75 Deductible	$700 OOP Max, $90 Deductible	$1000 OOP Max, $110 Deductible	$700 OOP Max, $150 Deductible
Child A	$67.23/ $236.60	$67.23/ $236.60	$107.23/ $196.60	$122.23/ $181.60	$107.43/ $196.40	$107.43/ $196.40
Child B	$105.09/ $324.93	$105.09/ $324.93	$145.09/ $284.93	$160.09/ $269.93	$171.81/ $258.21	$191.81/ $238.21
Child C	$1,242.23/ $1,236.60	$492.23/ $1,986.60	$1,000.00/ $1,478.83	$700.00/ $1,778.83	$1,000.00/ $1,478.83	$700.00/ $1,778.83

(see page 2 for descriptions of Child A, B, and C)

Table VI

2014 Estimated Consumer Cost Sharing and 2014 Estimated Plan Payments for Illustrative Children Under Various Plan Designs (in $)						
(first number represents consumer payment/second number represents insurance plan payment)			85% AV			
			Plan III		Plan IV	
	Typical DPPO Plan Pre-ACA	FEDVIP Plan Pre-ACA	$1000 OOP Max, $50 Deductible	$700 OOP Max, $65 Deductible	$1000 OOP Max, $75 Deductible	$700 OOP Max, $90 Deductible
Child A	$67.23/ $236.60	$67.23/ $236.60	$67.23/ $236.60	$77.73/ $226.10	$81.49/ $222.34	$93.49/ $210.34
Child B	$105.09/ $324.93	$105.09/ $324.93	$105.09/ $324.93	$115.59/ $314.43	$106.72/ $323.30	$118.72/ $311.30
Child C	$1,242.23/ $1,236.60	$492.23/ $1,986.60	$1,000.00/ $1,478.83	$700.00/ $1,778.83	$1,000.00/ $1,478.83	$700.00/ $1,778.83

(see page 2 for descriptions of Child A, B, and C)

These tables illustrate how varying combinations of AV, OOP maximum, other cost sharing features affect the out of pocket expenses for children with various needs. For a particular plan design, the move from a $1000 to a $700 OOP maximum has the effect of transferring cost away from Child C and increasing costs for Children A and B via increased deductibles and coinsurance. While the cost increases to Children A and B are modest, it should be recalled that Child C requires medically necessary orthodontia and is expected to represent less than 5% of the covered population.

This work product was prepared solely to provide assistance to the National Association of Dental Plans. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. Milliman recommends Recipient be aided by its own actuary or other qualified professional when reviewing the Milliman work product.

The tables also show how insurance plan payments vary by plan design. The ACA plans generally cover relatively less of the cost of care for Children A and B than the pre-ACA plans. For Child C, the pre-ACA FEDVIP plan covers the highest proportion of cost, followed by the ACA plans and then the pre-ACA typical plan design.

Children A, B, and C are illustrative and are not meant to represent the full range of potential out of pocket cost scenarios that could be seen.

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CAVEATS AND LIMITATIONS

I, Joanne Fontana, am a Consulting Actuary for Milliman. I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

Milliman has prepared this report for the specific purpose of providing actuarial value, premium, and cost sharing estimates for various illustrative pediatric dental benefit plans. This information may not be appropriate, and should not be used, for any other purpose. This report has been prepared solely for the internal business use of, and is only to be relied upon by, the management of NADP. We understand that this report may be shared with representatives of the Center for Consumer Information and Insurance Oversight (CCIIO) and other third parties. 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.

The results presented herein are estimates based on carefully constructed actuarial models. Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

In performing this analysis, we relied on data and other information provided by NADP. We have not audited or verified this data and other information but reviewed it for general reasonableness. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

Milliman does not provide legal advice, and recommends that NADP consult with its legal advisors regarding legal matters.

The terms of Milliman's Consulting Services Agreement with NADP dated March 17, 2011 and signed March 24, 2011 apply to this letter and its use.

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