CONSUMER OUT OF POCKET EXPENSES FOR PEDIATRIC DENTAL BENEFITS

BACKGROUND: To be a Qualified Health Plan (QHP) beginning in 2014, medical plans offering the essential health benefits package must also limit cost-sharing for these benefit packages to a specific amount. The amount is pegged to the out-of-pocket limits for high deductible health plans (as defined by the health savings account provisions of the IRS Code). For 2013 this is $12,500 annually for a family of 4 and $6250 annually for an individual.

Separate dental plans are not subject to the limitation on cost sharing as they are not QHPs, as well as exempted specifically in Sec. 2707 (b). Consistent with this reading, when essential pediatric oral services described in Sec. 1302(b)(1)(J) are covered by separate dental plans, they are exempted from the reduction of cost sharing limits imposed on QHPs for consumers receiving premium subsidies1 (Sec. 1402(c)(5)).

While pediatric oral services provided by separate dental plans as part of the EHB package are not subject to the ACA’s out-of-pocket limits, protecting consumers from catastrophic costs for children’s dental coverage may be an appropriate requirement for dental plans offering coverage of those services on Exchanges. NADP commissioned Milliman to review pediatric dental claims to determine the point at which children’s dental claims escalate outside of normal levels and to model the impacts of setting a catastrophic out-of-pocket limit for children’s dental services.

CONCLUSIONS: The Milliman Memo is available for review on request2. It states in part that:

“...95% of children are expected to incur total dental/orthodontia claims of $900 or less with out-of-pocket costs of $230 or less-- assuming a commercial plan of benefits like FEDVIP plus medically necessary orthodontia. At two standard deviations above the mean (the 96.5th percentile), children are expected to incur out-of-pocket costs of $270.

Thereafter, claim levels increase rapidly, as the medically necessary orthodontia costs come into play more heavily starting around the 98th percentile. In the 98th and 99th percentiles children would be expected to incur out-of-pocket costs of $900 and $2,850 respectively.

Based on these results, defining “catastrophic” as two standard deviations above the mean (96.5th percentile) does not capture the point in the claim distribution at which costs start to escalate rapidly. It

---

1 Consumers with incomes between 133% and 400% of poverty are eligible for premium subsidies when purchasing health coverage in Exchanges.
2 The release of the Milliman memo requires a signed release.
may make more sense to define catastrophic at a point slightly higher than that, potentially closer to the 99th percentile.”

The memo includes the premium impacts of setting an out-of-pocket limit for children’s dental services. In short at the 99th percentile, the “per child” premium increase is 8% and rises 30% at the 96.5th percentile. These increases are in addition to the “per child” additional 13.9% premium ($3.40) required to cover medically necessary orthodontia as part of the Essential Health Benefit package.

**RECOMMENDATION:** Based on this analysis, NADP recommends that any OOP limit applied to pediatric oral services be set either at the 98th ($900) or 99th percentile ($2,850), depending on how tolerant of the resulting increased premium HHS believes consumers purchasing on Exchanges will be.

**CONSIDERATIONS:** With 96.5% of children incurring $270 or less in out-of-pocket dental costs, setting a separate limit on out-of-pocket cost for children’s dental services is a better approach for protecting consumers from catastrophic costs for children’s dental services than coordination of dental claims with a medical carrier. Coordination between carriers is administratively complex and cost-prohibitive and should be avoided to keep premiums low and to create an easier claims experience for members. Furthermore, more consumers would benefit from a separate limit on dental, since it is not contingent on their meeting the higher cost sharing limits set for QHPS. However, there are other factors to consider when setting a catastrophic OOP limit for children’s dental services for consumers purchasing separate dental coverage in Exchanges.

### Impact of Premium Increases

**Average Dental Market Premium Increases**—Premiums for in-force family dental DPPO coverage increased only 3.1% in 2011. In general dental premium increases have been under 4% for the past several years. The smallest premium increase estimated by Milliman is more than twice the most recent year’s premium increase.

**Consumer Price Sensitivity**—NADP Consumer Surveys have found that cost is the top consideration for a consumer in purchasing dental coverage—even before procedures covered. Small changes in price affect consumer decisions to purchase.

**Premium Difference from Current In-Force Coverage**—Premiums that are in-force today for families will be increased by the elimination of annual maximums on pediatric coverage and coverage for medically necessary orthodontia. The consideration of high additional premiums for catastrophic OOP limits should be balanced by the impact on adults dropping their own coverage to afford higher cost premiums for their children.

### Differences in Dental Markets

**Coverage Outside the Exchange Market**—Requirements applied to children’s dental coverage purchased through the Exchanges are not applicable to separate dental plans offered in the small group/individual market outside the Exchanges, nor is the extension of the OOP limits to the large group market under Sec 2707(b) applicable to separate dental plans [Sec 2707(d)]. Employers are hesitant to add provisions that increase cost while benefitting only a small portion of employees. So the addition of OOP catastrophic limits for children covered through Exchanges will create additional market disparities for children whose parents obtain coverage outside the Exchanges.

**Differences in Payment for Orthodontia by Market**—In the commercial market orthodontia is usually covered as an additional benefit option or rider to a dental policy with a separate lifetime limit—usually
$1000 to $1500\textsuperscript{3}. There is no medical necessity requirement applied to orthodontic procedures although there may waiting periods and age limits like those in the FEDVIP plan used as a pediatric dental benchmark.

Milliman estimates the average national orthodontic claim to cost $6350. Consumers with dental policies today are commonly paying $4850 to $5350 of this cost. At 50% cost sharing that is commonly applied to orthodontia, a consumer purchasing coverage in an Exchange or in the small group and individual market after 2014 will be paying only $3175 for orthodontia when it is medically necessary. Based on a standard definition of medical necessity, Milliman estimates that roughly 30% of the pediatric orthodontic claims would qualify for coverage\textsuperscript{4}. Consumers with orthodontic claims in this market that are not medically necessary will pay the full cost.

**Equity for Dental Consumers**

**Dental Coverage included in Medical Coverage**—Consumers purchasing medical coverage with pediatric dental services included will be impacted in two ways unless a separate dental OOP maximum is also applied to embedded dental benefits. First, consumers will have to meet the full out of pocket expense limits for pediatric dental services. As well, adding pediatric dental expenses to the medical OOP limit results in a smaller portion of the maximum being utilized for medical expenses. This will increase medical premiums.

**ALTERNATIVE RECOMMENDATION:** Other than orthodontia there are limited cases where a consumer would incur significant out of pocket costs for children’s dental services. Given orthodontia is rarely paid at more than a $1000 to $1500 maximum in the commercial market, the FFE should consider setting an allowable co-payment for orthodontia beyond which treatment is covered 100%. This co-payment could be applied both to separate dental coverage and dental coverage included in a medical plan.

Milliman estimates that $2850 is the consumer out-of-pocket cost at the 99\textsuperscript{th} percentile. If this were set as a co-payment for medically necessary orthodontia beyond which 100% of the procedure is covered, the impact on cost is the lowest calculated, i.e. 8%. This copayment is about 45% of the cost of treatment and is about $2000 less than what other consumers will be paying out-of-pocket in the commercial market.

This approach would provide more certainty for consumers and carriers. It approximately doubles the reimbursement available to other consumers with orthodontic coverage in the commercial market. It would be simpler and less costly to administer than tracking all dental claims for the out-of-pocket expenses paid by consumers.

\textsuperscript{3} NADP’s 2011 Premium and Benefit Utilization Trends Report found that 89% of orthodontic annual limits were less than $2000.

\textsuperscript{4} A common guideline for medical necessity is critical to managing costs and delivering benefits across the states.