



## Dental is Different

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A briefing on key differences between medical  
and dental plan administration for the FSSB  
June 15, 2016

# + California Dental Market

## Enrollment by Plan Type

Plan Type	Enrollment
Private Plans	
DHMO	3,292,852
DPPO	14,802,222
Indemnity	975,515
Other Private	259,694
Public Plans	
Medicaid	12,665,782

Source: Data from the CMS and 2015 NADP Dental Benefits Report on Enrollment

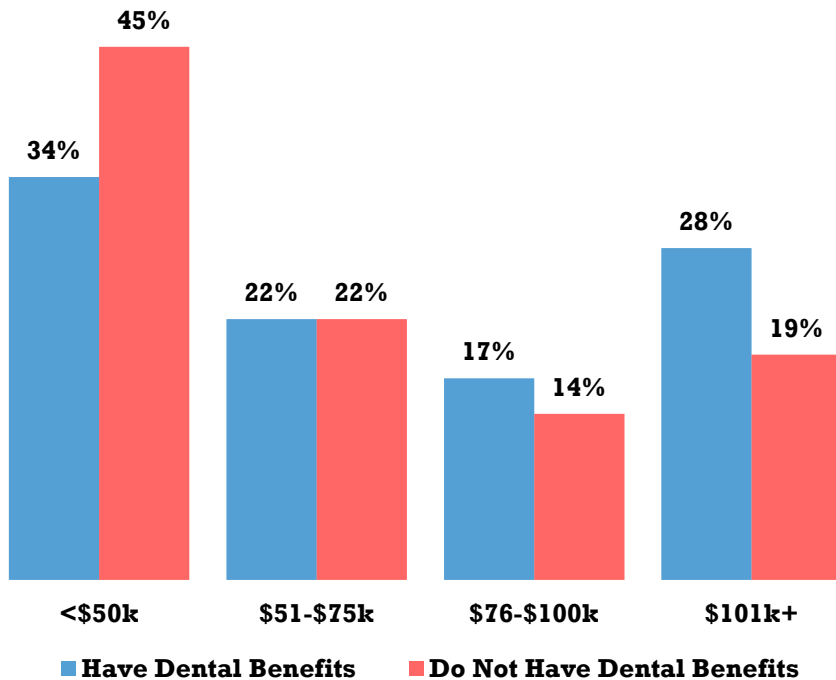
## California Premium Facts

	DHMO	DPPO	Indemnity
Small Group	\$10.63	\$49.73	\$68.55
Large Group	\$11.78	\$44.51	\$44.04
Individual		\$40.79	
National All Group Avg	\$17.01	\$31.69	\$36.13

Source: NADP 2015 Dental Benefits Report: Premium and Benefits Utilization Trends

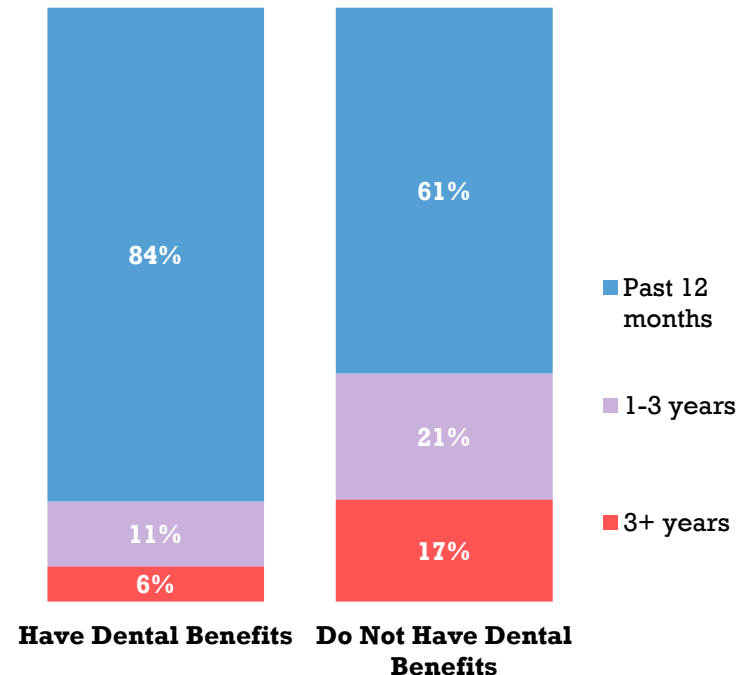
# + California dental market

**Consumers with and without dental benefits by household income**



Source: 2015 NADP Survey of Consumers

**When was your last visit to the dentist?**



Source: 2015 NADP Survey of Consumers

# + Structure of dental coverage

- Common way to describe coverage is by class of service – 100/80/50, 100/50/50, ...
- Preventive and Diagnostic/Basic/Major
- PPO - Coinsurance by category
- DHMO – Copay by Procedure Code
- Deductibles – PPO (D&P usually waived)
- Yearly Benefit Limit on PPO only (more on this later)
- PPO pays FFS
- DHMO pays FFS, CAP, CAP and Supplements
- Wide range of products and prices
- Product and price crafted to meet consumer demand



# Is dental coverage important?

## ■ Oral and overall health connection

- Diabetes and periodontal disease – Diabetics more susceptible to oral infections and gum disease which can have a negative impact on blood glucose levels.
- Cardiovascular disease and periodontal disease – up to 4x increased risk for heart disease in people with periodontal disease.
- Pregnancy and periodontal disease – periodontal disease increases risk of premature low birth weight.
- 2013 study shows dental-medical integration, outreach and dental plan design (over 6 years) resulted in hospital admissions down by 3.5%; medical claims costs down by 17%; dental claims costs for major/basic services down by 42%; diabetes control up 45% over 1.5M patients.

## ■ Periodic dental care is extremely important!



## Congress intentionally omitted dental benefits from the ACA's loss ratio provisions



- In 2009, the Senate Finance and House Energy and Commerce committees consulted with healthcare actuaries, healthcare economists and other leading thinkers prior to crafting the ACA's MLR provisions.
  - The resulting exemption from market reforms for dental, including minimum loss ratio requirements, was no accident.

# + So why exclude dental?



# + Relative to dental plans, medical plans look like these



There are two types of elephants: African and Asian, with two varieties of each

- Non-catastrophic health plans come in various shapes and sizes, with different degrees of cost sharing, but otherwise, look similar in terms of what's mandated for coverage, cost components, and what purchasers are looking for.



# + Relative to medical plans, dental plans look like these



There 339  
breeds of  
dogs.

Delta Dental  
administers  
over 14,000  
distinct plan  
designs.

- Not mandated, nor regarded as a “must have,” dental plans come in all shapes and size, usually engineered to fit a purchaser’s budget. They sometimes cover a lot, sometimes only a little, on the premise that “something is better than nothing.”

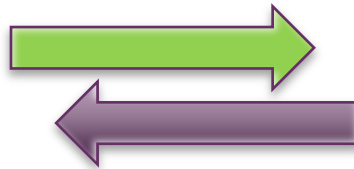


# What's so different about dental?

- Premiums < 1/15<sup>th</sup> cost of medical plans, despite sharing many of the same administrative and regulatory requirements.
- Premiums vary depending on plan type & market segment, from <\$9 pmpm (DHMO) to > \$40 (DPPO).
- Plan design is market-driven; DMHC requires cost sharing >50%, but entire classes of services sometimes excluded.
- DHMOs less than half the cost of DPPOs while providing comparable or even richer benefits with no annual maximums. (Medical HMOs/PPOs far closer to each other in price and coverage.)
- Brokers often charge a higher % of lower premium in commission so dental is worth their trouble. Hits dental admin more as a %.
- Unlike medical, individuals feel less need to pay premiums to guard against high dental costs. Makes selling dental to individuals and small groups price sensitive.



# What's similar about medical and dental plans?



- **Administrative requirements (and costs) are similar**
  - Call centers, claims payment, enrollee notices and disclosures, processing of eligibility and billing, network management, group contracting, broker commissions, etc.
- **Regulatory requirements (and costs) are similar**
  - Timely access, language assistance, quality assurance systems, enrollee grievance and appeals, provider dispute resolution, provider directory accuracy, provider credentialing, network adequacy, provider notices, plan licensure, financial filings, TNE limits, form filing, market conduct exams, HIPPA compliance, etc.



# How do the differences between medical and dental manifest?

- **Some employers want a Cadillac dental plan.**
  - These are the plan designs that cover the full scope of benefits, with less cost sharing than other plans. Administration as a percentage of premium is lower, meaning the administrative loss ratio trends higher (70+)
  
- **Others want bare bones, D&P-only dental plan**
  - For minimum investment, such plans bring people to the dentist for their diagnostic and preventive care, allowing them to see if they need more extensive treatment, which they fund at their own expense.
  
- **Most want something in the middle**
  - Every shade of grey is possible: Annual maximums from \$500 to \$4,000; deductibles from 0 to \$50; copays from 0% to 50%; plan designs with 1, 2 or three classes of service; no ortho to high \$2,000 lifetime ortho limit; narrow networks to wide networks.

+ How do the differences affect administrative loss ratios?

**It's a problem of scale!**



At \$400 PMPM with 85% MLR, average medical plan (HMO or PPO) gets \$60 to spend on admin



At \$12 PMPM (many are less), the average dental plan would get just \$1.80 for admin at 85% DLR

**Dental carriers cannot meet their obligations under the law at that rate.**



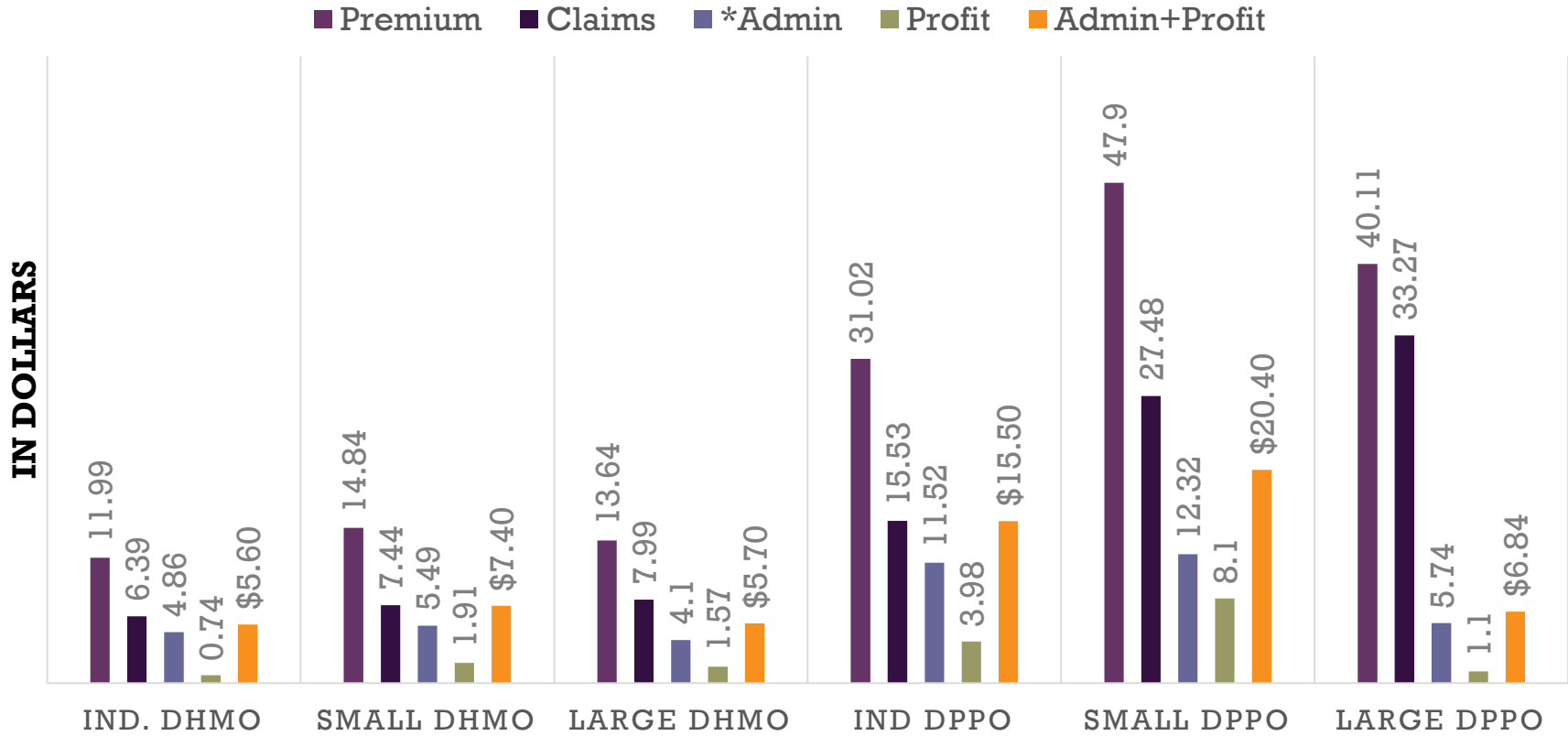
# Review of the 2014 DLR report: *Admin costs are not unreasonable*

	Ind DHMO	Small DHMO	Large DHMO	Ind DPPO	Small DPPO	Large DPPO
Total Admin and Margin (PMPM)	\$5.60	\$7.40	\$5.70	\$15.50	\$20.40	\$6.84
*Life Years	229,000	300,000	1.98 mil	293,000	1.0 mil	5.44 mil

**\*Life Years = number of enrollees over 12 full months**

- Total admin PMPM is appropriate in light of all required functions.
- Spend is less on DHMO than DPPO largely due to taxes, fees & commission, all of which are based on premiums.

# + Unless you benchmark against premium...

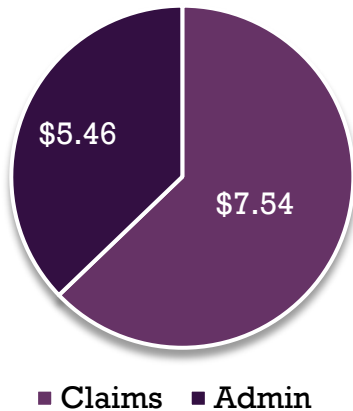




# Case study: What does a lower DLR plan buy, and who buys it?

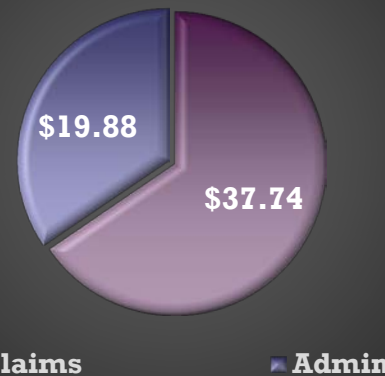
- Offered a choice between a \$13 DHMO, and a \$57 DPPO, 70,000 of Covered California 80,000 stand-alone dental enrollees with Delta Dental chose DHMO.
- Here's how the PMPM gets spent in both programs:

## \$13 DHMO (58% DLR)



No annual maximum

## \$57.62 DPPO (65% DLR)



\$1,000 annual maximum





# How much value can a \$13, low DLR plan really provide?

- Total out-of-pocket cost of a check-up, full mouth x-rays, fluoride treatment, a one-surface filling, root canal and crown, compared with the retail cost of these services at market rates:

	You Pay (OOP)	*Market Value
<b>2 Exams</b>	0	\$234
<b>2 Cleanings</b>	0	\$222
<b>2 X-rays</b>	0	\$158
<b>Filling</b>	\$25	\$156
<b>Root canal</b>	\$170	\$350
<b>Crown</b>	\$350	\$1,239
<b>Annual Premium</b>	\$155.88	N/A
<b>Total</b>	<b>\$700.88</b>	<b>\$2,359</b>

\* based on California average costs, using Fair Health database



# What happens to premium if this plan has to meet a minimum?

- With administration fixed and profit already minimal, the only way this plan can meet a higher DLR requirement is by raising premium. Payment to dentists need to increased above what dentists currently agree to in their plan contracts.

## ■ Questions:

1. How many of the 70,000 with this plan today would still choose to obtain dental coverage at these higher rates and how many would drop?
2. How many of those who drop would defer seeking needed dental care rather than paying market rates?

<b>DLR Level</b>	<b>PMPM</b>	<b>% rise</b>
<b>Current 58%</b>	\$12.99	NA
<b>65%</b>	\$15.69	21%
<b>70%</b>	\$18.30	41%
<b>75%</b>	\$21.96	69%



## Bottom line:

*Higher loss ratios do not translate into more dental care or better oral health.*

Low DLR Plans can be:

- More affordable to more people, especially those least likely to have premiums subsidized by an employer

High DLR Plans can be:

- Less affordable for individuals and small groups, who are more likely to defer their dental care needs.

**This is why dental is exempt from  
the loss ratio provisions of the ACA!**



# Milliman white paper on its way:

*Independent actuarial firm's analysis of the DLR report*

## ■ Excerpts as follows:

- "...it is easy to conceive of minimum DLR standards that could make entire products financially unsustainable."
- "...many administrative expenses of a dental plan do not decrease significantly for products that have less expensive benefits."
- "If a DHMO product [has lower dental costs] then the relatively fixed administration expenses become a larger piece of total premium."
- "The primary drivers of high DLRs among large group plans are the economies of scale achieved in the administration of claims for larger groups of employees and for richer plan designs, as well as the lower fees and commissions paid to agents and brokers."

# + Is actuarial value the answer?

- Defined as % of covered services paid by the plan, not the consumer out-of-pocket. (e.g., copays or coinsurance)
  - Consumers care more about this than % of premium used for admin.
- In exchanges, HHS requires pediatric dental AV to be 85% or 70% as a means to standardize dental. CCA only offers 85.
- Dental plans must calculate and attest to their own AV, as there is no AV calculator like medical plans have.
- Outside exchanges, the vast range of dental products complicates AV; Broader scope dental plans that cover restorative or ortho, for instance, score lower AV, while lean benefits are higher. (see below)

No Deductible	Base	With ortho	D&P Only
<b>Annual Max</b>	<b>\$1,500</b>	<b>\$1,500</b>	<b>No Max</b>
<b>Class I</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Class II</b>	<b>80%</b>	<b>80%</b>	<b>NC</b>
<b>Class III</b>	<b>50%</b>	<b>50%</b>	<b>NC</b>
<b>Child Ortho 50% to \$1,500 max</b>	<b>NC</b>	<b>Yes</b>	<b>NC</b>
<b>Estimated AV</b>	<b>78.6%</b>	<b>73%</b>	<b>100%</b>



# Conclusion:

*Dental is different - elephants aren't like dogs*



- There are too many breeds of dental plan for loss ratios to work across them all, as intended under the ACA's standardized tiers.
- Dental premiums are too varied across products and market segments. Fixed administrative expenses don't scale down with lower premium products, some of which offer better benefits in more limited networks as the prices goes down.
- A DLR threshold threatens the most affordable dental products, leaving in place those least likely to be selected on a voluntary basis among those least likely to have dental coverage: **small groups and individuals.**

# + Questions / Discussion

