Insurance Market Working Committee

April 24, 2014

9:30 a.m.

1100 15th St. NW, 8th Floor Conference Room

Members Present:
Kevin Lucia (Chair), Dr. Henry Aaron, Kate Sullivan Hare

Presentations by:
Dr. Leighton Ku, Board Member and Chair of the Dental Plan Advisory Working Group (by telephone)

Health Benefit Exchange Staff Present:
Mary Beth Senkewicz, Associate General Counsel and Policy Advisor

I. Opening Comments

Chairman Kevin Lucia explained the purpose of the meeting was to discuss the non-consensus recommendations contained in the Dental Plan Advisory Working Group's Second Report dated April 18, 2014. Consensus items go straight to the Board. He thanked the members of the Working Group and staff for their work in formulating and discussing the issues.

II. Discussion of Issues Relating to Dental Plans

Mr. Lucia called on Dr. Leighton Ku, Board Member and Chair of the Dental Plan Advisory Working Group, to provide background information to the Committee on the issues detailed in the Working Group's report.

Stand-alone Pediatric Dental Plans

Dr. Ku stated that the first issue was the status of stand-alone pediatric dental plans (SAPDs). Last year, dental carriers did file SADPs with the Department of Insurance, Securities and Banking (DISB) for approval. However, all the major medical carriers chose to embed the pediatric dental benefits in their QHPs, so DISB decided that the SADPs were duplicative and did not approve them for sale on the Exchange. The terminology on this issue is as follows: a QHP with pediatric dental benefits embedded is a 10.0 plan; a QHP without pediatric dental benefits is a 9.5 plan; and an SADP is a .5 plan.

SADP plans were understandably concerned about what happened, and had a specific request: would the Board consider requiring major medical carriers to offer some 9.5 plans, thereby paving the way for .5 plans to be sold on the Exchange.

Dr. Ku reported that the working group discussed the issue thoroughly, and ultimately the non-consensus recommendation was to maintain the status quo – that is, allow the carriers to choose whether or not to embed the pediatric dental essential health benefit. The dental carriers filed a minority report.

On the embed side, carriers say they have a right to include an EHB in a QHP, the Board does not have authority to preclude them from doing so, there is one plan, every child has the benefit, and the APTC is only available when a QHP is purchased. On the SADP side, those carriers argue they have superior networks and benefits, they have a legal right under the ACA to be offered, they have maximum out-of-pocket (MOOP) limits and there will be advantages to consumers without children to pick a 9.5 plan. Dr. Ku also noted that the market will be consolidated in 2016, and the dental carriers had requested that the Working Group continue to meet to deliberate the issue for 2016.

Dr. Aaron asked what the price was for embedded pediatric dental benefit. Ms. Senkewicz reported that DISB's chief health actuary said it was about $1.25. Dr. Ku stated the dental carriers might contest that. Dr. Aaron asked if we knew anything about the networks. Dr. Ku stated Delta Dental had provided some information, and it was his sense that the dental carrier networks might be better than some of the major medical networks but not all. But, we really do not know. Dr. Aaron asked if we knew anything about the rates in California for 2015. Ms. Senkewicz did not, and noted that she did not think they were filed yet.

Dr. Aaron noted that having 9.5 plans might not be in the best interest of children if the result might be fewer kids with dental benefits. This might occur, he said, if the lower price of 9.5 plans led some parents to buy them but shortsightedly not to buy the stand-alone dental plan as well. Ms. Sullivan Hare asked if the Board could have a rule that requires an applicant with children to buy pediatric dental benefits.

Ms. Senkewicz said she would find out if California just has a mix of all three types of plans due to the multiplicity of carriers, or if the California Exchange is requiring carriers to offer 9.5 plans.

Ms. Sullivan Hare asked whether the Congressional enrollees were losing their dental coverage. Ms. Senkewicz said no, they still get dental benefits through FedVip.

Mr. Lucia asked the Committee members to consider the non-consensus recommendation of maintaining the status quo, and pointed out the minority report is asking for a requirement of some 9.5 plans. He is sympathetic to the QHPs having all the EHBs, but on the other hand, why preclude the dental carriers from offering a product that might be useful? He acknowledged that more data will be needed, but he proposed for the 2015 plan year, the Committee accept the majority's non-consensus recommendation but add that DISB be requested to accept the SADPs. Dr. Ku stated that had been discussed in the working group, and the dental carriers indicated that was not useful to them. Mr. Lucia still thought SADPs might be useful. He was also intrigued by the situation in California and wanted more information. Dr. Aaron was unsure how he felt about .5 plans. He wanted to hear from DISB about its decision. If the networks and benefits are different, SADPs might not be duplicative.

Ms. Sullivan Hare stated her preference for 9.5 and .5 plans in SHOP for 2015. She had no opinion as to having 9.5 plans for all metal levels or just the lower tiers. She thought employees with children should not be able to check out of SHOP until they had chosen a pediatric dental benefit. On the individual side, she was interested in having 9.5 and .5 plans in future years.

Deductibles

Dr. Ku explained that consumer representatives had raised the issue of deductibles regarding pediatric dental benefits. The problem is there are no parameters on how they may be set. Major medical carriers handle pediatric dental in different ways. Some plans have a zero or very low deductible for pediatric dental benefits, while others have one overall combined ("blended") deductible. In the latter case, the consumer can be disadvantaged when routine pediatric dental services are subject to the blended deductible. That is, if the overall deductible is $2000, then it is plausible that no pediatric dental care will be covered unless the child also has serious medical problems. The Working Group report has a non-consensus recommendation: Require major medical QHPs with embedded pediatric to have deductibles for pediatric dental services not to exceed $50 for individuals and $100 for families for in-network dental benefits and not to exceed $100 for individuals and $200 for families for out-of-network benefits beginning in 2016.

Ms. Sullivan Hare believed that truly meaningful pediatric dental benefits must be ensured in the Exchange. Blended deductibles, if not fully explained, result in coverage the consumer misunderstands.

In response to questions, Dr. Ku said there had been no significant study of the correct dollar amount arrived at in the recommendation. Dr. Aaron preferred that the Working Group perform a detailed analysis of the deductible and cost-sharing issues. However, all members of the Committee agreed that the blended deductible needed to be phased out and that carriers must be put on notice: pediatric dental benefits must be meaningful and easily accessed. The Committee members agreed that beginning in 2016, 10.0 plans must have a separate deductible for pediatric dental benefits that will contain a maximum dollar amount. That maximum dollar amount will be determined in the future based on recommendations from the Dental Working Group, or other group to which the Board may assign the issue. To be clear, the separate deductible may be zero if the carrier so chooses.

III. Vote

The Committee members voted to accept the majority Working Group's non-consensus recommendation on maintaining the status quo regarding embedding pediatric dental benefits, but added to ask DISB to accept SADP plans. That recommendation was:

Major medical carriers have the choice to embed, or not embed, the pediatric essential health benefits in their qualified health plans.

The vote was 2-1. Mr. Lucia and Dr. Aaron voted yes and Ms. Sullivan Hare voted no.

The Committee members voted to amend the majority Working Group's non-consensus recommendation on deductibles and adopted a recommendation as follows:

Beginning in 2016, 10.0 plans must have a separate deductible for pediatric dental benefits that will contain a maximum dollar amount. That maximum dollar amount will be determined in the future based on recommendations from the Dental Working Group, or other group to which the Board may assign the issue. To be clear, the separate deductible may be zero if the carrier so chooses.

The vote was unanimous, with Mr. Lucia, Dr. Aaron and Ms. Sullivan Hare voting yes.

IV. Closing Remarks and Adjournment

Mr. Lucia thanked the members of the Committee and the Working Group for their thoughtful consideration of the issues. The meeting was adjourned.