DC Health Benefit Exchange Authority

DC Health Benefit Exchange Dental Working Group Second Report

April 18, 2014

This report is submitted to the Health Benefit Exchange Authority by the Dental Plan Advisory Working Group chair (Leighton Ku) and Vice-Chair (Katherine Stocks). The group included representatives of dental carriers, major medical carriers, insurance associations and consumer groups and met three times in March in person with conference call capability. HBX staff provided background and advice. The purpose of this report is to outline the recommendations of Dental Plan Advisory Working Group regarding three basic issues:

1. With respect to SHOP standalone dental plans, (a) which sets of standalone dental plans can employers choose to offer to their employees; (b) what contribution methodology should employers be able to offer towards standalone dental plans; and (c) should employers be required to contribute a minimum amount towards standalone dental plan premiums? A consensus was reached on these issues.
2. Should the Exchange require some major medical plans to be offered without embedded dental benefits? We have a recommendation, but no consensus on this issue and a minority report is attached.
3. Should there be maximum deductible levels for embedded pediatric dental plans in major medical plans? We have a recommendation, but no consensus was reached.

SHOP Issues

Background

Since the HBX will be able to offer dental plans in SHOP in the not-too-distant future, policy decisions need to be made. Decisions for the following SHOP standalone dental plan issues also have implications for the current IT system that has been implemented for DC Health Link. Certain capacities are built into the IT system, but others are not. If those options are selected, reprogramming would be needed which presents operational costs and challenges for HBX. The options are:

A. Plan Selection Options: Which sets of standalone dental plans can employers choose to offer to their employees?

Employers will be able to select a set of standalone dental plans to make available to eligible employees. Eligible employees will be able to choose whether or not to enroll in one of the

standalone dental plans offered by the employer.

- Option 1: Any number of selected plans?
- Option 2: One plan?
- Option 3: All plans from a dental carrier?
- Option 4: All plans from a certain level (i.e. high or low)?
- Option 5: All plans from all carriers and all levels?

Presently, the system can support Option 1 above: the out of the box product allows the employer to select any number of plans from the full list of plans. However, as a policy matter there are other options, listed above.

Options 2, 3, and 4 are presented as they are similar to the **medical** plan selection options currently available to employers.

B. Employer Contributions: What contribution methodology should employers be able to offer towards standalone dental plans?

- Option 1: % of member-level age rate within a reference plan selected by the employer
- Option 2: % of premium of whichever plan is selected by the employee

Presently, the system can support Option 1: the out of the box product allows the employer to choose a "reference plan" from all of the dental plans it offers to its employees, and the employer then chooses a percentage of the premium that it will contribute based on the reference plan premium regardless of the employee's plan choice. This method mirrors the major medical plan contribution option currently available to employers.

Option 2 is not currently supported by the system. Also, since this contribution option is not offered for medical plans, it might be confusing to offer it for dental plans.

C. Minimum Contribution: Should employers be required to contribute a minimum amount towards standalone dental plans?

The system can support a zero minimum employer contribution to a dental plan. There will be a small cost to requiring a minimum employer contribution on the dental side. Also, staff believes a zero minimum employer contribution to a dental plan is the common practice presently.

For medical plans, SHOP employers are required to contribute at least 50% towards employee only coverage in the selected reference plan, except for medical plans with a January 1 effective date, a minimum contribution is not required.

Discussion

In opening this discussion, Dr. Ku noted that if the group recommends the options that are functional now, the recommendation can move forward and SHOP consumers will be able to

choose dental options sooner rather than later. He also noted that improvements could be made available in the future.

With respect to the plan selection options for employers, Dr. Ku noted that while the system can support Option 1 above and allow the employer to select any number of plans from the full list of plans, the employer can in effect choose some of the other options in A by manually selecting those plans. Working group members noted that it made sense to have the same functional options for both major medical and standalone dental plans so as not to be confusing to the employer.

Consensus Recommendation 1

Employers may offer any number of selected plans to their employees.

The second SHOP issue is what contribution methodology should employers be able to offer towards standalone dental plans? Mr. Mullen argued that Option 1, the employer contributing a percentage of the member-level age rate within a reference plan selected by the employer, is a sum certain for the employer and will assist in the employer's budgeting process. Furthermore, Option 1 is readily available.

There was some discussion of reference plans, and what if the employer chose a pediatric only plan as the reference plan. Working group members noted that there needed to be a feasible way to educate the employers as to the ramifications of their choices. It was noted that the employer community was more likely to use brokers and agents to help them.

Members questioned whether the contribution is for the pediatric dental portion only. It is not – the contribution is for the entire dental plan. Ms. Mitts asked whether Option 2, a percentage of premium of whichever plan is selected by the employee, would be available in the future. Hannah Turner, HBX staff, replied that the IT is particularly difficult on that option. She also noted that it is already confusing for employers and they have difficulty understanding the contribution model as it is with one model, and she thought having two models would be doubly confusing. Dr. Ku noted that the HBX could look at other options in the future as we gain more experience.

Consensus Recommendation 2

The employer contribution methodology should be the employer contributing a percentage of the member-level age rate within a reference plan selected by the employer.

The third SHOP issue is whether employers should be required to contribute a minimum amount towards standalone dental plans. The system can support a zero minimum employer contribution to a dental plan. As with the other two SHOP options, the working group members agreed that the default option of zero percent should be the recommendation at this time.

Consensus Recommendation 3

Employers should not be required to contribute a minimum amount towards standalone dental plans.

Standalone Pediatric Dental Plans Issues

Background

When the major medical carriers filed their forms and rates with the Department of Insurance, Securities and Banking (DISB) in the spring of 2013, all the major medical plans had embedded the pediatric dental essential health benefit. (In its initial filing, Kaiser did not so embed, but in re-filings did embed the pediatric dental essential health benefit.) Thus, DISB determined that there was no need for a standalone pediatric dental plan and they were not approved to be sold on the Exchange. Dental carriers argue that without a requirement for at least a few QHPs to offer major medical plans without pediatric dental benefits inside the Exchange, there is no viable market for QDPs offering pediatric dental in compliance with the Affordable Care Act (ACA). Therefore, they argue, the Exchange denies dental carriers the opportunity to sell ACA-compliant pediatric dental in OR outside the exchange in the non-group and small group markets. Current HBX policy permits standalone family dental plans to be sold on the Exchange and there was no discussion of changing that policy.

Discussion

Over the course of the three working group meetings, the members of the working group engaged in a far-ranging discussion on a number of issues with respect to standalone pediatric dental plans. The issues can be grouped into the following categories: system capabilities; consumer choice; networks; deductibles; tax credits; carrier administrative issues; legal authority; transparency; and consumer confusion.[1]

In general, the standalone dental carriers argue that their plans have more extensive networks, more easily understood and beneficial cost-sharing (embedded dental plans can make diagnostic and preventive benefits subject to a deductible, though most of the major medical plans do not), and more transparency of the actual benefit for the consumer. They argue that having standalone pediatric dental plans on the exchange is market-friendly and provides more choice to the consumer. They also note that having some major medical plans without embedded pediatric dental could be advantageous to consumers without children, since those premiums will not include the cost of pediatric benefits they will not use. Last, they note that there is no separate out of pocket maximum for dental when embedded. They argue this means children will seldom if ever reap the benefit of receiving 100 percent coverage for extensive dental needs, even if they incur what we would regard as fairly catastrophic dental care needs up to $6,600 in annual costs.

[1] The range of costs for a PPO dental plan is $30-$40 per member per month (pmpm) for an adult and $30 pmpm for a child. The price for a child drops to $9-$13 in a DHMO. DHMO products are outselling the PPO products across the exchanges nationally.

The major medical plans counter that they have the right to embed pediatric dental plans, that their networks are not inferior, there is one plan and one premium, and that the administrative complexity involved in un-embedding pediatric dental benefits is burdensome, onerous and poor public policy. They also note that embedding pediatric dental means that children will always get dental coverage when they select a medical plan; while if there are medical plans without dental coverage, there is a risk that some children will lack dental coverage if they do not select a standalone plan. (The ACA requires that pediatric dental benefits be offered, but not that they be purchased.) They also noted that the advanced premium tax credit is only available with respect to major medical plans. If there was to be any requirement about um-embedding pediatric dental benefits, it should not include the second-lowest cost silver plans.

In that vein, there was some discussion whether the HBX Board had the authority to require a major medical plan to not include an essential health benefit in a qualified health plan. CareFirst believes the Board does not have such authority. The dental carriers disagree, say our enabling legislation provides sufficient authority to the Board, and note that it had occurred in California for 2014.

Additionally, there was significant discussion about the major medical carriers voluntarily providing at least one plan in each metal level tier (except silver) without pediatric dental benefits. In the second meeting, Dr. Ku asked major medical plans if they would be willing voluntarily to offer at least some plans without embedded pediatric dental. In the third meeting, it did not appear that any of the major medical carriers supported this voluntary option.

The working group notes that prior to the ACA, there were no pediatric-only dental plans, as this was a concept created under the ACA, and 98% of all dental coverage today is purchased separately in the commercial market. We looked at information from a variety of states and found that there was broad variation in the extent to whether major medical plans embedded pediatric dental or not. Further, statistics from the Federally Facilitated Marketplace states indicated that 95%-96% of all standalone dental plans purchased through Exchanges are family plans including adults and relatively few are pediatric only.

Consumer groups were also concerned about consumer confusion if there were plans with pediatric dental and plans without. In fact, to require un-embedding would create even more plan choices on the exchange, perhaps even doubling them. All working group members agreed that education of navigators, assisters, certified application counselors and brokers would be key to alleviating consumer confusion and employer choice of a reference plan. Consumer groups also questioned the long-term viability of keeping medical and dental coverage separate.

Dental carriers noted that the SHOP market would be consolidated in 2016, and they believe the dynamics are different with the SHOP market than with the individual market. In essence, as the SHOP market consolidates, there will be no outside market. Mr. Wrege asked if the working group could re-think plan requirements for 2016. Dr. Ku suggested that the group think on a broader basis both for dental and major medical for 2016, and in a more timely manner (before the end of 2015, so that there is adequate time for guidance and response by carriers)

Given the assessment that major medical carriers did not want to uncouple pediatric dental from their medical plans, Dr. Ku recommended that we retain the current policy (to not require major medical plans to offer at least some plans without embedded pediatric dental benefits), but that we ask to DISB to consider approving standalone pediatric dental plans, even if they duplicate benefits offered in major medical plans. This would permit consumers to select a standalone dental plan if they thought it was a superior option, even if it duplicates benefits in their main QHP. This offering will most likely take the form of family dental plans, which pursuant to federal guidance must also include the pediatric essential dental benefits. But it was also recommended that the exchange portal caution the consumer that this would consist of duplicative purchase if they included under age 19 enrollees on the standalone family plan, which is primarily being offered within the Exchange to meet the adult population demand for dental coverage, seeing that the children are already covered under the embedded QHP.

Non-Consensus Recommendation

Major medical carriers have the choice to embed, or not embed, the pediatric essential health benefits in their qualified health plans.
This recommendation was favored by major medical plans and consumer organizations, but opposed by the dental carriers. Dr. Ku invited the dental carriers to submit a minority report jointly or separately; the minority report is attached.

Deductibles for Embedded Pediatric Dental Plans & Transparency

Background

Consumer groups were concerned about deductibles in major medical plans. 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 deductible. In the latter case, the consumer can be disadvantaged when routine pediatric dental services are subject to the combined 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. Consumer groups argue that transparency is key here; some working group members suggested developing a separate dental summary of benefits that provides much more information about the dental benefits. Dr. Ku mentioned that the HBX Board generally supports more transparency.

Discussion

With respect to deductibles, California has shielded the pediatric dental benefit from a medical deductible by eliminating any deductible for pediatric dental. On DC Health Link, the carriers run the gamut: Kaiser has no deductible for pediatric dental; CareFirst has a $25 in-network and $50 out-of-network deductible for pediatric dental; United, if there is no medical deductible, has a $100 individual and $200 family deductible for pediatric dental, but if there is a medical deductible, then all charges accrue to it (also known as a “blended deductible”); and Aetna has a blended deductible. The consumer groups think the ideal situation is no deductible for pediatric dental, but wants the carriers to ease into no or a de minimus pediatric dental deductible. They

note that 2015 plans are in the works already, however. United stated it would be difficult to achieve for 2015, but was willing to take the issue back to company policymakers.

Dr. Ku recommended that HBX establish maximum deductibles for pediatric dental for major medical plans of: $50 for individuals and $100 for families for in-network dental benefits and $100 for individuals and $200 for families for out-of-network dental benefits. (That is, plans could establish lower deductibles if they wish.) Given that 2015 plans must be established soon, this would be a recommendation for 2015, but be required for the 2016 plan year. Because we do not have policies regarding dental benefits for adults, this would apply only to pediatric dental. Because standalone dental plans have a different set of cost-sharing requirements under the ACA, this would apply only to major medical plans with embedded pediatric dental.

An additional recommendation was that the website provide greater transparency about the nature of pediatric dental benefits, clearly noting if they are included in major medical plans as well as coverage and cost-sharing. Brendan Rose mentioned that improvements to the website about description of plan benefits was ongoing and that this should not be a problem.

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.

No one objected to this recommendation, but other than Kaiser (which already meets this policy), representatives of major medical plans were uncertain of the impact and would discuss this with their colleagues. Dr. Ku noted that if there were serious concerns they could be addressed well before the 2016 plans are filed. Although there was no serious opposition, the uncertainty causes this to be a non-consensus recommendation.

Consensus Recommendation

Provide greater transparency about pediatric dental benefits in the website.

Working Group Members

The Dental Plan Advisory Working Group is comprised of representatives from dental plans, health plans, pediatric dentists and consumer advocates. Three meetings were held, on March 7, 14 and 28, 2014, all three with in-person and conference call participation.

Participant Name	**Organization**
Leighton Ku, Chair	The George Washington University Center for Health Policy Research (HBX Board member)
Katherine Stacks, Vice-Chair	The Goldblatt Group
Joseph Winn	Aetna
Geralyn Trujillo	America's Health Insurance Plans
Tonya Kinlow, Louisa Tavakoli	CareFirst
Colin Reusch, Meg Booth	Children's Dental Health Project
Anupama Rao Tate	Children's national Medical Center
Jim Mullen, Jeff Album, Kevin Wrege	Delta Dental
Frank Kolb	Delta Dental Association
Andre Beard, Colin Johnson	Department of Insurance, Securities and Banking
Dean Rogers	Dominion Dental
Lydia Mitts	Families USA
Joseph DeCresce	Guardian
Tiffinie Severin, Laurie Kuiper	Kaiser Foundation Health Plan of the Mid-Atlantic
Mike Hickey	MetLife
Kris Hathaway	National Association of Dental Plans
Jonelle Grant	Pediatric Dentist
Guy Rohling	United Concordia
Colleen Cohan	UnitedHealthcare