maryland health connection

Pediatric Dental Plans

New Policy & Operational Decisions
March 12, 2013

A service of Maryland Health Benefit Exchange

Pediatric Dental Plans

- The Final Rule on Essential Health Benefits released by HHS on February 20, 2013 included new provisions for handling pediatric dental benefits
  - Metal levels do no apply but instead new “Tiers” and Actuarial Value standards have been created
    - Low Tier = 70% (+/- 2%)
    - High Tier = 85% (+/- 2%)
  - Unlike qualified health plans (QHPs), and Actuarial Value calculator does not exist for stand-alone dental plans
  - Inside/Outside Purchase Requirements
    - Inside Exchanges
      - Allows medical plans to exclude pediatric dental from the benefit design
      - Clarifies that consumers are NOT required to purchase pediatric dental in the exchange if the medical plan does not include pediatric dental benefits
    - Outside Exchanges
      - Does not allow a medical plan to exclude pediatric dental from the benefit design
      - Creates an exception to this if the carrier is “reasonably assured” that the individual has pediatric dental through an exchange certified stand-alone plan

Key Decision for Today

- Another key element of the final EHB rule established separate cost sharing for stand-alone dental plans
  - Requires that pediatric dental plans have out of pocket maximums
  - Gives states flexibility to set the out of pocket maximums

- The MHBE must define “reasonable” out of pocket maximums for pediatric dental plans that will be offered on Maryland Health Connection

Timing Issues

- The MHBE and the MIA have been working closely to ensure carriers file products in time to perform all requirement plan review and certification processes
- For stand-alone pediatric dental plans, the filing deadline was established as March 1, 2013
- The filing deadline for stand-alone pediatric dental plans has been moved to March 22, 2013 to allow the MHBE and carriers to interpret the guidance
- MHBE must make a determination of out of pocket maximum requirements for stand-alone pediatric dental plans despite the fact that these plans are new to the market and no AV calculator is available

Sample Pediatric Dental Policy

Terms

- Deductible
  - Consumer's cost before coverage starts
- Coinsurance
  - Portion paid by insurance company and the remainder is paid by the consumer (e.g. 80% paid by insurance company and 20% paid by consumer)
  - Higher coverage percentage for in-network vs. out-of-network
- Out of Pocket Maximum
  - Maximum consumer can pay above deductible costs for amounts paid as coinsurance
  - Will be particularly meaningful for people who require extensive and/or expensive dental services

Typical Commercial Pediatric Dental Policy

- $50 deductible
- Class I services – usually covered 100%
  - Diagnostic, Preventive Services (e.g., cleanings, exams, fluoride, x-rays, sealants)
- Class II services - usually covered at 80%
  - Basic restorative care and periodontics (e.g., fillings, oral surgery, root canals, scaling and root planing)
- Class III services – usually covered at 50%
  - Major restorative care (e.g., crowns, bridges, dentures)
- Class IV services – coverage varies but generally up to 50%
  - Orthodontia (e.g., braces, retainers)

Premium Rate Impacts

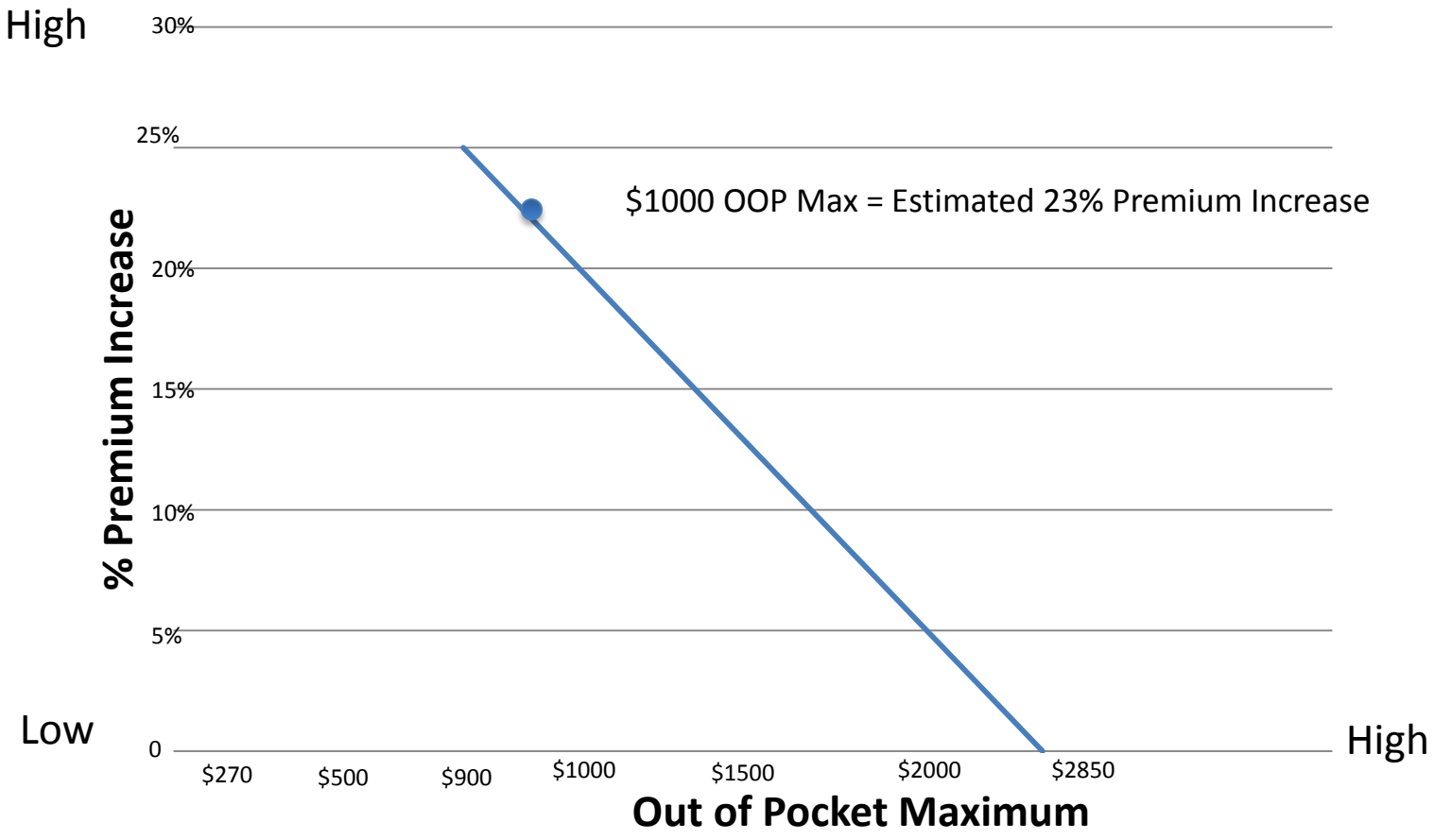
Out of pocket maximums create risk

- Out of pocket maximums are new to the commercial dental industry
- Historically stand-alone dental plans have used “annual maximums” and not out of pocket limits
  - Annual benefit maximums worked by limiting the amount of services a consumer could get in a plan year
  - Claims costs limited to $1500 - $2500 per plan year
- Moving to out of pocket maximums introduces new risk into premium pricing for dental carriers
  - No ability to control/project dental cost by setting an upper limit
  - Unknown claims exposure since benefits are not capped

Conundrum: The lower MHBE establishes the out-of-pocket maximum, the higher the premium.

- Factors Influencing Premium:
  - Cost-Sharing; and
  - Benefits(Preventive, Orthodontia, etc.).
- As cost-sharing rises, premium decreases, vice versa.
- Only the APTC available after the purchase of a QHP can be used to pay for the premium of a stand-alone dental plan.
- Cost-Sharing reduction assistance does not apply to stand-alone dental plans.

Conundrum: The lower MHBE establishes the out of pocket maximum, the higher the premium.



Source: Milliman Study November 2012. *Out of Pocket Maximum for Pediatric Dental and Orthodontia Benefit Plan to Prevent Catastrophic Dental Costs*

Recommendation

Out of Pocket Maximum

Federal and/or State Requirements	Options
The Final Rule on Essential Health Benefits released by the HHS indicates that state-based exchanges must decide what constitutes a reasonable out of pocket (OOP) maximum for pediatric stand-alone dental plans.	1. Perform a study to identify the appropriate OOP maximum to be used and how these limits will impact premiums and consumer uptake. 2. For pediatric coverage, use OOP maximums that will be used by the Federally Facilitated Exchange • 1 child - $1000 OOP max, no annual/lifetime limits • 2 or more children - $2000 OOP max, no annual/lifetime limits
Key Considerations **Current Market Practice** Stand-alone dental plans have not traditionally used OOP limits in Maryland. No Maryland specific historical data is available. **Timing** Stand-alone dental plans must file their plans to the MIA by 3/22/13. **Consumer Impacts** OOP limits used will impact the affordability for stand-alone dental plans. Lower OOP limits will result in higher premium costs. Higher OOP limits will result in lower premium costs.	**Recommendations** For year 1, stand-alone pediatric dental plans must use the same Out-of-Pocket limits that will be used by the Federally Facilitated Exchange. • 1 child - $1000 OOP limit, no annual lifetime limits • 2 or more children - $2000 OOP limit, no annual lifetime limits Evaluation & Re-Assessment For year 2, the MHBE will perform a study to identify the impact of key dental issues including OOP limits on consumer affordability, consumer uptake of stand-alone and opportunities for coordination across carriers.

Next Steps - Carriers

- Work with the MIA to ensure carriers are made aware of the out of pocket maximums required for pediatric dental plans

- Stand-alone pediatric dental plans must be filed on or before March 22, 2013

Next Steps - CCIIO

- As noted, CCIIO limits premium assistance for stand-alone dental coverage raising questions about affordability of these plans.

- Write CCIIO and the IRS requesting that they consider expanding the interpretation of the rules regarding advanced premium tax credits to provide greater assistance to those seeking to purchase a stand-alone dental plan.

Questions?

Thank you!

For questions on the information
contained in this presentation, please contact:

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