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Dental Market Overview

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Overview

- **How Dental Insurance differs from Medical Insurance**
  - Plan Design
  - Rating Considerations
  - Nature of the Risk
  - Data
- **Market Overview**
  - Enrollment Trends
  - Funding Trends
- **Current/Future Key Issues**

HOW DENTAL DIFFERS FROM MEDICAL

Basic Components of Dental Plan Design

Dental insurance is **different** from medical insurance:

- Designed to **emphasize preventive care** over catastrophic coverage
- **Elective** nature of many dental benefits compared to medical
- Often sold on **voluntary** basis
- **Cost sharing** designed to limit adverse selection
- Substantial **out-of-pocket cost** and **benefit limits** to control utilization
- Benefits divided into **class structure**

Classes of Dental Benefits

- **Class I – Preventive and Diagnostic**
  - Oral Exams, X-Rays, Cleanings, Fluoride, Sealants
- **Class II – Basic**
  - Fillings, Endodontics, Periodontics, Extractions
- **Class III – Major**
  - Inlays, Onlays, Crowns, Bridges, Dentures
- **Class IV – Orthodontics**
  - Sometimes excluded, or included just for children

Common Plan Designs (Pre-ACA)

- **Coinsurance**
  - Common Plan Coinsurance Structure by class- 100%/80%/50%/50%
- **Deductible**
  - May be waived for certain services (e.g. Class I)
- **Annual Benefit Maximum**
  - Industry standard on employer-sponsored plans
  - Often separate annual or lifetime max for orthodontia
- **OOP Maximums** – Rarely found in dental policies

Adverse Selection in Dental

- Relationship between risk and purchasing behavior
- Many dental benefits are elective, especially Class II and Class III benefits
- Immediate coverage of these benefits creates large opportunity for adverse selection
- Important to construct product design to mitigate adverse selection

Avoiding Adverse Selection

- Waiting periods
  - The amount of time immediately following the member's effective date for which the plan does not reimburse expenses for specified services
- Placement of certain services in Class II versus Class III
  - Endodontics, Periodontics and Oral Surgery may be covered as Class II or Class III services
- Progressive Benefits
  - Increase in coinsurance levels in years 2+
- Annual Benefit Maximums
  - Limits coverage of expensive benefits such as implants and dentures
- Benefit Exclusions
  - Missing tooth

Selection and Durational Loss Ratios

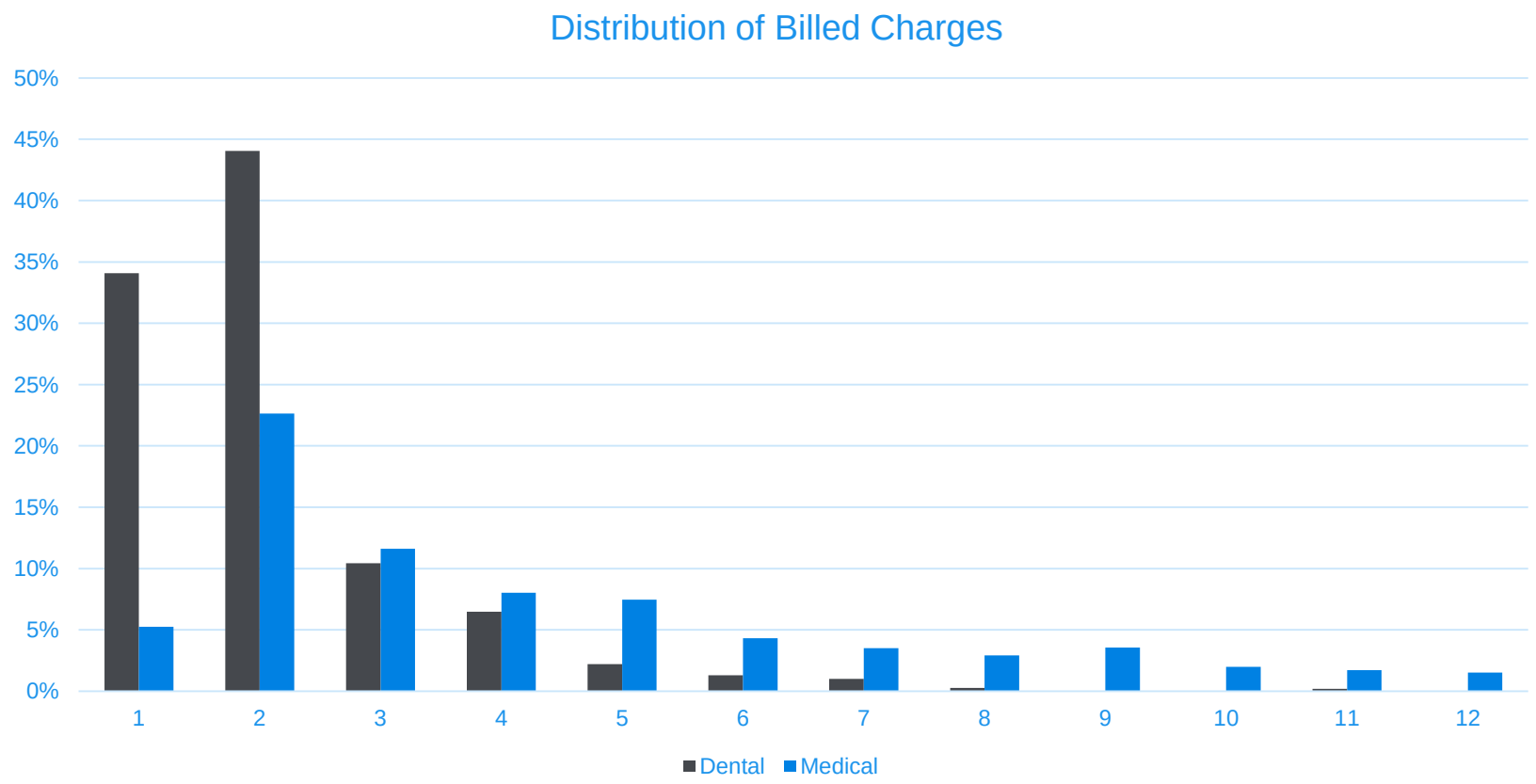
- **Only a mature block of stand-alone dental business will have stable loss ratios**
- **New policy form with waiting periods**
  - 1st year claims lower than lifetime target loss ratio
  - 2nd year claims might be higher than lifetime target loss ratio
    - Example: Pent-up demand with a 12 month Class III waiting period
- **New policy form without waiting periods**
  - 1st year claims much higher than lifetime target loss ratio due to adverse selection
  - Cumulative loss ratio higher than lifetime loss ratio for several years depending upon multi-year pricing model
  - Could present cash flow issues for insurer

Claims Cost Differences – Distribution of Charges

- **Dental claims have much lower volatility than medical claims**
- **"Zero Bucket"**
  - Dental – 35%
    - Even with focus on Preventive and Diagnostic care
  - Medical - 5%

Source: Milliman's Health Cost Guidelines - Dental

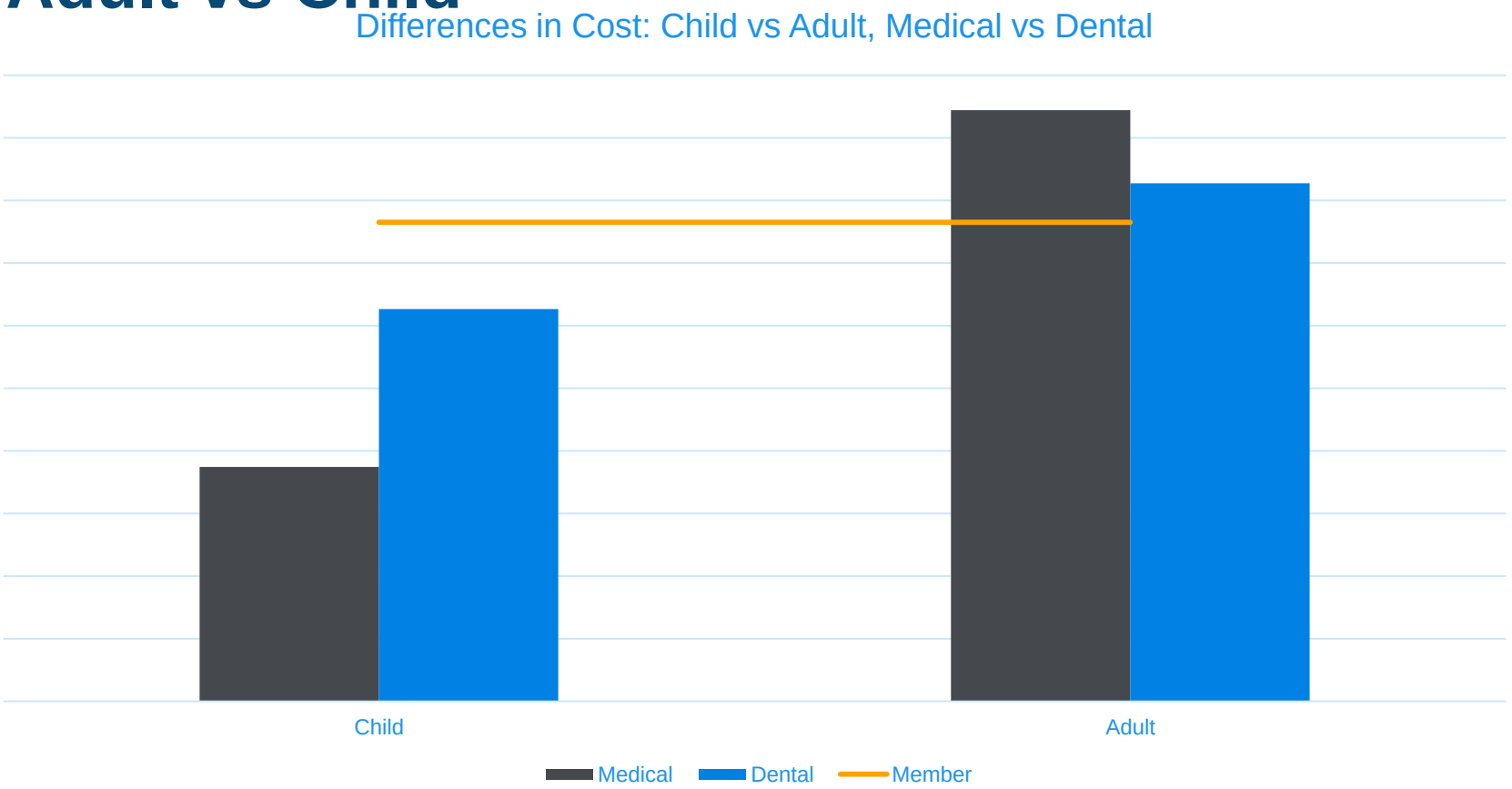
Claims Cost Differences – Distribution of Charges



*Only 75% of medical distribution shown

Source: Milliman's Health Cost Guidelines - Dental

Claims Cost Differences – Medical vs Dental, Adult vs Child



- Dental Child Claims – High Frequency, Low Severity
- Dental Adult Claims – Low Frequency, High Severity
- Ortho could change the relationship shown

Source: Milliman's Health Cost Guidelines - Dental

Dental Data

Dental Data - Composition

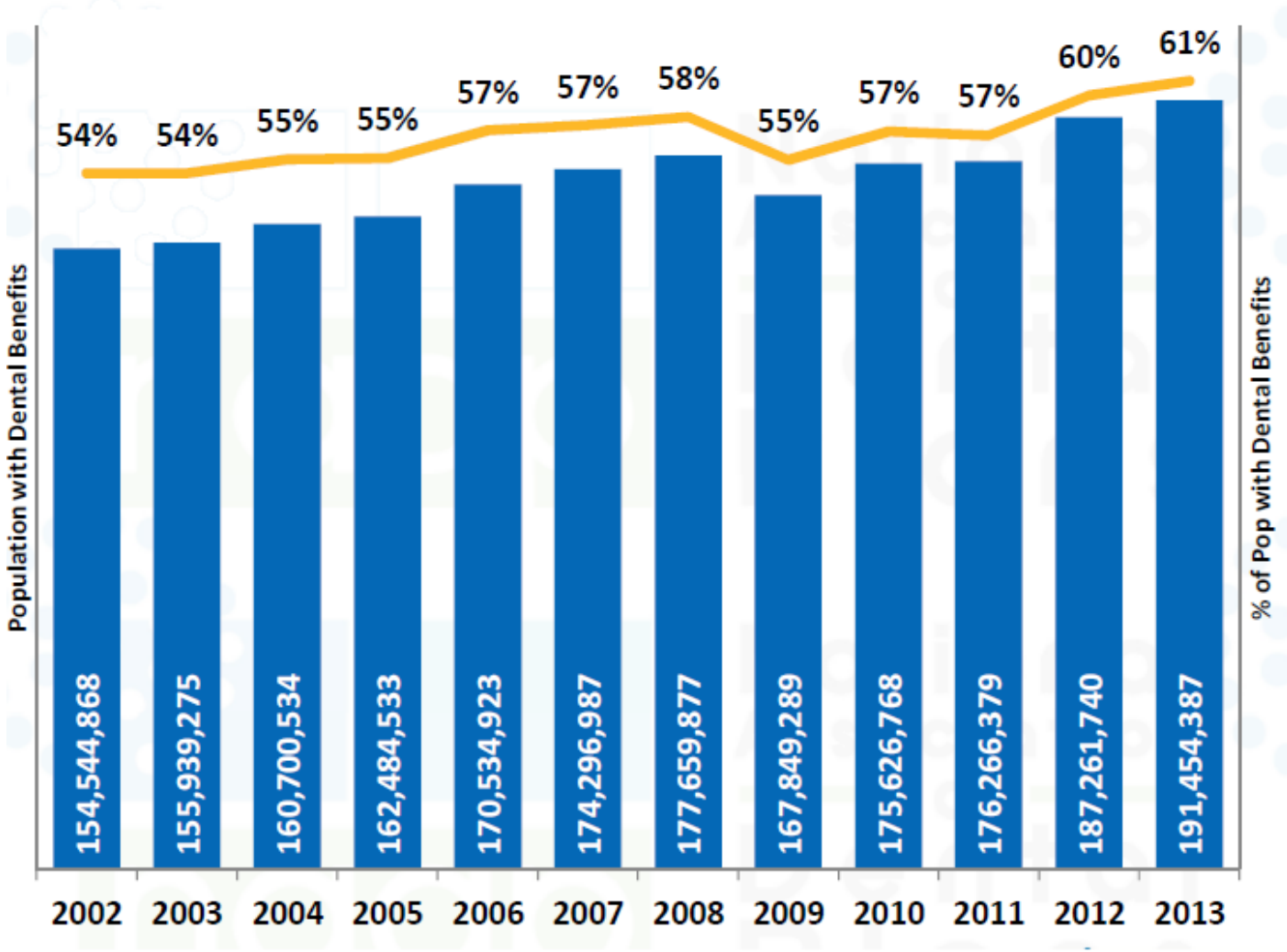
- **Dental procedure codes follow a uniform code type**
  - ADA Codes – CDT Codes - “D” Codes
  - DXXXX
  - Hundreds of different codes

% Of Total Cost	Number of Codes
50%	10
90%	40
95%	60

Source: Milliman’s Health Cost Guidelines - Dental

INDUSTRY OVERVIEW

Enrollment Trends



Source: NADP 2015

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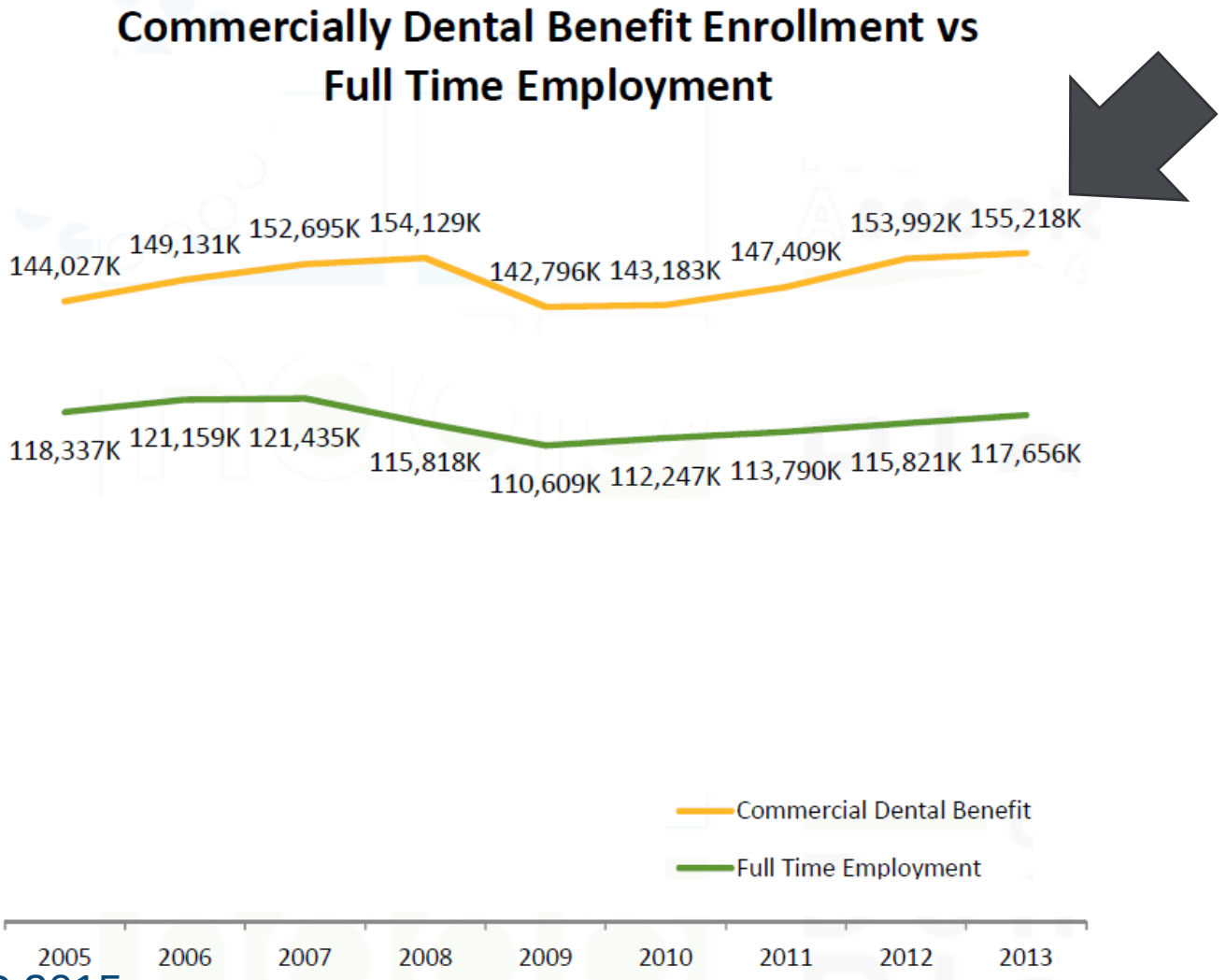
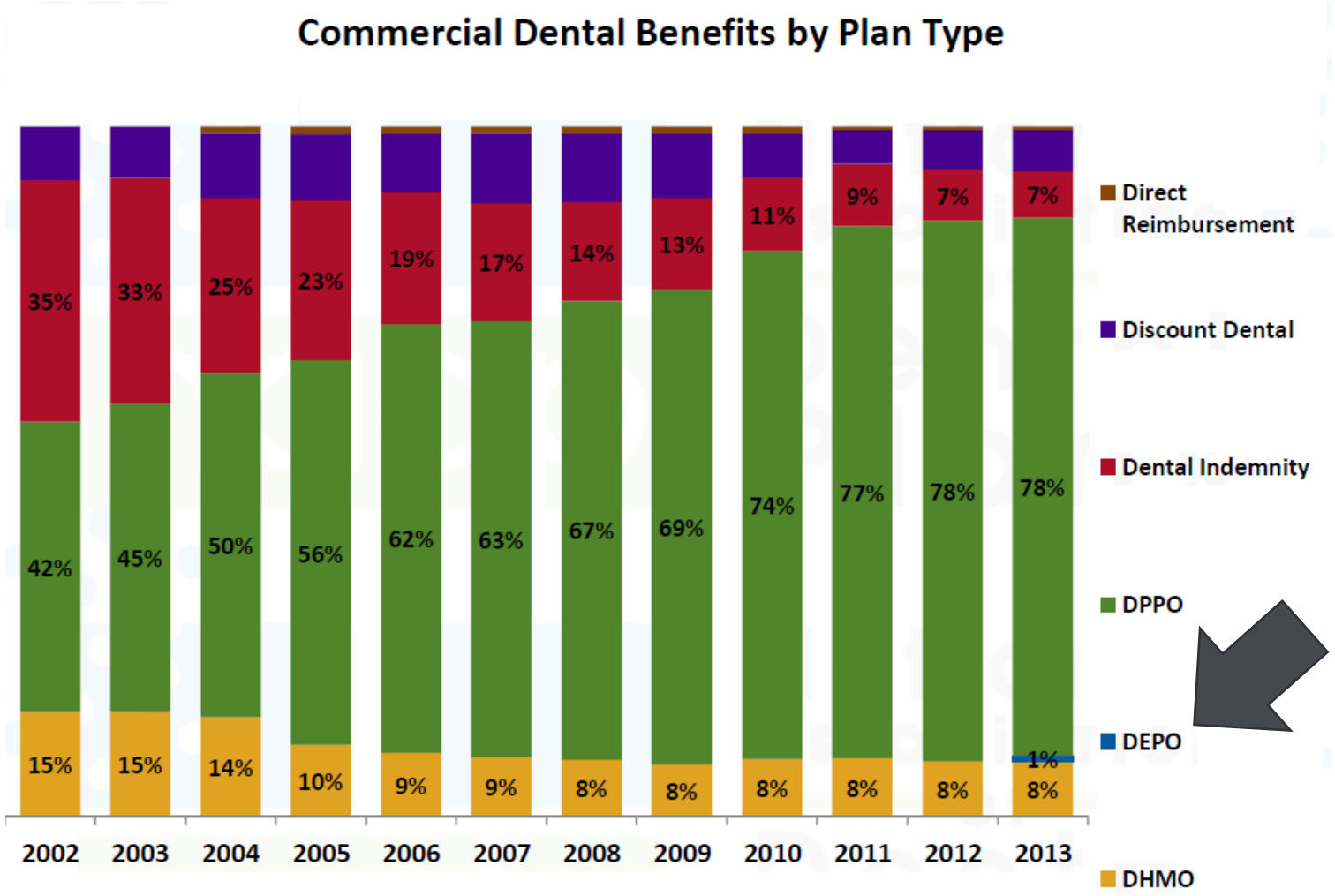
Enrollment Trends - Commercial



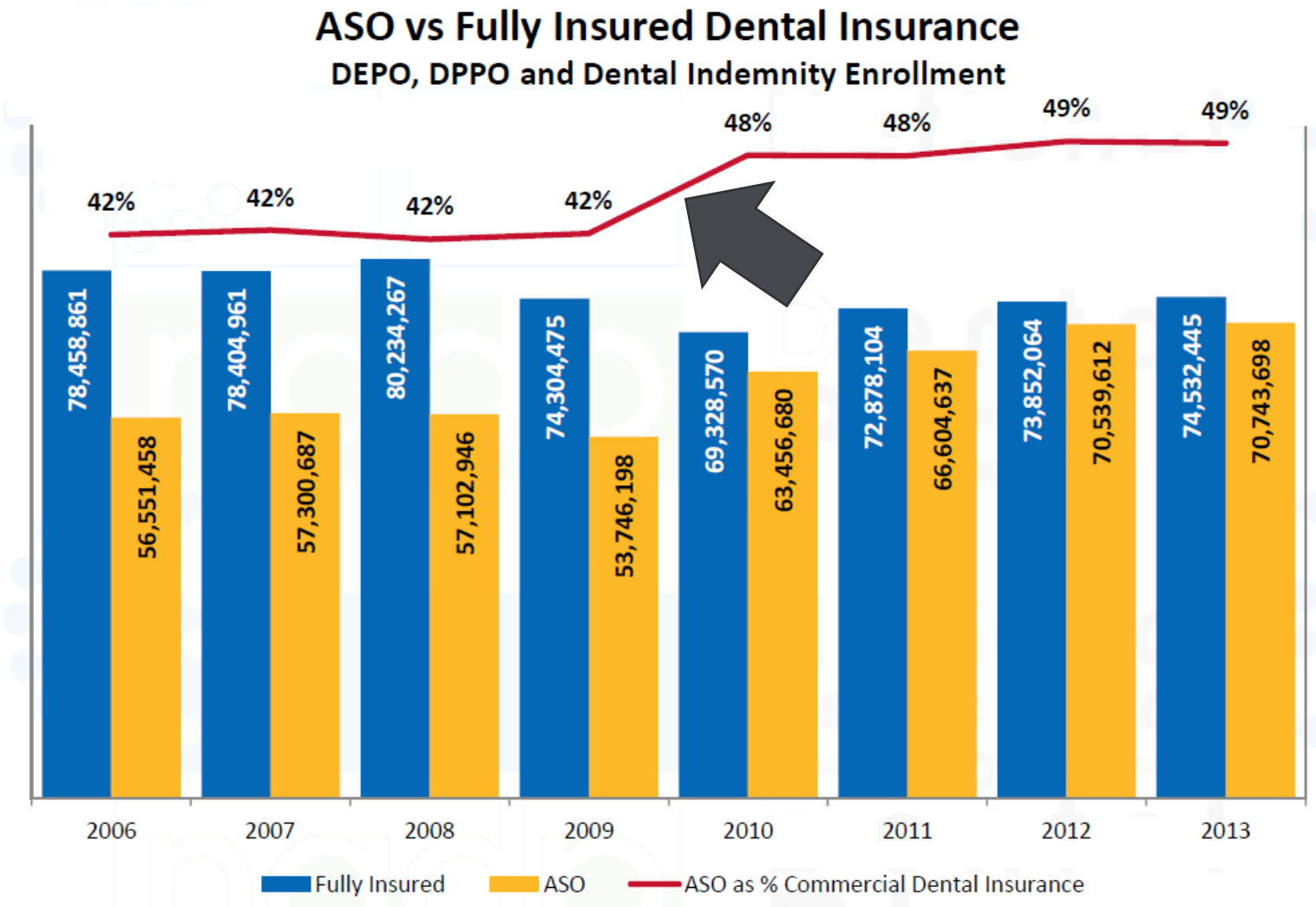
Source: NADP 2015

Enrollment Trends - Commercial



Source: NADP 2015

Enrollment Trends – ASO vs Fully Insured



Source: NADP 2015

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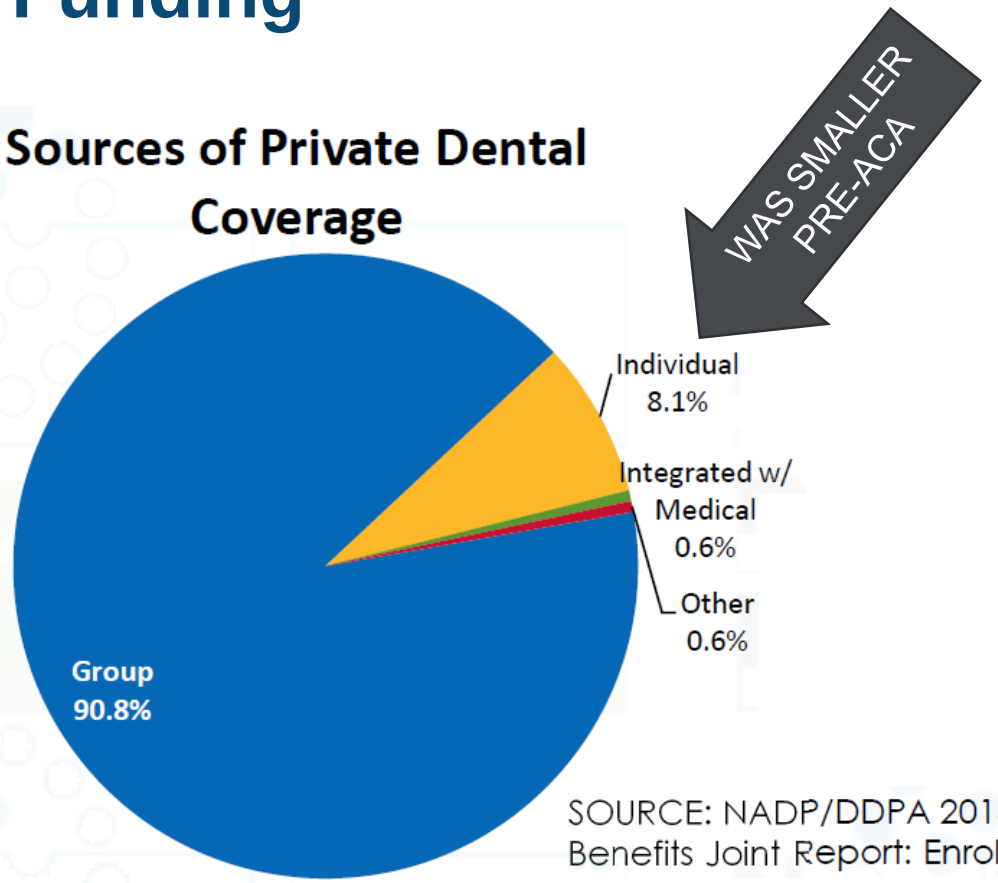
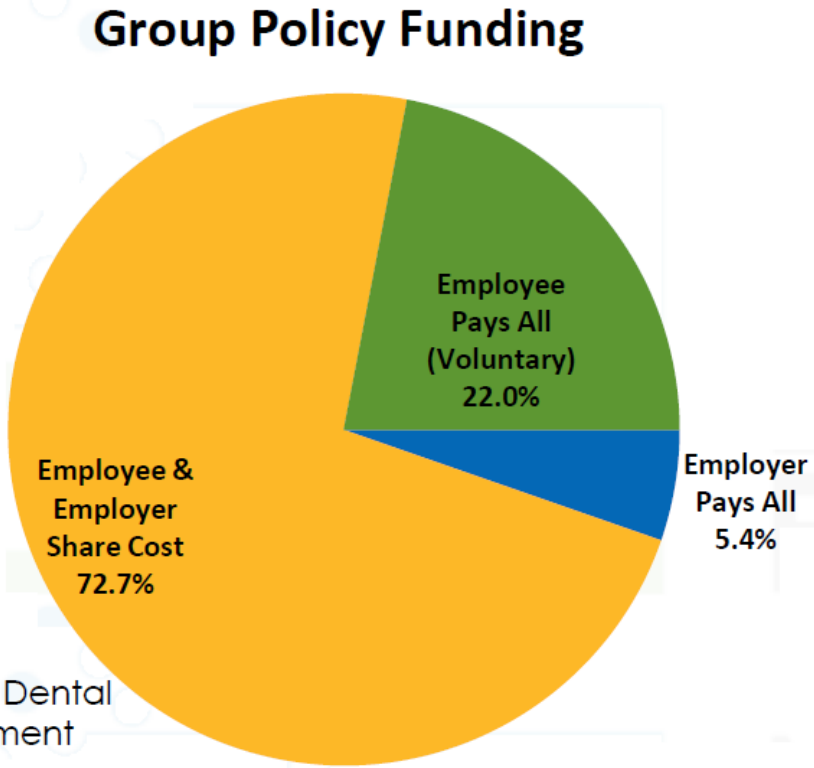
Enrollment Trends – Benefit Sources and Funding

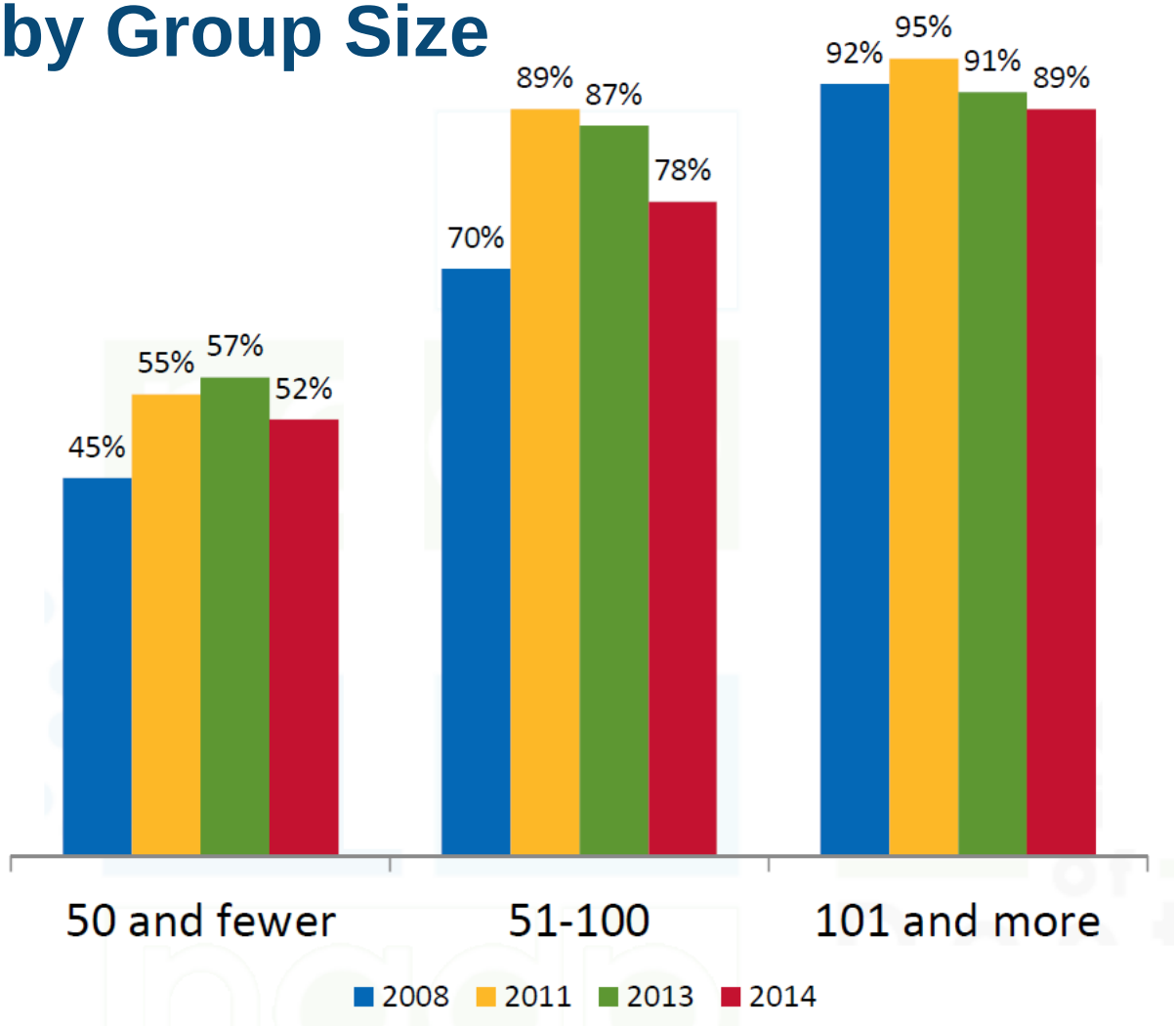


SOURCE: NADP/DDPA 2014 Dental Benefits Joint Report: Enrollment



- Minimum participation % is important

Enrollment Trends – Likelihood of Dental Benefit Offering by Group Size



Source: NADP 2015

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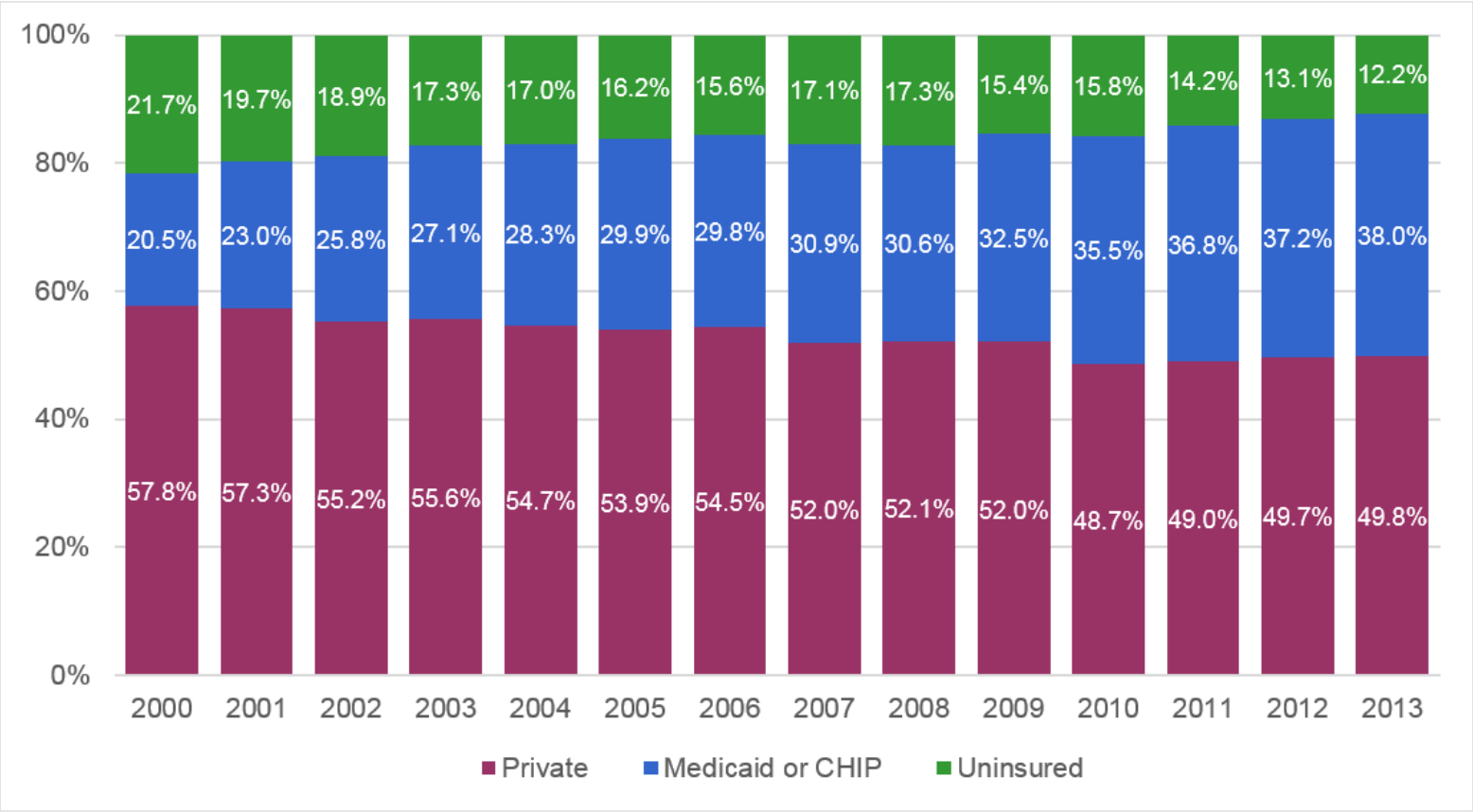
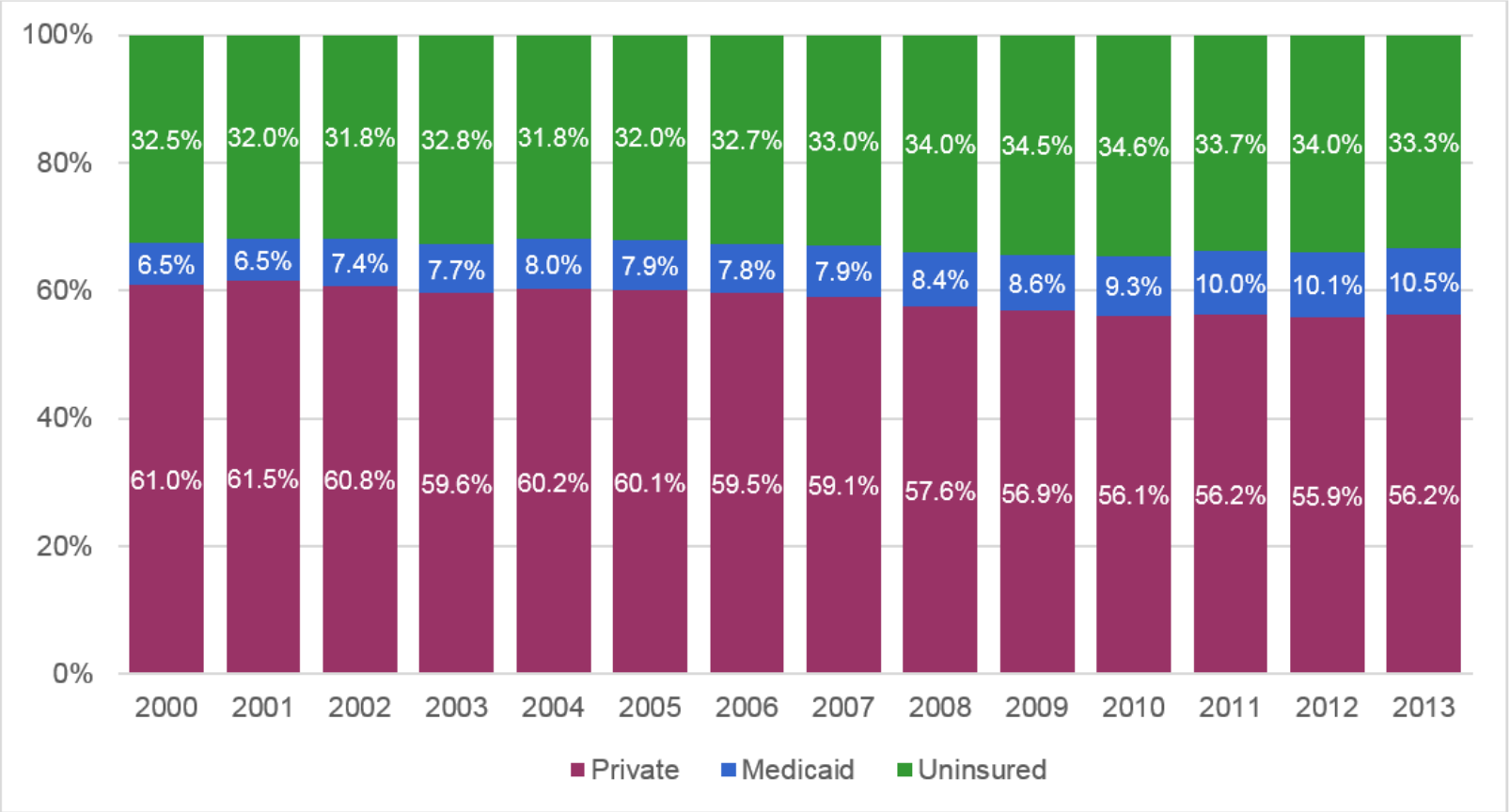
Dental Benefits Coverage – Children Ages 2-18



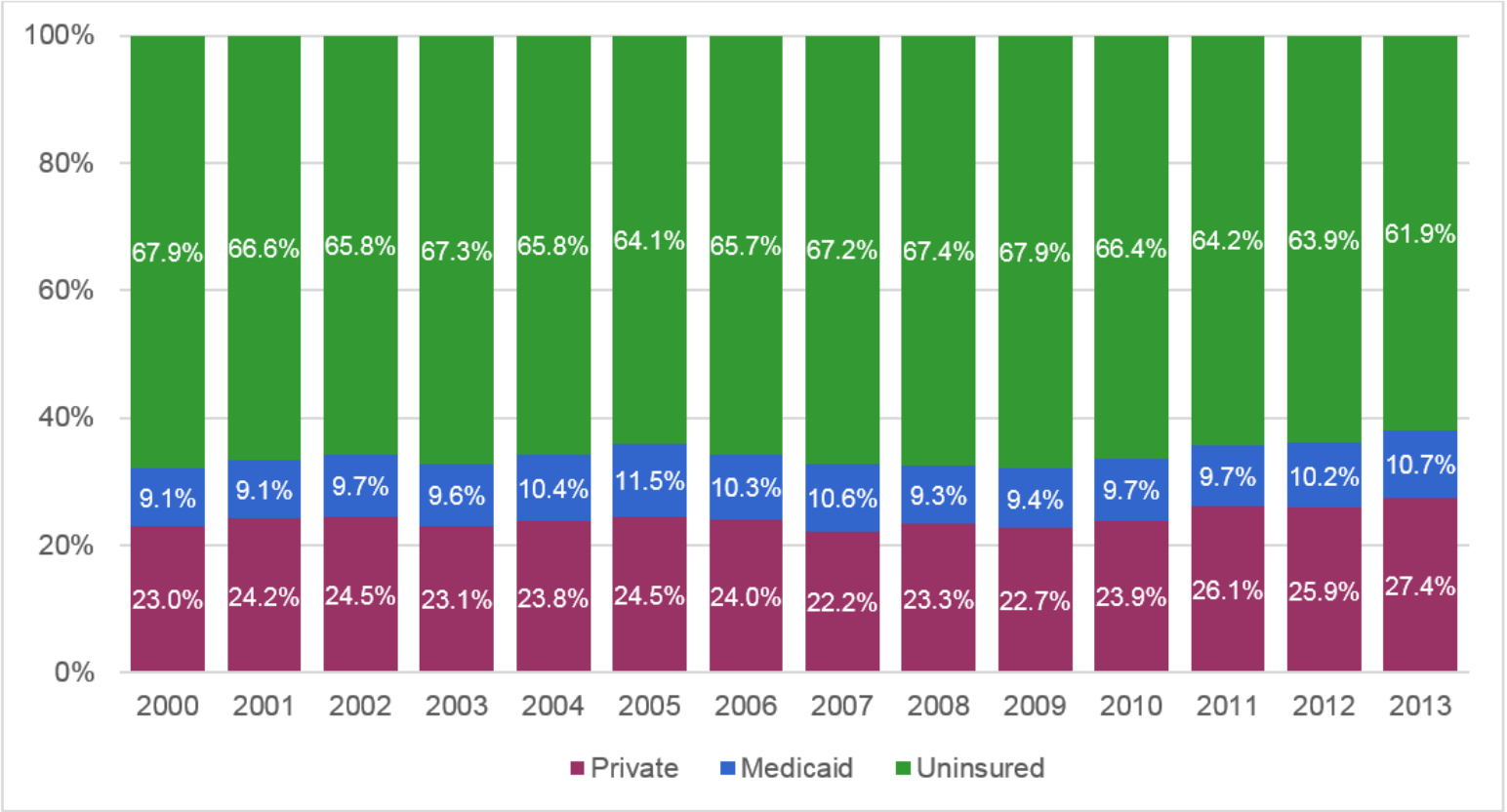
Source: Health Policy Institute analysis of the Medical Expenditure Panel Survey, AHRQ. **Notes:** All changes were significant at the 1% level (2000-2013). All changes from 2012 to 2013 were not statistically significant.

Dental Benefits Coverage – Adults Ages 19-64



Source: Health Policy Institute Analysis of the Medical Expenditure Panel Survey, AHRQ. **Notes:** Changes for private and public were significant at the 1% level (2000-2013). All changes from 2012 to 2013 were not statistically significant.

Dental Benefits Coverage – Adults Ages 65+



Source: Health Policy Institute analysis of the Medical Expenditure Panel Survey, AHRQ. **Notes:** Changes in private and uninsured were significant at the 1% level (2000-2013). Changes in private and public from 2012 to 2013 were not statistically significant. Changes in uninsured from 2012 to 2013 was statistically significant at the 10% level.

CURRENT/FUTURE KEY ISSUES

Dental Industry Emerging Issues

- **Loss Ratio Requirements**
- **Potential for innovation**
  - Use of mid-level providers/dental hygienists
  - Embedded plans
    - Connections between oral health and overall health
  - Provider consolidation
  - Narrow Networks
- **What else?**

Caveats and Limitations

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Questions?

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