Dental is Different

Why application of a medical loss ratio to dental benefits doesn’t help, but harms consumers and providers

If MLRs are good for medical, why not dental?

Congress explicitly exempted dental from loss ratios in the ACA. Here's why.

- **The ACA overhauled how medical insurance was offered, thereby increasing access and affordability for many more Americans, and significantly increasing enrollment for all participating health insurers**
  - The ACA mandated every American without employer coverage buy an individual medical plan.
  - SCOTUS threw out the mandate, but enrollment still grew significantly thanks to tax credits for income-eligible Americans, later expanded under ARPA.
  - Other than the limited pediatric dental requirement, essential health benefits do not include dental.

- **The ACA standardized exchange-medical plans by setting their actuarial value at Platinum, Gold, Silver, & Bronze, creating an apples-to-apples comparison for consumers, and a level playing field for insurers.**
  - The "Stabenow amendment" enabled voluntary adult dental to be sold on the public health exchanges, but without tax credits and without standardized actuarial value.
  - This means a great variety of dental plan designs are available today on exchanges and off in many different forms, at many different price points.
  - All these dental products require a similar degree of administration, but the denominator (premium) is all across the board.

- **Lacking new enrollment or standardization, DLRs are impractical and bad public policy.**

DELTA DENTAL®

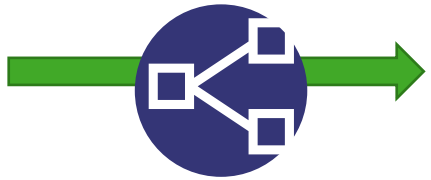
A solution in search of a problem

What exactly are we trying to solve for with a DLR?

Net gains for dental carriers without any current loss ratio requirement are far less on average than for medical plans compliant with 80-85% MLR

Just 2.5 to 3 percent for most standalone dental carriers

Net gains are even less for some dental plans bundled with medical, subsidized with profits from the medical side.



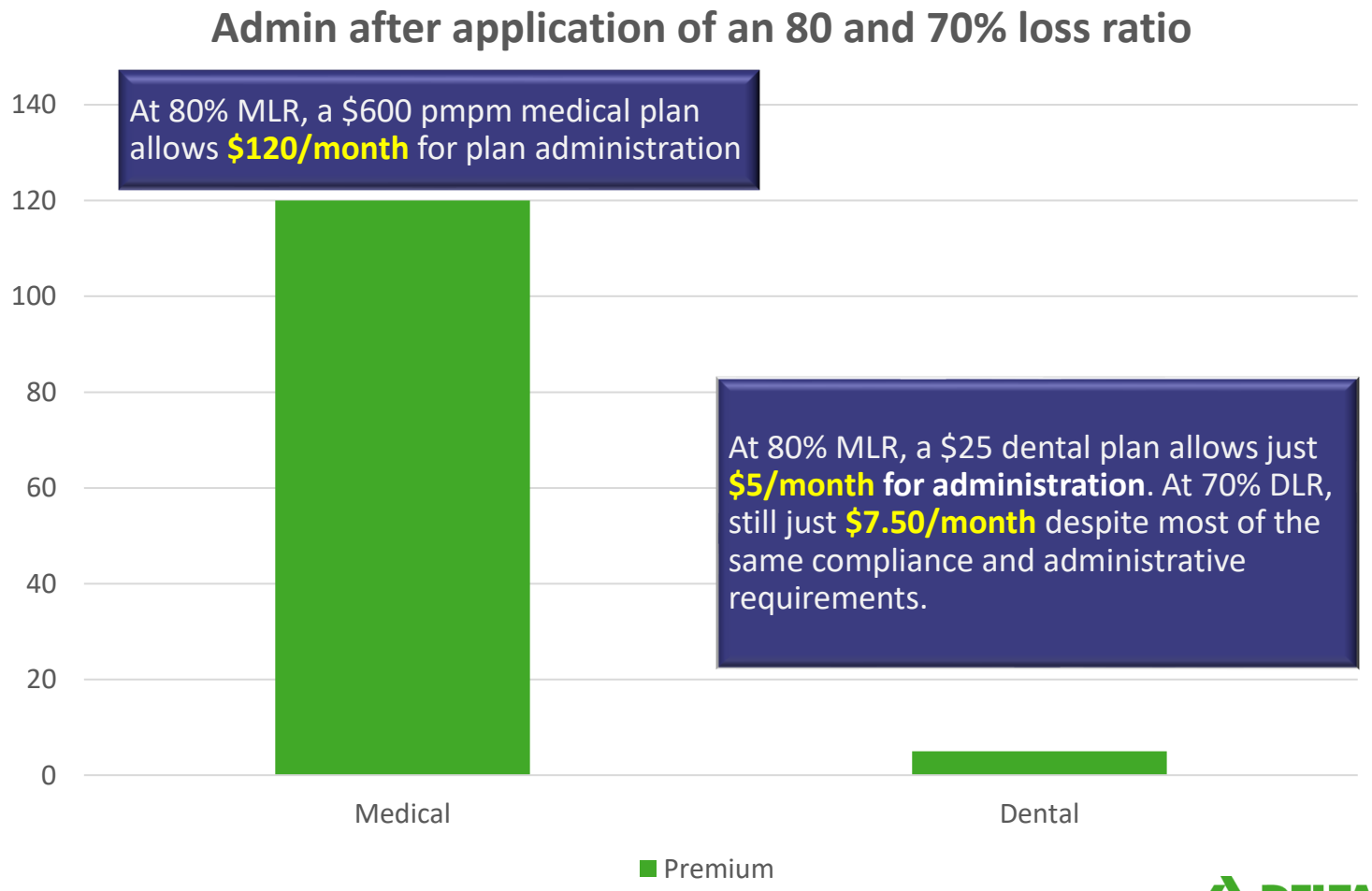
This very low net profit is predicated on high volume/takeup in the dental benefits marketplace

DELTA DENTAL®

Medical and Dental are just different

It’s a chiefly matter of scale

With premium in the denominator so low for dental, it’s impractical to administer individual and/or small business segments (among the least likely to be insured) with such small real dollars, compared with medical.



DELTA DENTAL®

DLR in CA

Let's look at the numbers

Small group and individual products pay higher broker commissions (as a percent) and face higher cost of acquisition, pushing the DLRs lower than for other lines of business.

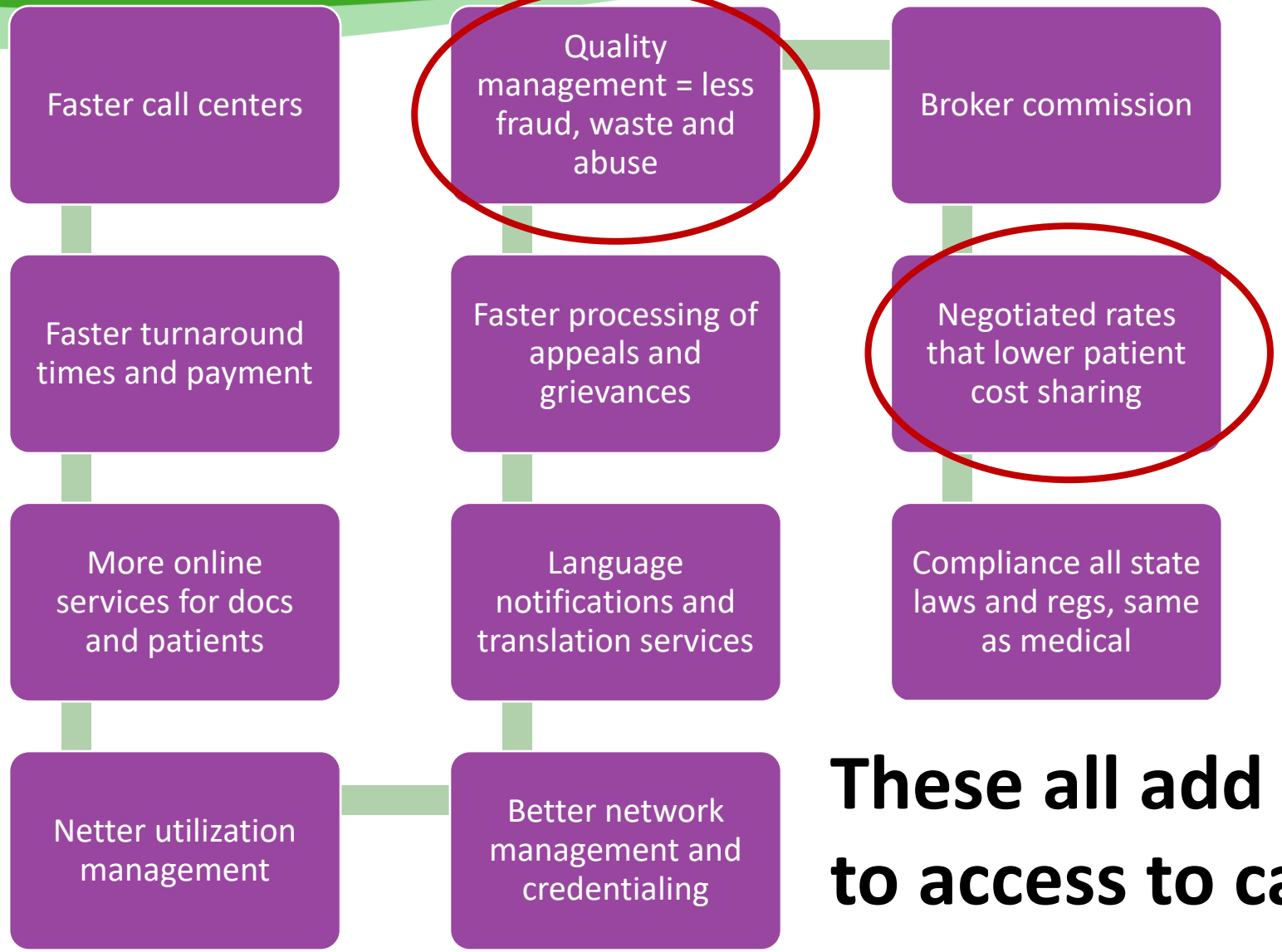
Source for chart at right:
dmhc.ca.gov

Year	DMHO			DPPO & Indemnity		
	Individual	Small Group	Large Group	Individual	Small Group	Large Group
2021	60.90%	48.90%	66.60%	61.50%	58.30%	88.20%
2020	62.70%	48.40%	65.90%	60.10%	58.40%	87.30%
2019	62.90%	48.80%	67.80%	59.50%	59.90%	88.50%
2018	64.10%	49.90%	68.40%	61.20%	60.60%	88.20%
2017	62.70%	50.50%	68.20%	65.50%	62.40%	88.70%

DELTA DENTAL®

Administrative costs equals administrative services!

Mandated DLRs squeeze investment in better provider and consumer experiences

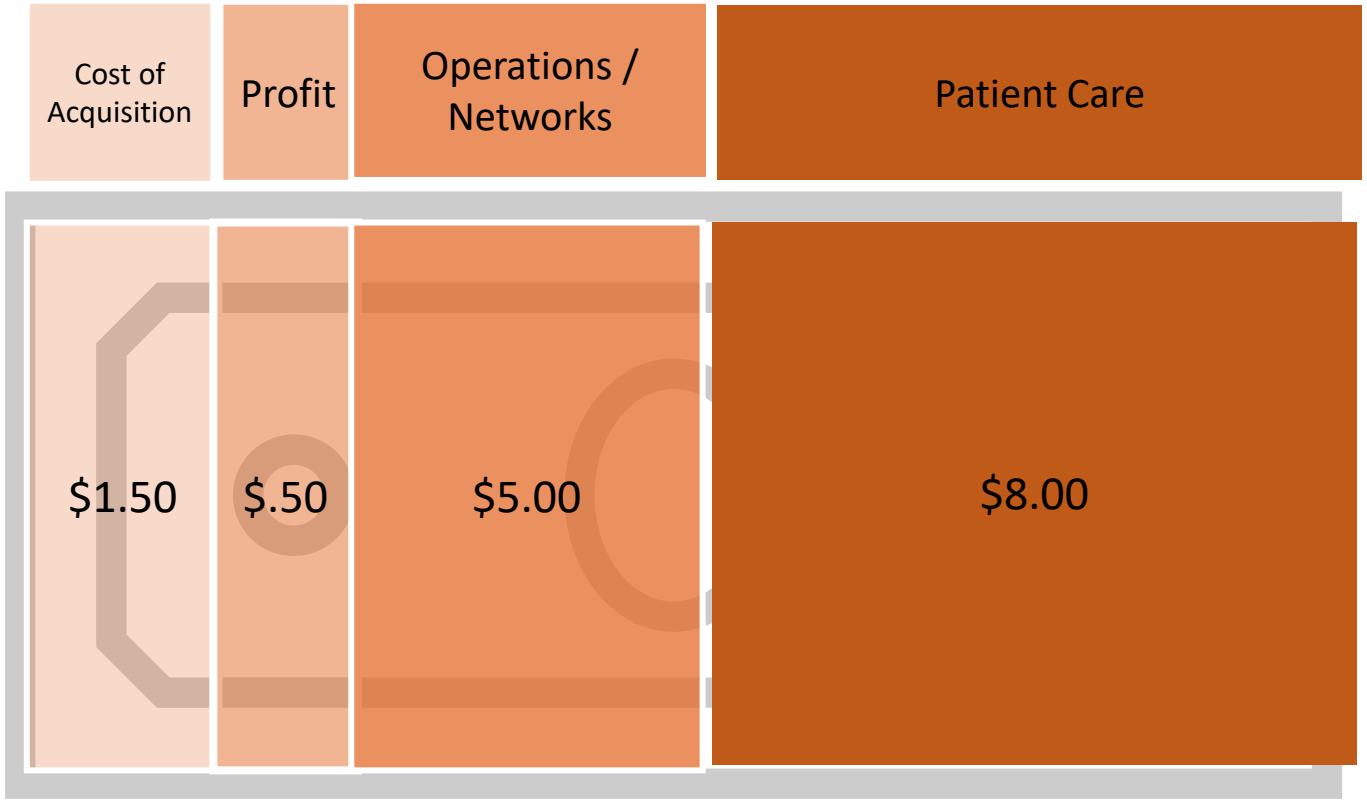


These all add up to access to care.

DELTA DENTAL®

Admin takes big bite out of low monthly premiums

How a month's $15 premium for Individual & small group gets spent



The lower the premium, the greater value for a consumer, despite a lower DLR, even if real dollars spent on administration is minimal.

8/15 is a 53% DLR

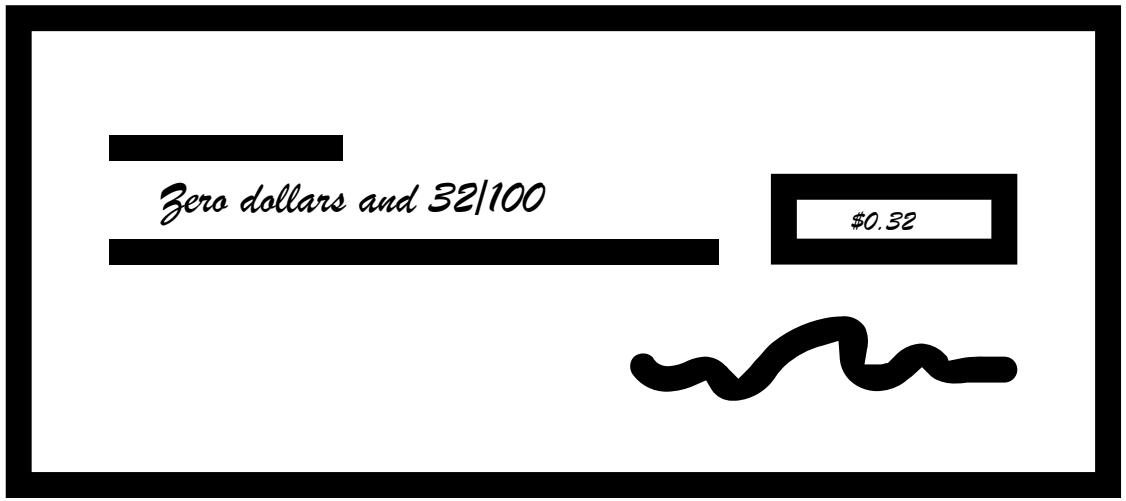
(taxes would lower this still further)

DELTA DENTAL®

Rebates are self defeating

It will cost more to issue most rebate checks than the amount being rebated

Rebate Check



Cost to Print

Envelope	$0.04
Printing	$0.33
Paper	$0.30
+ Postage	$0.60
Total	$1.27

…which further drives up cost of admin, which further drives down the DLR and increases our carbon footprint.

DELTA DENTAL®

How much value can a $13 (a month) dental plan actually deliver at a 58% DLR?

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:

*Note there is no annual limit on benefits!

DHMO	You Pay (Premium + OOP)[1]	Market Value[2]
2 Exams	0	$234
2 Cleanings	0	$222
2 X-rays	0	$158
Filling	$25	$332
Root canal	$170	$1,485
Crown	$350	$1,414
Annual Premium	$155.88	
Total	$700.88	$3,845
Enrollee's net savings:	$3,144	

[1] Based on copays for our California DHMO exchange plan
[2] Based on California average costs, using Fair Health database

DELTA DENTAL®

How much value can a $57 dental plan provide, with a 7% higher (65%) DLR?

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:

* Note there is a $1,500 annual maximum on benefits!

PPO	You Pay (OOP)[1]	Market Value[2]	Amount toward max
2 Exams 2 Cleanings 2 X-rays	0	$598	$316
Filling (single surface composite)	$21	$332	$84
Root canal	$364	$1,485	$364
Crown	$404	$1,414	$404
Annual Premium	$684	N/A	
Total	$1,473	$3,829	$1,168
Enrollee's Net Savings	$2,356		

[1] Based on benefit for our California PPO exchange plan and average dentist fees
[2] Based on California average costs, using Fair Health database

DELTA DENTAL®

Premium impacts in West Virginia

What a DLR at 80% does to the affordability of current dental offerings

WV	Basic
Current Premium	11.52
Current Minimum Loss Ratio	60%
Current Maximum Admin	40%
Current Admin Premium $	4.61
Proposed Minimum Loss Ratio	80%
Proposed Maximum Admin	20%
Proposed Premium	23.03
Increase Required	**100%**

For illustrative purposes only, this analysis based on an actual dental plan offered by Delta Dental in the West Virginia health exchange.

To meet a DLR of 80%, were our product portfolio limited to small group and individual products, we'd need to double the premium, putting these products out of reach for many thousands of West Virginians.

DELTA DENTAL®

There is only one possible conclusion!

Higher loss ratios ≠ better or more dental care

Dental Benefits Today:	• More affordable; offer more benefits w/o annual max; more often selected by people who would otherwise be uninsured.
Dental Benefits Under a DLR:	• Less affordable; have annual max with higher OOP costs (which leads some people to defer dental care).

DELTA DENTAL®

How will the market react to the imposition of a DLR?

Expectation, meet reality

How dental plans will likely react

- Exit or at least greatly reduce and curtail sales of their small group and individual book of business
- Exit health exchanges
- Self-insure all other groups, removing those plans from state regulation
- A few *might* try to eliminate some administrative services, hurting both customers and dentists

How dental plans won't react

- Increase dentist reimbursement above current in-network rates (market-driven)
- Increase patient coverage (employer-driven)
- Increase premiums above the market price

How consumers will react

- Withdraw or never buy a dental plan
- Defer needed dental care

How dentists will be affected

- Fewer patients; people without insurance are only half as likely to visit their dentist
- With fewer dentist visits, oral health will worsen. Diagnostic and preventive care will decline
- Fewer networks to choose from; small group insurers will leave the marketplace

DELTA DENTAL®

Are there other alternatives?

At least gather data and allow regulators to investigate the matter

In Maine this last legislative session, the Governor's office and the state legislature found it impossible, based on the absence of data or research, to determine whether a DLR threshold should be set, and if so, and at what level. Stakeholders hammered out a compromise approach. Like most compromises, what was arrived ay pleased no one. But at least it did not cause any one harm.

The Maine "compromise"

1. Dental plans submit their DLR annually to the regulator, using a standardize template mimicking the medical MLR reporting template.
2. The regulator tracks these rates for all regulated entities for at least three years to look for trends and outliers.
3. Regulator is charged with investigating any "outlier" whose DLR trends more than 1.5 times the standard deviation from the mean DLR of all companies.

…at least allows regulators to answer these basic questions:

1. Is there even a problem here?
2. How low is too low, and how (if at all) does it impact enrollees, dentists, or correlating to consumer complaints?
3. Might the regulator issue a corrective action plan to address an outlier determined to be "troublesome?"

DELTA DENTAL®

Questions / Discussion