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CORRESPONDENCE MEMORANDUM

DATE: October 23, 2012

TO: Group Insurance Board

FROM: Emily Loman, Manager, Alternate Health Plans
Bill Kox, Deputy Administrator

SUBJECT: Uniform Benefits for Dental Services

This memo is for discussion purposes only. No Board action is required. After this discussion, staff will proceed consistent with the direction provided by the Board, with any necessary follow up information being presented at the February meeting.

Insured Health Plans (Plans) participating in the Group Insurance Board's (Board) program are allowed to offer optional dental benefits at their discretion in addition to the medical benefits required under the Uniform Benefits medical certificate. The self-insured Standard and SMP plans do not have this component.

This memo addresses whether plans that choose to offer optional dental should provide a uniform benefit for dental services. If further action is required, staff will be providing an assessment of a uniform dental benefit to participating plans before making a recommendation to the Board to be incorporated into the Guidelines changes next spring for implementation in 2014. The purpose for beginning this process at this time is to give plans notice and sufficient lead time to make arrangements with their respective dental vendors should such a dental benefit design be forthcoming.

Background

Starting in 1984, plans unilaterally began adding various levels of dental coverage to attract enrollees, typically preventive services used by families with young children. By 1987, collective bargaining agreements required the state to continue to offer comparable insurance going forward and cited plans available in that year as examples of comparability. By this time, most alternate plans, particularly in Madison, had added dental coverage in order to remain competitive.

Board	Mtg Date	Item #
GIB	11.13.12	3C

Reviewed and approved by Lisa Ellinger, Administrator, Division of Insurance Services.

Lisa Ellinger
Signature

10/30/12
Date

In 1993, when uniform medical benefits were proposed, the Board opted to neither require nor prohibit dental benefits, thereby allowing plans to offer the coverage if they choose.

The Board adopted a recommendation in 2002 that a separate stand-alone statewide dental program be implemented, pending a meaningful contribution from the employer. This did not gain traction as the optional dental benefits provided by health plans was essentially cost-free to members; whereas any proposal for a stand-alone benefit would result in additional premium for employees.

Until 2004, the benefits generally remained stable, and several plans had yet to offer any dental benefit. Under the 105% employer premium contribution formula in effect until that time, there was little incentive for increasing dental benefits. By increasing benefits above the routine check-ups and preventive services, the plans were at risk for incurring adverse selection as relatively older individuals tended to favor a broader dental offering. Instead, the incentive remained for plans to limit the breadth of benefits, since they were at less risk of exceeding the 105% premium contribution threshold. Plans generally continued to limit their dental benefits to preventive services.

Beginning in 2004, plans began to gradually increase their dental offerings, as this remained one of the ways they could offer members enrollment inducements. The disincentive to offer broader dental benefits became less of a concern for some plans, and in some ways became a positive incentive to add dental benefits, after the statute was changed to provide for health plan tiering to determine the employer contribution.

While the tier-setting process accounted for the efficiency of dental benefits, it had less of an impact on the extent of dental benefits directly in determining plan tier placement. For this reason, a plan could offer increased dental benefits, primarily by offering coverage most appealing for individuals with higher medical risk, such as periodontics, endodontics, and crowns, and continue to maintain a tier-one placement as long as they managed their medical and dental costs efficiently for that population.

For plan year 2012 and again in 2013, plans were asked to freeze their dental offerings in response to state budget constraints. For 2013, several plans asked to increase their dental benefits and expressed concerns that their inability to materially increase benefits was affecting their competitive position. Staff worked with these plans to modify their offering while remaining cost-neutral, yet there remains considerable disparity in dental benefits offerings and concern over competitiveness.

Discussion

Deloitte reviewed the current dental offerings and developed a preliminary composite dental plan designed to provide a benefit neutral composite of the current weighted average dental benefit. We believe this approach will allow plans to continue to offer dental benefits on an optional basis, address some of the competitive concerns plans

raised, yet prevent any plan from gaining a competitive benefit advantage by either raising or lowering benefits in the future.

The proposed next steps, unless the Board provides different direction at the November meeting, will be to provide Deloitte's assessment of the plans' benefit structures to each individual plan to be certain that it accurately captures the cost of the benefit design. This will ensure that a composite uniform dental plan reflects as accurately as possible the current cost of benefits and that benefit changes overall are actuarially neutral, though individual participants will see benefit differences. Under Wis. Stats. 40.03 (6) (c), the Board is prohibited from making material changes to the benefit plan, and making benefit changes that are cost-neutral is viewed as being in compliance.

Under this scenario, the Board would maintain its 1993 determination that it neither requires nor prohibits dental benefits, thereby allowing plans to offer coverage if they choose, while maintaining control over increases in costs resulting from benefit increases driven by participating plans competitive perceptions. The implementation schedule for this change would be benefit year 2014.

As alternatives, plans could once again be allowed to offer dental benefits in 2014 at their discretion, thereby permitting them to design their own benefits package as they deem necessary. Or, plans could again be asked to freeze the value of their current packages in 2014, though this would not address concerns over the competitiveness of their offerings.

Finally, while this proposal would not directly move the state in the direction of a uniform stand-alone dental program, the exercise of developing a uniform benefit plan would be instructive. If there is a desire amongst the members of the Board to more fully explore this option, staff could be so directed. Whether or not participants were to share separately in the cost of such a dental benefit, statutory changes would be required and the timetable for such a change would likely be beyond 2014.

Summary

Since 1993, alternate health plans have been allowed to offer optional dental benefits as an add-on to the contract. Beginning in 2012, the value of these benefits has been fixed to that offered by each plan in 2011. This has raised significant concerns from several plans that indicate this decreases their ability to compete for state membership on an equal footing.

Staff is developing an actuarially-neutral uniform dental benefit design which would maintain overall benefits to our members, while addressing the plans' concerns. Staff is preparing to present this plan to the Board in February 2013, pending completion of Deloitte's analysis and consultation with participating plans.