A Critical Tipping Point

Why ASOs are surpassing fully insured dental plans in the commercial market and other key trends

by Bruce Shutan
The adoption of self-insured dental benefits is in overdrive as the Affordable Care Act (ACA) becomes fully implemented – much like on the group medical side of the market. The reason: All fully insured coverages, including stand-alone dental plans, were charged a more than 2% tax of total premium revenue beginning in 2014 – an assessment that will reach about 3% by 2016.

Since self-insured plans are exempt from various ACA requirements, they’re now more palatable than ever for dental plan sponsors and the trend is even trickling down market. One notable exception is that pediatric dental qualifies as one of 10 essential health benefits, but it isn’t expected to have much of an impact.

As of 2012, ASO contracts for self-insured dental plans accounted for 49% of the total commercial dental insurance market, which was up from 42% between 2006 and 2009 and 48% in 2010 and 2011. The numbers come courtesy of a long-standing annual survey on enrollment conducted by the National Association of Dental Plans (NADP) in collaboration with the Delta Dental Plans Association since 2002.

Evelyn Ireland, NADP’s executive director, predicts that self-insured dental plans will finally surpass fully insured plans once the 2013 data is finalized – with a 1% to 2% increase in self-insured business nationwide serving as a backdrop.

Additional NADP research supports this notion. Preliminary data from an employer survey, for example, suggests a significant increase in the self-insured dental market between 2013 and 2014, while an NADP analysis of carriers in California, the nation’s largest dental market, pegged ASO market share as high as 60% last year. The latter trend is expected to accelerate.

“In two or three years, there will most likely be a loss ratio applied out in California,” Ireland forecasts. “That’s just another incentive to push more of that business to the self-insured part of the market where you don’t have those limitations.”

The self-insurance trend is also expected to flow further down market as ACA implementation deepens. “When employers up to 100 [employees] become part of the small group market in 2016, they’re going to have their benefit structure dictated to them, and it’s still feasible to self-insure the 50 to 100 size employers,” Ireland says.

**Plan design issues**

Although the ACA sought to widen access to pediatric dental benefits, enrollment in stand-alone plans for children on public health insurance exchanges was only about 16% on average compared to 19% for adults. Employers are busy contemplating prudent plan design changes in this evolving marketplace.

Ireland says one such issue may be subjecting orthodontic coverage to a medical necessity requirement, adding that it’s “pretty much a recipe for a lot of employee complaints.” She says about 30% of children who typically have orthodontia on an annual basis (about 1.6% of all covered children) are estimated to qualify for a midlevel medical necessity requirement on a Salzmann Index of some sort. “We haven’t seen much backlash yet, but it’s still really early in the administration of these policies to get much information back,” she reports.

There may not be many plan design changes in pediatric dental plans, which traditionally have covered most of what is in the ACA requirements. “The difference could be in the coverage level or out-of-pocket cost, especially if it’s a bundled plan,” explains Fred Horowitz, D.M.D., a former practitioner and industry insider, as well as founder of OpenView Consulting, LLC. “There are minor changes, but they’re administratively more complex changes that an administrator would have to have.”

**The rise of ASOs**

In a recent conversation Ireland had with a midsize dental carrier in a highly populated state, she was told that more benefit brokers were suggesting self-insured solutions for smaller companies with between 50 and 100 employees. The individual went on to say national carriers have the economies of scale to manage the self-insured product as they would an insured product.

“Most individual employees don’t know that they’re in a self-insured program because it is still administered by an Aetna, a Cigna, a WellPoint, a UHC, or one of the big carriers,” she observes. “They may get a card that has that carrier name on it, because it is still administered by an Aetna, a Cigna, a WellPoint, a UHC, or one of the big carriers,” she observes. “They may get a card that has that carrier name on it, but it’s actually just managed by the carrier and not a fully insured product.”

While ACA premium taxes on fully insured medical and dental plans will, no doubt, influence whether an employer would prefer an ASO solution, they may not necessarily be a game-changer. “In our experience, it is simply one of many financial dynamics they take into account when making their decision,” reports Mark Moksnes, staff vice president of sales and marketing, specialty sales national accounts for WellPoint.

He says traditional fundamentals remain at the core of any purchasing decision. To wit: Service with meaningful guarantees, access to a strong dentist network and competitive administrative fee pricing. “We are also seeing a growing trend toward employers wanting the administrative simplicity of one bill and one ID card,” he explains. “It makes lives for the employer and their employees simpler.”

Moksnes cites a few key trends that could reshape the dental benefits landscape. One is how clinical integration can improve health outcomes and help lower costs.
“More than 100 medical diseases show signs in the mouth,” he says. “By synthesizing medical and dental claims data, multi-line carries will be in an increasingly strong position to deliver not just benefits, but complete care management programs, to treat the ‘whole’ person.”

Another development is the availability of high-performance networks that confine participation to dentists whose practice patterns deliver savings and are consistent with modern clinical science. “These networks are based on the fact that we’ve demonstrated through the analysis of more than 50 million dental claims that a dentist’s treatment decisions are a much greater factor than their fees for a particular service when it comes to delivering long-term value,” according to Moksnes. “Dentists who look at each patient’s individual needs, rather than on a one-size-fits-all basis, tend to deliver lower claim costs and better oral health.”

**Risk vs. Administration**

Asked whether self-insurance matters when offering voluntary dental benefits, which have become increasingly popular among smaller employers, Horowitz believes the underlying issue is whether carriers are focusing their profit on risk or administration. He sees a shift toward the latter; though there’s also enormous pressure to operate more efficiently because of much smaller administrative fees relative to medical plan carriers.

“Risk has always been something where there’s a potential for profitability loss in the insurance industry across the board,” Horowitz observes. “It’s always been a big portion of the insurance market on the dental side, but I think as dental is becoming a bit more of a commodity, that focus is shifting, and hence the ability to see the rise of more self-insured plans.”

Given this trend, he wonders how smaller dental plans in particular can move to self-insurance, but still believes many dental plans are more efficient than medical plans. “The cost of utilization review and some of the other care-management components of medical are much greater than they are in dental, but the pure administrative functions are almost identical,” he says.

Horowitz also sees the emergence of more managed care-like plans on the dental side in the style of HMOs rather than PPOs within the self-insured marketplace. “There’s not a lot of that now, but I think you’re going to see more and more of it as dental plans continue to innovate to stay relevant and provide all the required coverages,” he says.

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