AAPD 2017 LEGISLATIVE FACT SHEET

RECOMMENDATIONS FOR PEDIATRIC ORAL HEALTH COVERAGE UNDER ACA REPAIR OR REPLACEMENT LEGISLATION

AMERICA'S PEDIATRIC DENTISTS
THE BIG AUTHORITY on little teeth®

REQUEST: To assure that children receive the oral health care they need, and based on experience to date under the ACA, the AAPD makes the following recommendations:

a) Any required health insurance coverage for children should include pediatric oral health coverage, either through an appropriately structured stand-alone dental plan (SADP) or embedded medical plan.

b) Preventive dental services should have first dollar coverage, meaning they should be exempt from cost sharing (deductibles or co-pays) in embedded medical plans and SADPs. Embedded plans should have separate dental deductibles.

c) The Children's Health Insurance Program (CHIP), which has required pediatric dental coverage, should be reauthorized.

d) Any changes to Medicaid should preserve the existing requirement for oral health services for children up to age 21 while lessening financial and administrative burdens in the program.

Background on Pediatric Oral Health Coverage and the ACA. The ACA requires that pediatric oral health care coverage be offered in the individual and small group markets both inside and outside of state insurance exchanges as part of the essential health benefits (**EHB**) package. This must be "equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary." Under the ACA's directive, the Secretary of Labor conducted a survey of employer-sponsored coverage to determine the benefits typically covered. The Dept. of Labor report of April 15, 2011, included the following summary:

> " . . . Plans typically grouped dental services into categories, such as preventive services (typically exams and cleanings), basic services (typically fillings, dental surgery, periodontal care, and endodontic care), major services (typically crowns and prosthetics), and orthodontia. Cost sharing for dental services typically involved an annual deductible—the median was $50 per person. After meeting the deductible, dental plans often paid a percent of covered services up to a maximum annual benefit. The median percent paid by the plan was 100 percent for preventive services, 80 percent for basic services, and 50 percent for major services and orthodontia. The median annual maximum was $1,500; a separate maximum applicable to orthodontic services also had a median value of $1,500."

The Dec. 16, 2011, CCIIO Bulletin indicated that states were permitted to select benchmark plans, defined as: the largest plan by enrollment in any of the three largest small group insurance products in the state's small group market; any of the largest three state employee health benefit plans by enrollment; any of the largest three national Federal Employee Health Benefit Plan (FEHBP) options by enrollment; or the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state. If the pediatric oral health benefit is missing from the chosen benchmark plan, a state must supplement the benchmark to cover the EHB category with one of the following options: the Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment; or the state's separate CHIP dental program. This was confirmed in a FAQ document issued by the CMS Center for Medicaid and CHIP Services on Feb. 17, 2012, and in subsequent federal regulations (Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, Final Rule of Feb. 28, 2013, 78 FR 12834). More recently, federal regulations permitted states to select their own benchmarks for the 2017 plan year. (Proposed Rule of Nov. 26, 2014, FR 70674).

The Problem. *In practice, ACA pediatric oral health coverage has veered significantly from typical employer-based coverage, resulting in higher deductibles and consumer co-payment levels for children's oral health care.* While the AAPD does not take a position as to whether a certain type of pediatric dental insurance coverage (SADP or embedded) or any specific insurer is superior or inferior to another, we know that effective pediatric oral health insurance must encourage preventive care. Otherwise, having coverage will not result in improved oral health status.

The ACA was intended to increase access to dental benefits for children, via enrollment through the individual and small group health insurance markets under state health insurance exchanges. As noted, pediatric oral health is described in the law as an EHB that must be offered in these exchanges, and in individual and small group markets outside of exchanges. Traditionally dental coverage, in employer-based plans and elsewhere, has almost always been offered through separate SADPs rather than directly by medical insurers. In the drafting of the ACA, language was included to allow SADPs to be sold in health care exchanges even though they are not a qualified health plan (**QHP**) because they do not offer every EHB. HHS regulations interpreted the ACA as indicating that a medical plan need not include pediatric dental coverage if a SADP is offered in an exchange. Under ACA regulations, consumers in most states can choose between a SADP for their child, a SADP bundled with a medical plan (available in theory, not in actual practice to date), or a plan with pediatric dental coverage embedded within a medical plan (QHP). Pediatric services are defined as services for individuals under the age of 19, although states have flexibility to extend such coverage beyond the age 19 baseline.

Due to the technical wording in the ACA related to SADPs, HHS has concluded that within exchanges a family can obtain a medical insurance plan (QHP) with no pediatric dental coverage while not purchasing a SADP. This is technically different for someone purchasing a plan in the individual or small group markets outside of an exchange, where the pediatric dental coverage must either be embedded in the medical plan or the plan must be reasonably assured that the consumer has purchased a SADP. However, each state may define *reasonably assured* and for some states it is sufficient that SADPs are merely offered.

Analysis from the ADA Health Policy Institute **(HPI)** demonstrates the validity of concerns about the lack of a true mandate to purchase pediatric dental insurance and the incidence of high deductibles, based on data from 2015 that examined all silver embedded medical plans and SADPs[1]:

- Only 35.7 percent of medical plans included embedded pediatric or family dental benefits. Since a family with this type of plan does not have to purchase pediatric dental coverage via a SADP, many did not. Based on 2014 data, the average SADP purchase rate for children varied from 2.6 percent in South Dakota to 36.0 percent in California in 2014, with an overall average of 15.8 percent.[2] California addressed this gap for 2015 by requiring all medical plans to have embedded pediatric oral health coverage and separate dental deductibles and first dollar coverage for preventive dental care.
- If a plan has first dollar coverage for pediatric preventive dental services, then the consumer does not have to meet a deductible or pay a co-pay or co-insurance when they take their child to the dentist for preventive services. However, approximately 24 percent of embedded medical plans and 56 percent of SADPs did not offer first-dollar coverage for preventive

pediatric dental services. SADP deductibles ranged from $20 to $200. Embedded plans with a separate dental deductible ranged from $25 to $100, but plans with a combined medical/dental deductible ranged from $700 to $6000.**This latter situation clearly discourages a parent from seeking preventive dental services for their child.**

- Data is lacking on how many children obtained dental coverage through embedded plans in 2014 or 2015, and state by state data for SADP purchases was never released. Therefore it is impossible to measure the true impact of the pediatric dental essential health benefit on coverage rates for children.
- Information on dental benefit options was more transparent in the 2015 Federally-Facilitated Marketplace compared to 2014. However, further improvements are necessary especially regarding provider networks and orthodontia cost-sharing.

Unknowns about ACA pediatric oral health coverage include network adequacy, patient utilization, and provider reimbursement. In late 2015 the AAPD attempted to ascertain the current ACA impact on pediatric dental practices by conducting a survey of members. Many pediatric dentists reported problems with families not realizing their medical plans with dental coverage embedded had a high combined deductible (such as $5000). This resulted in the families cancelling or delaying preventive dental appointments for their children. No reasonable person would regard this as adequate pediatric dental insurance coverage. **This is a problem that must be fixed or else children will not obtain needed preventive dental services!**

The AAPD and the ADA raised this critical concern in regulatory comment letters submitted to CCIIO and CMS in the fall of 2015[3]: **The AAPD and ADA recommended that the following services, which align with the AAPD's dental periodicity schedule, be included in the definition of preventive oral health services provided in a dental plan (embedded or SADP) without cost-sharing implications:**

- Clinical oral examination and adjunctive diagnostic tools;
- Oral hygiene and dietary counseling for parents;
- Removal of supragingival and subgingival stains or deposits as indicated;
- Systemic fluoride supplements, if indicated;
- Caries risk assessment;
- Topical fluoride treatments every six months or as indicated by the individual patients needs (ages 12 months and above);
- Scale and clean the teeth every six months or as indicated by the individual patients needs (ages two years and above);
- Pit and fissure sealants for caries-susceptible primary and permanent molars, premolars, and anterior teeth (ages two years and above);
- Substance abuse counseling (e.g. smoking, smokeless tobacco) (ages 12 years and above).

Justification for ACA Amendments. These amendments will promote robust dental insurance coverage for currently uninsured children, rather than allowing an essential health benefit to be left out. ACA included pediatric oral health coverage as an EHB in order to address unmet oral health care for many children. A study published in the 2011 *American Journal of Public Health*, utilizing data from the 2008 North Carolina Health Assessment and Monitoring Program, concluded that children with poorer oral health status were more likely to experience dental pain, miss school and perform poorly in school. A study published in the January 2012 *Journal of the American Dental Association* found that the number of young children with early childhood caries who sought treatment at emergency departments and ambulatory surgery facilities in New York state rose sharply between 2004 and 2008. This reflects similar findings in California and Texas. Hence, policies that promote establishment of a dental home by age one, with ongoing preventive care, are essential. This is further supported by the research findings of the study "Do Early Dental Visits Reduce Treatment and Treatment Costs for Children?" that was published in the Nov.-Dec. 2014 issue of *Pediatric Dentistry*. Children who began dental care at younger than four had less treatment for restorations, crowns, pulpotomies and extractions than those who began care later. The early starters also had lower expenditures for treatment procedures.

Because of the current limitations of ACA pediatric oral health plans, it is also essential that funding for the Children's Health Insurance Program (CHIP) be extended. Absent Congressional action CHIP funding will expire on Sept. 30, 2017. CHIP includes dental benefit and programs imposes caps on out-of-pocket costs that make health benefits affordable—especially dental coverage. Numerous studies have concluded that CHIP has been successful in reducing un-insurance and unmet health needs among children. The overwhelming majority of CHIP-enrolled children have at least one working parent. This program has provided a stabilizing financial force for families and the working poor. CHIP has minimal premiums, and CHIP programs in 18 states do not charge a premium. Ideally CHIP should be extended for five years, through Sept. 30, 2022.

Medicaid reform is essential. The AAPD is pleased that: *"The percentage of children lacking dental benefits continued to fall in 2014 and is now at its lowest level since 1999, the first year that data became available."*[4] However, much of this expansion of coverage for children's dental insurance has been via Medicaid, a program fraught with low reimbursement and high administrative burdens for providers. As states continue to shift their Medicaid programs to managed care, we believe states should ensure that beneficiaries have access to high quality care. This includes maintaining oral health network adequacy, providing oversight of outreach performed by plans or state programs to educate enrollees on plan options and the importance of oral health, requiring quality reporting by plans, and additional oversight by the Centers for Medicare and Medicaid Services (CMS) to guarantee that actuarially sound payment rates are in place to ensure quality care while controlling costs. Providers should also expect fair and reasonable audits, based on peer review and accepted clinical practice guidelines of the AAPD.

[1] *Yarbrough C, Vujicic M, Nasseh K. More dental benefits options in 2015 Health Insurance Marketplaces. Health Policy Institute Research Brief. American Dental Association. February 2015. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0215_1.ashx*

[2] *Yarbrough C, Vujicic M, Nasseh K. Update: Take-up of pediatric dental benefits Health Insurance Marketplaces still limited. Health Policy Institute Research Brief. American Dental Association. May 2014. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPI%20Research%20Brief%20-%20Update%20Takeup%20of%20Pediatric%20Dental%20Benefits.ashx*

[3] *September 29, 2015 letter to CCIIO commenting on 2017 proposed state essential health benefit (EHB) benchmark plans; Dec. 18, 2015 letter commenting on CMS -9937-P; Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017.*

[4] *Nasseh K, Vujicic M. Dental benefits coverage increased for working-age adults in 2014. Health Policy Institute Research Brief. American Dental Association. October 2016. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1016_2.pdf.*

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