



# AAPD 2014 LEGISLATIVE FACT SHEET

## TECHNICAL CORRECTIONS CONCERNING PEDIATRIC ORAL HEALTH COVERAGE UNDER THE ACA/ ERISA DENTAL INSURANCE REFORMS

### TECHNICAL CORRECTIONS CONCERNING PEDIATRIC ORAL HEALTH COVERAGE UNDER THE ACA

**ACA REQUEST:** Due to a technical glitch in the Affordable Care Act (ACA), in a state health insurance exchange, a parent/guardian purchasing medical insurance that lacks pediatric dental coverage does not have to purchase a stand-alone dental plan (SADP) for their child. Such coverage only has to be offered. To provide critical coverage but maximum choice for parents/guardians, a technical correction to the ACA should require that a purchaser seeking coverage in the individual and small group market inside or outside of the exchange, if they have children, is required to obtain pediatric dental coverage either through a SADP, embedded plan, or bundled plan. Other ACA technical corrections are also needed. The ACA should be amended to clarify that premiums for SADPs are eligible for premium assistance tax credits. The ACA should require insurance exchanges to maximize consumer choice by offering all three types of plans and require all plans to exempt dental preventive services from any cost sharing (deductible or co-pay). Finally, dental coverage benchmarks should apply to all plans.

#### BACKGROUND:

The ACA requires that pediatric oral 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 discussion of pediatric oral health coverage:

“ . . . 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 will be 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 Children’s Health Insurance Program (CHIP).** 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).

During the transitional years of 2014-2015, if a state chooses a benchmark plan that is subject to existing state benefit mandates, those mandates would be included in the EHB package, obviating the requirement that the state defray the cost of the mandates. If the state selects a benchmark that does not include some or all of the mandates, the state would have to pay for those mandates not covered by the benchmark. For 2016 and beyond, the agency will develop an approach that might exclude some state benefit mandates from the EHB package.

**The AAPD, the American Dental Association, and other members of the Organized Dentistry Coalition (ODC) commented to CCIIO on Jan. 31, 2012, that the benchmark plans identified fall short of finding the proper balance between affordability and ensuring a comprehensive set of pediatric oral health benefits for the EHB package.** The potential for the selection of an inadequate dental benefit embedded in a qualified health plan (QHP) is simply too great. ODC urged D-HHS to address the pediatric oral health benefit in a separate guidance. ODC suggested the following general table be used as a guide for determining if the benchmark plan chosen by the state is **in line with the typical employer-sponsored plan currently offered in the dental benefits market.**

- Preventive and Diagnostic Services – 100 percent coverage
- Basic Restorative Services – 80 percent coverage
- Major Restorative Services – 50 percent coverage
- Orthodontics – 100 percent coverage for medically necessary treatment, including cleft palate and other similar craniofacial anomalies

ODC also referenced the American Academy of Pediatric Dentistry’s Model Dental Benefits Policy, which delineates the diag-

nostic, preventive and restorative services that are essential for the pediatric population: [http://www.aapd.org/media/Policies\\_Guidelines/P\\_ModelDentalBenefits.pdf](http://www.aapd.org/media/Policies_Guidelines/P_ModelDentalBenefits.pdf). ODC also recommended that a final guidance or proposed regulations address the need to ensure proper coordination between the coverage provided by medical and dental plans to avoid coverage denials by both plans that result in children with congenital craniofacial anomalies and other medical conditions “falling through the cracks.” This includes a requirement that benchmark plans include state requirements for general anesthesia for dental services in 2016 and beyond.

## TECHNICAL CORRECTIONS NEEDED FOR PEDIATRIC DENTAL INSURANCE

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 SADPs rather than directly by medical insurers.** In the drafting of the ACA, language was included to allow SADPs to be sold in healthcare exchanges even though they are not a “qualified health plan” (QHP) because they do not offer every EHB.

**The ACA was intended to enhance coverage and expand choices for consumers, not restrict them.** D-HHS regulations interpreted the ACA as indicating that if a medical plan does not include pediatric dental coverage, then a SADP must be offered in exchanges. Under ACA regulations, consumers in most states can choose between a SADP for their child, a SADP “bundled” with a medical plan, 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.

However, in the interpretation and implementation of the ACA, some significant challenges have arisen:

- Due to the technical wording in the ACA related to SADPs, D-HHS regulations have concluded that within exchanges, a family can walk away with a medical insurance plan (QHP) with no pediatric dental coverage without 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 is “mandatory.” Outside the exchange, the medical plans in the individual and small group markets must either offer the dental essential health benefit or 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.

- A negative impact is already occurring. For example, in the California exchange for 2014 where only SADPs were offered, only 27 percent signed up. California’s insurance exchange has reversed course by allowing only embedded plans in 2015, but that has other drawbacks as noted below.
- SADPs are not eligible for premium tax subsidies.
- Proposed federal regulations lowering maximum-out-of-pocket costs for SADPs might drive higher premiums and higher deductibles.
- While having pediatric dental coverage fully “embedded” in a medical plan sounds good on paper, additional financial burdens may apply through combined medical and dental deductibles before any coverage kicks in, including preventive services.
- Dental benchmark provisions for coverage are not required in an embedded plan.
- Network adequacy and provider reimbursement in ACA plans are big concerns and a big unknown at this point.

**To promote children’s oral health and ensure that children receive the oral health care they need, not merely coverage on paper, the ACA needs several technical corrections:**

- **Make SADPs a mandatory purchase if the parent/guardian does not obtain pediatric oral health coverage via an embedded or bundled plan.**
- **Clarify that SADPs are eligible for premium tax subsidies for lower income families.**
- **Require insurance exchanges to offer all three types of plans (SADP, embedded, and bundled).**
- **Require all plans to exempt dental preventive services provided by a dentist from any cost sharing (deductible or co-pay).**
- **Require that dental coverage benchmarks (FEDVIP or CHIP) apply to all types of plans.**

## JUSTIFICATION:

These recommendations address a major barrier to oral health care access to children by promoting robust dental insurance coverage for currently uninsured children, rather than allowing an essential health benefit to not be obtained. ACA included pediatric oral health coverage as an EHB in order to address unmet oral health care for many children. **However, ACA regulations on pediatric dental coverage have already resulted in significant departures from typical employer coverage, as evidenced by increasing deductibles and consumer co-payment levels.**

The AAPD does not take a position as to whether a certain type of pediatric dental insurance coverage (SAPD, embedded, or bundled) or any specific insurer is superior or inferior to another.

There are many details of each plan that a consumer needs to consider, especially access to their child's preferred dentist.

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 Jan. 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.

## DENTAL INSURANCE FAIRNESS ACT OF 2013

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**ERISA REQUEST:** *Co-sponsor the Dental Insurance Fairness Act of 2013 (H.R. 1798).*

**BACKGROUND:** Dental coverage currently helps 173 million Americans get care that is vital to ensuring good oral and overall health. During the 112<sup>th</sup> Congress, Representative Paul Gosar (R-AZ), a dentist by profession, first introduced the Dental Insurance Fairness Act. This bi-partisan legislation was re-introduced during the 113<sup>th</sup> Congress on April 26, 2013 as the "Dental Insurance Fairness Act of 2013," H.R. 1798. **The bill currently has 33 co-sponsors (15 Republicans and 18 Democrats).** Many employers maintain self-insured dental plans covered under the Employee Retirement and Income Security Act (ERISA), which means they are regulated by federal law rather than state insurance law (and fewer ACA requirements are applicable). ERISA plans are an important part of the health care system that should not be overlooked in overall discussions of needed insurance reform.

**JUSTIFICATION:** This bill would help consumers receive the full value of their dental coverage. **Passage of this legislation would provide a more equitable system for dental patients, making dental care more affordable and accessible.**

Unfair practices have crept into common practices of dental benefit plans. They hinder families' ability to receive the full benefits for which they pay. This can occur when a family pays premiums for coverage under two separate dental plans but the plans' practices prohibit a secondary plan from paying any of the

cost of care. As a result, a family is paying for coverage that is not there when they may need it. In addition, plans that prohibit beneficiaries from assigning payment for dental services directly to non-participating dentists, are unfairly and unnecessarily penalizing patients who choose to go outside a network to receive care. If families can't assign benefits, they are forced to pay the dentist themselves and then file paperwork and wait for their dental plans to reimburse them.

The Dental Insurance Fairness Act would require that:

- All self-funded health plans that offer dental benefits will provide **uniform coordination of benefits**. When a consumer is covered by more than one plan, the secondary payer should be responsible for paying the remainder of the claim (up to, but not exceeding, 100 percent of the amount of the claim). To do otherwise provides the insurance industry with an unfair gain at the expense of beneficiaries.
- All self-funded health plans that offer dental benefits will permit **assignment of benefits**. The bill will permit consumers to designate a dental plan's payment to providers who do not participate in the network (called "assignment of benefits"), so that the patient's family does not have to pay for covered services out-of-pocket and wait to be reimbursed by the plan.