

AAPD 2015 LEGISLATIVE FACT SHEET

AMENDMENTS NEEDED FOR PEDIATRIC ORAL HEALTH COVERAGE UNDER THE ACA



AMERICA'S PEDIATRIC DENTISTS
THE BIG AUTHORITY on little teeth

REQUEST: Amend the Affordable Care Act (ACA) to require that a purchaser seeking coverage in the individual and small group market inside or outside of an insurance exchange, if they have children, be required to obtain pediatric dental coverage either through an appropriately structured stand-alone dental plan (SADP) or embedded plan. The ACA should also be amended to clarify that SADP premiums are included under the calculation of premium assistance tax credits, and to exempt preventive dental services from any cost sharing (deductible or co-pay). Further, funding for the Children's Health Insurance Program (CHIP) should be extended for at least four years to avoid disruption of coverage for 10 million children.

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 were permitted to selected 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. 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).

As noted, the ACA references dental benefits under a typical employer-sponsored plan, which would essentially allocate coverage as follows:

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

In practice, ACA pediatric oral health coverage has veered from such 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 must encourage preventive care. Otherwise, having coverage will not result in improved oral health status.

Amendments Needed For Pediatric Oral Health Coverage. 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. D-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, D-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.

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 applies, including preventive services.

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 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, pulpomies and extractions than those who began care later. The early starters also had lower expenditures for treatment procedures.

ACA pediatric oral health shortcomings are real, not hypothetical. 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 in 2014 options:

- Only 26 percent of medical plans sold on the federal exchange included embedded pediatric dental benefits.
- When medical plans used a separate dental deductible, the average dental deductible is similar across these medical plans (\$34) and the SADPs (\$41). However, 34 percent of medical plans did not use a separate dental deductible. In these cases, the average combined medical plus dental deductible was \$2,935. This means that no preventive dental services will be covered until the parent has expended the combined deductible amount on their child.
- Through April 19, 2014, 88,101 children and 1,073,248 adults obtained SADPs through the federally facilitated marketplaces plus California. The great irony in this finding is that pediatric oral health coverage is an ACA essential health benefit while adult oral health coverage is not.
- “The average 2014 take-up rate of SADPs by children through the FFM was 15.8 percent, virtually unchanged from the take-up rate observed through February (15.9 percent).
- The take-up rate for children varies from 2.6 percent in South Dakota to 36.0 percent in California.
- In states where pediatric dental benefits are only available through SADPs (AR, CA, MS, MT, NJ, NM, UT), the average take-up rate

for children is higher at 26.1 percent. Among these states, the take-up rate varies from 17.9 percent in Utah to 36.0 percent in California. The average 2014 take-up rate for these states is slightly lower than the average take-up rate observed through February (26.6 percent). While the take-up rates in California and New Jersey increased since February, the take-up rates in Arkansas, Mississippi, Montana, New Mexico, and Utah decreased, resulting in a lower overall average take-up rate for these states.”

Recent analysis of 2015 dental options in insurance exchanges reveals some progress, with challenges still remaining:

- There is an upward trend in the share of medical plans with embedded dental benefits in the health insurance marketplaces.
- While pediatric dental benefits are an essential health benefit under the Affordable Care Act, many plans do not offer first dollar coverage for preventive dental services.
- Medical plans with embedded pediatric dental benefits are more likely than stand-alone dental plans to provide first dollar coverage for preventive dental services.
- Information on dental benefits is much more transparent in the 2015 Federally-Facilitated Marketplace compared to 2014.

However, many unknowns remain about ACA pediatric oral health coverage including network adequacy, patient utilization, and provider reimbursement. The ADA HPI ACA reports are all available on the AAPD website at: http://www.aapd.org/advocacy/aca_basics/.

Because of the current limitations of ACA pediatric oral health plans, it is also essential that funding for the CHIP be extended for at least four additional years. Absent Congressional action CHIP funding will expire on Sep. 30, 2015. CHIP includes dental benefits and 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 lack of 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. The Congressional Budget Office estimates that the families of nearly two million CHIP-enrolled children would not be eligible for subsidized coverage in the ACA health insurance marketplaces. CHIP has minimal premiums, and CHIP programs in 18 states do not charge a premium.

To promote children’s oral health and assure that children receive the oral health care they need, the ACA needs several amendments to:

- a) **Make pediatric oral health coverage mandatory for families with children, either through an appropriately structured SADP or embedded plan.**
- b) **Include any separate dental premium cost under the calculation of a tax subsidy for low income families.**
- c) **Exempt preventive dental services from deductibles or co-pays in embedded plans and SADPs.**
- d) **Extend CHIP funding for at least four years.**