

Offering Dental Benefits in Health Exchanges

A Roadmap for Federal
and State Policymakers



September 2011

*Presented by the National Association of Dental Plans (NADP)
and the Delta Dental Plans Association (DDPA)*

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National Association of Dental Plans (NADP), a Texas nonprofit corporation with headquarters in Dallas, Texas, is the “representative and recognized resource of the dental benefits industry.” NADP is the only national trade organization that includes the full spectrum of dental benefits companies operating in the United States. NADP’s members provide Dental HMO, Dental PPO, Dental Indemnity and Discount Dental products to 143 million Americans, over 85% of all Americans with dental benefits.



Delta Dental Plans Association (DDPA), based in Oak Brook, IL, is a national network of 39 independently operated not-for-profit dental service corporations specializing in providing dental benefits in all 50 states, the District of Columbia and Puerto Rico; covering more than 56 million people in over 95,000 groups across the country.

The recommendations contained herein are solely those of NADP and DDPA. NADP and DDPA acknowledge the firms of **McKenna Long & Aldridge, LLP** and **Milliman Inc** for their assistance in the development of issues and alternatives on which our organizations’ analysis and recommendations are based.

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Executive Summary

In this White Paper the term “policy” is used for the contract or certificate of coverage and the term “plan” is used for the carrier or company issuing the contract or certificate.

This White Paper addresses issues raised by the requirement of “pediatric oral services” as part of the Essential Health Benefits Package (EHBP) offered through Exchanges. The Affordable Care Act (ACA) requires the scope of benefits in EHBP be equal to the “typical employer plan.” Employer plans usually consist of separate medical and dental policies that deliver “pediatric oral services.” ACA provides that “pediatric oral services,” as defined by the U.S. Department of Health and Human Services (HHS), may be offered in Exchanges either as part of a medical policy or as a separate dental policy. This White Paper:

1. Frames the issues related to dental offerings in Exchanges;
2. Explains the unique characteristics of the dental marketplace for consideration on each issue;
3. Defines and analyzes the operational challenges inherent in offering dental plans through both AHBE and SHOP Exchanges;
4. Offers common-sense options for state and federal policymakers engaged in Exchange design.

The White Paper is presented by the National Association of Dental Plans (NADP) and the Delta Dental Plans Association (DDPA) as the two associations representing virtually all of the dental benefits industry in the United States. It is based on issues and alternatives developed by the firms of McKenna Long & Aldridge and Milliman, Inc. Specific references to Milliman’s work are noted in this document, with their full report attached as a technical appendix.

EXCHANGES: Exchanges are the new insurance marketplaces for both individuals and small businesses to access health insurance coverage required by the ACA. The American Health Benefits Exchange (AHBE) is the individual coverage market where federal subsidies of premium are available to qualified consumers. States must also provide a separate Small Business Health Options Program (SHOP) Exchange where employers with 100 employees or less can provide insurance to their full-time workforce. In some instances states can merge these Exchanges.

ESSENTIAL HEALTH BENEFITS PACKAGE: ACA establishes a specific benefit package to be offered in the Exchanges. This “essential health benefits package¹” (EHBP) includes ten categories of services; one of these is “pediatric services including oral and vision care.” EHBP is to be defined by the Secretary of the U.S. Department of Health and Human Services (HHS) as equivalent in scope to a “typical employer plan” i.e. health benefits offered by employers. For oral care today, most medical policies cover oral health assessments performed by pediatricians as part of well child visits and provide some coverage for oral care connected to medical conditions.² However, as medical policies do not typically cover services to prevent or treat the two dental diseases (decay and periodontal disease), most employers supplement their medical plan by offering a separate policy of dental benefits. These separate policies of dental benefits are most often provided by standalone dental plans or carriers and often on an “employee-pay-all basis.”

¹ As consumers purchasing coverage in Exchanges are only offered EHBP, it becomes their “Minimum Essential Coverage (MEC)” under ACA.

² Oral treatment for medical conditions includes reconstruction for cleft lip and palate or sequelae of trauma and cancer treatment or prophylaxis for kidney failure/dialysis and organ transplants or palliative and/or emergency treatment.

OFFER OF SEPARATE DENTAL POLICIES: To provide consumers access to the same policies and expertise of a typical employer plan available in the commercial marketplace, ACA provides states shall allow the offer of standalone dental policies in Exchanges. When a standalone dental policy is offered, state Exchanges must also allow a medical carrier to offer the EHBP without “pediatric oral services.”¹ Medical carriers can also offer the full EHBP in Exchanges as well.

The Secretary has yet to promulgate regulations detailing the requirements for EHBP; however, the possibility of including some of the specialized oral services typically covered by separate dental policies necessitates a more detailed look at dental coverage. Specialized dental coverage, and the dental benefits industry, possesses unique characteristics that must be considered as states and the federal government establishes Exchanges and the products offered on those Exchanges.

ISSUES, KEY POINTS AND RECOMMENDATIONS: Six issues are explored with regard to the offer of separate dental plans in Exchanges as required by ACA. The key points and recommendations offered by the National Association of Dental Plans (NADP) and the Delta Dental Plans Association (DDPA) are outlined for each issue below.

More detailed recommendations and background information to support key points and summaries highlighted in this Executive Summary are contained in each of the detailed Issue Briefs of the White Paper. The full White Paper can be found on nadp.org and deltadental.com.

Issue 1: What should constitute “pediatric oral services” required as part of the EHBP?

This is the most critical issue to all the options and recommendations outlined in this White Paper. The decision on this definition impacts the breadth of coverage offered as separate dental policies in Exchanges. It also impacts administrative requirements of Exchanges and carriers including the flow of federal subsidies and coordination of consumer out-of-pocket maximums, as well as the application of consumer protections. However, as HHS’s proposal on the EHBP may be one of the last regulations issued to implement ACA, all options for HHS’s definition of EHBP must be examined. Some options result in complex coordination of subsidies and out-of-pocket cost-sharing maximums to consumers selecting coverage through the ABHE Exchange. These options must be examined by states prior to design of Exchange IT systems to assure the offer of standalone dental policies in the Exchanges is a viable option for Exchange consumers.

While this paper does not recommend a specific benefit option for adoption, there are basic considerations for defining “pediatric oral services” which are described. Issue #1 in the White Paper arrays the options which could meet these considerations along with their impacts and costs. The funding available for subsidies and clinical appropriateness of care being provided to children under the EHBP will be important factors to weigh in determining the path for defining “pediatric oral services” as part of the EHBP.

Key Points:

- Federal or State: The federal government should take the lead in defining the EHBP. States will make the decision whether to allow additional coverage and apply state requirements to the package at their cost. The benefit defined for “pediatric oral services” will be applicable to both AHBE and SHOP Exchanges, as well as for the individual and small group market outside Exchanges.

- The design and cost of EHBP and particularly the “pediatric oral services” holds broad implications for continuity of coverage for those who currently have both public and private dental coverage, and access for children who do not currently have coverage.
- The age range covered by the term “pediatric” must be defined for benefits to be modeled and priced.
- ACA calls for the EHBP to have the scope of a “typical employer plan.” Most employer plans, i.e. commercial plans, provide coverage to the employee who may add family coverage through a range of benefit options. Both medical policies and dental policies offered by most employers cover pediatric oral services but usually only dental plans cover services to prevent and treat dental disease. Potential interpretations of “typical employer plan” include:
 1. an oral health assessment now covered in medical policies;
 2. preventive and diagnostic dental services with emergency treatment;
 3. a typical employer dental plan as described by the U.S. Department of Labor;
 4. a Medicaid or Children’s Health Insurance Program (CHIP) style benefit—with or without orthodontia; or
 5. a next generation employer-type dental plan with the application of risk assessment and medical necessity.The additional cost of this range of options is from a low of no change in cost to medical policies to a high of \$48.25 per child per month or \$579 per child annually in addition to medical coverage.
- Metal levels, representing specific actuarial values of coverage, should not be applied to “pediatric oral services” when offered as separate dental policies in Exchanges.

Recommendation:

HHS should define a core benefit level for “pediatric oral services” including the age encompassed by the term “pediatric” to create a consistent base for states to make both separate dental policies and dental services integrated with medical coverage available to consumers in Exchanges. This core or “essential” benefit for “pediatric oral services” should be affordable for consumers and administratively simple for Exchanges to administer.

Issue 2: How should “dental plans” be qualified to offer coverage through the Exchanges?

ACA provides states allow dental plans, i.e. carriers that provide standalone dental policies, to offer these policies in the Exchanges provided the policies cover the benefit defined by HHS for “pediatric oral services” as part of the EHBP. The National Association of Insurance Commissioners (NAIC) Model Act on Exchanges provides for dental carriers to become “qualified dental plans” to operate on Exchanges. Whatever the definition of “pediatric oral services” as part of EHBP, standalone dental policies are allowed to be offered in Exchanges. The definition will simply determine what dental coverage is offered and subsidized and what is optional for consumers to purchase at their own cost. The elements for qualification as a “qualified health plan” (QHP) are examined for their application to dental carriers in becoming “qualified dental plans” (QDP).

Key Points:

- Federal or State: the states have the primary responsibility for identifying and implementing criteria to qualify dental plans within Exchanges.

- Criteria developed for certifying QHPs are not necessarily applicable to dental plans when offering “pediatric oral services” as separate dental policies, particularly when the required benefit is pediatric only. States differentiate in regulations applied to medical plans and plans offering a single benefit like dental today. While dental policies offered on Exchanges should be licensed and compliant with relevant state statutes for solvency, market conduct and other standards, there are marked differences between medical and dental coverage to consider when determining the applicability of QHP criteria to QDPs.
- Plans offered on both the AHBE and SHOP Exchanges are required by ACA to be certified as QHPs. Therefore, criteria for dental plans – whether it be through the QHP or a separate QDP process – will be applicable to both Exchanges.

Recommendation:

1. Should criteria for qualification be established at the federal or state level?

As ACA provides for HHS to establish qualifications for health plans, it also directs states to allow separate dental policies to make offerings in the Exchanges, the establishment of criteria for standalone dental plans to qualify to offer coverage in the Exchanges appears to be the responsibility of the states. However, HHS may use its broad authority to apply or waive health plan standards to dental plans to establish a threshold of qualification standards for the states.

2. Should criteria created for certification of “qualified health plans” be applied to dental plans?

QHP criteria should not be indiscriminately applied to dental plans to be eligible to offer coverage in the Exchanges. The differences in medical and dental coverage must be considered in applying any of the QHP criteria to dental plans. As well, policymakers should weigh the value of the criteria and cost of implementation given the limited scope of the “pediatric oral services.” It will also be useful for each state to compare the criteria to existing state requirements for licensure.

3. If not, what criteria should be used?

Of the reviewed criteria:

- Accreditation is inapplicable to dental plans;
- The local nature of networks and uneven geographic distribution of dentists make a single, national network adequacy standard inappropriate for dental plans. States without network adequacy standards for dental plans that determine they are needed should apply them only to general dentists and allow the dental plan to specify a target appropriate to their coverage for approval;
- Relevant quality and performance measures are limited and may be difficult to narrowly apply to children. If utilization data for children’s services is required, it should be consistent with Medicaid measures now reported;
- Marketing limitations and disclosure requirements should follow existing state regulation;
- Metal levels, representing specific actuarial values of coverage, should not be applied to separate dental policies covering “pediatric oral services;”
- If standard disclosures are required to qualify dental plans, a separate form or requirements appropriate to the limited scope dental product offering should be developed.

Issue 3: How should the offer of child, adult and family dental coverage be structured in the Exchange to ensure consumers have appropriate information to make informed choices?

There are three options for providing “pediatric oral services” examined in this section. These options should be combined by an Exchange to mirror the options now available to consumers in the commercial market. The options include:

- Separate dental policy and separate medical policy;
- Co-offered dental and medical policies;
- “Pediatric oral services” integrated with a medical policy.

Providing all three of the above configurations of medical and dental policies, with information about the dental-only element within each, allows Exchanges to maximize transparency and choice for consumers. By emulating today’s marketplace, Exchanges can promote the conditions under which medical-only, dental-only and full service plans can compete and thrive in Exchanges while consumers choose what’s best for them.

Key Points:

- Federal or State: the federal government will provide guidance regarding consumer choices through Exchanges by both defining “pediatric oral services” and providing guidance for consumer information. States will design and implement the consumer interface which provides the information to make informed choices.
- If the definition of “pediatric oral services” in EHBP includes services typically covered by dental policies, recognition of existing coverage under a dental policy outside the Exchange is easily achieved and necessary to ensure consumers are allowed to keep the coverage they have and aren’t required to purchase duplicative coverage.
- Dental and medical benefits today are purchased in one of three configurations: separately from two different carriers; co-offered by a carrier and its affiliate, subsidiary or partner as separate medical and dental policies; or dental services integrated in a medical policy.² All three configurations should be allowed in Exchanges to ensure robust competition and consumer choice.
- Transparency with respect to cost can be achieved when a separate dental plan is offered in a state Exchange by requiring medical plans that integrate dental services in their medical policies to also offer a medical policy without dental services, and requiring any carrier, medical or dental, that chooses to offer dental policies also offers a separately priced “child-only” dental policy covering just the required “pediatric oral services.”
- Supplemental dental coverage for adults and non-essential pediatric dental benefits should be offered alongside the essential “pediatric oral services” so parents or guardians have access to family coverage, can access covered care from the same family dentist as their children/dependents, and are not discouraged from obtaining such coverage.
- Purchasers, both employers and consumers, generally make decisions about dental policies based on cost, benefits and access to dentists within a network. This information must be presented effectively to ensure tools are available to make an informed and educated choice regarding dental coverage.

- Presentation of consumer choices and related information will be relevant to both the AHBE and SHOP Exchanges. Employers in SHOP exchanges should also be allowed to specify the coverage offered to employees.

Recommendation:

1. How should the essential “pediatric oral services” be presented to consumers?

HHS should allow separate dental policies purchased outside Exchanges to meet the “pediatric oral services” required in EHBP when medical coverage is purchased through an Exchange meeting the balance of required services in EHBP.

If “pediatric oral services” is defined to include services normally covered by separate dental policies, this benefit should be offered and separately priced on the Exchange as a “child only” policy by all carriers choosing to offer dental policies.

ACA provides for medical carriers to offer policies in Exchanges which include all EHBP benefits, but medical carriers should also be required to provide a medical policy without “pediatric oral services” when a QDP is also offered in the Exchange to allow:

- Adults without children to purchase coverage without “pediatric oral services” and
- Consumers who have dental or medical policies covering “pediatric oral services” outside of Exchanges to keep their coverage and purchase medical coverage that is not duplicative

When consumers in a household with children fail to select a policy covering “pediatric oral services” and evidence of other dental coverage is not presented, Exchanges should apply automatic enrollment in the lowest cost dental “child-only” policy to assure required coverage is met.

2. How should supplemental dental products be presented to consumers?

Much like the required “pediatric oral services,” supplemental dental benefits should be presented as a separate policy option. Exchanges must take steps to both:

- a) Ensure consumers understand “pediatric oral services” as defined by HHS as part of the EHBP are subsidized and supplemental dental coverage is not; and
- b) Recognize separate family coverage which includes “pediatric oral services” meeting the HHS definition can meet the EHBP whether purchased inside or outside the Exchange, allowing parents and children to remain on or be covered under the same dental policy.

3. How can an Exchange uphold its responsibility for providing “standardized, comparative information” on plan options among QHP and standalone dental policies offering “pediatric oral services?”

While information presented to consumers should be manageable in scope, it should also provide enough detail for them to make educated choices about insurance options, including the availability of dental as a standalone option. Beyond that, Exchanges should maintain in-depth information about all plan choices and consumers should be able to access progressively more in-depth information on a proactive basis.

Issue 4: How can premium subsidies be applied to “pediatric oral services” purchased in a standalone dental policy?

ACA specifically provides premiums allocable to the purchase of “pediatric oral services,” under a separate dental policy, to be considered for the calculation of premium subsidies. ACA does not address whether the premium tax credit subsidy should be allocated between medical insurance and dental insurance or paid first to one or the other.

Key Points:

- Federal or State: the federal government has control over tax credits that subsidize the purchase of the EHBP, while states will determine how subsidies are distributed and premiums are collected and distributed.
- Relatively small dental policy premiums and a lack of infrastructure to collect premiums from individuals (as opposed to employers) make the premium collection from Exchange participants challenging for standalone dental plans. This scenario is further complicated by the limitation of the subsidized benefit to only “pediatric oral services,” which is expected to be a low dollar benefit compared to medical coverage. Exchanges must consider how to build on existing systems to keep costs low for carriers and ultimately consumers.
- Tax credit for subsidies are relevant only to the AHBE while premium payment issues are relevant to both the AHBE and SHOP Exchange.

Recommendation:

1. Should the applicable subsidy be split between the dental and medical carrier?

When a separate dental policy is selected covering “pediatric oral services,” the federal government should split the value of the tax credit on a basis proportionate to the premium for the “pediatric oral services” in the dental policy and the medical policy. The subsidy should be paid directly to the dental plan and medical plan as required by ACA. Where an aggregator is used by the state Exchange, the subsidy should be paid to the aggregator for distribution on the same basis as required for subsidies paid directly to the dental plan and medical plan.

2. Will the collection of the unsubsidized portion of the premium be centralized for distribution or the responsibility of the dental plan providing the separate policy?

States should provide for premium collection through a central location – either the Exchange or an aggregator in addition to ACA required consumer option for direct payment to the QHP. Centralized collection and aggregation with subsidies where appropriate will reduce administrative costs for plans, particularly standalone dental plans collecting small premium amounts. It also allows Exchanges to answer consumers’ questions on payment status in a real-time basis.

Issue 5: How should cost-sharing and out-of-pocket maximums be applied to medical and dental coverage?

ACA includes additional provisions which protect subsidized consumers, i.e. those between 133% and 400% of poverty, from excessive out-of-pocket cost due to health care expenses. Out-of-pocket expense for these consumers purchasing the EHBP in the AHBE is limited to the out-of-pocket maximum for a High Deductible Health Plan (HDHP) which is currently \$5,950 for an individual and \$11,900 for a family.

ACA also provides for a reduction in these out-of-pocket limits for consumers purchasing a silver level of coverage (70 percent actuarial value) to ensure subsidized consumers are not required to spend more than a specified threshold “out-of-pocket” on health care. However, when a subsidized individual enrolls in both a QHP and a separate dental policy to meet EHBP, the portion of the cost-sharing reduction properly allocable to “pediatric oral services” is not applied to the reduction in cost-sharing by the qualified health plan for the consumer’s out-of-pocket expense.³

So while reductions in out-of-pocket maximums do not apply to “pediatric oral services” purchased as a separate dental policy, some coordination must occur to provide subsidized consumers purchasing EHBP through the combination of a medical plan and a dental plan relief from additional out-of-pocket (OOP) costs when the maximum is reached.

Key Points:

- Federal or State: cost-sharing reductions and out-of-pocket maximum issues are largely federal, although states could play a role through Exchanges in the collection and tracking of information that triggers their application.
- ACA includes cost-sharing maximums on EHBP designed to limit consumers’ out-of-pocket spending on health care. These maximums apply to consumers who receive subsidies in Exchanges to purchase the EHBP, including both medical and “pediatric oral services” components.
- In today’s environment, medical and dental claims are processed separately, most often using different claim systems, even when offered by the same carrier. Therefore, coordinating out-of-pocket limits among medical and dental carriers offering the benefits required for the EHBP for subsidized consumers in the Exchange should be addressed carefully.
- Methods for addressing the splitting of cost-sharing limitations across separate medical and dental coverage include:
 - Designing “pediatric oral services” in a way that requires no cost-sharing;
 - Apportioning the total OOP maximum between medical and dental;
 - Developing individual carrier systems to administer a shared OOP maximum;
 - Setting up the Exchange to serve the function of claims aggregator.
- Cost-sharing and OOP maximum issues will apply only to the AHBE Exchange, not the SHOP Exchange. While ACA exempts dental policies from reductions in out-of-pocket cost-sharing limits, coordination between medical plans and dental plans to eliminate consumer OOP cost-sharing once consumers reach the standard out-of-pocket cost limit should occur.

Recommendation:

In summary, the key methods to manage the determination of achievement of OOP maximums by subsidized consumers, given the meshing “pediatric oral services” in the EHBP through separately purchased medical and dental policies are:

- Managing the process through the design of the “pediatric oral services,” covering specified procedures only, at 100 percent, such that no portion of the OOP maximum needs to be attributed to dental;
- Managing the process via a separate pediatric dental-specific OOP maximum;
- Providing carriers the responsibility of determining when the OOP maximum has been achieved, potentially using an exception process to handle any pediatric dental claim payment issues that could arise after a person has achieved their OOP maximum;
- Giving the Exchange the responsibility to build, maintain, and administer a process to aggregate claims for determination of OOP maximum achievement.

The appropriate option depends on HHS’s determination of the scope of “pediatric oral services” in the EHBP or splitting the OOP maximum when a consumer selects a separate dental policy and potentially, the sophistication of the Exchange’s IT systems.

Issue 6: Which of ACA’s consumer protections should be applied to “pediatric oral services” when provided under separate dental policies?

Dental plans are primarily regulated at the state level where many consumer protections exist today including summary of benefits, plain language requirements, as well as timely claims processing and appeals processes.

While in general the Health Insurance Portability and Accountability Act (HIPAA) “excepted” benefits remain outside the scope of most major medical market reform provisions of ACA, relevant consumer protections required for participation in the Exchanges can be applied to QDPs offering the “pediatric oral services” through standalone or separate dental policies. Under ACA, requirements for dental plans are deferred to states, but the federal government may establish requirements related to other ACA provisions.

In its Exchange Notice of Proposed Rule-making (NPRM),⁴ HHS notes some QHP certification requirements and consumer protections the state Exchange itself may determine to be relevant and necessary for standalone dental plans. This paper considers the standards HHS identifies in the NPRM, including:

- quality reporting;
- transparency measures;
- summary of coverage information;
- provider network standard;
- standards regarding the consumer’s experience in comparing and purchasing dental plans.

The White Paper focuses on applicability to “pediatric oral services” required as part of the EHBP when offered by a dental plan as a separate dental policy only.

Key Points:

- Federal or State: the federal government may establish or defer to the states' development of consumer protections under ACA to be applied to dental policies offered through both the AHBE and SHOP Exchanges.
- ACA implemented several insurance market reforms designed to protect consumers and require medical carriers to offer fairly valued coverage in a non-discriminatory manner. These requirements apply broadly to all group health plans and health insurance issuers as defined under HIPAA. Separate dental policies are "excepted benefits" under HIPAA and not subject to the insurance market reforms for medical coverage.
- An Exchange may apply relevant consumer protections to QDPs offering coverage in the Exchanges. NPRM identified these potential consumer protections as quality reporting, transparency measures, summary of coverage information, provider network standards, and standards regarding the consumer's experience in comparing and purchasing coverage.

Recommendation:

Any relevant ACA consumer protections should only be applied to separate dental policies covering "pediatric oral services" required as part of the EHBP.

Given existing state requirements for dental plans, the following consumer protections should be deferred to the states for conformance with current requirements specific to separate dental policies:

- provider network standards;
- plain language requirements.

Transparency requirements for the following areas could be established at the federal or state level taking into account the differences appropriate for separate dental policies covering a limited scope benefit for "pediatric oral services":

- cost-sharing disclosures;
- plan performance;
- summary of benefits.

The NAIC's expertise should be utilized in developing templates and standards appropriate to separate, non-integral dental policies.

WHITE PAPER:

Offering Dental Benefits in Health Exchanges

A Roadmap for Federal and State Policymakers

Dental Coverage in ACA and Framework of White Paper

The Affordable Care Act (ACA) establishes requirements for states to make health insurance exchanges (Exchanges) available as marketplaces for individuals and small businesses to purchase affordable health insurance. ACA provides alternatives for the states to work together or defer to a federally established Exchange if it chooses not to establish a state-based Exchange.

These Exchanges may have two segments. The American Health Benefits Exchange (AHBE) will offer products to individuals and include subsidized coverage for low-income individuals and families. Individuals with incomes between 133 percent and 400 percent of the federal poverty level may access federal financial assistance in the form of refundable tax credits and cost-sharing subsidies through the AHBE. The state must also provide a separate Small Business Health Options Program (SHOP) Exchange where employers with 100 employees or less can provide insurance to their full-time workforce and if the employer chooses, allow each employee to select a plan rather than have the employer pick the plan for all their employees.

States may choose to merge the AHBE and SHOP Exchanges, but only if they can show they have adequate resources to serve the needs of both the individuals and small employers. Beginning in 2017, states have the option to expand SHOP Exchanges to large employers (101+ employees), with approval from U.S. Health and Human Services (HHS).

These Exchange marketplaces assure all Americans have the means to meet the “Minimum Essential Coverage” (MEC)⁵ requirement of ACA. The MEC provision mandates all individuals, with limited exceptions, to have health coverage beginning in 2014. The MEC is not specifically defined within ACA, but does provide broad guidelines on what MEC cannot be. Typically, individuals with coverage in place through employers or public programs today will meet the MEC standards.

ACA does establish a specific “essential health benefits package” (EHBP) subject to further definition by the HHS Secretary (Secretary). The EHBP lists 10 services, such as emergency services and hospitalization, and includes “Pediatric services (including oral and vision care).”⁶ This package of benefits is the core coverage to be sold in the individual and small group markets, inside and outside of Exchanges. The EHBP essentially defines MEC for consumers purchasing coverage in the individual and small group markets since EHBP defines the minimum coverage medical carriers can offer for sale.

Through Exchanges, medical carriers can offer the full EHBP or, when a separate dental policy option is available, offer the EHBP without the “pediatric oral services.”⁷ To provide consumers access to the same policies and expertise of such specialized dental care available in the commercial dental benefits market, ACA also provides states shall allow the offer of standalone dental policies in Exchanges.⁸ In the small group and individual market outside of Exchanges (in the current private market), ACA is not clear as to whether medical and dental coverage can together provide the EHBP required for individuals to meet the MEC requirement.

The Secretary has yet to promulgate regulations detailing the requirements for EHBP. Typically, oral services are procedures covered by separate dental policies, thus the reason for a detailed look at dental coverage. Dental coverage and the dental benefits industry possess several unique characteristics that must be considered as states and the federal government establishes Exchanges and the products offered on those Exchanges.

This White Paper addresses issues raised by the requirement that “pediatric oral services” be included either as part of a medical policy or offered as a separate dental benefit policy through the AHBE and SHOP Exchanges. This paper seeks to:

1. Frame the issues related to dental offerings in Exchanges;
2. Explain the unique characteristics of the dental marketplace for consideration on each issue;
3. Define and analyze the operational complexities inherent in offering dental plans through both AHBE and SHOP Exchanges; and
4. Offer common-sense options for state and federal policymakers engaged in Exchange design.

The White Paper is designed with six specific questions the authors felt were most critical for Exchange policymakers to review. These questions are formulated into six distinct Issue Briefs which include key facts, and overviews of the issues with distinct subtopics. Options on how policymakers can best include dental within Exchanges are outlined with potential impacts. Each Issue Brief concludes with a brief summary of recommendations.

The Dental Benefits Industry Today

Dental Coverage

Dental benefits vary significantly from traditional medical insurance through the types of policies, services and products offered to purchasers. Virtually all Americans with a dental policy obtain it through some kind of group -- a large or small employer, union or public program. About 85 percent of employees pay all or part of the cost of their dental coverage⁹. Only one percent of dental policies are purchased by individuals¹⁰ (see Chart 1¹¹). With groups as the primary access point, employers usually provide the following options to their staff: employee, an employee with a dependent (spouse or child) or an employee and their family. With the exception of the federal Children's Health Insurance Program (CHIP) program, child-only policies are rarely offered in the private market.

In addition, dental policies are typically sold and purchased as a separate product, distinct and apart from medical coverage. In the private market (not including public programs), roughly 98 percent of Americans with dental coverage today have a dental benefit policy separate from their medical policy (see chart 2¹²). Only about two percent of Americans get their medical and dental policies integrated (or embedded) into one policy from the same carrier.¹³

In the majority of cases, dental policies are not provided by the same carrier that is providing the medical policy. Meaning, the carrier providing an individual or family with their medical coverage most often does not provide their dental coverage. Only 32 percent of employers offer dental policies from the same carrier as their medical policy,¹⁴ i.e. multiline companies, those that write both medical and dental coverage (albeit under separate policies). Even the dental policies written by the dental affiliate or subsidiary of a medical carrier are not always paired with a medical policy from that carrier. This is because of the specialized nature of dentistry and its evolution as a profession separate from general health care. Self-funded dental coverage follows this same pattern of separate design and administration from medical coverage.

Chart 1: How Americans Access Dental Plans

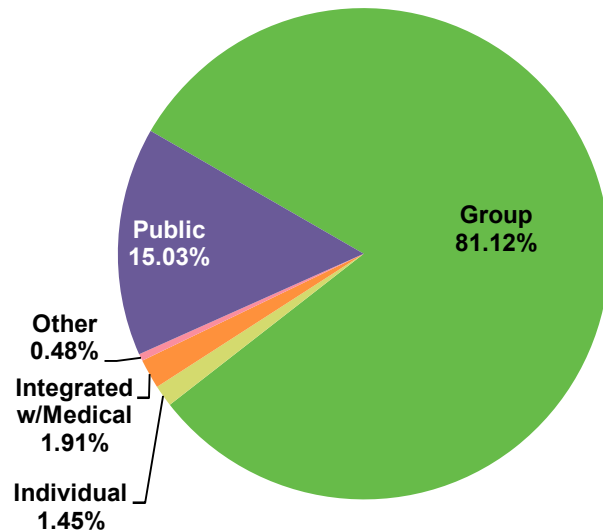
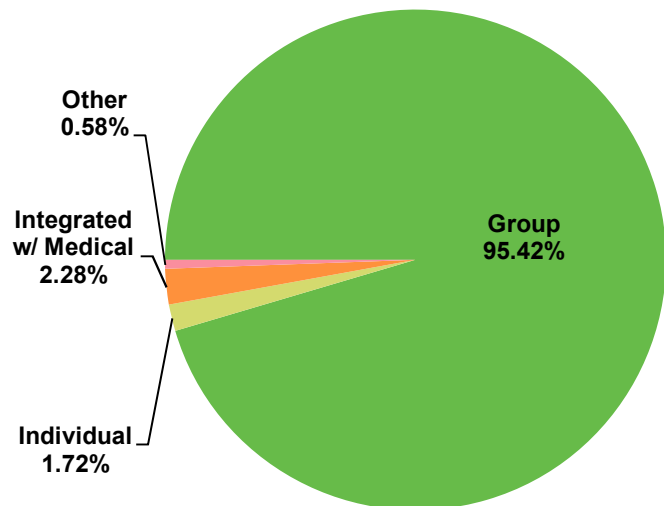


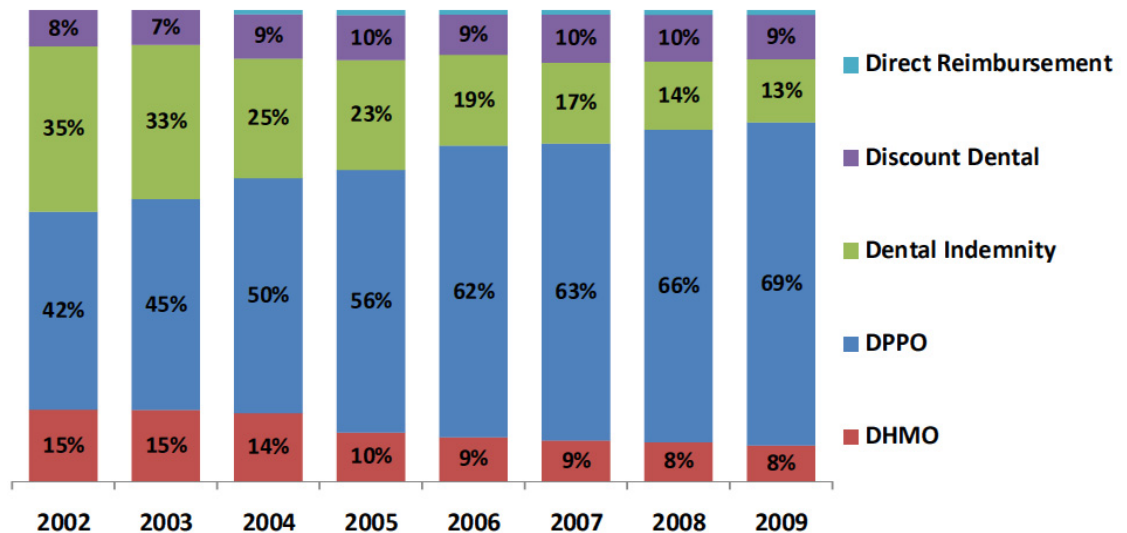
Chart 2: Sources of Private Dental Coverage



Types of Policies

Almost 70 percent of dental plans are structured as dental preferred provider organizations (DPPOs), which offer consumers different levels of coverage for in-network and out-of-network dental services (see Chart 3¹⁵). There are relatively few dental health maintenance organizations (DHMOs) or policies that only provide coverage for services provided by an in-network provider. The remainder of the market consists primarily of traditional dental indemnity plans as well as non-insurance product offerings such as “discount” plans, whereby services are simply provided to enrollees at a discount.¹⁶

Chart 3: Commercial Market Share by Plan Design



While a range of dental products are offered on the market, employers most often offer a standard DPPO policy which provides their employees with access to full coverage for diagnosis and prevention, small out-of-pocket costs for basic services, and high cost-sharing for major services, described as the “100/80/50 DPPO benefit design.” In addition, consumers often have an option to purchase “high” or “low” policy options. The high option plan design may include orthodontic coverage with a separate lifetime maximum. The low option dental plan might be a DHMO with a smaller network and specific dollar copayments for services rather than copayments based on a percentage of the procedure cost. As a result of both smaller networks and benefit design, DHMO premiums are a fraction of the cost of DPPO policies, allowing a “low plan” price point about seventy percent¹⁷ below a DPPO as a “high plan” option.

Annual deductibles for DPPO policies are typically \$50 per person with maximum annual benefits from \$1,000 to \$2,000.¹⁸ The recent report by U.S. Departments of Health and Human Services and Labor confirms this statistic, finding employer dental policies have annual maximum benefits on average of \$1,500.¹⁹ These limits keep dental coverage affordable while meeting the needs of most consumers. Surveys show today only three percent of consumers reach their annual maximum.²⁰ Thus, while dental plans offer policies with higher annual limits, employers typically do not select higher annual maximums because of limited need and slightly higher premium cost. While the cost of dental benefits does vary geographically by product and benefit design, in general dental policies cost about eight percent (less than 1/12) of medical policies.

Further, competition is widespread among dental carriers -- there are no fewer than 15, and often more than 30, dental plans in any of the contiguous 48 states and at least five in Hawaii and Alaska.²¹ Indeed, the dental benefits market is highly competitive in most states.

Dental Providers

The mix of providers delivering dental services is also different from the providers delivering medical care. While medical care is delivered by a mix of primary care and specialty physicians, approximately 85 percent of dental care is provided by general dentists in an office setting, usually by a solo practitioner. Further, while specialists outnumber generalists in the medical context, the opposite is true in dentistry, as most dentists are generalists. General dentists are well-trained in the breadth of dental procedures commonly utilized for children. Specifically, about 81 percent of dentists are general practitioners in contrast to the 12.3 percent of physicians delivering medical care who are in general practice.²² The American Dental Association recognizes nine dental specialties including pediatric dentists while the American Medical Association recognizes 36 medical specialties and 88 subspecialties.

This background is essential to understanding how dental plans currently operate in the private market, how they are treated under the ACA, and how they will be impacted by Exchanges.

How ACA Links to Dental Coverage

Oral Health

Oral health is a core component of overall wellness, particularly for children.²³ The Surgeon General recognizes caries (tooth decay) as the most significant uncontrolled childhood disease. According to National Institute of Dental and Craniofacial Research (NIDCR), dental caries in the baby teeth of children two to 11 declined from the early 1970s until the mid-1990s.²⁴ However, from the mid-1990s until the most recent National Health and Nutrition Examination Survey (1999-2004), this trend reversed. Recent data shows a small but significant increase in primary decay (caries) is more severe in younger children, low-income populations and minorities.

Congress has addressed this disparity for children in low-income families with the requirements for dental treatment in Medicaid and Children's Health Insurance Program (CHIP). Given the focus on dental care and oral health, it was not surprising Congress chose to list "pediatric oral services" as one of ten required essential health benefits within the individual and small group market under Affordable Care Act (ACA) even though it is not otherwise required as part of Minimum Essential Coverage (MEC).

With Congressional focus on dental health, there is anticipation "pediatric oral services" will be defined to include services typically covered by separate dental policies. Recognizing dental policies are offered and purchased separately, language was inserted into the health reform legislation allowing "standalone" dental plans to be active participants on the Exchanges.²⁵ In other words, ACA allows Exchange customers to access dental policies separately from their medical plan just as is commonly done in the commercial market today.

While separate dental policies offered on an Exchange must include the "pediatric oral services" defined by the U.S. Department of Health and Human Services (HHS), they are not limited to offering only policies which meet the Essential Health Benefits Package (EHBP). The law does not preclude the offering of adult and family dental benefits in addition to what is defined as "pediatric oral services." It is important to note, premium and cost-sharing subsidies can only be used to purchase dental benefits necessary to meet the minimum requirements for the "pediatric oral services" of the EHBP.

"Pediatric Oral Services" and the Essential Health Benefits Package

ACA stipulates non-grandfathered medical insurance coverage offered for individuals and small groups beginning in 2014 include the "essential health benefits package" (EHBP). While the U.S. Secretary of HHS has broad discretion in defining these benefits, ACA does require inclusion of at least the following categories of services:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services

- Preventive and wellness services and chronic disease management
- **Pediatric services, including oral and vision care** (emphasis added)

Coverage offered on the Exchange must comprise, at a minimum, an EHBP which is described as including:²⁶

- Essential Health Benefits;
- Limits on cost-sharing, including:
 - individual/family deductible limits of \$2,000/\$4,000 in 2014;
 - out-of-pocket maximum limits of \$5,950/\$11,900 in 2014;
 - preventive services covered in full with no member cost-share;
- Coverage in accordance with metal levels (bronze, silver, gold, platinum), representing actuarial values of coverage as specified in ACA.²⁷

The EHBP requirements inside Exchanges may be met by a medical plan alone that includes “pediatric oral services” or a medical plan and a separate dental policy which together fulfill the EHBP requirements. As stated previously, dental policies are almost always offered as a separate contract from medical benefits whether from the same carrier offering medical benefits or via a standalone dental plan (ancillary/supplemental carrier). Per the legislation, “pediatric oral services” may be provided through a standalone dental plan through separate dental policies on the Exchanges.²⁸

When designing the Exchange, policymakers should consider carefully the operational, cost, and presentation issues which may arise as a result of these options and take steps to ensure the intent of the legislation – consumer choice and insurance market competition – are maintained. As discussed in Issue Brief 3, providing consumers opportunities to compare costs of pediatric dental benefits in a transparent way will advance the goals of ACA.

Excepted Benefits Explained

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA) which includes provisions on transferring/maintaining medical policies for consumers when they change or lose their jobs, administrative simplification, security of health information, and market reforms. To clarify the application of these new requirements, HIPAA defined the range of benefits encompassed by the term “health plan.” HIPAA included a definition for “excepted benefits” clarifying separate, non-medical policies, such as accident and liability policies, as well as “limited-scope” dental and vision policies,²⁹ are not encompassed by the definition of health plan to which market reforms apply.

ACA’s health insurance market reforms were again designed specifically for medical coverage offered by health plans as defined by HIPAA. Since enactment of ACA, HHS has confirmed several times that HIPAA “excepted benefits” are not subject to ACA’s market reforms. First, a letter from the Honorable Kathleen Sebelius, Secretary of the Department of Health and Human Services (see Appendix C) reiterates what constitutes “excepted benefits.” And as well, both the background of HHS rules on “Grandfathered Health Plans,”³⁰ and the more recent HHS notice of proposed rules on Exchanges reference the exclusion of “excepted benefits.”³¹

Issues Related to Dental in Exchanges

ACA did not specifically address the process by which “pediatric oral services” will be offered as separate dental policies in Exchanges. Clarifying regulatory language must be developed to ensure consumers, who currently have dental coverage, can maintain their coverage as promised by Congress and the White House in passage of ACA and provide continuity of care for their children. In addition, children who do not currently have coverage need access to “affordable” and clinically appropriate coverage intended by the law.

This White Paper poses challenging questions and outlines possible options and corresponding considerations to address these questions. Each Issue Brief is organized starting with key points, a detailed description of the issue, potential impacts and recommendations and ends with a short conclusion summarizing decision points for state and federal regulators.

Issue Brief 1: What should constitute “pediatric oral services” required as part of the EHBP?

- How will pediatric age be defined?
- What are the benefit design options for “pediatric oral services” and what impact does each have on affordability, migration to and from both public programs and private coverage, and Exchange administration?
- How will the construct of the “pediatric oral services” impact the adult dental market?

Issue Brief 2: How should dental plans be qualified to offer coverage through the Exchanges?

- Should criteria for qualification be established at the federal level, state level or both?
- Should criteria created for certification of QHPs be applied to dental plans?
- If not, what criteria should be used?

Issue Brief 3: How should the offer of child, adult and family dental coverage be structured in the Exchange to ensure consumers have appropriate information to make informed choices?

- How should the pediatric dental benefit be presented to consumers to ensure transparency of pricing and services?
- How should adult dental products be presented to consumers?
- Will an individual or couples without children be required to purchase “pediatric oral services” as part of their coverage through Exchanges?
- Can plans covering families be offered if they contain “pediatric oral services”?
- How can the Exchange uphold its responsibility for providing “standardized, comparative information” on plan options among QHPs and separate dental policies offering “pediatric oral services”?

Issue Brief 4: How can premium subsidies be applied to “pediatric oral services” purchased in a standalone dental policy?

- How should the applicable subsidy be split between the dental and medical carrier?
- If split, should the subsidy be paid directly to the dental carrier or flow through the medical carrier to consumers?
- Will the collection of the unsubsidized portion of the premium be centrally collected and distributed or the responsibility of the dental plan?

Issue Brief 5: How should cost-sharing and out-of-pocket maximums be applied to medical and dental coverage?

- How does the inclusion of “pediatric oral services” as part of EHBP impact the application of cost-sharing and out-of-pocket maximums?
- Can cost-sharing limits and out-of-pocket maximums be coordinated between medical and dental carriers? What are the other options for properly applying maximums between medical and dental plans?

Issue Brief 6: Which of ACA’s consumer protections should be applied to “pediatric oral services” purchased in a standalone dental policy?

- Which consumer protections enumerated in the NPRM are relevant to the “pediatric oral services” as defined in EHBP?
- Which of the relevant consumer protections should be applied at the federal level or deferred to the states?

Application to AHBE and SHOP

As policymakers examine the questions above, they must be mindful of the vast differences between the markets served by AHBE and SHOP Exchanges (see Introduction for additional Exchange information). The function and customer base for each of these Exchanges is vastly different. For example, while the AHBE will be available to all consumers, it will largely serve as the point of access for individuals seeking tax credit and cost-sharing subsidies. Models anticipate as much as 80 percent of the population being served by the AHBE will be subsidized with the potential for many of the beneficiaries to move frequently between state health subsidy programs, such as Medicaid and CHIP, and employer-sponsored coverage. This particular concern has been labeled “churn” by health policy experts.

Businesses purchasing through SHOP will not have subsidies similar to AHBE. While ACA created limited small business tax credits for the purchase of insurance, a narrow subset of small businesses will be eligible for those credits for a maximum period of two years. By contrast to the AHBE, small employers will likely choose to access insurance through SHOP if the Exchange delivers the choices, economies of scale and valuable human resource functions enjoyed by large employers today. Solutions for the AHBE may not be appropriate for SHOP and vice versa. Thus, where appropriate, this paper points out the application of solutions to each type of Exchange.

ISSUE BRIEF 1: WHAT SHOULD CONSTITUTE “PEDIATRIC ORAL SERVICES” REQUIRED AS PART OF THE “ESSENTIAL HEALTH BENEFITS PACKAGE” (EHBP)?

Key Points

- Federal or State: the federal government should take the lead in defining the EHBP. States will make the decision whether to allow additional coverage and apply state requirements to the package at their cost.
- The benefit defined for pediatric oral services will be applicable to both AHBE and SHOP Exchanges, as well as for the individual and small group market outside Exchanges.
- The design and cost of EHBP and particularly “pediatric oral services” has broad implications for continuity of coverage for those who currently have both public and private dental coverage, and access for children who currently do not have coverage.
- The age range covered by the term “pediatric” must be defined for benefits to be modeled and priced.
- ACA calls for the EHBP to have the scope of a “typical employer plan.” Most employer plans provide coverage to the employee who may add family coverage through a range of benefit options. Both medical policies and dental policies offered by most employers cover pediatric oral services but usually only dental plans cover services to prevent and treat dental disease. Potential interpretations of “typical employer plan” include:
 - an oral health assessment now covered in medical policies;
 - preventive and diagnostic dental services with emergency treatment;
 - a typical employer dental plan as described by DOL;
 - a Medicaid or CHIP style benefit—with or without orthodontia; or
 - a next generation employer-type dental plan with the application of risk assessment and medical necessity.

The additional cost of these options ranges from a low of no addition to the cost to medical policies to a high of \$48.25 per child per month or \$579 per child annually in addition to medical coverage.
- Metal levels, representing specific actuarial values of coverage, should not be applied to “pediatric oral services” when offered as separate dental policies in Exchanges.

Issue

Affordable Care Act (ACA) provides that in developing the Essential Health Benefits Package (EHBP) to be equivalent to a “typical employer plan” i.e. health benefits offered by employers. States have the option of including additional benefit requirements, which would not be subsidized by the federal government. Both the federal government and the states have roles in determining the “pediatric oral services” required in Exchanges.

The Secretary of the U.S. Health and Human Services (Secretary) is expected to issue guidance further defining essential health benefits in the fall of 2011. In the meantime, the Department of Labor (DOL) conducted a survey of its existing reports on benefits typically covered by employers. The Institute of Medicine (IOM) has been

holding exploratory hearings to define broad parameters for consideration and to propose methods to update coverage requirements over time for the EHBP. While both processes will yield useful tools for the Secretary of the U.S. Department of Health and Human Services (HHS), defining what should constitute affordable, quality “pediatric oral services” is a complex process, requiring an understanding of:

- The requirements for an Essential Health Benefits Package and other provisions of ACA such as metal levels and health care quality improvement;
- The representative dental benefit levels in the current marketplace, including Medicaid, Children’s Health Insurance Program (CHIP), and employer-based coverage;
- The content and affordability of various dental benefit levels;
- The complexity of maintaining benefit continuity for individuals, given the potential for migration among Medicaid, Exchange-based coverage, and employer-based coverage described as “churn”;
- The complexities in keeping family dental coverage as a cohesive unit rather than having “dental coverage bifurcated into a cumbersome system where adult and pediatric coverage are split in two policies.”³²

In this Issue Brief, we will discuss each of these considerations in detail and develop illustrative dental benefit packages. We hope this discussion will be of use to those working to implement dental coverage seamlessly into Exchanges.

Inclusion of “Pediatric Oral Services” in Metal Levels³³

ACA establishes metal levels – Bronze, Silver, Gold and Platinum as a means for carriers to differentiate policies based on generosity or “actuarial value” (AV). The AV of a plan is the percentage of an average individual’s medical costs the carrier (versus the consumer) can be expected to pay. The EHBP must be categorized into these various metal levels. Medical plans seeking to be certified as a QHP must offer at least Silver and Gold level coverage.

Metal Levels and Actuarial Values (AVs):

Platinum	90%
Gold	80%
Silver	70%
Bronze	60%

The metal level applies to the EHBP as a whole; it is important to clarify each service within the EHBP need not vary according to the AV rules. As an example, for a Gold plan, it is not the case each type of service – hospital stays, office visits, and the like need to have an 80 percent AV, but rather the benefit policy as a whole meets the 80 percent criteria. With respect to dental coverage, it is not necessarily the case four different levels of “pediatric oral services” must be developed. Rather, the focus should be on providing “High” and “Low” affordable “pediatric oral services” policy options.

In fact, due to the construct of dental benefits, achieving a wide range of AV for the “pediatric oral services” would be difficult. For example, a policy covering in full a limited number of specified dental procedures would have an AV of 100 percent as there would be no member cost-share. A benefit that mirrors national average employer-

based coverage, with 100/80/50 percent coinsurance for diagnostic and preventive, basic and major dental services respectively would have an AV of roughly 86 percent. In order to reduce the AV to a Silver or Bronze level, significant cost-sharing on the consumer would have to be implemented, putting the benefit plan out of line with industry norms.

What is it about dental insurance that makes varying AV levels harder to achieve?³⁴

Higher concentration of preventive services in dental: In many dental policies, a substantial proportion of the cost comes from preventive services. Compare that to medical plans, in which preventive care costs are dwarfed by other categories of care such as hospital stays and surgeries. Because a large proportion of dental care costs are preventive in nature and typically covered at 100 percent as ACA now requires for preventive care under medical plans, it is difficult to adjust the cost-sharing of a dental plan to meet lower AV levels.

Use of dollar benefit maximums in dental insurance: Dollar benefit maximums are the one method by which dental policies limit utilization and pass the cost of additional utilization to the customer. Frequency limits and varying co-insurance are also used. Medical coverage generally does not rely on maximum benefit levels by service category. Under some scenarios, this avenue for adjusting AV remains available for the “pediatric oral services” essential benefit.

Less prevalent use of deductibles in dental insurance: While some employer-based dental policies have small annual deductibles, usually \$50 or less, they are less prevalent than on medical benefits, and are usually only applied to certain non-preventive types of procedures. Deductibles provide another avenue for medical plans to adjust member cost-sharing and hence the AV of a plan. While deductibles are allowed on EHBP, a dental deductible separate from medical may not be incorporated into some designs for the “pediatric oral services” essential benefit. With much of the cost of dental care being preventive in nature and therefore covered in full, and the small level of typical deductibles, the deductible limits impact on premium cost.

Lower in-network utilization in dental insurance: Most medical plans see high levels of in-network utilization due, in part, to broad provider networks. The dentist population is sparser and more heterogeneous across geographies, and dental provider networks are often smaller than their medical counterparts. In addition, some dental preferred provider organizations (DPPO) do not differentiate in the percentage reimbursement between in-network and out-of-network providers. As such, adjusting in-network cost-sharing has a smaller impact on a dental policy AV than on a medical policy.

Dental Benefit Levels in Today’s Market

To define the “pediatric oral services,” we must first understand the level of coverage people receive today through employer-sponsored coverage as well as existing public programs such as Medicaid and CHIP.

Employer-sponsored Insurance

The private dental market covers roughly 166 million people, with the vast majority through employer-sponsored insurance. The Department of Labor submitted a report in April 2011 (DOL Report)³⁵ based on data from 2008 and 2009 detailing benefit levels in employer-sponsored insurance to aid in developing parameters for the EHBP. The DOL Report found, “[p]lans 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.”

While virtually all policies were found to include preventive, basic and major services, orthodontia was noted as covered with a separate deductible which is often added as a separate rider. Detailed data from the National Compensation Survey (NCS), on which the DOL Report is based, shows about one-third of policies covering “employees and dependents” covered orthodontia and another third of the policies had orthodontic coverage just for dependents. According to the DOL Report, cost-sharing for dental services typically involved an annual deductible—the median was \$50 for an individual and \$150 for families. 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.³⁶

The DOL Report also found the median annual maximum was \$1,500. A separate maximum applicable to orthodontic services also had a median value of \$1,500. The range of maximums by industry and region was from \$1,000 to \$1,500 with employers of one to 99 having a median annual maximum of \$1,200. NADP’s annual Premium Trends Report has shown over the past several years less than three percent of Americans with dental benefits reach their dental policy’s annual maximum.

In the small group market, which is impacted by the inclusion of “pediatric oral services” in the EHBP, 1.65 million small businesses currently provide dental coverage for their employees and families. Of these businesses, just fewer than 44 million enrollees are covered, including 22.9 million children.³⁷

Medicaid and CHIP

All children under age 21 enrolled in Medicaid receive dental care through the federally required Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. The coverage requirement, however, is only broadly defined as including “all medically necessary diagnostic and treatment services within the federal definition of Medicaid medical assistance,” thereby allowing for variation by state.³⁸

The Children’s Health Insurance Program Reauthorization Act of 2009 requires pediatric dental benefits to be included in state CHIP programs up to the age of 19. CHIP specifically mandates “child health assistance provided to a targeted low-income child shall include coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.”³⁹

In Kaiser Family Foundation’s “CHIP Tips,” published March 2010, describes CHIP dental programs in detail. The scope of coverage under CHIP is quite comprehensive, including preventive and diagnostic care, sealants, space maintainers, fillings, crowns, and endodontic procedures as well as emergency care and orthodontia. Service limitations may be set in line with accepted periodicity schedules. Medical necessity criteria may be applied to determine the frequency of services or eligibility to receive certain services.⁴⁰ Although separate CHIP dental coverage may be based on benchmark plans in the commercial market, the cost-sharing provisions are subject to federal guidelines that limit total out-of-pocket expense to five percent of income for a family with CHIP coverage. This cost-sharing limit must be coordinated between medical and dental carriers if different.

A study released in May 2011 by the Pew Center on the States notes coverage via Medicaid or CHIP does not necessarily translate into dental care for children, citing in 2009, only 44 percent of children enrolled in Medicaid or CHIP actually received any dental services.⁴¹ The Pew report also states, due to the impact of ACA, an additional 5.3 million children will have dental insurance by 2014, with most of those through expansions in Medicaid and CHIP. In order to ensure these children receive adequate oral care, the report recommends specific standards for states, including adequate Medicaid reimbursement rates, sealant and fluoridation programs, and grades for each state on achievement of these standards.

Continuity of Coverage

Publicly funded programs cover a significant number of people. June 2010 Medicaid enrollment nationwide exceeded 50 million, including 26 million children.⁴² CHIP enrollment in December 2009 was just over five million.⁴³ With the upcoming expansion of Medicaid eligibility to 133 percent of the federal poverty level in 2014, the number of people covered by this public program is expected to rise by almost 16 million by 2019.⁴⁴ It is estimated over five million children will have first-time access to dental coverage as a result of ACA with most being added to public programs.⁴⁵

Much of this newly-insured population is expected to migrate or “churn” among public coverage, subsidized Exchange coverage, and employer-provided coverage. A recent article published in the journal *Health Affairs* estimates as many as 28 million people are expected to move from one coverage to another in the first year of Exchange implementation.⁴⁶ This type of movement among plans can disrupt patients’ access to health care providers, present unexpected out-of-pocket costs, and undermine the long-term health of individuals. As a result, ensuring continuity of dental care for these individuals is a key factor when developing the Exchange’s dental benefits.

Further, most children access dental coverage today as part of a family policy. Post-2014, “pediatric oral services” may complicate family coverage as this coverage will be eligible for tax credit subsidies, while adult or family coverage will not.

“Pediatric Oral Services” Options

Now that we have examined the landscape of dental benefits offered by private insurance and public programs, we can construct a spectrum of options for “pediatric oral services” and assess the relative impacts and the affordability considerations associated with each option. This Issue Brief is a general analysis using national average assumptions.

How is “Pediatric” Defined?

It will be critical to define the pediatric age limit to determine the impact on the cost of the benefit, as well as what services are important to include. The definition of “pediatric” should consider clinical guidelines as well as consistency with public programs currently serving children.

On the clinical side, the “2011-2012 CDT: The ADA Practical Guide to Dental Procedure Codes” references the definition of child as determined by American Dental Association (ADA) Resolution 635 passed in 1991. That resolution states dental plans should determine adult or child status based on the clinical development of the patient’s dentition,⁴⁷ or if chronological age is to be used as a basis, then plans should consider patients as adults beginning at age 12 with the exclusion of orthodontics and sealants. This is at the age when adult teeth have typically replaced baby teeth.

Social programs cover children beyond the clinically recommended age: CHIP programs are required to cover dental care for children up to age 19, and Medicaid child dental coverage lasts until age 21. Including estimates on all age ranges would be cumbersome, therefore the cost estimates in this paper encompass all of these age ranges by using the Medicaid age limit of up to 21.

Below we discuss several potential models for “pediatric oral services” of the EHBP. It will be critical to understand the impact of the definition of “pediatric” when determining the affordability of each model, in terms of

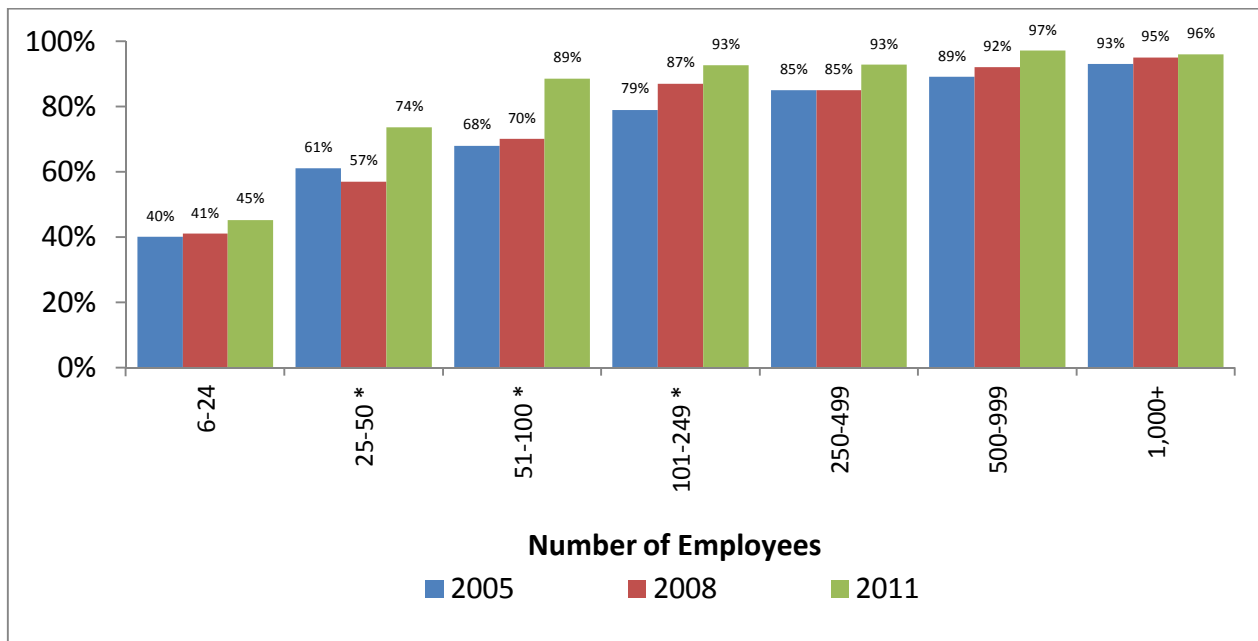
both required federal subsidy dollars and premium costs to the consumer, as well as the appropriateness of the services covered by each option.

The key factor in deciding among the following options is a determination of the scope of “typical employer plan” as the reference for determining the scope of the EHBP. Does this phrase include all policies employers typically offer that cover each of the benefit categories in the EHBP, or does the phrase refer only to the health plan that offers medical treatment by physicians?

If the phrase is determined to apply only to health coverage, then, as explained in the background, only two percent of health plans include benefits typically covered under separate dental policies. Thus, coverage of most dental treatment should not be included in the EHBP and Option 1 would be the path for defining “pediatric oral services” in the EHBP.

If however, “typical employer plan” is interpreted to include both medical and dental policies commonly provided by employers to cover the range of services included in the EHBP, then the definition of “pediatric oral services” should reflect coverage provided by separate dental policies more typically provided to children through both public programs and employers today. Most employers providing health benefits include separate dental coverage (see Chart 5), and while DPPOs are the most common dental policies (as explained in the background section of this paper) there are an array of options in today’s market for these services and new options under development that merit consideration for provision of clinically appropriate dental services. With this interpretation, Options 2 through five are offered for consideration.

Chart 4: Employers Offering Dental Coverage⁴⁸



Option 1: Pediatrician Delivered Services

If a typical commercial plan is seen as limited to a medical policy, one way to define the “pediatric oral services” is to refer to the American Academy of Pediatrics oral health guidelines. These guidelines are referenced in the July 2010 Interim Final Rules Relating to Coverage of Preventative Services.⁴⁹ These regulations give guidance on which services are considered preventive in nature and therefore required to be covered in full and not subject to

consumer cost-sharing under ACA. The oral health component referred to in these regulations consists only of pediatrician-delivered services including:

- Oral health screenings at various ages, as recommended in “*The Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care*,” consisting of discussing the child’s oral hygiene with the parent and looking in the child’s mouth to assess the risk of caries;
- Prescribing fluoride supplements for children in areas where water is not fluoridated;
- Three-year and six-year well-child visits to determine whether the patient has a dental home. If the patient does not, then a referral should be made to one.

IMPACTS: Option 1 removes dental providers and separate dental policies and creates an EHBP wholly contained in a medical benefit plan. This is the simplest and easiest-to-administer as it allows for all subsidies, cost-sharing allocations, and consumer decisions to be made on a medical-only basis. The decision to purchase a dental policy on or off an Exchange could be handled separately from medical policies and could be made on a family basis as is done today, causing the least disruption for consumers with current dental coverage.⁵⁰ Under this option, if separate dental coverage was offered on Exchanges, separate dental plans covering dental procedures would need to include treatment by pediatricians as defined by EHBP. Since these services would be covered as preventive at 100 percent, there would be no cost-sharing issues.

Option 2: Preventive and Diagnostic Dental Services⁵¹

Broadening the “pediatric oral services” essential benefit definition from a medical-only model to one including typical dental coverage and dental providers, the EHBP could be developed to include a basic level of preventive and diagnostic services delivered by dentists. For example, a lean essential benefit option could cover preventive, diagnostic, and emergency care only, at 100 percent.

IMPACTS: Option 2 has the advantage of not requiring any out-of-pocket expenses for consumers on covered services, obviating the need to split out-of-pocket maximums between the medical and dental portions of the EHBP. It also provides an affordable base-level required benefit which promotes prevention and critical care that can be supplemented with additional coverage as desired by the consumer at their cost. Since most small employer coverage is voluntary, i.e. paid for by the employee not the employer, this option may be more typical of employer-sponsored coverage in this market from a consumer payment perspective. However, if the family does not choose to supplement the coverage, this plan covers fewer services than the average CHIP plan or commercial plan, creating a potential discontinuity in care if a child moves between CHIP, employer-sponsored insurance, and the Exchange.

Option 3: Typical Employer-Sponsored Dental Coverage

About 69 percent of separate dental policies are DPPO (see Chart 4), i.e., dental preferred provider plans. These dental plans have broad provider networks in which about two-thirds of privately practicing dentists participate nationally. However, if services are obtained from a dentist not in the network, some coverage is still provided. In some instances, the percentage payment for services outside the network is reduced. The DPPO structure described in the DOL Report is typical of traditional DPPO coverage although the economy has spawned a broad array of options. The traditional DPPO structure described in the DOL Report is what is priced for comparison in this section, i.e. in-network coverage of 100 percent of diagnostic and preventive services, 80 percent of basic services, and 50 percent of major services with an annual maximum of \$1,500. If orthodontia is added as a rider, on a required or optional basis, it would be covered at 50 percent as well with a separate lifetime maximum. DPPOs often reduce these percentages for services obtained out-of-network to 80/60/40 or some other level of

coverage based on employer's concerns such as cost of coverage. This reduced coverage for treatment received out-of-network is referred to as an "active DPPO."

IMPACTS: While Option 3 reflects the traditional DPPO benefit structure, it does not reflect the typical payment mechanism in the small group market where consumers pay for the coverage themselves, i.e. voluntary coverage. Also, as this coverage is usually constructed for employees and their dependents, the median annual limit of \$1,500 cited in the DOL report may be more than would be needed for the services provided only to children. The MEPS Chartbook 17 shows the average annual expense for children from birth to 20 with a dental visit in 2004 was \$635 for children with private dental coverage and \$272 for children with public dental coverage. With the application of annual limits for a child-only policy of \$1,000, this coverage would be more affordable. Application of out-of-pocket cost-sharing limits and apportionment of subsidies would make this option more complex and would need to be addressed⁵² (see Issue Brief 5 for solutions.)

Option 4: Medicaid and CHIP Type Coverage

Expanding the definition even further, the "pediatric oral services" could be modeled after dental coverage required by Medicaid and CHIP. Both programs cover a broad array of dental services, including not only preventive and diagnostic care, but also restorative care, medically necessary orthodontia,⁵³ and other services. Early and periodic screening, diagnostic, and treatment (EPSDT) services are required services under the Medicaid program for most individuals under age 21 including dental services.⁵⁴ Signed into law in February of 2009, the Children's Health Insurance Program Reauthorization Act requires CHIP programs which are often offered through commercial dental carriers to cover comprehensive dental benefits.⁵⁵ While defined broadly, each state has its own structure for frequency of treatment and financial limits for these benefits. For instance, Texas limits CHIP preventive dental services to \$175 annually and therapeutic services (all other treatment) by an assessment of the child's needs from Tier 1 at \$285 annually to Tier III at \$565 annually. Other states have no financial limits or cost-sharing, but apply frequency limits and require prior approval for an array of procedures.⁵⁶

IMPACTS: Option 4 is a comprehensive benefit level without dollar limits or cost-sharing and would be more expensive than a typical employer-sponsored dental plan with annual limits. While the CHIP/Medicaid approach could be useful in addressing churn issues between public programs, it would be difficult to design a single package that would fit with each state's approach to CHIP and Medicaid coverage. Additionally, without limits or cost-sharing, this option would be significantly more robust than typical employer-sponsored coverage—essentially extending coverage designed for lower income populations covered under public programs to a significant portion of the population. Also, unless the plan covered all services with no cost-sharing (an extremely expensive option), this option would also require allocation of out-of-pocket maximums between the dental and medical coverage, adding administrative complexity.⁵⁷ Additionally, if no maximums or cost-sharing are included, some mechanisms would need to be developed to control overutilization.

Option 5: Next Generation Employer Type Coverage Including Application of Risk Assessment and Medical Necessity

Option 5 includes a method for adjusting conventional plan designs, to include the latest scientific evidence-based recommendations from appropriate federal agencies such as the Centers for Disease Control and Prevention and the Food and Drug Administration, as well as professional organizations such as the American Dental Association and the American Academy of Pediatric Dentistry, while eliminating annual limits. Individualized risk-based assessment for susceptibility to disease could also be used to determine appropriate frequency of diagnostic services and preventive therapies. Both would assist in controlling costs while appropriately directing resources to children based on their level of risk for developing dental disease. The administrative complexities of coordinating out-of-pocket cost-sharing limits would still exist with this model.

IMPACTS: Option 5 represents an opportunity to reinvent pediatric benefit plan design and provide the potential to provide needed services with a view to both cost effectiveness and medical need. While it would leverage practices taught as part of today's dental school curriculum, it would represent a shift in the prevalent practice patterns of today. Additionally, it would require business process changes for both dentists and carriers relative to what services are compensated and how claims are processed. Key to this would be the addition of a risk assessment procedure which dentists would be compensated for and carriers would have to track at the patient level in their systems to properly adjudicate claims. Consistent use of diagnostic codes, not currently used in the administration of dental benefits would be required. The development of diagnostic codes is addressed in the Quality section of Issue Brief #2.

Affordability and Access Considerations

With any of the essential benefits models described above, understanding the cost level of such a benefit will be critical. Creating a benefit which requires an unsustainable level of subsidy dollars, or a benefit so costly consumers choose not to purchase additional adult dental coverage for themselves, runs counter to the intent of ACA in expanding coverage and improving overall health⁵⁸. Adults and children with dental coverage go to the dentist more frequently and have fewer unmet treatment needs.^{59 60 61} Both adults and children should get the dental care they need to maintain oral health which is increasingly being shown to impact overall health — particularly for adults with periodontal disease. With proper oral health care, the cost of medical care for adults with chronic diseases and high-cost medical conditions may decrease.⁶²

The cost of a pediatric dental essential benefit can be affected by:

Provider Network and Reimbursement Levels⁶³: Dentists participating in CHIP are generally paid at or around Medicaid reimbursement levels which can be significantly lower than what providers are paid for services by a commercial dental plan. If a dental policy on the Exchange is based on commercial reimbursement levels, a child migrating between CHIP and the Exchange may see their dental services subject to a higher cost structure, affecting the premium paid for coverage and out-of-pocket costs by the individual and the subsidy paid by the federal government. Reimbursing providers at a level more consistent with Medicaid would result in a lower price point; however, providers may not accept lower reimbursement for a larger swath of the population. Medicaid provider networks are often smaller than their commercial counterparts, which can also impact the cost of care (if more services are sought out-of-network), as well as continuity of care for children migrating among public programs, the Exchange, and employer-based coverage. These issues are critical to understanding the cost of providing a standard EHBP, as they will affect the cost of the subsidies provided by the federal government and the remaining premium the consumer must bear.

Use of Benefit Limits or Medical Necessity Criteria: As discussed previously, both public programs and commercial insurance use benefit limitations to control cost while still providing comprehensive coverage. Examples include dollar benefit maximums, common in commercial plans and Medicaid programs, and number of visit limitations, used by many CHIP and Medicaid programs. Public programs also often apply medical necessity requirements in order for the consumer to obtain certain dental services. For “pediatric oral services” as defined in ACA, if annual dollar benefit maximums are not permitted for separate dental policies, this would be an important differentiator that raises the cost of a child dental essential benefit in relation to a commercial or public plan covering the same services.⁶⁴

Risk assessment and medical necessity criteria could be used to determine eligibility for higher-cost services in lieu of annual benefit maximums. However, while commercial dental plans now apply some medical necessity standards to high cost procedures like removal of third molars (wisdom teeth), risk assessment is a newer innovation. Both medical necessity and risk assessment are used to some extent by public programs, but public programs often apply more stringent standards of risk or need before covering a procedure than commercial plans.⁶⁵ Application of these screening techniques will be a new element for both commercial dental plans and dental offices. Additionally, the cost of enhancing claims processing and administration systems to address these changes must be considered.

Comparison of Projected Costs of Options for “Pediatric Oral Services”

Shown below are representative national average costs for the various “pediatric oral services” from the options described above. These are based on industry average assumptions. Costs in a particular state may vary significantly from these numbers due to geographic cost differentials, provider network size, in-network provider discount levels, and other factors. These costs were developed assuming coverage up to age 21 as allowed under Medicaid. A younger age limit would also affect the cost levels. These numbers represent the full cost of the “pediatric oral services,” not the lesser final cost to the consumer after subsidies are applied. These are per-child costs in addition to medical coverage, so a family with multiple children would incur this cost for each covered child. Additional detail on these calculations is shown in Appendix A.

Chart 5: 2014 Illustrative Costs per Child, in Addition to Medical^{*66}

OPTION	Per Month	Per Year
Screenings by Pediatricians	\$0	\$0
Diagnosis/Prevention/Emergency Treatment	\$18.50	\$222
Common Employer-sponsored DPPO without Ortho \$1,500 Annual Maximum*; In Network: 100/80/50 with \$50 deductible; Out-of-network: 80/60/40 with \$50 deductible	\$21.25	\$255
Common Employer-sponsored DPPO with Ortho \$1,500 Annual Maximum with separate Ortho Maximum of \$1,500; In Network: 100/80/50 with \$50 deductible; Out-of-network: 80/60/40 with \$50 deductible	\$25.40	\$305
CHIP Equivalent without Ortho no annual maximums or cost-sharing	\$29.25	\$351
CHIP Equivalent with Ortho with no medical necessity criteria applied; no annual maximums or cost-sharing	\$48.25	\$579
Next Generation Employer Type Dental Plan with risk assessment and medical necessity criteria applied (without Ortho)	\$19.00*	\$228*

NOTES: Premium estimates developed by Milliman, Inc based on national industry averages; state costs may vary. Age of 21 used and costs calculated per child.

*Premium estimate for “Next Generation” Dental Plan developed by DDPA.

In considering these options, the impact of the cost of “pediatric oral services” on families purchasing coverage should be considered. In 2009, enrollment in dental coverage dropped for the first time since NADP and DDPA have been tracking enrollment. Through 2008, 57 percent of the population had dental coverage; in 2009 this dropped to 54 percent with 10 million fewer Americans having dental coverage. The lower enrollment reflects both decreased employment and employees choosing not to purchase coverage for which they pay all or a substantial portion of the cost. Survey data confirms high price sensitivity to increases in the price of dental policies among consumers.

The EHBP approach of requiring coverage of only “pediatric oral services” and requirement of child only policies changes the offer of coverage from employees and dependents to dependents first. If the cost of the children’s coverage is excessive, then adults may not continue dental coverage for themselves. For instance, the cost of coverage per child per month can be decreased to \$19.75 per month⁶⁷ if a \$1,000 annual maximum (which is more common in small employer groups) is used. With the Surgeon General’s finding that dental coverage results in more dental visits by both adults and children and the more recent linkages of oral and overall health, any degradation of dental coverage will have an overall negative impact on oral health, overall health and ultimately costs of medical conditions like diabetes, cardiovascular disease and low birth weight babies.

Based on consumer surveys, NADP has projected half of adults with employer-provided dental coverage in the small group market today, i.e. 11 million, would drop coverage if their dental coverage is separated from their children’s coverage. With the Pew Institutes estimate that 5.3 million children will be added to programs providing dental coverage -- both public and commercial, the loss in coverage and reduction in access to dental care could be significant.

Summary & Recommendation

HHS should define a core benefit level for “pediatric oral services” including the age encompassed by the term “pediatric” to create a consistent base for states to make both separate dental policies and dental services integrated with medical coverage available to consumers in Exchanges. This core or “essential” benefit for “pediatric oral services” should be affordable for consumers and administratively simple for Exchanges to administer.

The following elements should be considered when constructing “pediatric oral services”;

- The age limit associated with pediatric benefits;
- The scope of “typical employer plan”;
- The scope of services in existing employer-sponsored dental coverage and public programs with dental benefits as well as their affordability and clinical appropriateness;
- The impact on access to care and maintenance of oral health by all populations;
- The fact “pediatric oral services” are one element of the EHBP and need not separately meet the actuarial levels of coverage, i.e. “metal levels” defined by ACA;
- Advancements in dental science based on evidence.

ISSUE BRIEF 2: HOW SHOULD DENTAL PLANS BE QUALIFIED TO OFFER COVERAGE THROUGH THE EXCHANGES?

Key Points

- Federal or State: the states have the primary responsibility for identifying and implementing criteria to qualify dental plans within Exchanges.
- All criteria developed for certifying QHPs are not necessarily applicable to dental plans when offering “pediatric oral services” as separate dental policies, particularly when the required benefit is pediatric only. States differentiate in regulations applied to medical plans and plans offering a single benefit like dental today. While dental policies offered on Exchanges should be licensed and compliant with relevant state statutes for solvency, market conduct and other standards, there are marked differences between medical and dental coverage to consider when determining the applicability of QHP criteria to QDPs.
- Plans offered on both the AHBE and SHOP Exchanges are required by ACA to be certified as QHPs. Therefore, criteria for dental plans – whether it be through the QHP or a separate QDP process – will be applicable to both Exchanges.

Issue

Affordable Care Act (ACA) requires plans offering coverage on the Exchange to be certified as “qualified health plans” (QHP). ACA provides for the Secretary (Secretary) of the U.S. Department of Health and Human Services (HHS) to establish the criteria for certification of QHPs⁶⁸ and sets out minimum requirements within the statute. The law also provides “each Exchange within a State shall allow an issuer of a plan that only provides limited scope dental benefits...to offer the plan...if the plan provides pediatric dental benefits...” ACA does not, however, establish criteria for certification of dental plans nor specifically provide the Secretary with authority to establish such criteria.

In the development of its American Health Benefit Exchange Model Act (Model), the National Association of Insurance Commissioners (NAIC) recognized plans providing “dental only” policies would also need to be qualified and included a definition and requirements for a “qualified dental plan” (QDP) for state consideration in establishing Exchanges. The Model provides a QDP need not be licensed to offer medical benefits and shall comply with the provisions applicable to a QHP “to the extent relevant.” This Issue Brief examines the unique characteristics of the dental product and market to identify which provisions might meet that test of “relevance.”

The evaluation below analyzes the proposed QHP criteria in the NAIC Model which encompasses the minimum requirements of ACA to identify areas where proposed criteria for certifying QDPs should differ from those applied to QHPs and, where appropriate, suggests alternatives.

The criteria applied to QDPs are applicable to both the American Health Benefits Exchange (AHBE) and Small Business Health Options Program (SHOP) Exchange.

Criteria for QDPs

Overall Approach

There are a variety of state approaches to Exchange purchasing and operations ranging from an “open market” approach to “selective contracting.”⁶⁹ Any approach should maintain and enhance the competition that occurs in the marketplace today. States should utilize existing state standards to qualify dental carriers for Exchange participation wherever possible, rather than creating new, duplicative or conflicting standards. Dental plans that meet licensure requirements including solvency, market conduct, and contract and rate requirements applicable in the relevant state, should be eligible to offer dental policies in Exchanges. Use of current state standards will ensure efficiency and continuity in the marketplace and minimize disruptions and unnecessary administrative costs which increase consumer’s costs.

If additions to current state statutory requirements are considered, the following discussion analyzes the applicability of the minimum requirements under ACA to QDPs.

Network Adequacy

ACA applies the network adequacy standards of section 2707(c) of the Public Health Service Act to QHPs. This provision is not applicable to separate dental policies (specifically HIPAA excepted benefits – see earlier discussion). What are the considerations for determining whether states should develop or apply other network adequacy to qualify dental plans? Key differences in dental and medical plans should be considered:

Network adequacy is a standard usually applied to Health Maintenance Organizations (HMO) where consumers must use a network provider and networks are smaller. Nationwide, dental HMOS have one fifth the number of participating dentists as dental Preferred Provider Organizations (DPPO). DPPOs, which are more flexible in providing some level of payment for in and out-of-network providers, are the predominant dental product in the marketplace. Over 80 percent of dentists are general dentists while only 12.3 percent⁷⁰ of physicians focus on primary care. Children are more likely to utilize general dentists than services of dental specialists.

State Dental Network Adequacy Standards

There is no single accepted network adequacy standard within an NAIC Model, state statute, or commercial dental plans. While large employers typically specify network requirements for their dental benefit programs, these are highly specific to the employer and geographic area of operation. Fewer than a dozen states have network standards applicable to dental and those are generally requirements carriers establish with their own targets rather than state specified targets. Often these requirements apply only for dental HMOs. States have implemented standards for public programs, but even they vary widely with no discernible pattern for the differences other than cost factors and localized preferences.

As described in the introduction, the dental benefits industry comprises primarily DPPO products, wherein customers have the freedom to choose from a variety of dentists both in and out-of-network. For those large employers who specify a network requirement, it is usually expressed as one or two general dentists within a specified number of miles from the various residential zip codes of their employees. Such a standard would be difficult to apply uniformly across the variety of geographies in every state. Given the relative network freedom present in the vast majority of dental insurance products, establishing network adequacy standards to qualify dental plans may be less critical. If a state has a network adequacy standard for a dental HMO or DPPO and either is offered in an Exchange, that standard would be met by virtue of licensure without further specification of criteria to qualify the dental plan.

Dental Providers

Over 80 percent of dentists are general dentists in contrast to about 12.3 percent of physicians who focus on primary care. There are approximately 56 dentists in active practice per 100,000 people in the U.S vs. 312 physicians per 100,000.⁷¹ As 85 percent of services are delivered by a general dentist in an office setting, immediate and local access to dental specialists is less critical than it is for medical specialists.

Children are much less likely than adults to need treatment from a dental specialist requiring network adequacy standards for specialty care. In addition, in some states with sparse populations there are only a few dentists of certain specialty types, making a standard of a specialist within specified distance virtually impossible to achieve. Standards for network adequacy in medical plans therefore should not be applied to dental plans. If network adequacy standards are used to qualify dental plans, those standards should take into account the limitation of the “pediatric oral services” to only children, the distribution of providers, and the limited availability and use of dental specialists.

Recommendation

The local nature of networks and uneven geographic distribution of dentists make a single national network adequacy standard inappropriate for dental plans. Network adequacy would be applied by those states which have such standards in place now for dental HMOs and DPPOs by virtue of licensure. When a state determines network adequacy is needed as a QDP qualifying criteria, it should be applied only to general dentists, and the dental plan should be allowed to specify a target appropriate to its scope for approval of the Exchange.

Accreditation

Generally, accreditation standards were developed for medical coverage and not available to dental carriers offering separate dental policies. Well known medical plan accreditation bodies, such as National Committee for Quality Assurance (NCQA), do not accredit dental plans. While there are isolated instances in which dental plans were required by a state to obtain a statutorily required accreditation, the process was significantly modified. Widespread application to carriers offering separate dental policies would be disproportionately costly and administratively burdensome. Furthermore, employers as well as states have not viewed accreditation as a critical standard for dental policies and have not required accreditation in their selection of dental plans.

Recommendation

The lack of current accreditation programs for dental plans would make their use in certifying QDPs to provide “pediatric oral services” unworkable in the near term.

Quality

Similar to the scenario described above related to accreditation, dental plans are rarely judged according to specific quality metrics. This is because dentistry does not have diagnostic codes and therefore has no means of tracking outcomes or establishing specific quality benchmarks.

There are systems of diagnosis codes under development; however, no system has been fully tested or widely adopted. As of January 1, 2012, electronic dental claims have a data field to accept diagnostic codes. Prior to October 1, 2013, if a diagnostic code is used, it must be an ICD-9 code. After that date it must be an ICD-10 diagnostic code. ICD-9 and ICD-10 codes that relate to dental are limited. Separate dental diagnostic codes are years from implementation by the dental profession to utilize and develop outcome measures.

While development of diagnostic codes is underway, significant work is proceeding in developing appropriate dental quality metrics. In particular, the Dental Quality Alliance, established at the request of CMS through the American Dental Association, is working to develop evidence-based oral health care performance measures and measurement resources. While this work holds much promise, it is in the very early stages of development and could not be used to qualify dental plans today.

Historically, the primary performance measure collected by Medicaid programs for dental care was the number of annual visits. CMS Form 416 was implemented in 1999 and expanded dental reporting requirement to assessments of the types of services provided. These are still only measures of utilization, not quality, i.e. the number of eligible children receiving certain services — prevention, diagnosis, sealants, and any other dental service.

These measures are not typically reported for commercial populations although utilization data may be provided to employers on utilization by procedure. Development of new systems to pull and report data on a commercial population will create additional administrative cost which should be weighed against the value of the data.

Recommendation

If performance measures applied to separate dental policies provide value in qualifying dental plans, they should be consistent to those required by Medicaid and limited to the required “pediatric oral services” under the HHS definition of EHBP.

Dental Plan Performance

Performance measures typically relate to administrative functions. Dental plans measure and report call center speed of answer, turnaround time on electronic and paper claims, and consumer satisfaction. While call center and claim processing is tracked similarly across the industry, satisfaction reporting has not been standardized.

Recommendation

While reportable on a broad basis, performance measures typically available for all enrollees could not be reported solely for children receiving the required “pediatric oral services.” Regulators should weigh the cost of collection and relevance of these measures to specific performance in covering children.

Marketing

Currently, requirements on marketing materials and marketing efforts vary by state, group size and whether the coverage is provided through a public program. Some states have laws and regulations applicable to small group which is most often defined as 50 or fewer employees. Frequently, medical and dental plans serving public programs must abide by a host of marketing restrictions that include limitations on direct-to-consumer marketing and restrictions on where products can be sold. While many of the marketing restrictions placed on medical plans are in fact applicable to dental plans, there may be instances where states have chosen to differentiate the rules applicable to dental vs. medical carriers for various reasons.

Recommendation

States should utilize their existing regulations related to marketing standards specific to dental policies.

Standard Disclosure

Providing consumers access to simple, accurate, publicly available information is critically important. Information should not only include plan choices as discussed in Issue Brief 3, but also relevant materials related to financial

stability and patient rights issues. Dental plans are accustomed to reporting this information for purposes of licensure or state consumer disclosures. However, depending on individual state laws, it will most likely be necessary to prepare a separate form or requirements for dental as opposed to medical plan reporting.

Recommendation

If standard disclosures are required to qualify dental plans, a separate form or requirements appropriate to the limited scope dental product offering should be developed.

Coverage Levels and Cost-sharing

Within the requirements to be certified as a QHP offered by the NAIC, there are two additional requirements that may pose challenges for dental plans. ACA requires a QHP must provide:

- At least a “bronze” level of coverage;
- At least one silver and one gold level plan; and
- Adhere to specific cost-sharing limits.

While the first two issues are discussed in greater detail as part of Issue Brief 1, requiring dental plans to offer plans within specified coverage tiers may not be appropriate. “Pediatric oral services” are one of the ten EHBP categories of services, and each service by itself is not required to meet actuarial values. The scope of “pediatric oral services” and the historic prevalence of diagnostic and preventive dental services being covered at 100 percent, results in even the most basic of plan designs having an actuarial value of “silver.” So if the requirement is applied to require the “bronze” level of coverage instead of bronze being a floor beneath which coverage cannot be provided, dental plans may not be able to comply. Requiring dental plans to meet several different actuarial value targets separate from medical plans may be confusing for consumers and produce variation in benefit levels that are not meaningful.

Further, as outlined in Issue Brief 5 on cost-sharing and out-of-pocket maximums, the separate claims processing systems of medical and dental plans impedes tracking the progression of out-of-pocket limits.

Recommendation

Policymakers should not require “pediatric oral services” to be offered at every actuarial level of coverage, i.e. “metal levels.” Instead, a high and low option should be allowed which will, as discussed in Issue Brief 1, exceed the actuarial value of the silver level.

Summary & Recommendation

1. Should criteria for qualification be established at the federal or state level?

As ACA provides for HHS to establish qualifications for health plans, it also directs states to allow separate dental policies to make offerings in the Exchanges. The establishment of criteria for standalone dental plans to qualify to offer coverage in the Exchanges appears to be the responsibility of the states. However, HHS may use its broad authority to apply or waive health plan standards to dental plans to establish a threshold of qualification standards for the states.

2. Should criteria created for certification of QHPs be applied to dental plans?

QHP criteria should not be indiscriminately applied to dental plans to be eligible to offer coverage in the Exchanges. The differences in medical and dental coverage must be considered in applying any of the QHP criteria to dental plans. As well, policymakers should weigh the value of the criteria and cost of implementation given the limited scope of the “pediatric oral services.” It will also be useful for each state to compare the criteria to existing state requirements for licensure.

3. If not, what criteria should be used?

Of the reviewed criteria:

- Accreditation is inapplicable to dental plans;
- The local nature of networks and uneven geographic distribution of dentists make a single, national network adequacy standard inappropriate for dental plans. States without network adequacy standards for dental plans that determine they are needed should apply them only to general dentists and allow the dental plan to specify a target appropriate to their coverage for approval;
- Relevant quality and performance measures are limited and may be difficult to apply narrowly to children. If utilization data for children’s services is required, it should be consistent with Medicaid measures now reported;
- Marketing limitations and disclosure requirements should follow existing state regulation;
- Metal levels, representing specific actuarial values of coverage, should not be applied to separate dental policies covering “pediatric oral services”;
- If standard disclosures are required to qualify dental plans, a separate form or requirements appropriate to the limited scope dental product offering should be developed.

ISSUE BRIEF 3: HOW SHOULD THE OFFER OF CHILD, ADULT AND FAMILY DENTAL COVERAGE BE STRUCTURED IN THE EXCHANGES?

Key Points

- Federal or State: the federal government will provide guidance regarding consumer choices through Exchanges by both defining “pediatric oral services” and providing guidance for consumer information. States will design and implement the consumer interface which provides the information to make informed choices.
- If the definition of “pediatric oral services” in EHBP includes services typically covered by dental policies, recognition of existing coverage under a dental policy outside the Exchange is easily achieved and necessary to ensure consumers are allowed to keep the coverage they have and aren’t required to purchase duplicative coverage.
- Dental and medical benefits today are purchased in one of three configurations: separately from two different carriers; co-offered by a carrier and its affiliate, subsidiary or partner as separate medical and dental policies; or dental services integrated in a medical policy.⁷² All three configurations should be allowed in Exchanges to ensure robust competition and consumer choice.
- Transparency with respect to cost can be achieved when a separate dental plan is offered in a state Exchange by requiring medical plans that integrate dental services in their medical policies to also offer a medical policy without dental services, and requiring any carrier, medical or dental, that chooses to offer dental policies also offers a separately priced “child-only” dental policy covering just the required “pediatric oral services.”
- Supplemental dental coverage for adults and non-essential pediatric dental benefits should be offered alongside the essential “pediatric oral services” so parents or guardians have access to family coverage, can access covered care from the same family dentist as their children/dependents and are not discouraged from obtaining such coverage.
- Purchasers, both employers and consumers, generally make decisions about dental policies based on cost, benefits and access to dentists within a network. This information must be presented effectively to ensure tools are available to make an informed and educated choice regarding dental coverage.
- Presentation of consumer choices and related information will be relevant to both the AHBE and SHOP Exchanges. Employers in SHOP exchanges should also be allowed to specify the coverage offered to employees.

Issue

Given the flexible and competitive nature of the dental insurance market, consumers will likely want a number of similar, yet slightly different dental choices in Exchanges. Therefore, a vital goal of any Exchange should be to

ensure consumers can evaluate medical and dental policy choices using accessible, easy-to-understand information. The National Association of Insurance Commissioners (NAIC) has provided input to the U.S. Department of Health and Human Services (HHS) to assist in its guidance regarding consumer information in the Exchange, yet each state will likely design its own consumer interfaces.

As previously presented, the majority of consumers today access dental policies through a plan not connected with their medical policy. Even in instances when consumers buy dental and medical insurance from the same carrier, they most often purchase them as separate policies. What then is the best way to present consumers with available dental benefit options in an Exchange? This section will discuss the need to recognize coverage held outside of Exchanges, the three configurations for presenting medical and dental in exchanges, the offer of dental coverage supplemental to “pediatric oral services” required in the Essential Health Benefits Package (EHBP) and the provision of consumer information with the overall goal of fostering competition, choice and transparency.

Recognition of Coverage Held Outside of Exchanges

Recognizing and maintaining existing dental coverage is key to keeping the promise that Americans can keep the coverage they already have and like. There are approximately 141 million consumers, 43 million of whom are children, who currently have dental coverage in the private market. Of these Americans with dental coverage, there are 44 million receiving coverage through small employers that will be directly impacted by the inclusion of “pediatric oral services” in the definition of EHBP in 2014. HHS should consider that over half of the 44 million consumers covered through small employers are children who may have to be removed from their parent’s dental coverage unless it is accepted as meeting the EHBP.⁷³

The impact of the definition of EHBP is even greater than the 44 million that are covered through small employers. There are instances when one parent is employed by a small employer that does not offer dental coverage, and the other parent is employed by a large employer which does offer dental coverage. When the parent employed by the small employer comes to the Exchange, will he or she be required to duplicate the dental coverage the family has through the parent employed by a large employer? If so, millions more insured in two parent families are impacted.

A recent survey of employers found only about 21 percent of employers with 100 or fewer employees that currently offer dental do not intend to maintain dental coverage outside of Exchanges.⁷⁴ If “pediatric oral services” are defined to reflect a “typical employer plan,” as referenced in Affordable Care Act (ACA), the dental coverage most employees have today will likely satisfy, and potentially far exceed, the HHS threshold for essential “pediatric oral services.” Thus, a parent coming into the Exchange could have dental coverage of their own or through the other parent which meets the “pediatric oral services” required as part of the EHBP. Unless their existing dental coverage is recognized at the time they apply for coverage from the Exchange, separate dental policies or medical policies with integrated dental services will be duplicative for the children of these parents.

Recognizing separate dental policies purchased outside the Exchanges will require qualified health plans (QHPs) inside Exchanges offer medical coverage options without “pediatric oral services” inside Exchanges to assure consumers aren’t required to purchase duplicative coverage. Accepting dental coverage purchased outside the Exchange also eliminates the necessity to coordinate limits on out-of-pocket costs between medical and dental policies as only those policies purchased inside the Exchange are subject to limits on out-of-pocket (OOP) costs.

Recommendation: HHS should allow separate dental policies purchased outside Exchanges to meet the “pediatric oral services” required in EHBP when medical coverage is purchased through an Exchange meeting the balance of required services in EHBP.

Exchanges should, pending further guidance from HHS, provide means for consumers with children to provide evidence of policies covering “pediatric oral services” at the time of enrollment in coverage through the Exchange in lieu of mandatory Exchange enrollment in dental or medical policies covering “pediatric oral services.” This evidence could be as simple as an attestation from the consumer or a dental ID card or certificate of coverage. In Small Business Health Options (SHOP) Exchanges, the attestation could be made by the employer that continues to offer dental policies outside the Exchange.

Medical and Dental: Together or Separate?

Overall Approach

“Pediatric oral services” are required as part of the EHBP offered through Exchanges. As a result, consumers with children who meet the “Minimum Essential Coverage” (MEC) requirement by purchasing coverage through the Exchanges are, in effect, required to purchase coverage which includes “pediatric oral services” as defined by HHS. (A separate discussion on whether to require adults without children to purchase policies with “pediatric oral services” is included later in this Issue Brief). For purposes of this section of the paper, we presume this coverage will include services typically provided by a dentist, beyond any oral services a pediatrician would provide as part of well-child visits. ACA also requires Exchanges allow dental policies to be sold as “standalone” products, which consumers may purchase alongside a medical insurance product that does not include “pediatric oral services” to fully satisfy their EHBP coverage requirement. Therefore, a core question policymakers face is how to present dental benefit choices to consumers shopping in an Exchange.

As ACA establishes that standalone dental plans are allowed within the Exchanges to satisfy “pediatric oral services,” state Exchanges will need to carefully structure the certification process and offering rules to facilitate this. An initial Request for Interest (RFI) sent to carriers in each state will allow an Exchange to determine early on the availability of one or more standalone dental plans with aspirations to become a qualified dental plan (QDP) able to meet certification requirements. With that information on hand, the Exchange will know if it can accept medical-only plans, i.e. without embedded benefits for “pediatric oral services,” as ACA allows, and also begin the work of structuring its web portal and other sales channels to enable consumers to purchase appropriate coverage.

All dental plans available in such an optimally dynamic Exchange should be presented on web portals in a manner which balances simplicity with choice, and includes appropriate information about the dental-only component of the EHBP, as is done today in numerous online employer portals.

To accomplish this, Exchanges will need to develop robust search engine capabilities such as those used by many large employers and on commercial websites to enable customers to browse and search for specific plan characteristics, including the number of participating dental providers. The federal dental and vision program – FEDVIP (<http://www.opm.gov/insure/dental/index.asp>) – provides one example of how these functions can be performed successfully.

“Pediatric Oral Services” Coverage

As referenced in the key points, there are three basic configurations in the private market today, which establish a blueprint for how Exchanges might offer the “pediatric oral services” required by the EHBP, and supplemental dental coverage for adults and children that exceeds the essential benefit threshold. Without inclusion of all three configurations, exchanges may meet the statutory requirement for the offer of separate dental benefits in Exchanges, yet fail to meet the often stated objective in ACA and by HHS of ensuring there is full transparency for the consumer. These options can be managed by an Exchange to easily mirror the options now available in the employer market to consumers, and allow each of those options to work smoothly for the consumer. The options include:

- Separate carriers, i.e. dental and medical policies from different carriers;
- Co-offered, i.e. separate dental and medical policies from the same carrier or with the dental policy from its affiliate, subsidiary or partner;
- Integrated dental services (including “pediatric oral services”) within a medical policy.

The discussion below explains these options as well as the implications and merits of ensuring each are successfully managed so as to optimize the consumer shopping experience.

Configuration 1: Dental and Medical Policies from Separate Carriers

While states are specifically required by ACA to allow the offer of separate dental policies, this configuration is only viable if medical policies with no coverage for “pediatric oral services” are also offered on Exchanges. Most of the larger QHPs offer dental policies through an affiliate, subsidiary or partner they will want to use in Exchanges. And in almost all states, the top two QHPs today cover at least half of all state residents with health insurance. In some states, the top two QHPs cover as many as 95% of all residents with health insurance.

Therefore, the offer of standalone dental by dental carriers will be viable only if QHPs are always required to make available a medical policy option without “pediatric oral services,” i.e. “medical-only” that can be purchased alongside a standalone dental product. Failure to require the separate offer of a medical-only option by all QHPs would prevent consumers from choosing the dental option they may want, or which possibly includes their current family dentist.

Under ACA, dental carriers may offer separate dental policies, but are not required to offer a separate medical policy, which is beyond their scope. The proposed structure therefore mirrors dental benefit coverage in today’s employer market, while conforming to the often stated goals of ensuring transparency, competition and choice within Exchanges.

Configuration 2: Co-Offered Dental and Medical Policies

Another configuration available in the employer market today is a dental policy co-offered by the carrier offering the medical policy or by its affiliate, subsidiary or partner. Such arrangements are allowed under ACA in Exchanges. This configuration may provide a simplified process to purchase both medical and pediatric dental coverage required by the EHBP. To support the intent of ACA’s mandate to allow standalone dental carriers to compete for the required “pediatric oral services” (as well as other supplemental dental benefits), carriers co-offering medical and dental policies should make their policies available separately. Such separate offer and pricing does not preclude the packaging of medical and dental policies for a discounted price from a single carrier, affiliated carriers or strategic partners.

Additionally, it is important to note co-offering medical and dental policies does not dictate post-sale administrative practices. This means the consumer could deal with one or two companies for the administration of their coverage, depending on the agreement between those companies for the co-offering.

It is critical when Exchanges make co-offered medical and dental coverage available, they do so under a set of guidelines or rules – and with a robust web interface – which provides consumers with the tools they need to weigh and compare the dental-only element of the co-offered EHBP with the separate standalone dental options. Cost transparency and ability to access one’s existing dentist should be readily visible to all who shop for coverage in the exchange in all configurations.

Configuration 3: “Pediatric oral services” integrated within a medical policy

The third configuration in today’s market is medical plans that integrate or embed dental services within their medical policy. ACA specifically requires QHPs to include all of the benefits defined as the EHBP. However, where a separate dental plan is available in the Exchange, the QHP can be qualified without the inclusion of “pediatric oral services.” This configuration would not undermine transparency or choice so long as QHPs with embedded “pediatric oral services” are also required to offer a medical-only policy, i.e. a medical policy without “pediatric oral services.”

Consumers opting for embedded or integrated dental will have simplified purchase and administrative processes, because their EHBP is delivered under a single policy from the same carrier. Additionally, as embedded dental services are “integral” to the medical policy under the Public Health Service Act, they would no longer be “excepted benefits” and subject to the market reforms applicable to medical plans under ACA.

As with co-offered medical and dental, integrated medical and dental services should be offered with the online shopping and comparison tools which allows the consumer to compare the dental portion of the offer with the other dental coverage options available in the exchange.

Providing all of the three above configurations of medical and dental, with information about the dental-only element within each, allows Exchanges to maximize transparency and choice for consumers. By emulating today’s marketplace, Exchanges can promote the conditions under which medical-only, dental-only and full service plans can compete and thrive in Exchanges while consumers choose what’s best for them.

Recommendation: Dental policies should be offered in Exchanges under all three of the configurations found in today’s private marketplace.

When a separate dental policy is offered on the Exchange, QHPs should be required to offer a medical policy without integrated “pediatric oral services” to allow consumers who purchase dental coverage outside of Exchanges a medical policy that does not duplicate their dental coverage, and to ensure the standalone dental offering within the Exchange is a viable option.

If “pediatric oral services” is defined to include services normally covered by separate dental policies, a child-only dental policy covering the “pediatric oral services” required in EHBP should be a separate option offered by all carriers offering dental policies.

Requirement for Purchase

Although “pediatric oral services” are required benefits in EHBP in the small group and individual market, they are not directly a part of ACA’s requirement for consumers to maintain MEC. This raises a question as to whether all consumers must select a “pediatric oral services” benefit as part of an Exchange purchase.

Two issues should be addressed by Exchanges with regard to consumers to purchases of coverage inside Exchanges:

- Provision for adults without children to purchase EHBP without “pediatric oral services;” and
- Automatic enrollment in “pediatric oral services” for consumers in households with children that do not provide evidence of other dental coverage that meets the “pediatric oral services” required in the EHBP.

Adults without Children

Pending further guidance from HHS on the EHBP, Exchanges should consider whether adults without children are required to purchase policies with “pediatric oral services.” Many consumers currently purchase medical insurance that includes coverage they do not use or are exclusively for the opposite sex. For example, single males may have policies which cover a gynecological exam. Yet, customers are not asked to proactively select these benefits; they are simply included within their overall medical package that is priced based on the projected utilization of the groups that are covered and individuals who are purchasing coverage. As “pediatric oral services” will be offered under a policy separate from medical plans, should adults without children be required to purchase this coverage? Typically, medical and dental coverage is sold as employee only, employee and dependent (could be a spouse or a child) and as employee and family—each with a different price. So in “typical employer plans,” employees are not required to select and purchase coverage for anyone other than themselves.

Exchanges, with guidance from HHS, must decide if and how they are going to allow Exchange customers without children to “opt-out” of the “pediatric oral services” when it is not embedded in the overall medical plan. The offer of medical plans that do not include “pediatric oral services” or—perhaps as an “adult-only” or “adult plus adult dependent” plan would facilitate the “opt-out.” Exchanges would already be designing operational processes to determine whether the individual applying for coverage wants to cover others in their household including children.

Since the requirement of ACA is 1) MEC be maintained by all Americans but MEC is not defined as a specific set of benefits, and 2) EHBP is required to be offered in the small group and individual market but consumers are not specifically required to purchase EHBP, consumers could be allowed to purchase the coverage which fits their circumstances as is done in the commercial market today. Allowing adults without children to “opt out” of coverage for “pediatric oral services” which they will not use would also reduce the federal cost of subsidies.

Automatic Enrollment

To address instances where consumers fail to choose “pediatric oral services” to meet the EHBP requirement, customers not making a selection—that have not provided evidence of other dental coverage (outside of the Exchange or under a policy of another parent inside the Exchange)—could automatically be enrolled in the lowest cost pediatric dental plans on a predetermined basis.

Recommendation: Given the requirement in ACA for states to allow separate offer of dental coverage, HHS and Exchanges should allow adults without children to purchase an EHBP without “pediatric oral services.”

As appropriate, Exchanges should apply automatic enrollment in the lowest cost dental benefits policy for children to assure required coverage is met when children are present in a household purchasing coverage and evidence of dental coverage is not provided.

Adult Coverage and Additional Child Coverage

Adult dental coverage is not included as an essential health benefit under ACA. However, ACA provides Exchanges to allow the offer of separate dental policies which include at a minimum the defined “pediatric oral services.” This does not limit dental benefits offered on the Exchanges only to a policy covering the essential “pediatric oral services.” But as the purchase of adult dental and pediatric coverage above the EHBP threshold is optional, the Exchange offering for dental can be approached differently than the core medical offering. For example, after individuals have purchased their medical coverage they could be presented with the array of dental options or a pop-up window or other prompt asking, “Would you like to add adult dental coverage?” If the answer is yes, the customer will go through the selection process and add optional adult and additional child dental coverage to their “cart.” The array of benefits displayed could show the range of products available such as those illustrated below. Once a category is selected, the offerings of different carriers and dental policies⁷⁵ could be displayed.

	Basic Child Only Dental *	Expanded Child Only Dental	Basic Child Dental with Adult Dental	Expanded Child Dental with Adult Dental	Basic Family Dental Coverage	Expanded Family Dental Coverage	Adult Only Dental Coverage
DIAGNOSTIC & PREVENTIVE BASIC MAJOR							
ORTHODONTIA Deductible Annual Limits							

NOTE: Households with Children must select this coverage at a minimum. This coverage will be included in the calculation of the federal subsidy applicable to your income level. You can select higher levels of coverage or coverage for the adults in your household; however, the expanded coverage will be at your expense.

Throughout the coverage selection process, it should be clear pediatric dental is required only to the extent of “pediatric oral services” as part of the EHBP (or with additional requirements as included and funded by the state). Whether “pediatric oral services” is required to be purchased by all households or just by households with children is a determination that should be made by HHS or the states prior to establishing the enrollment process (see prior discussion on “adults without children”).

Moreover, depending on how the Exchange chooses to present the “pediatric oral services,” it should also be clear parents can satisfy the mandatory pediatric requirement through the purchase of a family dental plan which includes the required “pediatric oral services.” Finally, adults purchasing separate dental policies will also need to be notified their dental coverage is not eligible for a subsidy; Exchanges will determine when and how that notification is made during the process.

SHOP Considerations

To attract and retain small businesses, it will be critical for SHOP Exchanges or a combined Exchange serving both individuals and small businesses to offer separate adult dental coverage to replicate existing small business benefit options. While SHOP customers will need to understand their employers' contribution when choosing coverage, SHOP Exchanges will not have to navigate the subsidy calculation issues associated with AHBE. The three configurations of dental policies, i.e. separate carrier, co-offered dental with medical and integrated dental in medical would be available in the SHOP for the employer's or consumer's choice.

Recommendation: Exchanges should provide for the offer of expanded children's dental benefits and adult coverage beyond the required "pediatric oral services." Throughout the browsing and purchasing process, it should be clear what coverage is subsidized as HHS defines "pediatric oral services" in the EHBP and expanded children's coverage and adult coverage is optional and not eligible for a subsidy.

In addition, Exchanges should consider ACA's intent to ensure continuity of coverage for those with dental insurance and increase access for those without dental insurance when designing their subsidy calculation tools. In particular, consumers should be able to provide proof of dental coverage held outside the Exchanges as well as clearly recognize the cost of mandatory, subsidized, "pediatric oral services" versus optional, adult or expanded coverage.

Consumer Information – How Much Is Too Much?

Consumers generally make decisions about dental coverage based on cost, benefits and access to dentists within a network. Studies show consumers process information most effectively when it is limited in scope. Yet, according to a 2011 national survey⁷⁶ conducted by Morpace, Inc. and commissioned by DDPA, parents would prefer to have more, rather than fewer, insurance options. Therefore, delivering consumers information they want in a scope and environment that lends itself to simplicity is critical.

Experience from the Massachusetts Health Connector and various research reports suggests Exchanges should consider limiting information directed at consumers to "what you can comfortably see on one screen." This applies to both the "pediatric oral services" (if it is offered as a separate product) as well as adult dental offered on the Exchange. For example, the Massachusetts Health Connector typically displays high level information on standardized medical plan choices for no more than five medical insurance carriers at a time, and only allows consumers to compare detailed information up to three plans at the same time. The federal voluntary dental and vision program, FEDVIP, provides for consumer comparison up to four carriers at one time (<http://www.opm.gov/insure/dental/search/fedvipsearch.aspx>). Further, any information should be easy-to-understand and free of undefined technical terms.

Yet, consumers must be empowered to make informed choices about their medical and dental coverage. In addition to strong search engine capabilities, Exchanges should consider developing benefit "grids" for these purposes, wherein various dental plans are listed as columns and criteria for consideration are used as rows. Individuals typically choose dental insurance based on cost, benefits and access to dentists within a network. The "look and feel," navigation features and layout should follow closely the set-up of the medical plan comparison charts as developed by the NAIC, so consumers can get comfortable accessing, viewing and evaluating information in a single format. In addition to premium information, the dental grid should explain how and if the plan covers preventive and diagnostic procedures, basic procedures, major procedures and orthodontia as well as a link to what is covered by each category.

Chart 6: Dental Plan Comparison

	DENTAL PLAN 1	DENTAL PLAN 2	DENTAL PLAN 3
Phone Number			
Website Link			
Plan Brochure			
Link to Provider List			
Basic Child Benefits			
DIAGNOSTIC & PREVENTIVE			
BASIC			
MAJOR			
ORTHODONTIA			
Deductible			
Annual Limits			
Subtotal Cost			
Additional Child, Adult or Family Benefits			
DIAGNOSTIC & PREVENTIVE			
BASIC			
MAJOR			
ORTHODONTIA			
Deductible			
Annual Limits			
Subtotal Cost			
TOTAL COST			

These grids, and the overall Exchange consumer interface, should be designed in a way that offers consumers the opportunity to seek progressively more in-depth information. For example, the grid may have information listed that is linked to a more extensive explanation of the benefit. Additionally, it should be noted carriers may place procedures in different categories. For instance, root canals are classed as basic by some carriers and major by others. This gives the consumer the opportunity to tailor their information load based on their own interest and needs. In particular, depending on how dental plans are presented on the Exchange, it may be useful to offer filtering tools, allowing customers to identify if their dentist is within the plan network.

Recommendation

While information presented to consumers should be manageable in scope, it should also provide enough background for them to make educated choices about insurance options. In particular, Exchanges should maintain in-depth information about all plan choices; consumers should be able to take actions to access progressively more in-depth information on a proactive basis.

Billing and Payment

We discuss billing and payment in further detail as it relates specifically to subsidies and the ABHE Exchange in Issue Brief 4. As we discuss consumer-oriented issues, it is worth noting consumers should ideally receive one

premium bill for medical and dental benefits. Separate bills could create confusion and lead to non-payment for the medical carrier, dental carrier or both.

SHOP Considerations

SHOP customers may have the benefit of their employers or brokers in helping them choose their dental product. Further, a recent survey of employers by NADP found only about 21 percent of small employers with dental coverage today will not maintain their dental policies outside the Exchange.⁷⁷ Thus, the acceptance of this coverage is critical in the design of coverage available to employers in the SHOP exchange as well.

Summary & Recommendation

1. How should the essential “pediatric oral services” be presented to consumers?

HHS should provide that a separate dental policy purchased outside of Exchanges covering “pediatric oral services” exempts a consumer from purchasing a policy with “pediatric oral services” inside the Exchanges.

If “pediatric oral services” is defined to include services normally covered by separate dental policies, this benefit should be offered and priced separately on the Exchange as a “child only” policy by all carriers choosing to offer dental policies.

ACA provides for medical carriers to offer policies in Exchanges which include all EHBP benefits, but medical carriers should also be required to provide a medical policy without “pediatric oral services” when a QDP is also offered in the Exchange to allow:

- Adults without children to purchase coverage without “pediatric oral services”;
- Consumers who have dental or medical policies covering “pediatric oral services” outside of Exchanges to keep their coverage and purchase medical coverage that is not duplicative.

When consumers in a household with children fail to select a policy covering “pediatric oral services” and evidence of other dental coverage is not presented, Exchanges should apply automatic enrollment in the lowest cost dental “child-only” policy to assure required coverage is met. .

2. How should supplemental dental products be presented to consumers?

Much like the required “pediatric oral services,” supplemental dental benefits should be presented as a separate policy option. Exchanges must take steps to both:

- a) Ensure consumers understand that “pediatric oral services” as defined by HHS as part of the EHBP are subsidized and supplemental dental coverage is not; and
- b) Recognize separate family coverage which includes “pediatric oral services” meeting the HHS definition can meet the EHBP whether purchased inside or outside the Exchange, allowing parents and children to remain on or be covered under the same dental policy.

3. How can an Exchange uphold its responsibility for providing “standardized, comparative information” on plan options among QHP and standalone dental policies offering “pediatric oral services”?

While information presented to consumers should be manageable in scope, it should also provide enough detail for them to make educated choices about insurance options, including the availability of dental as a standalone option. Beyond that, Exchanges should maintain in-depth information about all plan choices and consumers should be able to access progressively more in-depth information on a proactive basis.

ISSUE BRIEF 4: HOW CAN PREMIUM SUBSIDIES BE APPLIED TO “PEDIATRIC ORAL SERVICES” PURCHASED IN A STANDALONE DENTAL POLICY?

Key Points

- Federal or State: the federal government has control over tax credits that subsidize the purchase of the EHBP, while states will determine how subsidies are distributed and premiums are collected and distributed.
- Relatively small dental policy premiums and a lack of infrastructure to collect premiums from individuals (as opposed to employers) make the premium collection from Exchange participants challenging for standalone dental plans. This scenario is further complicated by the limitation of the subsidized benefit to only “pediatric oral services,” which is expected to be a low dollar benefit compared to medical coverage. Exchanges must consider how to build on existing systems to keep costs low for carriers and ultimately consumers.
- Tax credit for subsidies are relevant only to the AHBE while premium payment issues are relevant to both the AHBE and SHOP Exchange.

Issue

How much will consumers need to pay for “pediatric oral services”? Affordable Care Act (ACA) provides sliding scale premium tax credit subsidies for individuals between below 133 percent and up to 400 percent of the Federal Poverty Level (FPL) to make health insurance more affordable. These subsidies can only be used to purchase health insurance containing the Essential Health Benefits Package (EHBP) through the American Health Benefits Exchange (AHBE). They cannot be used to purchase health insurance through SHOP. An individual’s (or family’s) subsidy combined with their own contribution make up the insurer’s premium payment.

According to an analysis by the Congressional Budget Office during passage of ACA, only for individuals or families under 150 percent of poverty will virtually all of the cost of health coverage be subsidized (see Appendix B), i.e. those with incomes between 133 percent and 150 percent of poverty will have 96 percent of the cost of their MEC subsidized. Between 150 percent of poverty and 400 percent of poverty, premium subsidies begin at 83 percent and decline to 35 percent of the premium. The highest dollar amount to be provided as a subsidy to a family of four for the estimated annual premium of \$14,100 is \$13,500 while the lowest amount for those between 350 percent and 400 percent of poverty will be \$4,900.

ACA specifically provides premiums allocable to the purchase of “pediatric oral services,” under a separate dental policy, to be considered for the calculation of premium subsidies. ACA does not address whether the premium tax credit subsidy should be allocated between medical insurance and dental insurance or paid first to one or the other. How should the value of those tax credits reach insurers and how should individuals pay their share of the premium? This section will describe some of the potential options for tax credit allocation and premium payment in the Exchange.

Tax Credit Subsidies

While the cost of dental benefits does vary geographically, by product and the benefit plan design, in general dental policies cost about eight percent (less than 1/12) the cost of medical insurance annually. A dental preferred provider organization (DPPO) covering an individual costs on average about \$28.50 a month, i.e. \$340 a year while family DPPOs coverage costs about \$1,140 a year or \$95 a month.

Tax credit payments could reach their intended recipients through a number of means. This will be a federal level decision, since the federal government is charged with administering the premium tax credits. ACA indicates tax credit payments are made to the insurer. There are several options to fulfill this provision:

Option 1: Medical insurer receives the full tax credit

Under this model, the medical carrier would act as a collector and possibly distributor of tax credits. In other words, all tax credit payments would be made to the medical insurer. The tax credit could be applied fully to medical coverage or the medical insurer could remit a dental share to the dental carrier based on a pre-determined federal formula or pre-negotiated split. This model would require all qualified health plans (QHP) operating in the Exchange to be willing to serve this role and develop the necessary interfaces with all qualified dental plans (QDP) in the Exchange, a significant administrative cost. While this approach is direct from the federal government's perspective, states may need to implement policies to make it operational on the plan level, such as notification of the medical plan of the dental plan selected by their enrollees, etc.

Option 2: Federal government splits value of tax credit proportionately

Under this model, the federal government would split the value of the individual's premium tax credit and deliver the appropriate portion of the premium subsidy to either the medical and dental insurer or a designated aggregator based on the proportionate value of the premiums. While this would require the federal government to develop a formula to determine the proportion by which the tax credit would be split, it would forgo the need to develop infrastructures on the medical and dental plan levels which could increase premium costs. While it may be reasonable to split the tax credit amount respective to the proportion of medical and dental premiums, both carriers would still need to collect premium payments from consumers. This creates a host of challenges for carriers, particularly dental plans.

Option 3: Federal government splits value of tax credit with full payment of dental coverage with the balance to medical coverage

Under this model, the federal government would split the value of the individual's premium tax credit and deliver the premium subsidy to both the medical and dental insurer or a designated aggregator based on the subsidy level of the individual. This option would not require the development of a formula to determine the proportion by which the tax credit would be split. Rather, the federal government would pay the full amount of the subsidized coverage for the "pediatric oral services" and transmit the balance to the medical carrier. This approach avoids additional costs to develop infrastructures on the medical and dental plan levels which could increase premium costs. It is the most consumer-friendly as they would then have a single bill from the medical carrier for the portion of the premium not subsidized. As the pediatric dental premium is diminutive compared to an individual's medical premium, at no level of consumer subsidy would the dental premium not be covered (see Appendix B).

Recommendation

When a separate dental policy is selected covering "pediatric oral services," the federal government should split the value of the tax credit on a basis proportionate to the premium for the "pediatric oral services" in the dental policy and the medical policy. The subsidy should be paid directly to the dental

plan and medical plan as required by ACA. Where an aggregator is used by the state Exchange, the subsidy should be paid to the aggregator for distribution on the same basis as required for subsidies paid directly to the dental plan and medical plan.

Premium Collection

Dental insurers most often collect lump sum premium payments from employers which provide coverage for all the employees and their dependents. The individual dental market is small, i.e., less than one percent of the overall dental market. Thus, the infrastructure and efficiency required to collect premiums from individuals is not as well developed as in the medical insurance market. Furthermore, dental plans collect relatively small premium amounts when compared to medical plans. In some circumstances, an individual's premium contribution toward their dental plan in the AHBE could be as little as a few dollars a month. The cost to the dental plan of collecting this small premium relative to the value of the premium may make it cost prohibitive for dental plans to collect AHBE premiums on an individual basis unless done on an annual basis or through an automatic deduction from a designated account or credit card. This scenario will likely be exacerbated by the expected low-dollar value of the required "pediatric oral services" under ACA unless the full cost of these services is funded by the federal subsidy. Below are a few options for collecting premium payments from individuals as alternatives to requiring the dental plan to engage in individual premium collection.

Option 1: Medical insurer collects premiums

As with the premium credit process described above, medical carriers could collect all individual premium payments on behalf of dental carriers. As we discussed in the section on consumer information, it is preferable for consumers to get a single bill. Under this scenario, medical insurers would bill and collect premiums from the consumer for both medical and dental plans. However, this approach would require extensive infrastructure integration of both medical and dental plans. This is likely to be administratively burdensome and something the medical carriers would not do, unless the dental company is a subsidiary, or they have a defined partnership agreement for this and other functions.

Option 2: Federal or virtual aggregator collects premiums

Another option is for the federal or a state government entity to implement an aggregator function. This process would allow a bank or other financial institution to collect premiums from individuals, match them with the appropriate premium subsidy amount and deliver a lump sum payment to either or both the medical or dental insurer. Additional guidance from HHS may be necessary to implement an aggregator function.⁷⁸ Presumably, the federal government could contract with a federal aggregator or state governments could seek guidance to establish some sort of "virtual aggregator" that collects premiums outside of the Exchange and matches them with the appropriate tax credit subsidies. While ACA requires premium payments to be paid directly to the insurer, a contract could be setup between the carriers and the aggregator to meet this requirement.

Option 3: Exchange collects premiums

Finally, Exchanges could collect premium payments from consumers and pay medical and dental carriers based on enrollment and the selected benefit choices. Throughout consumers' eligibility determination and enrollment process, there will necessarily be an exchange of data between insurers and the Exchange as well as Exchanges and relevant federal agencies. Further, Exchanges will likely need to engage in some sort of "reconciliation process," whereby they keep track of individuals' premium payments. This is because consumers will likely turn to the Exchange when they have a question about their enrollment status or subsidy and payment history. Therefore, it may be natural for Exchanges to collect premiums from consumers, pass the value along to plans and provide carriers with information on individuals' payment history. Similar to the issue in Option 2, ACA

requires premium payments to be paid directly to the insurer; a contract could be setup between the carriers and the aggregator to meet this requirement.

Recommendation

States should provide for premium collection through a central location – either the Exchange or an aggregator in addition to ACA required consumer option for direct payment to the QHP. Centralized collection and aggregation with subsidies where appropriate will reduce administrative costs for plans, particularly standalone dental plans collecting small premium amounts. It also allows Exchanges to answer consumers' questions on payment status in a real-time basis.

SHOP Considerations

As mentioned above, the issues related to the division of the tax credit premium subsidy is not an issue in the SHOP Exchange since employees cannot receive refundable tax credits through that Exchange. If the SHOP uses a payroll deduction and Section 125 plans, premium collection in the SHOP Exchange should parallel today's private market. It is worth noting, however, an aggregation function would be a valuable addition to any SHOP Exchange and would likely make the SHOP Exchange more attractive to insurers – medical and dental alike – and help drive competition among plans.

Summary & Recommendation

1. Should the applicable subsidy be split between the dental and medical carrier?

When a separate dental policy is selected within the AHBE covering “pediatric oral services,” the federal government should split the value of the tax credit on a basis proportionate to the premium for the “pediatric oral services” in the dental policy and the medical policy. The subsidy should be paid directly to the dental plan and medical plan as required by ACA. Where an aggregator is used by the state Exchange, the subsidy should be paid to the aggregator for distribution on the same basis as required for subsidies paid directly to the dental plan and medical plan.

2. Will the collection of the unsubsidized portion of the premium be centralized for distribution or the responsibility of the dental plan providing the separate policy?

States should provide for premium collection through a central location – either the Exchange or an aggregator in addition to ACA required consumer option for direct payment to the QHP. Centralized collection and aggregation with subsidies where appropriate will reduce administrative costs for plans, particularly standalone dental plans collecting small premium amounts. It also allows Exchanges to answer consumers' questions on payment status in a real-time basis

ISSUE BRIEF 5: HOW SHOULD COST-SHARING AND OUT-OF-POCKET MAXIMUMS BE APPLIED TO MEDICAL AND DENTAL COVERAGE?

Key Points

- Federal or State: cost-sharing reductions and OOP maximum issues are largely federal, although states could play a role through Exchanges in the collection and tracking of information that triggers their application.
- ACA includes cost-sharing maximums on EHBP designed to limit consumers' OOP spending on health care. These maximums apply to consumers who receive subsidies in Exchanges to purchase the EHBP, including both medical and "pediatric oral service" components.
- In today's environment, medical and dental claims are processed separately, most often using different claim systems, even when offered by the same carrier. Therefore, coordinating OOP limits among medical and dental carriers offering the benefits required for the EHBP for subsidized consumers in the Exchange should be addressed carefully.
- Methods for addressing the splitting of cost-sharing limitations across medical and dental coverage include:
 - Designing "pediatric oral services" in a way that requires no cost-sharing;
 - Apportioning the total OOP maximum between medical and dental;
 - Developing individual carrier systems to administer a shared OOP maximum;
 - Setting up the Exchange to serve the function of claims aggregator
- Cost-sharing and OOP maximum issues will apply only to the AHBE Exchange, not the SHOP Exchange. While ACA exempts dental policies from reductions in OOP cost-sharing limits, coordination between medical plans and dental plans to eliminate consumer OOP cost-sharing once consumers reach the standard OOP cost limit should occur.

Issue

In addition to the tax credit premium subsidies, Affordable Care Act (ACA) includes additional provisions that protect subsidized consumers, i.e. those between 133 percent and 400 percent of poverty, from out-of-pocket (OOP) cost due to health care expenses. In particular, ACA provides for cost-sharing subsidies and OOP limits to ensure subsidized consumers are not required to spend more than a specified threshold "out-of-pocket" on care. ACA does include an exemption when an individual enrolls in both a qualified health plan (QHP) and a separate dental policy, in that the portion of the cost-sharing reduction towards the "pediatric oral services" does not apply.⁷⁹

The inclusion of "pediatric oral services" in the list of Essential Health Benefits Package (EHBP) complicates the claims-paying and cost-sharing processes, usually handled separately by medical insurers and dental insurers. Dependent on the definition of "pediatric oral services," the OOP limit for the EHBP includes OOP expenses incurred when utilizing medical insurance and potentially "pediatric oral services" policies. This construct raises several issues which must be carefully considered in order to ensure cost-sharing limits are appropriately applied and coordinated between medical and dental benefits.⁸⁰

As discussed under “The Dental Benefits Industry Today” in this paper, dental policies are almost always offered separately from medical insurance, as a separate contract, often different from their medical carrier. Even if medical and dental coverage is purchased from the same plan, they are in most cases still subject to completely separate administrative processes within the insurance company system⁸¹ as dental carriers are often separate companies or subsidiaries of the medical carrier. One factor in this separation is the use of Current Dental Terminology (CDT)⁸² codes rather than Current Procedural Terminology (CPT) codes for billing dental procedures. There is also a separate dental claim form including a tooth chart for dental procedures. Typically, medical claim payment systems are not configured to accept either dental claim forms or CDT codes. So, key functions such as claims payment and enrollment, as well as the systems platforms supporting these processes, are separate and distinct between medical and dental plans.

As such, when considering how to process cost-sharing after attainment of OOP maximums for a given individual or family policy on the Exchange, it is critical to realize that combining medical and dental claims for that individual or group, while not impossible, is at the very least cost-prohibitive—especially when applicable for only a small segment of children covered in Exchanges. Trying to combine claims data in a timely and accurate manner from separate systems is fraught with difficulties.

With that commentary as a backdrop, we explore how to handle the division of cost-sharing subsidies and OOP maximums in a pragmatic way below.

“Pediatric Oral Services”

Benefit Design

The first consideration is whether the issue can be managed via the design of “pediatric oral services.” The answer depends greatly on how the policy is ultimately defined. If the EHBP can be constructed to cover only specified procedures, including but not necessarily limited to preventive and diagnostic dental services, at 100 percent with no member cost-sharing, then achievement of OOP maximums can be calculated on a medical-only basis. This may be a practical way to build the “pediatric oral services,”⁸³ providing required dental services as part of the EHBP while eliminating a potential administrative burden and additional cost for consumers.

A trade-off does arise, however, when defining which dental services should be covered. If a broad range of dental procedures is covered with no cost-sharing, the cost of pediatric services may become substantial enough to affect the affordability of the total EHBP coverage. A benefit structure which fully covers preventive and diagnostic dental care, as well as carefully selected additional procedures chosen to maximize child dental health while keeping costs reasonable, would be a potentially workable solution. A group of dental clinicians, along with dental actuaries, would be suited to recommend such an option.⁸⁴

Separate OOP Maximums Based on the Proportionality of Premium

Another potential means of controlling the issue through a plan design is to set a separate OOP maximum for the “pediatric oral services” defined as part of the EHBP based on the proportionality of premium between medical and dental plans.

The dental industry today does not commonly make use of OOP maximums as a cost-sharing mechanism. As a result of the more elective nature of dental care, elimination of annual and lifetime maximums by defining “pediatric oral services” as a Children’s Health Insurance Program (CHIP) type benefit without maximums could

lead to significant over-utilization and higher OOP consumer costs.⁸⁵ With defined “pediatric oral services” that excludes elective procedures and includes frequency limits on procedures, an OOP maximum could be defined for dental.

Using an OOP maximum specific to pediatric dental has the following advantages:⁸⁶

1. Simplification of claims processing;
2. Elimination of the need to split up the OOP maximums between medical and dental;
3. Provision of additional coverage past the OOP maximum in the rare instance a truly catastrophic dental situation were to occur.

If regulation is sought to define the proportion of the EHBP’s OOP maximum applicable to dental, then analysis of the proposed medical and “pediatric oral services” policy of the EHBP using state-specific assumptions could shed light on what proportion would be appropriate for each state.⁸⁷

Carrier Administration of a Single Maximum

If it is determined a separate dental policy with OOP maximum is not workable, and a combined medical and dental OOP maximum is to be utilized, then conceptually the combined OOP maximum somehow needs to be tracked in a coordinated manner between the medical and dental carriers. To build administrative systems to do so for each covered child would be cost-prohibitive, especially when the combinations of carriers would be different for each child, so other means of coordination should be examined.

In all likelihood, a person reaching their OOP limit would have incurred a high level of medical claims – from, for example, a hospital stay. Once the OOP limit is reached, all essential benefits, including pediatric dental, would be covered in full. For dental insurers, the relevant question to ensure claims are processed correctly is, *“In the case a consumer achieves the OOP maximum, how often would the consumer then seek out “pediatric oral services” normally covered at less than 100 percent?”*⁸⁸

The answer depends on the medical benefit’s richness and the composition of “pediatric oral services.” If, as we have discussed previously, the dental benefit comprises select procedures, all covered in full, then the question is moot and the entire OOP maximum can accrue to medical. If the “pediatric oral services” includes some cost-sharing, but it is rare the overall OOP maximum would be achieved, then a pragmatic approach might be to manage the OOP maximum accounting process after the fact.⁸⁹ In other words, dental carriers would pay claims based on the shared cost structure until notified by the consumer their child had hit the limits for out-of-pocket costs.

A back-end appeals process could handle the issue when a consumer receives only partial coverage for a dental procedure but expected full coverage, i.e. no cost-sharing, due to the OOP maximum. Handling these relatively rare appeals on a case-by-case basis may be less costly to the carriers than building the necessary infrastructure to administer the OOP maximum accounting on a coordinated basis.⁹⁰

However, an appeals process may also be burdensome for the consumer who would need to provide documentation to the medical or dental plan. An alternative would be to require the medical carrier selling an EHBP without “pediatric oral services” to notify the dental plan when the family hits their out-of-pocket OOP maximum. Then the dental carrier can make the adjustments to the family’s claims for their required “pediatric oral services.” Controls such as medical necessity requirements would have to be implemented to avoid overutilization of dental services once the OOP maximum is achieved.

Exchange Tracking

Another alternative within the Exchange is, similar to CHIP programs today,⁹¹ to take on the responsibility of determining whether OOP maximums have been met. A state Medicaid Management Information Systems (MMIS) vendor could potentially play a role in aggregating claims information from both medical and dental carriers for that purpose. The achievement of the overall OOP maximum would have to be calculated in a timely manner⁹² such that carriers could be notified in time to pay subsequent claims correctly. Alternatively, a reconciliation process could be built to adjust for these items after the fact. Either of these approaches would require early consideration as the processes and technology for Exchange operation are being developed.⁹³ However, since Exchanges have to build these systems and have federal support to do so, this would be less costly and less duplicative than having individual carriers develop these systems individually. As well, this process applies only to those individuals and families receiving subsidies through the Exchanges, so the apportionment of cost to the Exchange process rather than all consumers through insurers may be more equitable.

Summary & Recommendation

In summary, the key methods to manage the determination of achievement of OOP maximums by subsidized consumers, given the meshing of medical and dental through “pediatric oral services” in the EHBP are:

- Managing the process through the design of the “pediatric oral services,” covering specified procedures only at 100 percent, such that no portion of the OOP maximum needs to be attributed to dental;
- Managing the process via a separate pediatric dental-specific OOP maximum;
- Providing carriers the responsibility of determining when the OOP maximum has been achieved, potentially using an exception process to handle any pediatric dental claim payment issues which could arise after a person has achieved their OOP maximum;
- Giving the Exchange the responsibility to build, maintain, and administer a process to aggregate claims for determination of OOP maximum achievement.⁹⁴

The appropriate option depends on HHS’s determination of the scope of “pediatric oral services” in the EHBP or splitting the OOP maximum when a consumer selects a separate dental policy and potentially, the sophistication of the Exchange’s IT systems.

ISSUE BRIEF 6: WHICH OF ACA’S CONSUMER PROTECTIONS SHOULD BE APPLIED TO “PEDIATRIC ORAL SERVICES” WHEN PROVIDED UNDER SEPARATE DENTAL POLICIES?

Key Points

- Federal or State: the federal government may establish or defer to the states development of consumer protections under ACA to be applied to dental policies offered through both the AHBE and SHOP Exchanges.
- ACA implemented several insurance market reforms designed to protect consumers and require medical carriers to offer fairly valued coverage in a non-discriminatory manner. These requirements apply broadly to all group health plans and health insurance issuers as defined under HIPAA. Separate dental policies are “excepted benefits” under HIPAA and are not subject to the insurance market reforms for medical coverage.
- An Exchange may apply relevant consumer protections to qualified dental plans offering coverage in the Exchanges. HHS’s Exchange NPRM identifies these potential consumer protections as quality reporting, transparency measures, summary of coverage information, provider network standards, and standards regarding the consumer’s experience in comparing and purchasing coverage.

Issue

Dental plans are primarily regulated at the state level where many consumer protections exist today including summary of benefits, plain language requirements, as well as claims processing and appeals processes.

While in general Health Insurance Portability and Accountability Act (HIPAA) “excepted” benefits remain outside the scope of most major medical market reform provisions of ACA, relevant consumer protections required for participation in the Exchanges can be applied to qualified dental plans (QDP) offering “pediatric oral services” through standalone or separate dental policies. Under Affordable Care Act (ACA), requirements for QDPs are deferred to states, but the federal government may establish requirements related to other ACA provisions.

In its Exchange Notice of Proposed Rule Making (NPRM),⁹⁵ the U.S. Department of Health and Human Services (HHS) notes some qualified health plan (QHP) certification requirements and consumer protections the state Exchange itself determines to be relevant and necessary could apply to standalone dental plans. In this paper, we will consider the standards HHS identifies in the NPRM, including:

- quality reporting,
- transparency measures,
- summary of coverage information,
- provider network standards, and
- standards regarding the consumer’s experience in comparing and purchasing dental plans.

The White Paper focuses on which of these consumer protections are relevant to the “pediatric oral services” as defined in Essential Health Benefits Package (EHBP) when purchased as a standalone dental policy and whether the relevant consumer protections should be applied at the federal level or deferred to the states?

Consumer Protections and Applicability to “Pediatric Oral Services”

As its Exchange Notice of Proposed Rule-making (NPRM)⁹⁶ notes, given standalone dental policies are “excepted benefits,” certain consumer protections beyond ACA’s market reforms could be applied by Exchanges as requirements for certification to participate in Exchanges.

Quality Reporting

ACA requires the Secretary to develop annual reporting requirements for insurers or health plans offering group or individual health insurance coverage. The reporting is intended to include information on benefits and provider reimbursement structures that improve health outcomes, activities which reduce medical errors, and wellness and health promotion activities.⁹⁷

As indicated earlier in the paper, true quality measures do not exist in dental care although utilization measures, such as office visits and percentage of population receiving sealants are collected in public programs. Office visits for segments of the population are also collected periodically by HHS’s Agency for Healthcare Research and Quality (AHRQ) through the Medical Expenditure Panel survey (MEPS). If there is a defined purpose for collection of these performance measures from carriers that merits the cost of collection and reporting, reporting could be required for the “pediatric oral services” within the EHBP. Measures developed for medical plans should not be applied to “pediatric oral services.” However, the Secretary should track the development of dental diagnostic codes and dental quality measures to determine their future applicability to “pediatric oral services” defined by HHS.

Transparency Measures

ACA requires consumers have complete and comprehensible access to the QHPs they will be purchasing. Complete transparency of the “pediatric oral services” component of an EHBP, whether coverage is achieved through a QHP or from a separate dental policy would benefit consumers making purchasing decisions on exchanges. The NPRM on Exchanges notes transparency mechanisms include codifying reporting standards, use of plain language in coverage explanation, cost-sharing information disclosure and past performance of the health plan. Plain language requirements for explanations of coverage exist in most states so the Secretary may want to defer this standard to the states for conformance to current requirements. Standalone dental plans comply now with these standards for all coverage and should continue to do so.

Separate dental policies sold on Exchanges could comply with additional mechanisms to disclose cost-sharing and plan performance established at the federal level if the requirements take into account the unique characteristics of dental benefits and the limited scope of what is required for “pediatric oral services.” In establishing these federal requirements it is critical to separate the cost of “pediatric oral services” from the cost of the major medical package if “pediatric oral services” are defined by HHS as benefits traditionally coverage under separate dental policies. This will further transparency and increase competition on the Exchanges among dental plans and QHPs, and reflect how typical employer-sponsored coverage is offered and purchased in the marketplace today with brokers and purchasers separating medical and dental into two policies to offer the best coverage to their employees.

Standard Summary of Benefits and Explanation of Coverage

The Secretary will develop standards for compiling and providing to enrollees a summary of benefits and explanation of coverage accurately describing their benefits. The goal is to increase consistency in appearance, language, and content of insurance documents utilized by consumers. National Association of Insurance Commissioners (NAIC) is the resource for developing these standards. The template being developed for medical coverage is not appropriate for the more limited “pediatric oral services” covered by a separate dental policy. A similar template should be developed for dental carriers to use, taking into account the unique characteristics of dental coverage that require differences from the medical template, to ensure information related to the “pediatric oral services” is provided in an accessible, consistent and understandable manner.⁹⁸

Provider Network Standards

Separate dental plans have some of the most extensive, established networks of dentists in the market today. Over two-thirds of the dentists in active private practice participate in dental PPO networks, i.e. the most prevalent type of dental benefit in the market. One of the benefits of including these policies on Exchanges is consumers will be offered benefits which allow them to select the dentist they want. Importantly, each state has a unique spread of dentists within its boundaries. State exchange planners, with a deeper and more specific knowledge of where dentists currently practice in their borders, can develop standards consistent with current state requirements which are beneficial to consumers and take into account the unique features of the state. The availability of dental specialists, particularly pediatric dentists, is a factor that must also be considered.

Summary & Recommendation

Any relevant ACA consumer protections should only be applied to separate dental policies covering “pediatric oral services” required as part of the EHBP.

Given current state requirements that exist for dental plans, the following consumer protections should be deferred to the states for conformance with current requirements specific to separate dental policies:

- provider network standards;
- plain language requirements.

Transparency requirements for the following areas could be established at the federal or state level taking into account the differences appropriate for separate dental policies covering a limited scope benefit for “pediatric oral services”:

- cost-sharing disclosures;
- plan performance;
- summary of benefits.

NAIC’s expertise should be utilized in developing templates and standards appropriate to separate, non-integral dental policies.

Acknowledgements

McKenna Long & Aldridge

McKenna Long & Aldridge LLP provides business solutions in the areas of health care, complex litigation, government contracts, public policy and regulatory affairs, corporate law, political law, intellectual property and technology, real estate, energy, finance, environmental regulation and international law. Our clients are a mix of Fortune 500 and mid-size companies, major government contractors and non-profit organizations of all types. In addition, MLA offers clients a first-in-the-nation Health Insurance Exchange Team, a unique cross-practice initiative designed to help companies prepare strategically for the impact of health insurance exchanges on their business; specifically how Exchanges will affect providers, suppliers, insurers and employers.

Milliman, Inc. Caveats and Limitations

Milliman prepared the client report in Appendix D for the specific use of NADP & DDPA. This report is footnoted where it is used in the body of the White Paper. The terms and limitations of the report and data provided by Milliman are noted in the client report in Appendix D.

Appendices

Appendix A – Pediatric Dental Essential Benefit Pricing Details and Assumptions (see Milliman Report, Appendix D)⁹⁹

Underlying Pricing Assumptions for Pediatric Dental Essential Benefit Options
25 percent discount (national average commercial fee schedule level)
50 percent in-network utilization
Essential benefit covers children up to but not including age 21

Assumed Cost-Sharing Construct of CHIP-Style Benefit Option Without Ortho		
Class of Service	Coverages	Coinsurance In/Out-of-network
Preventive & Diagnostic	Oral Exams, Prophylaxis, Fluoride, X-Rays, Lab and Other Tests, Sealants	100%/100%
Basic	Emergency (Palliative)	100%/100%
	Space Maintainers, Simple Extractions, Surgical Extractions, Restorations, Periodontics, Endodontics	80%/60%
Major	Inlays and Crowns	50%/40%
Orthodontic	Orthodontia	Not Covered
Deductible In/Out-of-network: \$0/\$0		

If assumptions are different from those listed above, price points will differ from those listed elsewhere in this document. Some examples of price sensitivity to key assumptions are:

In-network utilization: The CHIP-style, no-orthodontia plan priced assuming 90 percent in-network utilization, rather than 50 percent, yields a price of \$28.50 rather than \$29.25. As dental network size and composition varies quite significantly in different geographies, the in-network utilization assumption must be developed based on the particulars of the location being priced.

Fee schedules: Similarly, if “pediatric oral services” is priced using Medicaid provider reimbursement levels rather than commercial, price points will generally be lower than those listed in the paper. Based on industry average differentials between Medicaid and commercial fee schedules, the plan described above would cost about \$25.00 on Medicaid-level provider reimbursement vs. \$29.25 at commercial levels.

Pediatric Definition: The age at which pediatric coverage ceases is also an important pricing factor; for example, covering children through age 14 reduces the cost of the benefit from \$29.25 to \$26.00 due to a change in the mix of services.

Other Pricing Factors: Depending on the construct of the EHBP, it may be necessary to consider other factors affecting the price of the benefit. For example, guaranteed issue loads are not included in the prices in this document; depending on the nature of the benefit and the resulting potential adverse selection associated with a guaranteed issue product, prices may need to be increased.

Appendix B – CBO Chart on Premium Subsidies

TABLE 2. Analysis of Exchange Subsidies and Enrollee Payments in 2016 Under the Patient Protection and Affordable Care Act

11/20/2009

		Estimate for "Reference Plan" in 2016 – 2nd Lowest-Cost "Silver" Plan		
		Actual Value	Average Premium	Avg. Cost Sharing
Single Policy		70%	\$9,400	\$1,900
Family Policy		70%	\$14,100	\$5,000

Single Person									
income relative to the FFL	Premium Cap as a Share of Income /a	Middle of Income Range /b,c	Enrollee Premium for Low-Cost "Silver" Plan	Premium Subsidy (share of premium)	Average Cost-Sharing Subsidy	Average Net Cost Sharing	Enrollee Premium + Avg. Cost Sharing		
							Dollars	Percent of Income	
100-140% /d	2.1% - 4.7%	\$ 14,700	\$ 800	94%	\$ 1,100	\$ 800	\$ 1,100	7%	
150-200%	4.7% - 6.5%	\$ 20,600	\$ 1,200	77%	\$ 500	\$ 1,300	\$ 2,500	12%	
200-250%	6.5% - 8.4%	\$ 26,500	\$ 2,000	62%	\$ -	\$ 1,900	\$ 3,900	15%	
250-300%	8.4% - 10.2%	\$ 32,400	\$ 3,000	47%	\$ -	\$ 1,900	\$ 4,900	15%	
300-350%	10.2%	\$ 38,300	\$ 3,900	25%	\$ -	\$ 1,900	\$ 5,800	15%	
350-400%	10.2%	\$ 44,200	\$ 4,500	13%	\$ -	\$ 1,900	\$ 6,400	14%	
400-450%	n.a.	\$ 50,100	\$ 5,200	0%	\$ -	\$ 1,900	\$ 7,100	14%	

Family of Four									
income relative to the FFL	Premium Cap as a Share of Income /a	Middle of Income Range /b,c	Enrollee Premium for Low-Cost "Silver" Plan	Premium Subsidy (share of premium)	Average Cost-Sharing Subsidy	Average Net Cost Sharing	Enrollee Premium + Avg. Cost Sharing		
							Dollars	Percent of Income	
100-140% /d	2.1% - 4.7%	\$ 40,100	\$ 800	98%	\$ 3,400	\$ 1,700	\$ 2,500	8%	
150-200%	4.7% - 6.5%	\$ 42,000	\$ 2,400	80%	\$ 1,800	\$ 3,200	\$ 5,600	13%	
200-250%	6.5% - 8.4%	\$ 54,000	\$ 4,000	72%	\$ -	\$ 5,000	\$ 9,000	17%	
250-300%	8.4% - 10.2%	\$ 56,000	\$ 6,100	52%	\$ -	\$ 5,000	\$ 11,100	17%	
300-350%	10.2%	\$ 78,000	\$ 7,900	44%	\$ -	\$ 5,000	\$ 12,900	17%	
350-400%	10.2%	\$ 90,100	\$ 9,200	35%	\$ -	\$ 5,000	\$ 14,200	15%	
400-450%	n.a.	\$ 102,100	\$ 14,100	0%	\$ -	\$ 5,000	\$ 19,100	19%	

Source: Congressional Budget Office and the Staff of the Joint Committee on Taxation.

a) The 2014 cap on premium cost would be the lesser of 100% of the individual's (or the plan's) federal adjusted gross income (AGI) in 2013, or the income-based cap would range from about 3% at 133% of the FFL to 9.5% at 400% of the FFL, and that 9.5% cap would extend to 100% of the FFL in subsequent 5-year, 1-year caps would be imposed.

b) For the 2014 plan year, the premium cost would be \$11,000 for a single person and \$16,000 for a family of four.

c) Subsidy would be based on enrollees' household income, as defined in the bill.

d) Under the bill, people with income below 133% of the FFL would generally be eligible for Medicaid and thus ineligible for exchange subsidies; the premium cost in 2014 for these individuals would be 152% of the FFL, or 11.2% of income.

Appendix C – Letter from Secretary Sebelius



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

September 8, 2010

Kim L.P. Lawson, Partner
Hogan Lovells US LLP
Columbia Square
555 Thirteenth St. NW
Washington, DC 20004

Dear Mr. Lawson:

Thank you for your letter expressing concern over whether limited scope dental and vision benefits provided under a separate health plan or policy will continue to be exempt from the substantive requirements of the Public Health Service Act (PHSA).

Limited scope dental and vision coverage are considered to be “excepted benefits” provided they are (1) offered as separate benefit policy, certificate, or contract of insurance; or (2) not an integral part of the plan. To be considered not an integral part of the plan, in general, participants must have the right to elect not to receive coverage; and if a participant elects to receive coverage, the participant must pay an additional premium or contribution for that coverage. See section 7222 of the PHSA, section 712 of the Employee Retirement Income Security Act (ERISA), and section 9831 of the Internal Revenue Code (Code) and their implementing regulations at 45 CFR 146.145(c)(3), 29 CFR 2590.712(c)(3), and 26 CFR 54.9831-7(c)(3).

As outlined in the preamble to the interim final regulations relating to status as a grandfathered health plan, the exceptions for excepted benefits in ERISA and the Code remain in effect. Moreover, the Department of Health and Human Services (HHS) also stated in the preamble that it does not intend to use its resources to enforce the PHSA requirements with respect to nonfederal governmental plans that offer dental and vision benefits that meet the definition of excepted benefits. States have the primary enforcement authority for insurance companies that sell coverage meeting the definition of an excepted benefit. HHS encourages states to exercise the same discretion and will not consider the state to be failing to enforce the PHSA with respect to dental and vision plans that meet the definition of excepted benefits. See 75 FR 34536, 34539-34540 (published June 17, 2010).

Again, thank you for your letter and for your continued advocacy and leadership on this important issue.

Sincerely,

Kathleen Sebelius

Appendix D – Milliman Report

Milliman Client Report



Considerations in Offering Dental Insurance on Exchanges

August 31, 2011

Prepared for:
National Association of Dental Plans

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Milliman Client Report

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National Association of Dental Plans
Exchange Issues for Dental

August 31, 2011

I. Description of Work

Milliman was engaged by the National Association of Dental Plans (NADP) to develop a white paper regarding the impact of the Affordable Care Act (ACA) on the offer of dental insurance given the establishment of health insurance Exchanges under ACA. As pediatric oral health is included in the “Essential Health Benefit Package” (EHBP) being developed by the Department of Health and Human Services, coverage of those as-yet undefined oral health services will be a required offering for children, meshing the medical and dental insurance markets in new and complex ways. Milliman was engaged to research and analyze the following issues:

- What benefits should constitute the “pediatric oral health” component of the EHBP?
- How should cost sharing and out-of-pocket maximums defined for the EHBP be applied to medical and dental coverage?

What follows is the result of our analysis of these issues.

II. What should constitute the “Pediatric Essential Health Benefit”?

Defining what should constitute an affordable, quality child’s dental benefit as part of the EHBP is a complex process, requiring consideration of:

- the provisions for an EHBP laid out in ACA;
- an understanding of typical employer-based coverage, which is supposed to be considered as a basis for development of the EHBP;
- an overall understanding of representative dental benefit levels in the current marketplace, including Medicaid and CHIP in addition to employer-based coverages;
- the content and affordability of various dental benefit levels;
- the desire to maintain benefit continuity for individuals, given the potential for member “churn” among Medicaid, Exchange-based individual coverage, and employer-based coverage;
- the desire to keep family dental coverage as a cohesive unit rather than “having...dental coverage bifurcated into a cumbersome system where adult and pediatric coverage are split in two”¹.

We will discuss each of these considerations in detail and develop illustrative dental benefit packages which we hope will be of use to those working to implement dental coverage seamlessly into an Exchange.

What is the EHBP and what does PPACA require for the EHBP with respect to dental coverage?

PPACA Section 1302 describes an EHBP defining the criteria that must be met for a benefit plan to be considered for offer on an Exchange:

- 1) Must provide coverage for all of the defined essential benefits, one of which is “pediatric services, *including oral and vision care*”.

This inclusion of child dental services in the EHBP requires that the offering of dental insurance plans be thoughtfully handled as an Exchange is built. Dental insurance is almost always offered as a separate contract from medical benefits, via a standalone dental insurance carrier. Per the legislation, the pediatric oral care essential benefit may be provided via a standalone dental plan. In that situation medical plans without the pediatric dental benefit could still be designated as EHBPs, as the combination of the medical and dental plans would cover all the essential benefits. Even so, the way the dental component is presented to the consumer, the cost of the dental coverage, and how child wrap-around, adult, or family dental coverage is offered will affect the ultimate uptake rate for dental insurance, potentially

¹ Ensuring Access to Stand-Alone Dental Plans and Competition for Dental Coverage. American Dental Association.

impacting the oral health of the population. We must thoughtfully consider these issues when developing the benefit level inherent in the children's dental essential benefit.

- 2) Must limit cost sharing for these essential benefits in accordance with set criteria, including individual/family deductible limits of \$2,000/\$4,000 and out-of-pocket maximum limits of \$5,950/\$11,900 in 2014, with indexed allowed increases in subsequent years. Preventive services must be covered with no member cost-share.

In a later section of this paper, we will address the issues associated with allocating cost-sharing limits equitably between the medical and dental components of the EHBP. For now, it's important to note that the structure of the pediatric dental essential benefit will affect the way in which the cost-sharing limits must be allocated.

- 3) Must provide Platinum, Gold, Silver, or Bronze coverage. Platinum coverage provides benefits of an Actuarial Value (AV) equal to 90% of the full actuarial value of the plan's benefits. Similarly, Gold, Silver, and Bronze coverage would represent benefit plans set at 80%, 70%, and 60% AV, respectively.

Simply put, the four metal levels are designed to present a spectrum of benefit plans with varying cost levels and benefit richness, so each consumer can make a choice to fit his or her health needs and finances. The metal level applies to the EHBP as a whole; it is important to clarify that each service within an EHBP need not vary according to the AV rules. With respect to dental coverage, then, it is NOT necessarily the case that four different levels of pediatric dental essential benefits must be developed. Rather, the focus should be on providing an appropriate range of dental benefit plans, each including at least the essential pediatric coverage, to fit people's needs. We discuss the AV issue in more detail later in this section.

What dental benefit levels, for both children and adults, are representative of today's marketplace, including Medicaid, CHIP, and employer-based coverages?

In order to define the pediatric oral care essential benefit, we must understand how people are covered for dental care today. The private dental market covers roughly 170 million people, the vast majority through employer-sponsored insurance. Dental Preferred Provider Organizations (DPPOs), network-based products in which members choose at the point of service to use contracted dentists for a lower cost and higher benefit level, or non-contracted dentists at a higher cost, represent over 2/3 of the market. The remainder is comprised of Dental HMO (DHMO), dental indemnity, and dental discount plans. A 2005 Bureau of Labor Statistics survey detailed dental coverage levels, by service category, for private industry workers. A summary of survey results is presented in the table below.

Service Category	What percentage of the time was this service covered?	Covered at what median percent of Usual, Customary, and Reasonable charges?	Maximum Benefit Provision?
Dental Exams	100	100	For all dental procedures except orthodontia: 88% of plans specify an annual maximum benefit, with an average annual maximum of \$1,321. About 1/3 use a \$1,000 maximum, 1/3 use \$1,500, and only 13% use greater than \$1,500.
X-Rays	100	100	
Fillings	100	80	
Surgery	99	80	
Periodontal Care	98	80	
Endodontics	98	80	
Crowns	98	50	
Prosthetics	100	50	
Orthodontia	73	50	For plans covering orthodontia, 79% specify a lifetime maximum benefit, of usually \$1,000 or \$1,500.

The survey showed these benefit levels to be generally consistent across industry, occupational group, firm size, and union/non-union subgroups.

In April 2011, the Department of Labor released a report intended to aid in the development of the EHBP, based on more recent employer data. The dental benefit designs contained in that study are similar to what is shown in the above table from the 2005 report.

Medicaid dental benefits, on the other hand, vary widely by state. The Kaiser Family Foundation's Kaiser Commission on Medicaid and the Uninsured published a comprehensive listing of state Medicaid program benefits as of October 2008. At that time, 46 states including the District of Columbia included some dental benefit in their program, while five did not. The benefit levels offered from one state to the next showed significant variation. Roughly a dozen states had provisions limiting dental coverage to emergency treatment and relief of pain or infection only. Others focused on preventive efforts, offering preventive and restorative services only, often including visit limitations such as one or two cleanings per year. Several had maximum annual dollar benefits, ranging from under \$500 to close to \$2,000, and 21 of the 46 states required member co-payments. In some states, pregnant women were able to receive higher levels of care than the rest of Medicaid population (e.g., periodontal procedures). No states appeared to cover orthodontia.

With respect to dental coverage for children via public programs, all children under age 21 enrolled in Medicaid receive dental care via the federally required Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. The coverage requirement, however, is only broadly defined as including "all medically necessary diagnostic and treatment services within the federal definition of Medicaid medical assistance", thereby allowing for variation by state². In addition, the Children's Health

² EPSDT and Title V Collaboration to Improve Child Health. From CMS website.

Insurance Program Reauthorization Act of 2009 (CHIPRA) requires pediatric dental benefits to be included in state CHIP programs³. CHIPRA specifically mandates that “child health assistance provided to a targeted low-income child shall include coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.” Existing EPSDT programs are considered as meeting the CHIPRA requirements. CHIPRA oral health benefits include children through age 19⁴, an important note as we determine who to include in the pediatric dental essential benefit. States may use one of three benchmark dental benefit plans defined in CHIPRA or develop their own CHIPRA dental benefit. State-specific dental packages are considered acceptable if all services required by statute are being offered. In demonstrating that a benefit package meets the requirements, the state must specify periodicity of preventive and restorative services, considering the guidelines published by the American Academy of Pediatric Dentistry. States need not provide coverage within each service category, but rather must cover any services in a category required according to the statute. As an example, states need not cover cosmetic orthodontic procedures, but if any are required to prevent disease, promote and restore oral health, or treat emergency conditions, then they must be provided.⁵

A web scan of various states’ CHIP dental programs showed that coverage under CHIP is quite comprehensive, including preventive and diagnostic care, sealants, space maintainers, fillings, crowns, and endodontic procedures as well as emergency care.

These publicly funded programs cover a significant number of people: December 2009 Medicaid enrollment nationwide topped 48 million⁶, and CHIP enrollment in December 2009 was just over 5 million⁷. With the upcoming expansion of Medicaid eligibility in 2014, these numbers will rise further. This population, especially those people on the upper end of Medicaid eligibility, will be likely candidates for Exchange-based coverage as their income levels vary over time, and ensuring the continuity of their dental coverage is a key factor to consider when developing the Exchange’s dental benefits.

Content and Affordability of Various Pediatric Oral Care Essential Benefit Options

Now that we’ve examined the landscape of dental benefits offered via private insurance and public programs, we can construct a spectrum of options for the pediatric dental essential benefit and assess the relative price point of each option. This is a general analysis using national averages as described in the previous section.

³ Policy Brief: ORAL HEALTH COVERAGE AND CARE FOR LOW-INCOME CHILDREN: THE ROLE OF MEDICAID AND CHIP. Kaiser Family Foundation Kaiser Commission on Medicaid and the Uninsured. April 2009. Publication #7681-03.

⁴ https://www.cms.gov/CHIPRA/13_oralhealth.asp#TopOfPage. CMS website -- CMS Home > CHIP > Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2009 > Oral Health.

⁵ CMS Letter to State Health Officials SHO #09-012, Re: Dental Coverage in CHIP. October 7, 2009.

⁶ <http://www.kff.org/medicaid/upload/8050-02.pdf>. Kaiser Commission on Medicaid and the Uninsured: Medicaid Enrollment December 2009 Snapshot.

⁷ <http://kff.org/medicaid/upload/7642-05.pdf>. Kaiser Commission on Medicaid and the Uninsured: CHIP Enrollment December 2009 Snapshot.

Option 1: Essential Benefit Encompassing Pediatrician-Delivered Services Only

One simple way to define the pediatric oral care essential benefit is to refer to the American Academy of Pediatrics oral health guidelines. These guidelines are referenced in the July 2010 Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventative Services. These regulations give guidance on which services are considered preventative in nature and hence may not be subject to consumer cost-sharing under ACA. The oral health component mentioned in these regulations consists only of pediatrician-delivered services including:

- Oral health screenings at various ages, as recommended in “The Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care”, consisting of discussing the child’s oral hygiene with the parent and looking in the child’s mouth to assess the risk of caries;
- Prescribing fluoride supplements for children in areas where water is not fluoridated;
- At 3-year and 6-year well-child visits, determine whether the patient has a dental home. If the patient does not, then a referral should be made to one.

This definition of the pediatric oral care essential benefit removes dental providers, and dental carriers, from the scope and creates an EHBP wholly contained in a medical benefit plan. The simplest and easiest-to-administer construct, this definition allows for all subsidies, cost-sharing allocations, and consumer decisions to be made on a medical-only basis. The decision to purchase dental insurance on or off an Exchange could be handled separately from medical and could be made on a whole-family basis as is done today, causing the least disruption for consumers with current dental coverage. On the other hand, this level of benefits does not ensure that children would have access to medically necessary dental care as consumers would not be required to purchase dental coverage for themselves or their children.

Option 2: Preventive and Diagnostic Dental Services

Broadening the pediatric oral care essential benefit definition from a medical-only model to one including typical dental coverage and dental providers, the EHBP could be developed to include a basic level of preventive and diagnostic services delivered by dentists. For example, a lean essential benefit option could cover preventive, diagnostic, and emergency care only, at 100 percent.

Option 2 has the advantage of not requiring any out-of-pocket expenses for consumers on covered services, obviating the need to split out-of-pocket maximums between the medical and dental portions of the EHBP. It also provides an affordable base-level required benefit which promotes prevention and critical care that can be supplemented with additional coverage as desired by the consumer at their cost. Since small employer dental coverage is often voluntary, i.e. paid for by the employee not the employer, this option may be more typical of employer-sponsored coverage in this market from a consumer payment perspective. However, if the family does not choose to supplement the coverage, this plan covers fewer services than the average CHIP plan or commercial plan, creating a potential discontinuity in care if a child moves among CHIP, employer-sponsored insurance, and the Exchange.

Option 3: Typical Employer-Sponsored Dental Coverage

We also develop an illustrative price point assuming that the essential benefit is constructed to reflect the Department of Labor study on typical employer-sponsored dental coverage – that is, a standard DPPO with a deductible, coinsurance, and benefit maximums. This is a helpful point of comparison as we look at the array of cost levels. However, it is important to note that this particular benefit construct is likely not viable as part of the EHBP due to the provisions of ACA. Specifically:

- A typical employer-based DPPO offers 80% out-of-network coinsurance on preventive services. This construct would likely not be allowed under ACA, as preventive services must be fully covered. A large proportion of child dental services are preventive in nature; if they are required to be covered at 100%, the price of the benefit would increase.
- An annual dollar benefit maximum would not be allowed under ACA to the extent that these benefits are part of the "Essential Benefit Package" as those services may not be subjected to such a maximum.

The application of the maximum and less-than-100% out-of-network coverage of preventive services has a very significant price impact; in the table of prices shown below, you will note that requiring 100% coverage of preventive services and an unlimited benefit maximum (as shown in the CHIP plan in the table) increases premiums by roughly 50% (i.e., \$30 range instead of \$20).

At the request of NADP we also priced slight variations on some of the above plan designs, to get a sense for the impact on premiums if certain parameters were changed. Specifically, we modified the annual maximum benefit showing both a \$1,500 and a \$1,000 annual maximum.

So, while Option 3 reflects the traditional DPPO benefit structure, it may not be a viable option for the EHBP due to the considerations just described. Also, application of out-of-pocket cost-sharing limits and apportionment of subsidies between medical and dental coverages increase the complexity of this option.

Option 4: CHIP Style Coverage

Expanding the definition even further, the pediatric oral care essential benefit could be modeled after CHIP coverage, providing a broad array of dental services, including not only preventive and diagnostic care but also restorative care, medically necessary orthodontia, and other services. This comprehensive benefit level would obviously be more expensive than a more limited essential benefit construct. Further, since the essential benefit per ACA may not impose dollar benefit limits as most CHIP plans do, a CHIP-style essential benefit plan would cost more than a CHIP plan with the same covered services, all else being equal. This is an important point: if such a broad array of services is deemed part of the EHBP, then dollar benefit maximums, a key cost control mechanism in commercial dental plans, would not be allowable for this benefit. Eliminating dollar benefit maximums greatly increases the cost of the benefit, as is shown in the table of premiums below. Further, the unlimited nature of the coverage could induce overutilization of services. Additionally, unless the plan covered all services with no cost-sharing (an extremely expensive option), out-of-pocket maximums would have to be allocated between the dental and medical coverages, adding administrative

complexity. On the positive side, this sort of essential benefit would keep minimum coverage levels the most consistent across employer-sponsored, public, and Exchange-based dental benefit plans.

We modeled Option 4 by starting with standard DPPO benefits but then adjusting all preventive services in- and out-of-network to be fully covered, and eliminating all dollar maximums. We show pricing both without orthodontia and with orthodontia to highlight the heavy cost burden of including orthodontia with no benefit maximum or application of medical necessity.

Comparison of Projected Costs of Options for “Pediatric Oral Services”

Shown below are representative national average costs for the various “pediatric oral services” definitions described above. These are based on industry average assumptions; costs in a particular state may vary significantly from these numbers due to geographic cost differentials, provider network size, in-network provider discount levels, and other factors. These costs were developed assuming coverage up to age 21 as allowed under Medicaid. A younger age limit would also affect the cost levels. These numbers represent the full premium for “pediatric oral services”, not the lesser final cost to the consumer after subsidies are applied. These are per-child costs in addition to medical coverage, so a family with multiple children would incur this cost for each covered child. Additional detail on these calculations is shown in Appendix A.

2014 Illustrative Premiums per Child, in Addition to Medical

OPTION	Description	Monthly Premium
1	Screenings by Pediatricians Only	\$0
2	Diagnosis/Prevention/Emergency Treatment covered at 100%	\$18.50
3 (no ortho)	Common Employer Sponsored DPPO <i>without Ortho</i> : \$1500 Annual Maximum In Network: 100/80/50 with \$50 deductible; Out of Network: 80/60/40 with \$50 deductible	\$21.25
3 (with ortho)	Common Employer Sponsored DPPO <i>with Ortho</i> : \$1500 Annual Maximum with separate Ortho Maximum of \$1500; In Network: 100/80/50 with \$50 deductible; Out of Network: 80/60/40 with \$50 deductible	\$25.40
3 (no ortho) with \$1000 max	Common Employer Sponsored DPPO without Ortho: \$1000 Annual Maximum*; In Network: 100/80/50 with \$50 deductible; Out of Network: 80/60/40 with \$50 deductible	\$19.75
3 (with ortho) with \$1000 max	Common Employer Sponsored DPPO with Ortho: \$1000 Annual Maximum with separate Ortho Maximum of \$1500; In Network: 100/80/50 with \$50 deductible; Out of Network: 80/60/40 with \$50 deductible	\$23.90
4 (no ortho)	CHIP Equivalent without Ortho; no annual maximums or cost sharing	\$29.25
4 (with ortho)	CHIP Equivalent with Ortho with no medical necessity criteria applied; no annual maximums or cost sharing	\$48.25

NOTES: Based on national industry averages; state costs may vary. Age limit of 21. Costs calculated per child.

Affordability and Access Considerations

With any of the essential benefits models described above, understanding the cost level of such a benefit will be critical. Creating a benefit which requires an unsustainable level of subsidy dollars, or a benefit so costly that consumers choose not to purchase additional adult dental coverage for themselves, may run counter to the intent of ACA in expanding coverage and improving overall health.

The cost of a pediatric dental essential benefit can be affected by:

- *Provider Network and Reimbursement Levels:* Dentists participating in CHIP are generally paid at or around Medicaid reimbursement levels which can be significantly lower than what providers are paid for services by a commercial dental plan. If a dental policy on the Exchange is based on commercial reimbursement levels, a child migrating between CHIP and the Exchange may see their dental services subject to a higher cost structure, affecting the premium paid for coverage and out-of-pocket costs by the individual and the subsidy paid by the federal government. Reimbursing providers at a level more consistent with Medicaid would result in a lower price point; however, providers may not accept lower reimbursement for a larger swath of the population. Medicaid provider networks are often smaller than their commercial counterparts, which can also impact the cost of care (if more services are sought out-of-network) as well as continuity of care for children migrating among public programs, the Exchange, and employer-based coverage. These issues are critical to understanding the cost of providing a standard EHBP, as they will affect the cost of the subsidies provided by the federal government and the remaining premium that the consumer must bear.
- *Use of Benefit Limits or Medical Necessity Criteria:* As discussed previously, both public programs and commercial insurance use benefit limitations to control cost while still providing comprehensive coverage. Examples include dollar benefit maximums, common in commercial plans and Medicaid programs, and number of visit limitations, used by many CHIP and Medicaid programs. Public programs also often apply medical necessity requirements in order for the consumer to obtain certain dental services. For “pediatric oral services” as defined in ACA, if annual dollar benefit maximums are not permitted for separate dental policies, then this is an important differentiator that raises the cost of a child dental essential benefit in relation to a commercial or public plan covering the same services.
- *Pediatric Definition:* The age at which pediatric coverage ceases is also an important pricing factor; for example, covering children through age 14 reduces the cost of the CHIP-style benefit from \$29.25 to \$26.00 due to a change in the mix of services.

Actuarial Value of Pediatric Oral Care Benefit

As mentioned earlier, the EHBP offering should correspond to Platinum, Gold, Silver or Bronze levels of actuarial value, or AV. AV compares the cost of a plan after cost-sharing is taken into account against that same plan’s full allowed value. AV applies to the EHBP as a whole; as such, it is not the case that four different levels of pediatric oral care coverage have to be developed. In fact, to do so would be difficult, due to the nature of dental coverage and pediatric dental in particular. Option 4 above has an AV of approximately 80%, putting it at a Gold level of coverage. We analyzed several

benefit adjustments to this plan to determine what levels of cost sharing would be necessary to create benefit plans with AV at the Platinum, Silver, or Bronze levels. We found that, in order to offer a comprehensive set of benefits at a Platinum level (90% AV), the plan's cost would be quite high and the benefit level would be out of line with what is generally seen in the dental insurance market today. Conversely, it is difficult to create a cost-sharing level at or below Silver (70% AV), as it would require very high member coinsurance, copays, or other cost sharing mechanisms.

Creating wider ranges of plan richness for medical insurance is less of an issue than it is for dental insurance. What is it about dental insurance that makes the AV ranges harder to achieve? There are several differences between dental insurance and medical insurance that make this so:

- *Higher concentration of preventive services in dental:* In the dental benefit plans priced above, over half the cost comes from preventive services. Compare that to medical plans, in which preventive care costs are dwarfed by other categories of care such as hospital stays and surgeries. Because PPACA requires preventive care to be covered without cost sharing, and because a large proportion of dental care costs are preventive in nature, it is difficult to adjust the cost-sharing of a dental plan to meet lower AV levels.
- *Use of dollar benefit maximums in dental insurance:* Dollar benefit maximums are the primary method dental benefit packages use to limit utilization and pass the cost of additional utilization to the consumer. Medical coverages generally do not rely on maximum benefit levels by service category. Since dollar maximums are not allowed under PPACA for essential benefits, coinsurance variations become the main avenue to adjust consumer cost-sharing for dental. As such, the overall AV of a dental plan will closely mirror its average coinsurance level.
- *Less prevalent use of deductibles in dental insurance:* While some employer-based dental plans have small annual deductibles, of usually \$50 or less, they are less prevalent than deductibles on medical benefits, and are often only applied to certain non-preventive types of procedures. Deductibles provide another avenue for medical plans to adjust member cost-sharing and hence the AV of a plan. While deductibles are allowed on EHBPs, a separate dental deductible would not be available for the pediatric essential oral care benefit, and there are operational concerns with trying to split a deductible between medical and dental care (to be discussed in more detail in a later section of this paper). And, again, with much of the dental cost being preventive in nature, the deductible would not be applicable to that portion of the cost.
- *Less prevalent use of copays in dental insurance:* While some dental benefit plans require copays for certain services, they are used much less frequently than in medical benefit constructs. Again, copays present another method for adjusting consumer cost-sharing and hence the AV of a plan.
- *Lower in-network utilization in dental insurance:* Most medical plans see high levels of in-network utilization due to broad provider networks. The dentist population is sparser and more heterogeneous across geographies, and dental provider networks are often smaller than their medical counterparts. As such, adjusting in-network cost-sharing has a smaller impact on a dental plan's AV than on a medical plan's.

Summary

In summary, it may make sense to construct a pediatric dental essential benefit for the American Health Benefit Exchange (AHBE) by: 1) assessing the specific procedures covered by Medicaid/CHIP and the appropriateness of including each as an essential benefit; and 2) considering the affordability and continuity of coverage implications of the benefit package.

Comments on SHOP Exchange

Does the same list of essential benefit package options just described also make sense for the SHOP Exchange for small groups? As the coinsurance levels are generally in line with current average employer benefits, the packages may provide a reasonable starting point. Family wrap coverage including any pediatric dental services typically found in employer-based dental plans but not in the EHBP, as well as adult coverage, would be available for purchase alongside the required pediatric dental essential package. Pricing for the plan on the SHOP Exchange would look similar to what was already described, except for potential differences due to administrative cost structure, utilization assumptions, any network or provider reimbursement differences, and differences in selection assumptions.

III. How should cost-sharing and out-of-pocket (OOP) maximums be applied to medical and dental coverage?

The inclusion of pediatric oral health in the list of essential benefits complicates the claims-paying and cost-sharing processes, usually handled separately by medical insurers and dental insurers. The pediatric oral care essential benefit is subject to the overall cost-sharing structure of the medical benefit plan containing the essential benefits. That is, the out-of-pocket limit on the benefit plan should be calculated using out-of-pocket expenses for both medical costs and any out-of-pocket costs associated with the pediatric dental essential benefit. This construct raises several issues that must be carefully considered in order to ensure that cost-sharing limits are appropriately applied and coordinated between the medical and dental benefits.

Dental insurance is almost always offered separately from medical insurance, as a separate contract, often from a different insurance company than the medical coverage. Even if the medical and dental coverages are purchased from the same insurance carrier, they are almost always still subject to completely separate processes within the insurance company. Key functions such as claims payment and enrollment, as well as the systems platforms supporting these processes, are separate and distinct for medical and dental.

As such, when considering how to process cost-sharing and attainment of out-of-pocket maximums for a given individual or family on the Exchange, it is critical to realize that combining medical and dental claims for that individual or group would be quite difficult and potentially cost prohibitive. Trying to combine claims data in a timely and accurate manner from separate companies with separate systems would be quite a daunting and unconventional task.

With that commentary as a backdrop, we will explore how to handle the division of cost-sharing and out-of-pocket (OOP) maximum attainment in a pragmatic way.

The first consideration is whether we can manage the issue via *composition of the pediatric oral health essential benefit*. The answer to how to handle the division of cost-sharing and OOP maximums between the medical and dental components of the EHBP depends on how the pediatric dental essential benefit is ultimately defined. *If the EHBP can be constructed to cover only specified procedures, including but not necessarily limited to preventive dental services, at 100% with no member cost-sharing, then achievement of OOP maximum can be calculated on a medical-only basis.* This may be a practical way to build the pediatric dental essential benefit, providing required dental services as part of the EHBP while eliminating a potential administrative nightmare. The trade-off comes when defining which dental services should be covered; if a broad range of dental procedures is covered with no cost-sharing, the cost of the pediatric dental benefit may become large enough to affect the affordability of the total EHBP coverage. A benefit structure which fully covers preventive dental care, as well as carefully selected additional procedures chosen to maximize child dental health while keeping costs reasonable, would be a potentially workable solution. A group of dental clinicians would be suited to recommend such a construct.

Another potential means of controlling the issue via plan design is to set a separate OOP maximum for the pediatric dental essential benefit. If, on the Exchange, the pediatric dental plan is purchased as a separate contract, which, when combined with medical creates a full EHBP, then there doesn't

appear to be a compelling reason why a pediatric dental-specific OOP maximum couldn't be utilized. It would seem that, as long as the combined medical and pediatric dental OOP maximum does not exceed the ACA limits, the combination could meet the legislative requirements. Via regulation, at the state or federal level, a specific portion of the OOP maximum of the EHBP could apply to the pediatric dental benefit. Or, similarly, the pediatric dental benefit could be allowed to have its own OOP maximum set by the carrier, as long as the combined medical/dental maximum fell within defined limits. The dental industry today rarely makes use of out-of-pocket maximums as a cost-sharing mechanism; due to the more elective nature of dental care, OOP maximum provisions could lead to significant over-utilization. However, with a defined pediatric essential benefit that excludes elective procedures, an out-of-pocket maximum could be workable.

To explore this concept a little further, we started with the CHIP-style essential benefit construct and the same underlying assumptions as in Section II of this document, and determined the out-of-pocket costs under different scenarios.

For this essential benefit plan, *the average pediatric member's cost-sharing is approximately \$58 per year*. This is due to the fact that the most common services, Class I procedures, are fully covered; the coinsurance only applies to the less frequently used Class II and III services.

But for members seeking more services than average, how high can the out-of-pocket cost to the member get? Let's take a worst-case scenario: assume that a child incurs all services out-of-network (where there are no provider discounts to reduce cost levels), and that all of the claims are for Class III services for which the plan pays only 40% of the bill. In that case, the member's out-of-pocket cost would be approximately \$3,800. We can use that as an approximate upper limit on pediatric essential benefit out-of-pocket costs. In reality, that level of pediatric dental claims is a virtual impossibility; only 0.1% of children – about one in one thousand -- have claims that high to begin with, and virtually no one would incur them all on Class III services provided by out-of-network dentists. To show how quickly that number moves downward, let's look at that same child – with the highest 0.1% of claims -- but assume that half of the procedures are performed by in-network dentists, and that the procedures were a mix of Class II and III services; then the out-of-pocket cost would be approximately \$1,900.

The \$1,900 level may still be quite extreme, based on the highest 0.1% of the dental claim cost curve and assuming no Class I services, which generally make up about half the total claim cost. If we instead look at the highest 10% of pediatric dental claimants and assume an average distribution of Class I, II, III procedures, the average out-of-pocket costs are significantly lower, in the \$290 range. The highest 20% incur average out-of-pocket costs of only \$200.

This is another way in which dental claims differ from medical; while the medical claim cost curve has a long tail in which the highest-claim-cost members can incur huge claim levels, the dental cost curve does not. Catastrophic claims, always a concern under medical coverage, don't really exist in the dental realm. For example, from the above we have seen that an annual maximum out of pocket expense of \$3,800 for dental services is very uncommon, with more common levels being only a couple of hundred dollars or less.

So, under the assumptions we've used, the vast majority of pediatric dental members would not incur significant out-of-pocket costs. To develop a reasonable pediatric dental specific OOP maximum – one that would only marginally impact the benefit's price tag – for each state, the above analysis should be extended to consider state-specific characteristics including:

- dental network size;
- provider discount level;
- definition of pediatric dental essential benefit; and
- the particulars of the medical and dental benefit offerings.

Using an OOP maximum specific to pediatric dental has the following advantages:

- simplification of claim processing;
- elimination of the need to split up the OOP maximums between medical and dental; and
- provision of additional coverage past the OOP maximum in the rare instance that a truly catastrophic dental situation were to occur.

If regulation is sought to define the proportion of the EHBP's OOP maximum that should apply to dental, then analysis of the proposed medical and pediatric dental EHBP using state-specific assumptions would shed light on what proportion would be appropriate for each state.

If it is determined that a stand-alone pediatric dental essential benefit OOP maximum is not workable, and a combined medical/dental OOP maximum is to be utilized, then conceptually the OOP maximum somehow needs to be split to determine the portions applicable to medical and dental. Given what we learned through analyzing the out-of-pocket maximums for pediatric dental, we can see that it would be rare that child dental claims would put a person over his or her combined medical/dental OOP limit. In all likelihood, a person hitting his OOP limit would have incurred a high level of medical claims – from, for example, a hospital stay. Once that OOP limit is reached, all essential benefits, including pediatric dental, would be covered in full. So, for dental insurers, the relevant question to ensure that claims are processed correctly is: *In the case that a consumer achieves the OOP maximum, how often would the consumer then seek out pediatric essential dental services normally covered at less than 100%?*

The answer depends on the medical benefit's richness and the composition of the pediatric dental essential benefit. If, as we've discussed previously, the dental benefit is comprised of select procedures, all covered in full, then the question is moot and the entire OOP maximum can accrue to medical. If the essential pediatric dental benefit includes some cost-sharing, but it is rare that the overall OOP maximum would be achieved, then a pragmatic approach might be to manage the OOP maximum accounting process by exception.

A back-end appeals process would handle the issue when a consumer receives only partial coverage for a pediatric dental essential benefit but expected full coverage, i.e. no cost sharing, due to the OOP maximum. Handling these relatively rare appeals on a case by case basis may be less costly to the Exchange, the insurer, and the consumer than attempting to build the administrative process to pull together medical and dental claims for OOP maximum achievement determination.

If the Exchange takes on the responsibility of determining whether OOP maximums have been met, a state Medicaid Management Information Systems (MMIS) vendor could play a role in aggregating claim information from both medical and dental carriers for that purpose. The achievement of the overall OOP maximum would have to be calculated in a timely manner such that the carriers could be notified in time to pay subsequent claims correctly. Alternatively a reconciliation process could be built to adjust for these items after the fact. Either of these approaches would be expected to require significant building of processes, systems infrastructure, and administrative capabilities.

In summary, the key methods to manage the determination of achievement of OOP maximums, given the meshing of medical and dental in the EHBP are:

- Managing the process via pediatric dental essential benefit design, covering specified procedures only, at 100%, such that no portion of the OOP maximum needs to be attributed to dental;
- Managing the process via a separate pediatric dental-specific OOP maximum;
- Allowing the entire OOP maximum to accrue to medical, and use an exception process to handle any pediatric dental claim payment issues that could arise after a person has achieved his OOP maximum;
- Giving the Exchange the responsibility to develop a process to aggregate claims for determination of OOP maximum achievement.

IV. Caveats and Limitations on Use of Milliman Work Product

We, Joanne Fontana and William Thompson, are Consulting Actuaries for Milliman. We are members of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

Milliman has prepared this report for the specific purpose of providing research results and technical analysis for reference in the NADP/DDPA-authored white paper. This information may not be appropriate, and should not be used, for any other purpose. This report has been prepared solely for the internal business use of, and is only to be relied upon by, the management of NADP. No portion of this report may be provided to any other party without Milliman's prior written consent. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work even if we permit the distribution of our work product to such third party.

The results presented herein are estimates based on carefully constructed actuarial models. Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

In performing this analysis, we relied on data and other information provided by NADP. We have not audited or verified this data and other information but reviewed it for general reasonableness. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

Milliman does not provide legal advice, and recommends that NADP consult with its legal advisors regarding legal matters.

The terms of Milliman's Consulting Services Agreement with NADP signed on March 24, 2011 apply to this letter and its use.

Appendix A: Pediatric Dental Essential Benefit Pricing Details and Assumptions

Underlying Pricing Assumptions for Pediatric Dental Essential Benefit Options:
25% discount (national average commercial fee schedule level)
50% in-network utilization
Essential benefit covers children up to but not including age 21

Assumed Cost-Sharing Construct of CHIP-Style Benefit Option Without Ortho:		
Class of Service	Coverages	Coinsurance In/Out of Network
Class I	Oral Exams, Prophylaxis, Fluoride, X-Rays, Lab and Other Tests, Sealants	100% / 100%
Class II	Emergency (Palliative)	100% / 100%
	Space Maintainers, Simple Extractions, Surgical Extractions, Restorations, Periodontics, Endodontics	80% / 60%
Class III	Inlays and Crowns	50% / 40%
Class IV	Orthodontia	Not Covered
Deductible In/Out of Network: \$0 / \$0		

If assumptions are different from those listed above, price points will differ from those listed in this report. Some examples of price sensitivity to key assumptions are:

- In-network utilization:** The CHIP-style, no-orthodontia plan priced assuming 90 percent in-network utilization, rather than 50 percent, yields a price of \$28.50 rather than \$29.25. As dental network size and composition varies quite significantly in different geographies, the in-network utilization assumption must be developed based on the particulars of the location being priced.
- Fee schedules:** Similarly, if the pediatric dental essential benefit is priced using Medicaid provider reimbursement levels rather than commercial, price points will generally be lower than those listed in the paper. Based on industry average differentials between Medicaid and commercial fee schedules, the plan described above would cost about \$25.00 on Medicaid-level provider reimbursement versus \$29.25 at commercial levels.
- Pediatric Definition:** The age at which pediatric coverage ceases is also an important pricing factor; for example, covering children through age 14 reduces the cost of the benefit from \$29.25 to \$26.00 due to a change in the mix of services.
- Other Pricing Factors:** Depending on the construct of the essential benefit plan, it may be necessary to consider other factors affecting the price of the benefit. For example, guaranteed issue loads are not included in the prices in this document; depending on the nature of the benefit and the resulting potential adverse selection associated with a guaranteed issue product, prices may need to be increased.

Endnotes

- ¹ ACA Section 1302(b)(4)(F)
- ² NADP research reports show that about 2/3 of dental enrollment is through a carrier other than the medical carrier; just under 1/3 is through a medical carrier but under a separate dental policy and a very small percentage is dental services covered under a medical policy.
- ³ ACA Section 1402(c)(5) of ACA
- ⁴ “Establishment of Exchanges and Qualified Health Plans”, Federal Register, Vol. 76 No. 136, July 15, 2011
- ⁵ ACA Section 5000A
- ⁶ ACA Section 1302(b)(1)(J)
- ⁷ ACA Section 1302(b)(4)(F)
- ⁸ ACA Section 1311(d)(2)(B)(ii)
- ⁹ “NADP/DDPA 2010 Dental Benefits Joint Report: Enrollment”, October 2010
- ¹⁰ NADP 2008 Consumer Survey
- ¹¹ “NADP/DDPA 2010 Dental Benefits Joint Report: Enrollment”, October 2010
- ¹² Ibid
- ¹³ Ibid
- ¹⁴ NADP 2011 Purchaser Behavior Survey
- ¹⁵ “NADP/DDPA 2010 Dental Benefits Joint Report: Enrollment”, October 2010
- ¹⁶ “NADP/DDPA 2010 Dental Benefits Joint Report: Enrollment”, October 2010
- ¹⁷ “NADP 2010 Dental Benefits Report: Premium Trends”, December 2010
- ¹⁸ “NADP 2010 Dental Benefits Report: Premium Trends”, December 2010
- ¹⁹ “Report to the Congress on a Study of the Large Group Market”, U.S. Department of Health and Human Services in collaboration with the U.S. Department of Labor, March 2011
- ²⁰ “NADP 2010 Dental Benefits Report: Premium Trends”, December 2010
- ²¹ NADP Membership Enrollment Data, 2010
- ²² “Distribution of Dentists in the United States by Region and State”, ADA Survey Center, 2003
- ²³ “Oral Health in America: A Report of the Surgeon General”, U.S. Department of Health and Human Services, May 2000
- ²⁴ “Dental Caries (Tooth Decay) in Children (Age 2 to 11)”, Improving the Nation’s Oral Health, National Institute of Dental and Craniofacial Research, U.S. Department of Health and Human Services
- ²⁵ ACA Section 1311(d)(2)(B)(ii)
- ²⁶ ACA Section 1302
- ²⁷ ACA Section 1302(d); “Qualified Health Plans” sold on Exchange only have to be offered at silver and gold levels, unless state adds requirement for carriers to offer at all levels. If they do offer all levels, they have to meet the actuarial value rules within ACA.
- ²⁸ ACA Section 1311(d)(2)(B)(ii); Plan in this instance refers to a policy, certificate or contract, not a company or carrier.
- ²⁹ Section 9832(c)(2)(A) of the Internal Revenue Code of 1986
- ²⁹ “Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under ACA; Interim Final Rule and Proposed Rule”, Federal Register, Vol. 75 No. 116, June 17, 2010
- ³⁰ Ibid
- ³¹ “Establishment of Exchanges and Qualified Health Plans”, Federal Register, Vol. 76 No. 136, July 15, 2011
- ³² “Ensuring Access to Standalone Dental Plans and Competition for Dental Coverage”, American Dental Association
- ³³ “Considerations in Offering Dental Insurance on Exchanges”, Milliman, August 25, 2011
- ³⁴ Ibid

³⁵ “Report to the Congress on a Study of the Large Group Market,” U.S. Department of Health and Human Services in collaboration with the U.S. Department of Labor, March 2011

³⁶ Ibid; This structure describes the most common dental PPO; overall DPPOs are 69 percent of the total dental market.

³⁷ “NADP 2008 Purchaser Behavior Survey”, NADP, December 2008

³⁸ “EPSDT & Title V Collaboration to Improve Child Health”, Health Resources and Services Administration, U.S. Department of Health and Human Services

³⁹ “Policy Brief: Oral Health Coverage and Care for Low-Income Children: The Role of Medicaid and CHIP”, Kaiser Family Foundation, April 2009. Additional key points: Existing EPSDT programs are considered as meeting the CHIPRA requirements. CHIPRA oral health benefits include children through age 19, an important note as HHS determines who to include in “pediatric oral services”. States may use one of three benchmark dental benefit policies defined in CHIPRA or develop their own CHIPRA dental benefit. State-specific dental packages are considered acceptable if all services required by statute are being offered. In demonstrating that a benefit package meets the requirements, the state must specify periodicity of preventive and restorative services, considering the guidelines published by the American Academy of Pediatric Dentistry. States need not provide coverage within each service category, but rather cover any services in a category required according to the statute. As an example, states need not cover cosmetic orthodontic procedures, but if any are required to prevent disease, promote and restore oral health, or treat emergency conditions, then the services must be provided.

⁴⁰ “CHIP Tips. Children’s Oral Health Benefits”, Kaiser Family Foundation, March 2010

⁴¹ “The State of Children’s Dental Health: Making Coverage Matter”, The Pew Center on the States, May 2011

⁴² “Medicaid Enrollment: June 2010 Data Snapshot”, Medicaid Facts, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, February 2011

⁴³ “CHIP Enrollment: December 2009 Data Snapshot”, Kaiser Family Foundation

⁴⁴ “Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133%”, Holahan, John and Headen, Irene, Urban Institute, Kaiser Commission of Medicaid and the Uninsured, May 2010

⁴⁵ “The State of Children’s Dental Health: Making Coverage Matter”, The Pew Center on the States, May 2011

⁴⁶ “Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges”, Sommers, Benjamin et al, Health Affairs, February 2011

⁴⁷ “2011-2012 CDT: The ADA Practical Guide to Dental Procedure Codes” ©, American Dental Association, 2010

⁴⁸ “NADP 201 1 Purchaser Behavior Survey”, NADP, August 2011, Dallas TX

⁴⁹ “Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under ACA”, Federal Register Vol. 75 No.137, July 19 2010

⁵⁰ “Considerations in Offering Dental Insurance on Exchanges”, Milliman, August 25, 2011

⁵¹ Ibid

⁵² Ibid

⁵³ MEPS data shows that about 17.9 percent of the children with dental benefits get orthodontic care annually. However the cost is limited by the \$1500 lifetime maximum on ortho in commercial coverage. In CHIP and Medicaid programs, orthodontic care is limited to treatment of cleft palate and malformation which are rare.

⁵⁴ “Guide to Children’s Dental Care in Medicaid”, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, October 2001

⁵⁵ “CHIP TIPS: Children’s Oral Health Benefits”, Kaiser Family Foundation, March 2010

⁵⁶ “Programs in Your State”, InsureKidsNow.com, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services

⁵⁷ “Considerations in Offering Dental Insurance on Exchanges”, Milliman, August 25, 2011

⁵⁸ Ibid

⁵⁹ “Dental Insurance for Persons Under Age 65 Years with Private Health Insurance”, Bloom B, and Cohen RA, National Center for Health Statistics Data Brief No. 40, U.S. Department of Health and Human Services, June 2010

⁶⁰ “Dental care use: Does dental insurance truly make a difference in the U.S.?”, Manski R, and Cooper P, Community Dental Health, 2007

⁶¹ “Findings on Children’s Health Care Quality and Disparities Fact Sheet”, National Healthcare Quality Report and National Healthcare Disparities Report, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, 2009

⁶² “An examination of periodontal treatment and per member per month (PMPM) medical costs in an insured population”, Albert DA, et.al, Columbia University and Aetna, BMC Health Services Research, Aug 16; 2006

⁶³ “Considerations in Offering Dental Insurance on Exchanges”, Milliman, August 25, 2011

⁶⁴ Ibid

⁶⁵ Orthodontic coverage is a good example. There are indexes for determining the need for treatment for orthodontia; one of these is the Salzmann index. Where the recommended need level for treatment on Salzmann is 5; many state Medicaid programs will not pay for treatment unless the need level is in the 25 to 40 range. A commercial dental plan would presumably be required to use the recommended lower need level under the Salzmann index.

⁶⁶ “Considerations in Offering Dental Insurance on Exchanges”, Milliman, August 25, 2011

⁶⁷ Ibid

⁶⁸ ACA Section 1311(c)

⁶⁹ An open market approach refers to an Exchange designed to allow maximum participation from plans, as opposed to the “selective contracting” approach where Exchanges would allow only certain plans to offer in the Exchange.

⁷⁰ “Physician Characteristics and Distribution of Physicians in the US”, American Medical Association, November 2011

⁷¹ Ibid

⁷² NADP research reports show that about 2/3 of dental enrollment is through a carrier other than the medical carrier; just under 1/3 is through a medical carrier but under a separate dental policy and a very small percentage is dental services covered under a medical policy.

⁷³ Estimates of children with dental benefits in the private market are derived from several data sources, including “NADP/DDPA 2009 Dental Benefits Joint Report: Enrollment”; “NADP Consumer Survey” July 2009; “2009 Census Data” U.S. Census Bureau; “Employment Size of Employer and Nonemployer Firms, 2008” Statistics of U.S. Businesses, U.S. Census Bureau

⁷⁴ NADP 2011 Purchaser Behavior Survey, September 2011

⁷⁵ Dental policies offered as optional coverage should include the options available today in the commercial market, i.e. indemnity, DPPO, DHMO and dental discount.

⁷⁶ “DDPA Children’s Oral Health Study”, Morpace and Meyocks Group, 2011

⁷⁷ “Continued Availability of Limited Scope Dental Benefits Outside State Exchanges Under PPACA”, Legal memo to Secretary Kathleen Sebelius from Hogan Lovells, April 2011

⁷⁸ Within ACA premium tax credit subsidies are to be paid directly to insurers to avoid passing through the Exchange.

⁷⁹ ACA Section 1402(c)(5)

⁸⁰ “Considerations in Offering Dental Insurance on Exchanges”, Milliman, August 25, 2011

⁸¹ Ibid

⁸² Current Dental Terminology is a copyrighted system of coding owned by the American Dental Association.

⁸³ “Considerations in Offering Dental Insurance on Exchanges”, Milliman, August 25, 2011

⁸⁴ Ibid

⁸⁵ This could vary based on the level of the out-of-pocket maximum. High out-of-pocket maximums could lead to underutilization of benefits.

⁸⁶ “Considerations in Offering Dental Insurance on Exchanges”, Milliman, August 25, 2011

⁸⁷ Ibid

⁸⁸ Ibid

⁸⁹ Ibid

⁹⁰ Ibid

⁹¹ Federal guidelines limit consumer cost-sharing under CHIP to five percent of consumer income even when there are separate medical and dental policies.

⁹² “2010 LIMRA/NADP Claims Metrics Report”, LIMRA and NADP, July 2010. The Metrics Report states a median of 88 percent of all dental claims are processed in five days, 97 percent in six to ten days, and three of four claims are auto-adjudicated.

⁹³ “Considerations in Offering Dental Insurance on Exchanges”, Milliman, August 25, 2011

⁹⁴ Ibid

⁹⁵ “Establishment of Exchanges and Qualified Health Plans”, Federal Register, Vol. 76 No. 136, July 15, 2011

⁹⁶ Ibid

⁹⁷ “Considerations in Offering Dental Insurance on Exchanges”, Milliman, August 25, 2011

⁹⁸ Ibid

⁹⁹ Ibid



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