

OFFERING DENTAL IN HEALTH EXCHANGES A Roadmap for State and Federal Policymakers SEPTEMBER 2011

In developing the Affordable Care Act (ACA), Congress recognized the key role oral health plays in overall health by including “pediatric oral services,” as part of the Essential Health Benefit Package (EHBP) under the law. As a result, all individuals purchasing small group or individual health insurance inside or outside the Exchange must be offered “pediatric oral services” either through a medical plan or through the purchase of a standalone dental plan beginning in 2014.

Moreover, the ACA expressly allows the offering of standalone dental plans -- both child only and adult policies -- in Exchanges. This reflects the current dental plan market, wherein a vast majority of Americans access dental coverage under a policy that is separate from their medical coverage. While adult dental coverage may be purchased, the premium and cost sharing subsidies included as part of the ACA will only be applied to the purchase of benefits necessary to meet the “pediatric oral services” requirement of EHBP in the American Health Benefits Exchange. Adults eligible for subsidies for their medical coverage who wish to purchase dental coverage must pay for the full cost of their dental policies.

To implement the dental insurance provisions of the ACA successfully, state and federal policymakers must evaluate several key questions related to Exchange operations. In particular, governments must consider how to operate and administer Exchanges in a way that allows...

1. Parents whose children are covered through existing dental policies to maintain that coverage and the dentist they now see.
2. Parents of children who currently lack dental coverage to choose dental policies in Exchanges that meet their children’s needs.
3. Supplemental adult and non-essential pediatric benefits can be purchased in order to provide full family coverage.

The NADP & DDPA White Paper, “Offering Dental in Health Exchanges”, addresses 6 key questions Exchange policymakers must consider, including their various options, the related impacts and recommendations. Following are highlights of those 6 issue briefs within the White Paper.

ISSUE Brief 1: What should constitute “pediatric oral services” for the purposes of the essential health benefit requirement?

This decision holds broad implications for affordability of coverage -- for individuals, governments and employers -- as well as the ability of individuals to maintain the coverage they currently enjoy today. An extremely generous benefit could drive up the cost of coverage, while a less-robust package could threaten continuity of coverage for some enrollees.

U.S. Health and Human Services 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. The EHBP should be affordable for consumers and administratively simple for Exchanges to offer to enrollees.

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

- The age limit associated with pediatric benefits with options ranging from clinical age of 12, public programs utilizing 19, to dependent age of 26;
- The various policy types that include dental: a medical policy covering oral health assessments, a prevention-oriented dental benefit, a benefit typical of an employer plan or public programs, or a new, developing model of risk based benefits;
- Affordability and clinical appropriateness of each policy type;
- The impact on access to care and maintenance of oral health by all populations;
- Whether metal levels, representing specific actuarial values of coverage, are viable as applied to “pediatric oral services” offered as separate dental policies.

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

The National Association of Insurance Commissioners Model Exchange Act identifies criteria for qualified health plans (QHPs) participation in Exchanges. Yet, the specific features of dental plans require policymakers to evaluate the applicability of these criteria to the Model’s new definition of a “qualified dental plan” (QDP).

In general, QHP criteria should not be applied broadly to dental plans. Specifically, policymakers should consider the following QDP criteria might be inapplicable, inappropriate or in need of revision to relate accurately to dental plans:

- *Accreditation:* There is not an industry standard or accreditation system for dental plans. States currently utilize their own oversight rules when licensing dental plans.
- *Network adequacy:* The local nature of networks and uneven geographic distribution of dentists make a single, national network adequacy standard inappropriate for dental plans. States that develop new network adequacy standards for dental plans should apply them only to general dentists.
- *Quality and performance metrics:* Relevant quality and performance measures for dental coverage are limited and may be difficult to narrowly apply to children. If utilization data for children’s services is used as a standard, it should be consistent with Medicaid measures now reported.
- *Marketing restrictions:* Marketing limitations and disclosure requirements should follow existing state regulations.
- *Actuarial metal levels:* Metal levels, representing specific actuarial values of coverage, should not be applied to separate dental policies covering “pediatric oral services” as these limited scope benefits are only one element of the EHBP.
- *Standard disclosures:* If standard disclosures are required for the qualification of dental plans, separate 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 Exchange to ensure consumers have appropriate information about plan choices?

Consumers generally make decisions about dental policies based on cost, benefits and access to a dentist within the network. In general, information about plan choices must balance simplicity with choice. In addition, the Exchange must offer consumers clarity surrounding the applicability of tax credits and plan design of child-only, adult, and family dental plans. While exchanges may evaluate a number of approaches in this regard, they should ensure continuity of care as well as allowing for fair competition among all QHPs and QDPs offering dental coverage. Exchanges should:

- Allow families who have dental coverage outside the Exchange to keep their dental coverage intact even if purchasing medical coverage inside the Exchange.
- Provide that Medical/Multi-line carriers can offer coverage as they do today, whether embedding dental benefits into the medical policy, offering a dental policy in conjunction with their medical policy, or offering stand-alone dental policies. However, to ensure the viability of stand-alone dental plans in the Exchanges, multi-line carriers should be required to offer medical-only policies so that consumers
 - have the range of options the current market offers today, and
 - are not forced to purchase dental coverage when
 - they already have it,
 - they do not have dependent children, or
 - their children are covered under a spouse's policy.
- To enable consumers to purchase only the “pediatric oral services” required as part of EHBP, QHPs and QDPs that offer separate dental policies on the Exchange should be required to offer child-only policies. In addition, adults without children should not be required to purchase “pediatric oral services” as part of their EHBP.

Issue Brief 4: How can premium subsidies be applied to “pediatric oral services” purchase in a stand-alone dental policy?

When a consumer chooses a separate dental policy covering “pediatric oral health services” and qualifies for a subsidy, the dental-proportionate value of the tax credit based on premium should be paid directly to the dental plan. Where an aggregator is used by the state Exchange, the subsidy should be paid to the aggregator for distribution.

Moreover, given the low cost of dental premiums relative to medical premiums and the infrastructure needed to collect premiums from individuals (as opposed to employers), states should provide for premium collection through a central location – either the Exchange or an aggregator -- in addition to the ACA-required option for consumers to pay plans directly.

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

In today's marketplace, medical and dental claims are processed separately, most often by different carriers using different claims systems. Therefore, coordinating out-of-pocket limits among medical and dental carriers will likely pose significant logistical challenges. While cost sharing subsidies are not applicable to dental policies under ACA, out-of-pocket maximums are, and there are several approaches to managing these consumer protections between medical and dental policies under the ACA, including:

- Designing the “pediatric oral services” benefit in such a way that there will be no cost-sharing and therefore will not require any portion of the out-of-pocket maximum to be applied to dental (i.e. 100 percent preventive benefit.);
- Allocating a separate pediatric dental-specific out-of-pocket maximum;
- Requiring carriers to determine when out-of-pocket maximums are reached;
- Tasking the Exchange with aggregating claims for the purpose of determining out-of-pocket maximums.

The appropriate option depends on HHS's determination of the scope of “pediatric oral services” in the EHBP and whether the mandated plan design results in out-of-pocket costs to be applied to an out-of-pocket maximum.

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

Dental plans are regulated primarily at the state level, where many consumer protections exist today. In addition, dental benefits are classified as “excepted benefits” under HIPAA, which exempts them from medical market reform provisions included in the ACA. Nonetheless, an Exchange may apply relevant consumer protections to qualified dental plans offering coverage on the Exchange.

In particular, states should consider utilizing existing state laws and regulations, specific to dental plans where available for:

- *Provider network standards, and*
- *Plain language requirements.*

In addition, transparency standards for the following areas could be established at the federal or state levels specific to dental plans:

- *Cost-sharing disclosures,*
- *Plan performance criteria, and*
- *Summary of benefits.*

Any consumer protection provisions should only be applied to separate dental policies covering “pediatric oral services” as part of the EHBP. Policymakers should utilize the NAIC's expertise in developing standards for dental policies throughout this process.

SUMMARY

The unique nature of dental policies requires careful planning when designing the operational processes of Exchanges. In general, policymakers should be mindful of the existing market, infrastructure and requirements for dental plans and seek to build from this base as they design exchanges. Utilizing and improving upon the current market and infrastructure will increase affordable choices for consumers and maximize efficiency for plans. In particular, policymakers should:

- Develop an essential pediatric dental benefit that considers the state's existing public pediatric dental programs and typical employer-sponsored plans. The benefit should be affordable for consumers and administratively simple for Exchanges to administer.
- Recognize criteria for QDPs and QHPs will necessarily differ. Policymakers should look to existing state requirements to begin developing criteria for QDPs.
- Balance choice and simplicity when presenting consumers information and options for dental benefits, maximizing fair competition among plans within the Exchange.
- Direct the dental-proportionate value of tax credit subsidies used to purchase the pediatric essential benefit directly to the dental plan. Collection of premiums by Exchanges and/or third-party administrators acting as aggregators should also be considered.
- Design cost-sharing and out-of-pocket limits in a way that minimizes the need for separate dental and medical plans to coordinate claims processes.
- Apply applicable consumer protection provisions only to dental policies offering "pediatric oral services" and not supplemental family dental policies.

Dental plans are a key component of improving our nation's overall health and wellness. With careful consideration, Exchanges can help ensure Americans with dental coverage maintain continuity of coverage and Americans without dental benefits can access quality, affordable oral health options.

**Full White Paper available for download at NADP.org and DeltaDental.com,
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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's members provide Dental HMO, Dental PPO, Dental Indemnity and Discount Dental products to over 85% of all Americans with dental benefits.

Delta Dental Plans Association (DDPA) - is based in Oak Brook, IL that 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.





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