

To: Child Advocates
From: Children's Dental Health Project
Re: Recommendations for Essential Health Benefits Package
Date: December 21, 2011



On December 16, 2011, the Department of Health and Human Services (HHS), Center for Consumer Information and Insurance Oversight (CCIIO) issued a Bulletin providing preliminary guidance related to the implementation of the Essential Health Benefits (EHB) in the Affordable Care Act (ACA). The Bulletin reflects the HHS' intent to balance the comprehensiveness, affordability, and State flexibility in final regulations by proposing to define the EHB by a benchmark plan selected by each State, similar to what is done in the Children's Health Insurance Program (CHIP). While we recognize the difficulty of determining how these services will be designed and administered in a manner that balances comprehensiveness, affordability, and state flexibility, the guidance raises some specific concerns related to the design of pediatric oral services requirement.

In response to these concerns, the Children's Dental Health Project developed this memo to assist advocates with background information and talking points. The following information is specifically designed for State advocates seeking additional guidance on how their State may implement the pediatric oral services portion of the EHB while mitigating potential risks to families who will be purchasing coverage. We therefore recommend State advocates ask HHS for further clarification on these following issues.

- 1. Provide detailed guidance specific to the pediatric dental benefit**
- 2. Ensure that the Exchange regulations provide consumers equitable affordability of EHB**
- 3. Allow for flexibility to provide cost-effective risk-based pediatric dental benefits**

Congress designed the pediatric dental benefit in ACA as an essential part of overall child health coverage by including it in Section 1302(b)(J) [pediatric services, including oral and vision care]. However, traditional commercial dental coverage is appropriately regarded and provided by employers as "dental *benefits*" to help defray the cost of dental care rather than "dental *insurance*" to spread risk across beneficiaries in a group. To ensure affordability for employers while covering a wide range of dental services, they feature limited benefits with high out-of-pocket expenses for individuals generated by copayments, annual and lifetime caps, exclusions, and substitutions. The Medical Expenditures Panel Survey (MEPS) reports that more than one third (~40%) of dental expenditures for commercially insured persons are paid out of pocket – a higher rate than for medical expenditures. Today roughly 98 percent of dental coverage in the private market is obtained through a separate policy distinct from medical coverage. There are rare examples of child-only coverage which adds to the unique challenge of defining the EHB. This challenge is further complicated by the fact that stand-alone dental plans are not explicitly required by ACA to meet the same standards for cost-sharing reductions or annual and lifetime caps. In addition, as a result of the law's definitions of "excepted benefits" and "minimum essential coverage," there is no tax penalty for families who choose not to obtain supplemental pediatric dental coverage. Furthermore, families within the identified income category without dental coverage for their children would be allowed to apply all out-of-pocket dental expenses toward the limits to receive cost sharing reductions with a Qualified Health Plan (QHP). Therefore, without parity in how the dental benefit is defined and administered in an Exchange, there is tremendous uncertainty about out-of-pocket expenses incurred by families and ironically may create an incentive for some families to forgo

supplemental dental coverage for their child in order to spend down their total healthcare capped out-of-pocket expenditures.

Recommendation 1: Provide detailed guidance specific to the pediatric dental benefit

While the pediatric dental benefit is a small portion of the larger set of essential health benefits, without additional attention, the benefit could become meaningless. Therefore, state advocates should seek additional guidance from HHS specifically on the pediatric dental benefit. Both the National Association of Dental Plans and the Delta Dental Plans Association recognize that CHIP is the only market in which child-only policies are regularly offered.ⁱ As a result, the benchmark standards outlined in the Bulletin are of little value to states without further guidance. Additional information is needed from HHS on the method for determining the proportion of existing individual adult “self” benefits that accurately reflect the cost of pediatric-only coverage. CMS has yet to clarify this issue within CHIP, as regulations for the CHIP dental benefit required by CHIPRA are not expected to be released until the Spring of 2012. Unlike the ACA though, CMS has already stated in a 2009 State Health Official letter that CHIP requires the equivalent to one of the three dental benchmark packages in the CHIPRA statutes and is not allowed to provide actuarial equivalence or a modified benefit package.ⁱⁱ Therefore, further clarification will also be needed from HHS if a state determines to use CHIP as the pediatric dental benchmark for EHB.

Recommendation 2: Assure the Exchange regulations provide consumers equitable affordability of EHB

The design of the EHB is inextricably linked to the establishment of the Exchange. As a result, state advocates should recommend that HHS address the potential lack of parity in pediatric dental coverage in the Exchange regulations to ensure the affordability and comprehensiveness of the EHB. Stand-alone dental plans are required to meet the requirements of section 18022(b)(1)(J), which means that they must offer the same children’s oral care benefits as health plans offering essential health benefits package. However, under the statute, stand-alone dental plans are not required to provide the same consumer protections as health plans in the areas of cost-sharing reductions, annual caps, and lifetime limits, among others. Arguably, though, such consumer protections are an inextricable part of the essential health benefits package that must be offered by qualified health plans in the Exchanges. The value of a benefit is determined not only by which items and services are covered, but also by how those services are covered and how the benefit is structured. If reduced cost-sharing is available for children’s oral care benefits under a qualified health plan but not under a stand-alone dental plan, those two plans do not actually offer the same children’s oral care benefit, even if the plan otherwise cover the same items or services. We suggest that the only way to create parity among dental benefits (regardless of the carrier through which they are provided) in the Exchange(s) is to require that all plans provide the same relevant consumer protections in order to be certified to offer benefits on the Exchange. Specifically, advocates should recommend that the following “relevant and necessary” consumer protections and affordability standards apply to all pediatric dental benefits.

- coverage of recommended preventive services without cost-sharing
- applicability of cost-sharing reductions
- elimination of annual caps
- elimination of lifetime limits

Recommendation 3: Allow for flexibility and innovation to provide cost-effective risk-based pediatric dental benefits

While providing regulatory clarity to states for existing models of dental coverage is essential, state advocates should also recommend that HHS allow for flexibility to provide cost-effective risk-based pediatric dental benefits. On September 27, 2011 a letter was sent to Secretary Sebelius signed by 55

organizations and 39 dental benefit companies supporting a pediatric dental benefit that reflects current science, best practices and professional recommendations.ⁱⁱⁱ Additionally, 42 of the nation’s dental school deans (more than 2/3rds) sent a letter to the Secretary similarly calling for a comprehensive and risk-based dental benefit for children that aligns with current dental school curriculum. Such a benefit supports early, timely, and ongoing oral health care (preventive and corrective) that is tailored to a child’s level of risk and needs. While states should recognize that future EHB regulations will not likely provide this level of detail, CDHP has identified companies that are prepared to provide this type of benefit that emphasizes health promotion and disease management instead of dental repair and can be administered at a lower cost than the benchmarks outlined in the Bulletin. We have identified these companies because we are aware that some dental insurers are eager to provide a dental benefit that provides only an oral health screening by a medical professional and limited fluoride supplements with the opportunity to buy additional coverage through a family plan.^{iv} Such a “skinny” benefit would fail to meet children’s basic needs and, would not support flexibility for dental benefits companies to offer a cost-effective, evidence-based benefit that is sensitive to children’s various levels of risk. Future regulations would need to provide the flexibility and the incentive to those companies to participate without creating a race to the bottom.

Potential Cost of Dental Care to Families

To provide a context for the complexity of what families will face in determining and paying for their dental benefits, the following scenarios provide real life examples from the Federal Employees Dental and Vision Insurance Program (FEDVIP)^v, State CHIP benefit packages with approved State Plan Amendments^{vi}, and Children's Dental Health Project’s small business dental benefit plan. The examples include the cost to a family for an annual premium for a self plus one plan (or in the case of CHIP an individual child) and a range of services for a child that include routine preventive, restorative and medically necessary orthodontics with appropriate sedation.

Aetna Dental FEDVIP				
Quantity	Service	Cost	Cost-sharing	Out of Pocket Cost
2	Exam & Cleaning	\$300	0%	\$0
1	X-Ray	\$30	0%	\$0
3	Filling	\$300	40%	\$120
1	Panoramic X-Ray	\$100	40%	\$40
1	Maxillary Expansion	\$2,000	70%	\$1,400
2	Sedation	\$100	70%	\$70
Total		\$2,830		\$1,630
	Annual Cap	Premium		Total 1 yr out of pocket by family
	\$3,000	\$779		\$2,409
		% of cost paid by family		58%
		% of cost w/ premium paid by family		85%

GEHA Standard Dental FEDVIP				
Quantity	Service	Cost	Cost-sharing	Out of Pocket Cost
2	Exam & Cleaning	\$300	0%	\$0
1	X-Ray	\$30	0%	\$0
3	Filling	\$300	45%	\$135
1	Panoramic X-Ray	\$100	45%	\$45
1	Maxillary Expansion	\$2,000	50%	\$1,000
2	Sedation	\$100	35%	\$35
Total		\$2,830		\$1,215
Annual Cap		Premium	Total 1 yr out of pocket by family	
\$1,200		\$539	\$1,769	
% of cost paid by family			43%	
% of cost w/ premium paid by family			63%	

MetLife Standard Dental FEDVIP				
Quantity	Service	Cost	Cost-sharing	Out of Pocket Cost
2	Exam & Cleaning	\$300	0%	\$0
1	X-Ray	\$30	0%	\$0
3	Filling	\$300	45%	\$135
1	Panoramic X-Ray	\$100	45%	\$45
1	Maxillary Expansion	\$2,000	50%	\$1,000
2	Sedation	\$100	35%	\$35
Total		\$2,830		\$1,215
Annual Cap		Premium	Total 1 yr out of pocket by family	
\$1,200		\$539	\$1,769	
% of cost paid by family			43%	
% of cost w/ premium paid by family			63%	

United Concordia Dental FEDVIP				
Quantity	Service	Cost	Cost-sharing	Out of Pocket Cost
2	Exam & Cleaning	\$300	0%	\$0
1	X-Ray	\$30	0%	\$0
3	Filling	\$300	20%	\$60
1	Panoramic X-Ray	\$100	20%	\$20
1	Maxillary Expansion	\$2,000	50%	\$1,000
2	Sedation	\$100	50%	\$50
Total		\$2,830		\$1,130
Annual Cap		Premium	Total 1 yr out of pocket by family	
\$3,500		\$911	\$2,041	
% of cost paid by family			40%	
% of cost w/ premium paid by family			72%	

**Iowa - hawk-I
(State Defined Benefit Package)**

Quantity	Service	Cost	Cost-sharing	Out of Pocket Cost
2	Exam & Cleaning	\$300	0%	\$0
1	X-Ray	\$30	0%	\$0
3	Filling	\$300	0%	\$0
1	Panoramic X-Ray	\$100	0%	\$0
1	Maxillary Expansion*	\$2,000	0%	\$0
2	Sedation	\$100	0%	\$0
Total		\$2,830		\$0

Annual Cap	Premium	Total 1 yr out of pocket by family
\$1,000	\$0	\$0

% of cost paid by family	0%
% of cost w/ premium paid by family	0%

*Orthodontics that meet the State's definition of medically necessary are excluded from the annual cap.

**Montana - Healthy Montana Kids
(State Employees Benefits Plan as Benchmark)**

Quantity	Service	Cost	Cost-sharing	Out of Pocket Cost
2	Exam & Cleaning	\$300	0%	\$0
1	X-Ray	\$30	0%	\$0
3	Filling	\$300	0%	\$0
1	Panoramic X-Ray	\$100	0%	\$0
1	Maxillary Expansion	\$2,000	100%	\$2,000
2	Sedation	\$100	0%	\$0
Total		\$2,830		\$2,000

Annual Cap	Premium	Total 1 yr out of pocket by family
\$1,412	\$0	\$2,000

% of cost paid by family	71%
% of cost w/ premium paid by family	71%

**Nevada - Nevada Checkup
(State Defined Benefit Package)**

Quantity	Service	Cost	Cost-sharing	Out of Pocket Cost
2	Exam & Cleaning	\$300	0%	\$0
1	X-Ray	\$30	0%	\$0
3	Filling	\$300	0%	\$0
1	Panoramic X-Ray	\$100	0%	\$0
1	Maxillary Expansion*	\$2,000	0%	\$0
2	Sedation	\$100	0%	\$0
Total		\$2,830		\$0

Annual Cap	Premium	Total 1 yr out of pocket by family
none	\$0	\$0

% of cost paid by family	0%
% of cost w/ premium paid by family	0%

*Must be deemed medically necessary according to Nevada handicapping labiolingual deviation index.

United Concordia Dental Center for Nonprofit Advancement				
Quantity	Service	Cost	Cost-sharing	Out of Pocket Cost
2	Exam & Cleaning	\$300	0%	\$0
1	X-Ray	\$30	0%	\$0
3	Filling	\$300	20%	\$60
1	Panoramic X-Ray	\$100	20%	\$20
1	Maxillary Expansion	\$2,000	100%	\$2,000
2	Sedation	\$100	50%	\$50
Total		\$2,830		\$2,130
	Annual Cap	Premium	Total 1 yr out of pocket by family	
	\$2,000	\$585		\$2,715
		% of cost paid by family		75%
		% of cost w/ premium paid by family		96%

Considerable variability (from \$0 to \$2,700) exists for family out-of-pocket expenses when comparing across benchmarks. Families of children with more significant restorative needs than are demonstrated above would experience substantially higher out-of-pocket expenses due to their responsibility to pay the full cost of services after the annual cap is reached. In the case of CHIP, States establish procedures to waive the maximum caps but it is unclear how final CHIP regulations will deal with meeting the dental benefit definition defined in CHIPRA with annual caps. Finally, the example of a small business plan demonstrates the concerns outlined above that a benefit package in the small group market can easily provide less benefits for a higher price.

We hope this information will be useful to organizations seeking to ensure that the pediatric dental benefit created by ACA is implemented in a way that is that not only provides states with flexibility and value but also benefits children and families. Please do not hesitate to contact us at creusch@cdhp.org or 202.417.3595 with any questions.

ⁱ National Association of Dental Plans and Delta Dental Plans Association. *Offering Dental Benefits in Health Exchanges: A Roadmap for Federal and State Policymakers*. September 2011, available at: <http://www.nadp.org/Advocacy/HealthCareReform/ExchangeWhitePaper.aspx>.

ⁱⁱ Centers for Medicare and Medicaid Services (CMS), *Dear State Health Official Letter*, October 7, 2009, SHO#09-012, CHIPRA #7.

ⁱⁱⁱ Essential Benefit sign-on letter. September 2011, available at: http://www.cdhp.org/resource/dental_benefit_consensus_letter_secretary_sebelius.

^{iv} National Association of Dental Plans and Delta Dental Plans Association, op cit.

^v US Office of Personnel Management (OPM) website: <http://www.opm.gov/>.

^{vi} National Maternal and Child Oral Health Policy Center and National Academy for State Health Policy. *CHIP Dental Coverage: An Examination of State Oral Health Benefit Changes as a Result of CHIPRA*. December 2011, available at: <http://nmcohpc.net/2011/chip-dental-coverage-examination-state-oral-health-benefit-result-chipra>.