



# ACA & DENTAL COVERAGE

## THE BASICS

*The Affordable Care Act (ACA) requires Americans to purchase health coverage in 2014 and thereafter or pay a fine. Health coverage is defined as medical coverage offered through employers or public programs as well as individual policies. For the small group and individual market and Exchanges, the ACA sets a specific group of benefits, i.e. Essential Health Benefits (EHB) as the minimum health coverage that can be offered in those markets. Part of this set of benefits is “pediatric services, including oral and vision care.”*

**WHO GETS DENTAL COVERAGE UNDER THE ACA:** Children’s dental services are included as part of the Essential Health Benefit (EHB) package. So, ***children in segments of the population where the EHB package is required will have dental coverage offered as part of their health benefits.***

- The PEW Center on the States estimates that about 5.3 million additional children will get dental coverage under the ACA, although most will be added to public programs.

**WHERE IS THE EHB REQUIRED TO BE OFFERED?** The Essential Health Benefit package is the minimum package of benefits to be offered through Exchanges and in the small group and individual market outside of Exchanges. So this part of the market will have children’s dental services offered as part of the package of benefits to meet the mandate to buy coverage.

While the ACA defines small group as 100 or fewer, states define their small group markets as 50 or fewer. States can keep the definition of small group at 50 until 2016. For 2014 all states have maintained the small group market at 50 or fewer. ***So, in 2014, EHB will be offered at minimum to individuals, to employers of 50 or fewer and to anyone purchasing coverage through Exchanges.***

**IS CHILDREN’S DENTAL A REQUIRED OFFER FOR ALL CHILDREN UNDER THE ACA?** No, children that have coverage through a family member employed by a large employer are not required to have dental services offered to them under the ACA. However, most large employers offer dental coverage to their employees and families and often contribute to that coverage (see chart on page 3).

**WHAT WILL BE COVERED AS PEDIATRIC ORAL SERVICES?** This is a state-by-state determination. Each state sets its own package of “essential health benefits (EHB)” within HHS’s guidance. HHS’s guidance recommends that state CHIP programs or the largest dental plan offered through FEDVIP<sup>1</sup> as guides for children’s dental benefits if a state’s selected medical benchmark does not include children’s dental services.

The expectation for children is that the dental procedures that are covered will be fairly similar to those covered today under separate commercial dental policies or CHIP programs. HHS guidance however does restrict orthodontia (braces) to that which is medically necessary when it is covered. HHS did not define “medical necessity,” so the level of orthodontia coverage will either be state determined or defined by each carrier.

States that have finalized their EHB benchmark are generally selecting state CHIP programs to define children’s dental services (see [NADP US Map of Dental Benefit State Decisions](#)). As states have broad latitude to select benchmarks, at least one state has selected a benchmark that only covers semi-annual dental preventive visits with x-rays and sealants. Some states specifically include coverage of medically necessary orthodontia and some do not. State CHIP programs include a wide range of criteria for medically necessary orthodontia from coverage only for cleft palate to various levels of malocclusion measured on various indexes like Salzmann.

HHS's final EHB Rules set FEDVIP as the default dental benchmark for states that do not make a benchmark selection and have their Exchanges run as a Federally Facilitated Marketplace (FFM).

**WHAT COST SHARING WILL BE APPLIED?** HHS regulations on Exchanges eliminate annual and lifetime limits on coverage for pediatric dental services that are defined as part of the EHB package. HHS regulations on EHB require a separate "reasonable" annual maximum out-of-pocket (MOOP) consumer cost sharing limit<sup>ii</sup> for separate dental policies covering pediatric dental. Each state makes the determination for what is "reasonable."

NADP recommended, based on analysis by Milliman, that "reasonable" be defined initially as \$1000 per child in 2014 and indexed thereafter for inflation. The \$1000 limit allowed the plan design for an 85% actuarial value plan to be equal to typical commercial dental policies today. Many states have adopted \$1000 per child (\$2000 per family) as the pediatric dental OOP limit.

Initially, the FFM set the OOP limit for dental at \$1000. In response to concerns that the dental limit is an addition to the medical OOP limit set by statute<sup>iii</sup>, the CCIIO Annual Letter to Issuers lowered the dental OOP limit to \$700 per child (\$1400 per family) for 2014; this OOP limit will be utilized by states with exchanges run as FFMs. This lower OOP limit requires adjustments in deductibles or cost sharing on preventive and basic services to meet the two required actuarial value levels (70% and 85%) for pediatric dental coverage. As a result in these states 98% of consumers purchasing Exchange-certified pediatric dental coverage will have higher out-of-pocket costs under separate dental policies offered on Exchanges than they do today (see NADP Memo on [Dental Costs under the ACA](#)). The other 2% of consumers purchasing pediatric dental coverage separately in Exchanges will have lower OOP expense for high cost dental procedures—like medically necessary orthodontic treatment—than their peers who obtain dental coverage through large employers.

For 2014 only, when pediatric dental is included as part of a medical plan, HHS guidance allows a medical plan that uses a subcontractor to service that dental benefit to separately accumulate consumer dental OOP costs to the statutory limits for a medical plan, i.e. \$6350 for an individual or \$12500 for a family. This is in addition to the major medical coverage under the medical plan accumulating consumer OOP costs to those same statutory limits. In other words, the consumer could have two full MOOP's of \$6350 or \$12,500 in 2014 when dental is embedded in a medical plan. This allowance was made as less than 1% of dental coverage is embedded in medical plans today and carriers could not develop methods of accumulating to a single consumer OOP maximum in time for product sales for 2014.

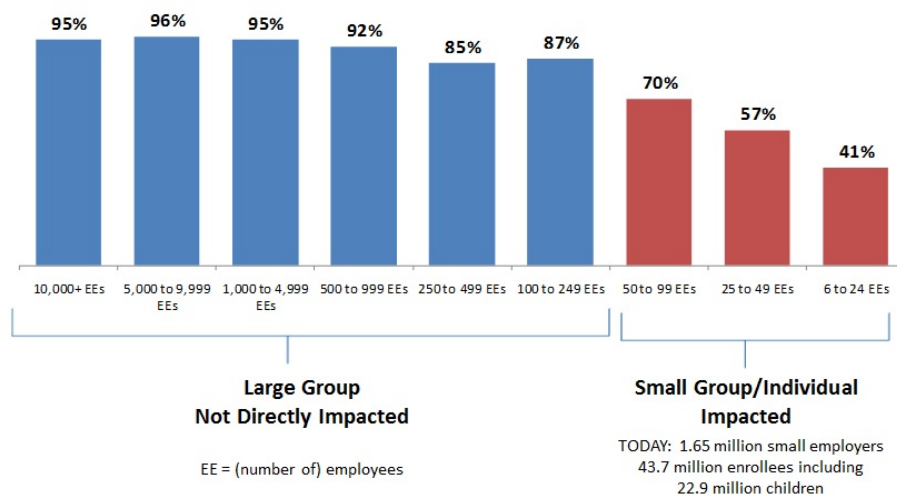
**HOW WILL THESE CHILDREN'S DENTAL BENEFITS BE OFFERED?** Today, 99% of dental benefits are sold under a separate policy from medical coverage. In fact almost 44 million consumers working for employers of 100 or fewer have separate dental coverage today. Less than 1% of consumers have dental benefits as part of their medical policies.

In Exchanges, consumers will continue to have these options, i.e. children's dental benefits in their medical policies or a medical policy plus a separate dental policy covering their children. In most state Exchanges, including those operated as FFMs consumers will also have the option of adding dental coverage for themselves, their spouses and dependents that do not qualify for pediatric dental services.

In the small group and individual market outside of Exchanges, the ACA makes a change in the way coverage is currently offered in 2014. It requires ALL medical policies offered to consumers to include children's dental coverage or the medical carrier must get "reasonable assurance" that the consumer purchases an Exchange certified stand-alone dental plan. This impacts the separate dental policies that now cover 22.9 million children in the small group and individual market (see chart on next page. These policies will either be duplicated by

medical coverage or they will need to be altered to make coverage Exchange compliant with respect to individuals under 19.

### Employers Offering Dental



HHS final EHB rule was not specific on what constitutes reasonable assurance. Some states are defining reasonable assurance as a notice to consumers while others indicate that an attestation on applications or some other form is needed.

To avoid duplication in premium costs and coverage in 2014, consumers with separate dental policies will have to decide whether to continue those policies for their children under age 19. One key issue in making

this decision is whether the dentist their children now see is in the network of the medical carrier. Another is the scope of benefits set by the state for children's dental services that is covered under the medical plan as some states will offer limited dental benefits for children. Finally consumers should examine the coverage under a medical plan to determine if it is subject to the full medical deductible and OOP limits. Given only 30% to 40% of consumers hit a medical deductible today and fewer (7% to 12%) hit their OOP medical limits, subjecting pediatric dental services to medical deductibles and MOOP limits could result in children's dental services being paid almost exclusively out-of-pocket when the family does not have significant medical expenses.

If consumers decide to drop their children from their dental policy, NADP consumer surveys show about half of covered adults will consider dropping their separate dental policy altogether. NADP estimates that this could result in 10 million fewer adults with dental coverage over the first few years of ACA implementation. Today 60% of the population is covered by dental benefits; every 3 million insured or uninsured changes this by 1%. If 5 million gain coverage, then about 62% of the population would be covered, but if 10 million also drop coverage, there will be a net loss in the number of Americans with dental benefits dropping to about 59%.

Any loss in coverage results in a decline in the overall oral health of Americans as lack of insurance is cited by consumers as the top reason for not visiting the dentist. Declines in oral health can impact overall health and the ability of individuals to be productive at work or school.

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<sup>i</sup> CHIP is the Children's Health Insurance Program; FEDVIP is the Federal Employees Dental and Vision Insurance Program. Specifically the FEDVIP dental plan with the highest enrollment is specified, i.e. the MetLife High Plan for 2012.

<sup>ii</sup> An annual consumer cost sharing limit caps the out-of-pocket expense a consumer will spend. Beyond that limit the insurer pays for all dental services for the balance of the year. This is sometimes referred to as an OOP limit or "out-of-pocket" limit. It should not be confused with a deductible which is the amount a consumer pays before a carrier pays for any portion of services.

<sup>iii</sup> The ACA links the OOP limit for medical plans to the limit in the IRS limits for contributions to Health Savings Accounts (HSA) linked to high deductible health plans. In 2014, the OOP limit is \$6,250 for self-only and \$12,500 for family and is adjusted annually for inflation.