

Fulfilling the Promise of Children's Dental Coverage

by Colin Reusch and Joan Alker

Second in a series of briefs on the future of children's health care coverage



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ABOUT THIS SERIES

This issue brief is the second in a series of papers from Georgetown University Center for Children and Families on the future of children's health coverage. The first brief, [The Future of Children's Coverage: Children in the Marketplace](#), focused on ways to improve marketplace coverage and the associated financial assistance for children. This second brief, written in partnership with the Children's Dental Health Project, focuses on pediatric dental coverage and ways to improve children's oral health.

INTRODUCTION

Tooth decay remains the most common chronic condition among children and teens, and it disproportionately affects low-income and minority families.¹ Failure to identify, treat, and prevent dental disease can result in extremely serious health problems for children as well as costly, long-term consequences as it impairs children's ability to eat, sleep, and perform up their potential in school. However, tooth decay is largely preventable early in life, and children who have dental coverage are far more likely to receive appropriate services than those who are uninsured.² Therefore, it is critical to expand dental coverage for children while maintaining and improving coverage options for those who are currently insured.

In the years since the passage of the Children's Health Insurance Program (CHIP) and the Affordable Care Act (ACA), the share of children without dental coverage has been cut by more than half.³ However, that coverage, more than any other aspect of health insurance, varies greatly in terms of comprehensiveness and affordability. There are a number of opportunities to improve how oral health care is delivered to children and adolescents in the health insurance marketplaces, CHIP, and Medicaid.



Marketplace Coverage under the ACA

The 2010 passage of the ACA represented an historic achievement for numerous reasons, not least of which was its focus on oral health. As a result of the ACA, for the first time, families purchasing coverage on their own or receiving it through a small employer are guaranteed a set of essential health benefits (EHBs) that must be offered in all private insurance packages. Congress explicitly included oral health coverage for children in the EHBs: “Pediatric services, including oral and vision care.”⁴ However, the implementation of this provision of the law has resulted in a number of complications affecting both the comprehensiveness and affordability of dental coverage under the ACA.⁵

Affordability and Consumer Protection

The ACA states that pediatric dental coverage can be offered “either separately or in conjunction with a qualified health plan [QHP],”⁶ allowing stand-alone dental plans to participate in the health insurance marketplaces to provide that aspect of EHB coverage. The regulations implementing the ACA stipulate that if there is at least one stand-alone dental plan providing pediatric dental benefits in the marketplace, QHPs are exempt from the requirement to include such benefits in their products.⁷ As a result, in the federally facilitated marketplace and in many state-based marketplaces, there is a mixed set of offerings for children:

- QHPs that include or “embed” pediatric dental services;
- Stand-alone pediatric dental plans;
- Stand-alone family dental plans that include pediatric dental coverage; and
- QHPs without any pediatric dental services.

These options vary widely, depending on where families live. In some areas, families looking to purchase dental coverage for their children must do so through a stand-alone dental plan, incurring additional cost-sharing burdens and paying an average of nearly \$30 per child, per month in

additional premiums—with no additional tax credit to help cover these costs.⁸ *Children only account for about 8 percent of the total enrollment in marketplace stand-alone dental plans.*⁹

QHPs that embed pediatric dental benefits provide the full range of consumer protections and affordability measures to families. Furthermore, if they are structured appropriately, QHPs can provide the same level of coverage as a stand-alone dental plan with little impact on overall premiums and out-of-pocket costs for families. While some QHPs subject dental services to the full medical deductible, an increasing number of insurers are exempting pediatric dental services from deductibles altogether, making services more affordable for families.¹⁰

While the law was intended to allow for a variety of pediatric dental offerings in the marketplaces, the consequences have been far more complicated:

- Families purchasing their children’s dental coverage through a stand-alone dental plan are not guaranteed the full range of consumer protections established by the ACA, such as guaranteed rates and the right to an external appeals process.¹¹
- Cost-sharing reductions for low-income families do not apply to stand-alone dental plans. Subsequent regulations have established a separate maximum out-of-pocket limit (MOOP) for stand-alone pediatric dental coverage (on top of the law’s previously established MOOP for QHPs).
- The IRS ruled that the cost of stand-alone pediatric dental coverage could not be included in the calculation of premium tax credit amounts.

Altogether, these factors erect a considerable barrier to affordability for families purchasing dental coverage through stand-alone plans in the marketplace.¹²



States that stand out as exemplars for how to provide children's dental coverage in the marketplace include California, Connecticut, Maryland, and the District of Columbia. Each of these states implemented standard plan designs that shield pediatric dental services from high medical deductibles while incorporating them into QHPs. While the law allows state-based marketplaces greater flexibility, the federal government could ensure that families shopping on the federally facilitated marketplaces receive more comprehensive and affordable dental coverage for their children through a similar approach. In fact, recent guidance from the Department of Health and Human Services (HHS) laid out options for standard plan designs for QHPs offered on the federally facilitated marketplaces; however, it is unclear how these designs will address pediatric dental benefits when implemented.¹³ Including pediatric dental benefits in standard QHP designs and exempting those services from the medical deductible would ensure that every child enrolled in coverage through the federally facilitated marketplace would have comprehensive dental coverage at no additional cost to the family, thereby ensuring that all families benefit from the consumer protections and affordability measures established by the ACA.

Child-Focused Benefits

Even an ideal approach to dental coverage through standard plan designs with embedded pediatric dental benefits may fall short of ensuring that all children receive the care that they need given existing EHB guidelines. The current benchmark approach and lack of specified services for children presents families with plans that are not tailored to kids' needs.

Following the passage of the ACA, instead of outlining specific EHB services, HHS allowed states to choose from a set of predetermined benchmark plans as a means of identifying which services must be covered by private health and dental insurers in the new health insurance marketplaces.

Recognizing that most of these benchmark health plans did not appropriately cover pediatric dental benefits, HHS established supplementary EHB benchmarks for pediatric dental coverage, namely the Federal Employee Dental and Vision Insurance Program (FEDVIP) and the dental services outlined in separate state CHIP programs—many of which also use a benchmark approach for covered services. While these supplementary benchmarks tend to be fairly comprehensive in terms of the covered services, they are based on a rigid, one-size-fits-all approach to oral health care, largely ignoring the fact that dental caries, the disease that causes tooth decay, takes hold early in life and must be managed as a chronic condition. Children at higher risk for caries (e.g., those with early signs of tooth decay, lack of access to fluoride, or a diet high in sugar) may need more frequent dental visits and additional interventions—such as counseling or fluoride treatments—to keep the disease from progressing. As implemented, the benefits on paper are a stark departure from the benefits envisioned by the ACA and, certainly, from those required under Medicaid.

First, the current benchmark selection process does not ensure that all children have comprehensive coverage. For example, as its EHB benchmark, Utah selected a state employee health plan that covers only basic preventive dental services, such as cleanings and x-rays, but that excludes any medically necessary restorative or orthodontic care.¹⁴ Utah was not required to select a supplementary pediatric dental benchmark that would have provided more comprehensive coverage. As a result, children receiving coverage on the Utah marketplace are left without the full range of dental services they need to maintain optimal oral health.

Second, the oral health needs of individual children vary greatly, just as their need for many pediatric services do. Clinical guidelines from the American Academy of Pediatric Dentistry (AAPD) and the American Academy of Pediatrics (AAP) recommend



that oral health services be tailored to each child's individual risk level for disease, based on the findings of an oral health risk assessment.¹⁵ Higher-risk children may need to receive fluoride varnish or other dental services numerous times within a given plan year, while lower-risk children may only need to visit the dentist once or twice a year. Unfortunately, the current plan structures in both the EHB benchmarks and actual insurance plans offered on the marketplace typically apply a one-size-fits-all approach—relying on the outdated model of care by which every child receives services every six months, regardless of the child's risk level for dental disease.

In addition, the ACA established a set of preventive services that must be covered by all private health plans at no cost to enrollees. Included in this list are all “A” and “B” recommendations by the U.S. Preventive Services Task Force, as well as the comprehensive guidelines supported by the Health Resources and Services Administration, which are known as the AAP Bright Futures Guidelines. Unfortunately, the final regulations for preventive services under the ACA referred only to the Bright Futures periodicity schedule, leaving out the full range of oral health services recommended for children.¹⁶

What Does the Affordable Care Act Require for Children?

The ACA requires that private health insurers cover certain oral health services with no out-of-pocket costs for children and families. These services include the following: fluoride varnish application for all children through the age of 5 by a physician, fluoride supplements for children living in areas without community water fluoridation, and oral health risk assessment by a physician and referral to a dentist.

However, these services are only a small piece of what children should be receiving. The AAP's Bright Futures guidelines outline a comprehensive set of oral health services that should be provided to children by a combination of medical and dental professionals.

Data and Evaluation

The ACA holds great promise for expanding affordable, comprehensive, and age-appropriate oral health coverage to nearly all children nationwide. However, at this point, it is difficult to evaluate the success of the law because relatively little data have been made available by HHS. Current enrollment reports do not provide detailed information about pediatric dental coverage enrollment. Although the percentage of QHPs with embedded pediatric dental coverage in the marketplaces increased during the 2015 plan year, no data have been released to help assess the impact of this trend. This major gap in available data makes it difficult—if not impossible—to determine whether and how families are purchasing dental coverage for their children and, more importantly, what factors may be influencing their choices. Future marketplace enrollment reports should provide detailed information on dental insurance enrollment in both state-based and federally facilitated marketplaces, including QHPs that embed pediatric dental coverage.

While enrollment data offer a good starting point to assess whether children have access to dental coverage, such data are not a proxy for measuring the extent to which children are receiving the services they need. The Marketplace Enrollee Experience Survey should—but does not currently—include questions about children's dental services.^{17, 18} Moreover, only one dental-related performance measure—the percent of children between the ages of 2 and 20 who received an annual dental visit—is included in the criteria used in the star quality rating system (QRS) that is under development to assist consumers in evaluating different QHPs.¹⁹ However, child-only plans and stand-alone dental plans are excluded from the Consumer Experience Survey and the QRS. The federal marketplace should consider following the lead of California's state-based marketplace, Covered California, which has adopted the pediatric dental measures starter set developed by the Dental Quality Alliance, an organization initiated by CMS and tasked with developing quality measures for oral health.²⁰



CHIP: Bridging the Gap

More than 8 million children have dental coverage financed through the Children's Health Insurance Program (CHIP). In November 2015, the Centers for Medicare and Medicaid Services (CMS) released a long-awaited certification report comparing health plans in the ACA's health insurance marketplaces to the coverage offered by separate CHIP programs, and in May 2016, the Assistant Secretary for Planning and Evaluation (ASPE) released a related background paper providing more detail on the certification report. Both reports concluded that children's coverage under CHIP is more comprehensive and far more affordable than coverage under plans available through the marketplaces.²¹ Dental benefits were cited as a key area of disparity between the two coverage options. This finding supported analyses by the Medicaid and CHIP Payment and Access Commission (MACPAC), the Government Accountability Office (GAO), and members of the children's health community.²²

If funding for CHIP is extended, there will be opportunities to improve how dental care is provided in the program. The 2009 reauthorization of CHIP defined a new statutory standard that requires separate CHIP programs to cover dental services *"necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions."* States can demonstrate compliance with this definition by covering a pre-defined range of dental service categories or they can adopt a dental benchmark plan. However, dental

benefits based on private insurance benchmarks typically do not adequately tailor care to the needs of individual children and may not meet the statutory standard above. Furthermore, in contrast to Medicaid and EHB coverage, CHIP rules still allow for annual dollar limits on dental services, which may pose a financial barrier to obtaining necessary oral health care and thus fall short of the statutory standard.

In order to ensure compliance with the statutory standard and current best practices in dental coverage design, CMS should issue regulations that clearly outline the coverage options for states. First, CMS should allow for a benefit design that creates greater flexibility in providing care according to each child's needs in order to better align separate CHIP programs with Medicaid and Medicaid Expansion CHIP programs, which adhere to Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements, and with current best practices.²³ Second, CMS should eliminate dollar limits on dental coverage in order to adhere to the statutory standard and place CHIP families on an equal footing with those enrolled in Medicaid or marketplace plans. Third, CMS should clearly define how states may adopt a benchmark plan while maintaining compliance with the statutory standard. Finally, CMS should improve data reporting in order to ensure that there are reliable data on access to dental care in separate CHIP programs, enabling stakeholders to evaluate consumer experience in CHIP compared to Medicaid and private insurance coverage.

Medicaid: The Need to Align Policies

Nearly 37 million children rely on Medicaid to cover needed dental services, and there are some indications that access to basic oral health services has improved in recent years.²⁴ Over the last decade and a half, most state Medicaid programs have been able to increase the proportion of kids receiving at least one preventive dental service.²⁵ In addition, CMS recently finished a five-year-long Oral Health Initiative during which improving access to preventive dental care was a priority.²⁶ These efforts have put some state

Medicaid programs on par with private insurance in terms of annual dental visits for children. However, on their own, annual preventive dental visits are insufficient to prevent tooth decay or manage caries as a chronic condition, and Medicaid could do more to provide a comprehensive approach to oral health care.

Medicaid programs are required to provide dental services "both (1) at intervals that meet reasonable standards of dental practice and (2) at other intervals



as indicated by medical necessity.” However, a recent report by the HHS Office of Inspector General (OIG) suggests that access to necessary services is still lacking, especially with regard to the comprehensiveness and appropriateness of care. The OIG report focused on four states (California, Indiana, Louisiana, and Maryland) and exposed significant issues:²⁷

- 78 percent of children enrolled in Medicaid across these four states did not receive dental care in accordance with the states’ periodicity schedules;
- 28 percent of enrolled children did not have a dental visit at all during that time period; and
- Two of the four states had reimbursement policies that were in direct conflict with their Medicaid dental periodicity schedule, preventing them from paying for certain outlined services.

HHS encouraged the formation of the Dental Quality Alliance (DQA), an initiative of the American Dental Association, to advance quality measurement for children’s oral health services. The DQA, which involves a broad group of pediatric stakeholders, has fostered the creation of a 10-measure starter set of pediatric dental measures.²⁸ Yet, the Child Core Set of Health Care Quality Measures for children enrolled in Medicaid and CHIP includes only one of the DQA’s measures—dental sealants for 6- to 9-year-old children at elevated caries risk, which is new for the 2015 reporting period. The other dental measure in the child core set is the percentage of eligible children who received a preventive dental service, which is drawn from state-required reporting on EPSDT. In looking forward, HHS should encourage the development of a measure that evaluates whether children are receiving a risk-based oral health assessment as recommended by the AAPD and AAP.

Children from low-income and minority families are disproportionately affected by tooth decay. Given that Medicaid serves a population with greater need, it is troubling that even when children see a dentist, many of them do not receive the range of services recommended by professional guidelines. Moreover, children under the age of 3 are the least likely to receive dental care. Because tooth decay is a disease

process that can start in infancy, not receiving a dental visit until the age of 4 or later means the disease may have already progressed to form cavities.²⁹ Dental disease that starts in childhood may have long-term impacts. Both children and adults report impaired social functioning, such as avoiding laughing or smiling, due to perceived poor appearance of teeth. Additionally, untreated dental disease leads to tooth loss of both primary and permanent teeth, which can hamper the ability to eat a varied diet that meets nutritional guidelines.³⁰

State Medicaid programs can take advantage of a new opportunity to better meet the needs of children by aligning their policies with established clinical guidelines and incentivizing clinical approaches that will prevent and manage tooth decay. HHS created this opportunity and increased flexibility for state Medicaid programs when the agency approved the new caries risk assessment codes allowing states to receive federal matching funds for a wider range of oral health services. This new policy is based on the latest research in evidenced-based clinical care and the premise that services should be based on individual needs.

In addition, because many children do not see the dentist in the first few years of life—especially those with lower incomes who are enrolled in Medicaid—the engagement of primary care and non-dental providers is almost certainly an opportunity to provide preventive care outside of the dental office before tooth decay becomes a problem. Furthermore, CMS can incentivize innovation in oral health care by restructuring the next iteration of its Oral Health Initiative so that state programs are measured in a manner that reflects appropriateness of care.

Recommendations

Since enactment of the Children’s Health Insurance Program and the Affordable Care Act, millions of American children have gained dental coverage. But that coverage varies from state to state: Coverage is not always as comprehensive as it ought to be and is too often unaffordable for families. Policymakers at the state and federal levels have options available to them that could vastly improve the delivery of children’s oral health care.



Policy Options to Strengthen Children's Dental Coverage

Options for Federal Agencies

- HHS should establish a standard plan design for QHPs in federally facilitated and partnership marketplaces. This standard plan should be similar to those of states like California, Connecticut, and Maryland, and the District of Columbia, which include comprehensive pediatric dental coverage and protect children's dental services from high deductibles. In addition, future marketplace enrollment reports should provide detailed information on dental insurance enrollment in both stand-alone and embedded plans.
- HHS should not exempt child-only plans and stand-alone dental plans from the QRS and QHP Enrollee surveys. Additionally, the federal marketplace should incorporate the DQA pediatric measures in the QRS.
- The IRS should revisit the regulations on Health Insurance Premium Tax Credits and allow for the inclusion of all pediatric dental coverage options as part of the tax credit calculation. This would enable all families to receive the full tax credits to which they should be entitled.
- HHS should expand the preventive services regulations to add all oral health services included in the guidelines supported by the Health Resources and Services Administration (i.e., Bright Futures). This will help ensure that tooth decay is treated like any other chronic condition.
- CMS should issue regulations implementing the dental coverage standard in CHIP as outlined in the Children's Health Insurance Program Reauthorization Act of 2009.
- CMS should encourage state Medicaid programs to align policies and care delivery with established clinical guidelines and should facilitate states' ability to refine their Medicaid programs to strengthen oral health among preschool-age children. For example, CMS could enhance its Oral Health Initiative to measure appropriateness of care through receipt of services based on risk assessment.
- CMS should foster the development of a measure that evaluates whether children are receiving a risk-based oral health assessment, as recommended by the AAPD and AAP. Such a measure, along with other DQA pediatric dental measures, should be considered for inclusion in the child core set. Moreover, reporting on the child core set should become a mandatory requirement for states.

Options for Congress

- Congress should direct HHS to conduct a review of the EHB in 2016 with specific attention to pediatric services and professional guidelines on pediatric oral health care.
- Congress should instruct HHS to release detailed enrollment data for pediatric dental coverage, including enrollment in stand-alone dental plans and QHPs that embed pediatric dental coverage, by age, state, plan, race and income.

Options for States

- States should adopt a dental periodicity schedule for their Medicaid/CHIP programs that requires caries risk assessment and treatment plans that reflect a child's risk for dental disease. Furthermore, states should align their payment policies and contracting arrangements with these guidelines.
- States should refine Medicaid/CHIP policies to encourage and incentivize the use of oral health risk assessments and fluoride varnish by pediatricians. Moreover, states should adopt the American Dental Association's dental billing codes for caries risk (CDT codes D0601, D0602, and D0603) and reimburse these services.
- States should work to report accurately on the new dental sealant Core Set measure and consider adopting additional Dental Quality Alliance measures for performance indicators in oral health moving forward.



Endnotes

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Center for Children and Families
Health Policy Institute
Georgetown University
Box 571444
3300 Whitehaven Street, NW, Suite 5000
Washington, DC 20057-1485
Phone (202) 687-0880
Email childhealth@georgetown.edu



ccf.georgetown.edu/blog/



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