



Dental Benefits in Health Insurance Marketplaces: An Update on Policy Considerations

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Introduction

The Affordable Care Act (ACA) includes pediatric dental services as one of ten Essential Health Benefits (EHBs) that health plans in the small group and individual markets must cover. Adult dental services are not required, but are being offered by marketplace plans as well. However, the way that the ACA structures dental coverage has created a number of implementation challenges relating to affordability, benefit design, and consumer experience.

In 2014, the National Academy for State Health Policy (NASHP) examined these issues in a comprehensive report.¹ In early 2015, NASHP convened a follow-up call with marketplace and dental leaders to discuss progress on addressing these issues.

This brief provides an update of current activity across the marketplaces. Key issues addressed include:

- Impact of decisions to offer pediatric dental coverage through medical plans or stand-alone dental products on affordability and implementation of marketplace systems;
 - State interest in offering optional adult dental coverage;
 - Enhancing data and reporting on access to and purchase of dental coverage;
 - Improving outreach, enrollment, and dental plan quality;
 - Impact of future state and federal decisions about coverage programs on dental coverage through marketplaces, including decisions about federal funding for the Children's Health Insurance Program (CHIP).
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Dental Plan Design and Enrollment

Dental benefits are treated differently than other EHBs offered by certified marketplace plans, otherwise known as Qualified Health Plans (QHPs). Dental benefits may be offered alongside, or “embedded” with medical benefits, or offered separately through a stand-alone dental plan (SADP).

This structure has remained basically unchanged over the first years of marketplace operation, and several key issues raised in NASHP’s 2014 report remain true:

- If an SADP is offered on a marketplace, QHPs generally have an option not to cover the dental Essential Health Benefit for children.²
- Families seeking coverage for their children on the marketplaces are not required to purchase stand-alone dental coverage, except in a few states that instituted requirements to purchase dental coverage. This could result in families opting not to purchase “essential” dental coverage for their children.
- The cost of stand-alone dental coverage is not factored into the calculation of Advance Premium Tax Credits (APTC), which means financial support may not be available to help subsidize the purchase of children’s dental coverage.

According to recent federal reports, approximately 11.7 million consumers are enrolled in QHPs. Of these, 1.4 million are enrolled in SADPs. Approximately 1.38 million of those enrolled in SADPs came through the 38 states that use the federally-facilitated marketplace (FFM) platform.³ An additional 25,000 people are enrolled in SADPs through the 13 states that run State-based marketplaces (SBMs). According to dental plans this projection may be low due to limitations of data available from the SBMs.

Young adults ages 26-34 were the most likely group to purchase stand-alone dental coverage, with 302,000 individuals (20 percent of enrollees) on the FFM opting to purchase stand-alone dental coverage. Fourteen percent of enrollees ages 0-18 (approximately 100,000 enrollees) on the FFM enrolled in an SADP.⁴ As in the 2014 report, there are no data currently available in either SBM or FFM states to document the number of children enrolled in QHPs with embedded dental benefits, creating an incomplete picture of how many children are enrolled in coverage for all 10 EHBs.

In most states, a mix of embedded and stand-alone plans were offered during the 2014-15 open enrollment period. Exceptions include Alaska, California, Connecticut, Vermont, and West Virginia, which embedded pediatric dental benefits in all QHP offerings. California did not require, but strongly encouraged embedded models in its solicitation for 2015 plan offerings. In Arkansas, New Mexico, and Washington, QHPs did not embed pediatric dental, and the marketplace only offered SADPs. Washington required dental to be offered and priced separately from medical coverage per their 2013 marketplace legislation. An American Dental Association (ADA) analysis of 40 states found that on average, 35.7 percent of medical plans embedded pediatric or family dental benefits in the 2015 plan year.⁵ In 2016, all states using the FFM platform will offer at least one SADP.⁶

Adult Dental Benefits

Since the ACA’s launch, focus has largely been toward meeting, improving, and evaluating the basic requirements of the marketplaces. However, states have expressed interest in adding or enhancing adult and family dental offerings in the marketplaces. This may be reflective of a high level of unmet need among marketplace customers. A recent survey found that more than 20 percent of adults – including almost 24 percent of those with medical insurance between 138 and 400 percent of the Federal Poverty Level – reported forgoing dental care because of cost.⁷

The ADA found that marketplaces were offering more family SADPs in the 2015 plan year, and attributed the growth to interest in dental coverage among young adults.⁸ As noted above, federal data during the second open enrollment show that young adults ages 26-34 are the most likely to purchase stand-alone dental coverage.⁹ Family coverage is the only vehicle to provide SADP adult benefits through marketplaces. Since all SADPs must include the pediatric EHB, the product must either be child-only or “family” coverage. QHPs can opt to embed adult dental benefits, similar to pediatric benefits, but this is rare.

Kentucky, Massachusetts, Minnesota, New York, Oregon, Vermont, and the District of Columbia have offered SADPs that include adult benefits since the marketplaces opened in 2013. Other states, like Idaho, direct consumers to purchase adult coverage directly through carriers, sometimes via websites external to the marketplace. Connecticut followed this model during the first open enrollment period, but during the second, transitioned to offering dental coverage for adults directly through the marketplace. Similarly, Maryland directed consumers to purchase adult dental directly from carriers with certified plans. But for the 2015-16 open enrollment, the state has improved its system so now the marketplace is capable of offering adult dental coverage. California began offering stand-alone family plans, inclusive of adult coverage, during the 2015-16 open enrollment period. The state plans to extend regulations and consumer protections to plans similar to those that exist for its medical health insurance plans. Washington intends to offer family dental plans on its marketplace, contingent upon the identification of a funding source to offset operational costs associated with offering adult dental benefits.

Premium and Cost Sharing Calculations

Nearly 86 percent of individuals that enrolled in coverage through the marketplaces qualified for financial assistance, mainly through APTC.¹⁰

For dental benefits, financial assistance is only available for children’s dental benefits, though federal rules limit the applicability of APTC to premiums for stand-alone dental coverage. A marketplace’s approach to embedded plans can affect how APTC is calculated, as well as how the credit is used to help offset costs of dental premiums (see text box on next page). It is also important to note that consumers enrolling in silver plans can also receive cost-sharing reductions (CSRs) to reduce out of pocket costs. CSRs can be applied to pediatric dental benefits in embedded plans, but are not available for stand-alone dental benefits.

During the first and second years of open enrollment, this complicated situation presented technical hurdles to some states that offered SADPs including Kentucky, Rhode Island, and Washington. Marketplace staff in Kentucky hand-adjusted APTC amounts for families to support payment of SADPs. Similarly, this issue factored into California’s decision to request all QHP issuers embed pediatric dental benefits in the 2015 plan year.¹¹

Accessing Plan Cost and Affordability

Another key consideration with respect to embedded and stand-alone dental offerings is accurately assessing the affordability of each approach for marketplace consumers. This involves examining the total cost of dental benefits for consumers, inclusive of premiums and out-of-pocket costs. An analysis of 32 states by the ADA found that, in 2015, embedding pediatric dental benefits in silver-tier QHPs added \$16.21 to total monthly premiums. This was an increase from 2014, when dental benefits only added approximately \$6 to monthly premiums. This current cost is still below the average monthly premium rate for SADPs which is between \$27.61-\$35.95 per month.¹² The report also indicated that premiums differed widely across states and product-type. For example, in 10 states, average premiums for QHPs that embedded pediatric dental benefits were lower than for plans that did not embed pediatric dental.

Calculating APTC

- Calculation of an individual's APTC is based on the premium of the second-lowest cost silver-level QHP in a state's marketplace, regardless of whether that QHP includes dental benefits. When the pediatric dental EHB is embedded in this QHP, the APTC calculation is inclusive of the cost of the embedded dental benefit.
- If pediatric dental benefits are not included in this QHP, APTC calculations will not account for the additional premium costs associated with pediatric dental coverage.

Applying APTC to Premiums

- If APTC fully covers the premium cost of the QHP selected for a child, any additional tax credit may be applied to the child's SADP premium. (APTC is not available for adult dental benefits.)
- This is likely a rare occurrence, as silver-level plans are also the most popular plans, meaning that APTC often covers nearly the premium amount paid just for the QHP. Consumers who purchase lower-cost bronze plans are more likely to have APTC they can apply to SADP premiums.

Beyond premiums, overall costs associated with dental coverage, including deductibles and out-of-pocket spending, vary between embedded and stand-alone offerings. The ADA found that, among the embedded QHPs they studied, almost 90 percent had a single deductible (averaging over \$2,800) for medical and dental services, which could expose families of children with extensive needs for restorative dental services to high out-of-pocket costs. However, among these plans, about three-quarters had first-dollar coverage for preventive dental services (e.g., check-ups). The remainder of embedded plans established a separate dental deductible (averaging \$50), or exempted dental services from deductibles entirely. Stand-alone dental products, by comparison, were slightly less likely to have a deductible and first-dollar coverage for preventive services. Among those plans with a deductible, the average was \$63.

A recent study by the National Association of Dental Plans estimated that consumers with children with low dental needs may spend less out-of-pocket with an embedded plan, whereas consumers with children with high dental needs may spend less with a SADP.¹³ Maximum out-of-pocket costs for QHPs in 2015 are \$6,600 for individuals and \$13,200 for families; SADPs have separate out-of-pocket maximums of \$350 for one child, and \$700 for families with multiple children (see our April 2014 report for a full discussion of the interaction of QHP and SADP out-of-pocket maximums). Additionally, some have argued that the lower premium costs for embedded dental benefits may mask the true costs of dental benefits, since embedded premiums are paid by all plan enrollees, including adults who do not use pediatric dental services. This suggests that state and federal policy makers may wish to work with their QHP issuers to develop embedded plan offerings that protect consumers from high out-of-pocket costs, or maintain a mix of embedded and stand-alone products on marketplaces.

Data and Reporting

One issue of continuing concern is the availability and quality of data related to dental coverage in the marketplaces. As noted above, there are limited publicly available data that report enrollment in stand-alone dental coverage by state, and no publicly available information on enrollment in QHPs that embed dental benefits. Current enrollment data provides a national breakdown of SADPs based on age categories¹⁴ but no further details exist on enrollees to analyze trends or potential targets for enrollment. For example, little information is currently available about rates of individuals that drop dental coverage, leaving researchers with limited means to monitor sustained take-up of dental coverage particularly SADPs available for adults.

A suggested solution is to improve reporting options about dental plans through the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF), which is used to collect data about marketplace plans. Current reporting lacks mechanisms to share details regarding dental offerings including definitions of services and differentiations between basic and major dental care for children and adults. Furthermore, some state leaders noted limitations in the SERFF template that limits the ability of states to report if costs are attributable to child-only or family dental plans. Improved data and reporting will be necessary for states and other stakeholders to develop policies to promote improved dental coverage for consumers. Improved data and reporting could also be used to assist with development of improved customer-facing tools to assist consumers with the process of purchasing dental coverage.

Future Issues for Marketplace Dental Coverage

As the marketplaces continue to evolve in structure and operations, considerations about dental coverage may change as well.

Assessment and Monitoring of Plan Quality

Beginning with the 2016-17 open enrollment period, all marketplaces will be required to publically report quality ratings for each QHP.¹⁵ Currently, quality reporting requires only one pediatric dental measure, the Healthcare Effectiveness Data and Information Set (HEDIS) measure for annual visits for children. Long-term, some states are also considering how quality-rating systems can be used to influence consumer behaviors, not just for purchasing coverage, but also to improve efficiencies in how consumers seek and use care. California has taken a first step by adopting the Dental Quality Alliance (DQA) Pediatric Measure Set in its Qualified Dental Plan contracts for plan year 2016.¹⁶ Similarly, marketplaces may wish to consider standards for certifying dental plans, especially where they refer consumers to outside websites to purchase coverage. Such mechanisms can assure that

consumer protections and safeguards are in line with those enforced through QHPs. While quality measurement is still nascent in dentistry, the DQA developed seven National Quality Forum endorsed standardized measures including use of preventive dental services, continuity of dental care with a dental provider, and emergency room use for avoidable dental conditions.¹⁷ California plans to implement these measures across all of its QHPs.

Improving Enrollment In and Awareness of Dental Offerings

While Recognizing an interest in dental coverage from marketplace consumers, states are increasingly focusing marketing efforts that promote their dental offerings. In California, a study of strategies for marketplace consumers found that dental-specific marketing was one driver of consumers' considerations to purchase coverage. For the 2015-16 open enrollment period, the state released a "shop-and-compare" tool that includes new functionality to assess costs across dental plans,¹⁸ as well as releasing new dental-focused marketing materials. Kentucky plans to increase its dental-specific marketing efforts in counties with documented poor dental hygiene.¹⁹ Outreach will include distribution of 10,000 toothbrushes branded with the marketplace logo to area schools and health clinics.

Evolving Coverage Landscape

Several potential changes to the coverage landscape may also influence decisions about how and what dental coverage is offered through the marketplaces in the future. First, there are continuing conversations across states about whether marketplaces might offer stand-alone dental coverage to those who otherwise do not have access to it. In plan year 2014, for example, Nevada offered marketplace dental plans to adults enrolling in Medicaid, since Medicaid does not provide routine adult dental coverage.²⁰ Potentially, this strategy could be extended to individuals with medical coverage, but no dental coverage, or seniors, since dental benefits are generally not covered in basic Medicare.

Second, the Supreme Court's decision in *King v. Burwell* has validated the existence of the FFM as a viable marketplace model, which may lead to more states moving toward a marketplace model that leverages the FFM platform, including website and enrollment and eligibility functions, while still maintaining other marketplace operations (e.g., consumer assistance and plan management functions) within the state. This may require additional work to ensure that the federally-facilitated platform can accommodate states' policy goals for dental coverage, for example in states like Colorado, Kentucky, and Washington that require families to purchase pediatric dental coverage for eligible children. As an alternative, states wishing to improve their dental-focused functions may look to leverage the resources already developed by their peer states, including codes for IT infrastructure, vendor or plan contracts that relate to oral health activities, and policies developed by other states and legislatures.

Finally, there are particular considerations with regard to the Children's Health Insurance Program (CHIP). Federal appropriations for CHIP are currently authorized through federal fiscal year 2017; Congress will likely consider whether to extend funding for the program during the upcoming year. MACPAC, the Medicaid and CHIP Payment and Access Commission, found in its March 2015 report to Congress that if federal funding for CHIP ceases, approximately 3.7 million children in states operating separate CHIP programs would lose coverage. About 1.4 million of those children would be eligible for coverage through health insurance marketplaces. Due to the lack of strong requirements to purchase dental coverage, and the lack of financial supports for stand-alone dental products, MACPAC expressed concern about the cost and coverage of dental services for children moving from CHIP to the marketplaces. The report noted that the premium cost of stand-alone marketplace dental coverage could, in some cases, exceed the cost of a family's entire current CHIP premium. As state and federal officials think about the future of children's coverage, they may wish to pay close attention to the effect that shifts to marketplace coverage have on dental coverage. MACPAC's policy options for Congress to consider included requiring QHPs to embed pediatric dental benefits, or adjusting premium tax credits to take into account the additional cost of stand-alone dental coverage.²¹

Conclusion

In the first two years of enrollment in health insurance marketplaces, the treatment of dental benefits and dental products in the ACA has generated unique challenges and policy considerations related to affordability, benefit design, and consumer experience. Though the base issues regarding the availability of financial supports for dental coverage have not changed in the past two years, state and federal marketplace officials have worked to resolve technological issues and make dental coverage more available for both children and adults. Moving forward, the evolving coverage landscape may highlight a need for a more robust role for federal and state policy makers in assuring dental coverage through the marketplaces.

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