

IMPROVING INTEGRATION OF DENTAL
HEALTH BENEFITS IN HEALTH INSURANCE
MARKETPLACES

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EXECUTIVE SUMMARY

The Affordable Care Act (ACA) includes pediatric dental services as one of ten essential health benefits that health plans in the small group and individual markets must cover. This is an important step forward in ensuring that all children have dental coverage and it builds on progress made in Medicaid and the Children’s Health Insurance Program. While adult dental services are not required as an essential health benefit, marketplaces may offer an opportunity for adults to also gain dental coverage.

However, the way that the ACA structures dental coverage has created a number of implementation challenges to ensuring dental coverage for children and offering it for adults. These challenges include:

- **Benefit design.** The ACA allows marketplaces to offer dental benefits in three ways: (1) “embedded” in a Qualified Health Plan; (2) as a “stand-alone” product offered by a dental plan; or (3) as a “bundled” product that pairs a medical and a dental policy. Stand-alone products make up most of the existing commercial market for dental coverage and they specialize in designing dental plans and maintaining dental provider networks. Plans that embed dental benefits, however, include a range of consumer protections that don’t apply to stand-alone dental products. Most marketplaces offered both embedded and stand-alone dental products in the 2014 plan year, though a few state-based marketplaces such as Connecticut’s offered only embedded pediatric coverage, and states like Nevada, Washington, and California offered only stand-alone products in the individual market.
- **Affordability.** Federal regulations were written such that several key affordability protections do not apply to the purchase of stand-alone dental products. Stand-alone dental products are not included in the calculation of Advanced Premium Tax Credits (APTC)—which help individuals under 400 percent of the Federal Poverty Level purchase marketplace coverage. Cost-sharing reductions—which help mitigate out-of-pocket spending—are also not applicable to stand-alone dental products. Dental products may also have a separate out-of-pocket maximum stacked on top of the out-of-pocket spending limit for a medical plan. Action related to affordability is occurring at the state and federal levels, but some concerns remain. In March 2014, the Centers for Medicare & Medicaid Services issued a final rule lowering the dental out-of-pocket for plan year 2015 to \$350 for one child and \$700 for two or more children. A 2013 law in California caps out-of-pocket spending across medical and dental benefits at a single level beginning in plan year 2015.
- **Consumer experience.** While marketplaces are required to allow the offer of stand-alone pediatric dental products, there is no federal requirement that individuals must purchase dental benefits for their children. This, combined with affordability concerns and website designs that may not highlight dental information, could result in families opting not to purchase dental coverage for their children. Kentucky, Nevada, and Washington all instituted requirements to purchase pediatric dental coverage in their state-based marketplaces. Some stakeholder groups have also developed dental-specific training information for consumer assistors that states are incorporating.
- **Adult benefits.** The ACA only includes dental services for children, and not adults, in the required essential health benefits. This creates a variety of inconsistencies and technical issues between coverage inside and outside the marketplace. Several states, however, are offering adults the option of purchasing unsubsidized dental coverage through their marketplaces. This is a potentially promising way to reduce high levels of dental uninsurance among adults.

The National Academy for State Health Policy convened an expert meeting in January 2014 to identify potential policy solutions that state and federal policymakers could consider to improve how dental benefits are provided in future years. Experts identified a range of actions that can be taken through legislation, regulation, plan design, website design, and monitoring strategies to track and improve the provision of dental benefits. These actions, which are a compilation of suggestions made by experts and do not represent an effort to gain consensus, include:

Benefit design

- Evaluate 2014 experience with embedded and stand-alone dental offerings to determine how many children enrolled in dental coverage, which benefit design approach worked best for consumers, and whether dental products offered in 2014 met the marketplace's goals.
- Examine ways that marketplaces could solicit and offer stand-alone dental products to provide coverage for individuals without dental insurance, including adults inside and outside the marketplace, or families with employer-sponsored medical insurance but no dental coverage.
- Monitor patterns in service utilization and premium payment among adults to determine if those gaining dental coverage through the marketplace are keeping it through the year.
- Explore options to encourage issuers to offer embedded pediatric dental products.
- Consider state legislation or regulation to apply insurance reforms (e.g. guaranteed issue, medical loss ratio) to stand-alone dental products.
- Consider plan certification requirements that extend consumer protections including age and geographic rating factors and guaranteed rates to stand-alone dental products.
- Develop a state approach to essential health benefits for adults that promotes consistency between plans purchased inside and outside the marketplaces.
- At the federal level, consider expanding the ten essential health benefit categories to include adult dental.

Affordability

- Revisit federal APTC guidelines to include the cost of dental benefits in the calculation of APTC for all who purchase pediatric dental benefits.
- Revisit preventive services guidelines to exempt routine preventive dental services from cost-sharing.
- Monitor the effect of any changes to dental out-of-pocket maximums on dental product premiums and consumers' uptake of coverage.
- Plan ways to ensure that affordability protections extend to children covered in the marketplaces, especially any children who move from CHIP to the marketplace should CHIP funding not be extended beyond FFY 2015.
- In states offering embedded pediatric dental benefits, consider implementing a "protective" dental deductible and/or out-of-pocket maximum inside the overall cost-sharing limits.

Consumer experience

- Provide dental training for navigators and other consumer assistance entities to ensure they understand the specifics of dental benefits in their state's marketplace.

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- Utilize feedback from navigators and other consumer assistance entities to address consumer concerns and improve the provision of dental benefits.
 - Monitor uptake, purchasing demographics, and any issues with access to care among the newly insured, in order to identify issues and create targeted solutions. Provide periodic data reports to stakeholders.
 - Develop relationships with other state entities that have expertise with oral health programs—including Medicaid, CHIP, Title V, and state dental directors—to partner around efforts to monitor uptake of dental insurance, measure access to care, and conduct dental-specific outreach.
 - Require more robust and standardized benefit, premium, and cost-sharing information to enable comparisons of dental coverage between plans.
 - Ensure that marketplace websites are designed to display clear information and messaging about dental products and options; highlighting the use of the Summary of Benefits and Coverage form to identify whether dental is included in a medical plan or not.
 - Design websites to present adults shopping for Qualified Health Plans (and potentially Medicaid) with the option to purchase dental coverage prior to checkout.
 - At the state level, require families with children to purchase pediatric dental in a state offering stand-alone dental products.

The inclusion of a policy on this list does not imply that all participating in the expert meeting agreed with the option. It is also important to note that it is still early in ACA implementation, and there may not be data available to determine which options would work best.

While implementation of dental benefits is only a small part of the work that state and federal officials must do to implement ACA, maintaining good oral health is important to every person's ability to eat, learn, work, and interact with others, so it is important that this coverage work as intended.

INTRODUCTION

Oral health is an important but often overlooked part of health and health care. Dental disease remains a common childhood chronic disease—42 percent of children ages 2 to 11 have dental caries (tooth decay)—and left untreated, dental decay and disease can have negative results on child growth, development, and school attendance.¹ For adults, poor oral health and missing teeth can affect an individual’s ability to eat nutritious food, as well as get and keep employment.² Good oral health requires regular dental visits with routine opportunities for prevention, early diagnosis, and treatment. Dental insurance is positively associated with greater access to dental care. In 2010, 57 percent of individuals with private dental coverage and 33 percent with Medicaid coverage had a dental visit, compared to 18 percent of uninsured individuals.³ The availability of dental insurance is also a top factor motivating enrollment into Medicaid and CHIP. In 2011, 68 percent of low-income parents surveyed chose access to dental care as a top reason for enrolling their child in coverage.⁴

The Affordable Care Act (ACA) brings significant change to the entire health insurance landscape, including dental insurance. The major ACA provision impacting dental insurance is the requirement that health plans in the small and individual market both inside and outside of the health insurance marketplace offer pediatric dental benefits as part of a core package of items and services, known as essential health benefits (EHB). It is estimated that nearly 4 million children will gain coverage through the marketplaces under the ACA, and these children are also envisioned to gain dental coverage.⁵ This coverage builds on the foundation of dental coverage in Medicaid and the Children’s Health Insurance Program (CHIP), which each require states to provide dental coverage to enrolled children.

The ACA and subsequent federal guidance treat pediatric dental benefits differently from the other EHB categories, creating unique challenges in implementing the vision of a guaranteed pediatric dental benefit. Federal policy allows marketplaces to offer stand-alone dental products separately from medical coverage. These stand-alone products are not included in calculations for financial assistance, so purchasing separate dental coverage may be an additional cost for marketplace enrollees. Moreover, while marketplaces must offer pediatric dental coverage as part of EHB, there is no federal requirement for individuals shopping on the marketplace to purchase such coverage. Taken together, these federal provisions may mean that some families will choose to forgo “essential” pediatric dental coverage. For adults, while the ACA does not include adult dental coverage as an essential benefit, there are several important policy nuances that have arisen, particularly around individuals who are purchasing coverage outside of the state and federal marketplaces.

To discuss the benefits and challenges of various policy approaches to implementing dental benefits in the marketplace, the National Academy for State Health Policy (NASHP) convened a January 2014 meeting of state marketplace leaders, dental experts, and health policy experts (meeting participants are listed in Appendix A). Meeting participants examined current federal and state approaches and identified key issues and potential policy solutions to addressing these challenges in future years.

This report synthesizes materials compiled for the meeting with key themes and findings from the discussion to describe major issues and identify policy solutions for improving the integration of dental benefits in marketplaces. Meeting participants identified a broad variety of actions that can be taken to address concerns about affordability and uptake of dental benefits—not only state and federal legislative or regulatory changes, but also decisions about plan design, changes to IT systems, consumer assistance

training, and monitoring strategies. This report includes all policy suggestions offered and discusses the pros and cons as identified by meeting participants. However, the conclusions drawn are NASHP's and do not necessarily reflect the views of all expert meeting participants. It is also important to note that it is early in the ACA implementation process and in many cases data indicating best policy options are not yet available. We hope that focusing attention on this specific but important policy area will help state and federal officials as they work to realize the ACA's vision for health care coverage, improved health outcomes, and lowered costs in future years.

THE DENTAL COVERAGE LANDSCAPE

Dental care service delivery, coverage, and financing systems have traditionally been separate from the medical care system. (A notable milestone was the enactment of Medicare in 1965, which more closely tied medical care to health insurance, but did not include dental coverage.) While there have been notable gains for children over the last ten years, coverage and access to dental care for adults lags behind. Consumers are two to three times more likely to be without dental insurance than medical insurance.⁶ This separation contributes to some of the policy issues that arise under the ACA.

PUBLIC COVERAGE PROGRAMS

Medicaid and CHIP are critical sources of dental coverage for children in families with low incomes. Medicaid provides health coverage for 28 million children and 20 million adults, and these numbers will grow in light of the ACA's expansion of the program.⁷ By including pediatric services, including dental services, as part of the essential health benefit provision, the ACA builds on the comprehensive benefits and guarantees of dental coverage that exist in Medicaid and CHIP.

Since 1967, Medicaid has required that enrolled children under the age of 21 receive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, which include medically necessary preventive, restorative, and emergency dental services. Medicaid-enrolled children are exempt from most out-of-pocket cost-sharing. Limited access to dental providers and low utilization of dental services have been perennial problems for state Medicaid programs, though there has been progress in the past decade. From 2007 to 2011, almost half of all states attained at least a 10 percentage point increase in the proportion of children enrolled in Medicaid who received a preventive dental service.⁸ States have worked to improve this performance through strategies that have included increasing payment rates to dentists, contracting with specialized dental benefit administrators, providing targeted outreach to families, and focusing on better integration of medical and dental care.^{9,10}

About eight million children in families with income too high to qualify for Medicaid and who cannot afford private coverage receive coverage through CHIP.¹¹ Dental coverage for children in CHIP was an optional benefit for the first 12 years of the program (although most states opted to include it), and became a federal requirement in 2009 under the Children's Health Insurance Program Reauthorization Act (CHIPRA). Prior to CHIPRA, states that operated stand-alone CHIP programs (rather than expansions of their Medicaid programs) were able to tailor CHIP dental coverage to look more like private dental coverage, with more substantial cost-sharing and annual benefit limits. CHIPRA required all state CHIP programs to either offer a state-defined dental benefit package that includes all services required by the CHIPRA statute or choose one of three dental benchmark plans also outlined in the law. While CHIP has been largely successful in covering children, funding is currently authorized only through September 30, 2015. If CHIP funding is not extended, more than five million children may transition into the marketplace.¹² Many of these children may go from having a guarantee of dental coverage to a situation where families can opt not to purchase dental coverage, as discussed in more detail in this report.

While there has been progress for children's dental coverage through Medicaid and CHIP, dental services are an optional benefit for adults. Many states currently provide only a limited adult dental benefit, and often only to a subset of adult enrollees. In 2012, eight states did not include any adult dental coverage in Medicaid, and 17 states provided emergency dental coverage only. Only 11 states provided comprehensive dental benefits to all adults.¹³ Some states extend dental coverage to Medicaid- or CHIP-

enrolled pregnant women as a “pregnancy-related service.” The ACA’s expansion of Medicaid to adults without children does not change the optional status of dental benefits for adults.

Access to dental coverage is also limited for adults enrolled in Medicare since dental services are not covered in traditional Medicare. A limited number of Medicare Advantage plans include dental care, but by and large, the 12.7 million individuals in the program do not have dental coverage.¹⁴

PRIVATE COVERAGE

Individuals who receive health benefits through employment or who purchase coverage through the individual market are less likely to carry dental insurance than medical insurance. For instance, in 2012, only 54 percent of firms offering health benefits to their employees offered or contributed to a dental insurance benefit.¹⁵ When dental benefits are offered, they are typically delivered through a “stand-alone dental policy” – a limited-scope insurance product, often administered by a specialized vendor focused only on dental benefits. These stand-alone policies are either purchased separately from medical benefits or as a rider to medical coverage. The National Association of Dental Plans (NADP) reports that 99 percent of dental plans in 2014 are sold as separate products.¹⁶ Dental insurance products typically have tiered cost-sharing—for preventive services, like examinations and cleanings, the plans typically pay 100 percent of the charge; for restorative services (such as fillings), plans typically pay 80 percent, with 20 percent coinsurance by the patient; and for more complex services (such as crowns), plans typically pay 50 percent with 50 percent coinsurance. Products typically have an annual maximum benefit of \$1000-\$2000 which, NADP estimates, fewer than 5 percent of individuals reach in a given year.¹⁷ Meeting participants noted that with this cost-sharing structure, commercial plans have traditionally aimed to emphasize prevention and early diagnosis of dental health issues.

DENTAL COVERAGE UNDER THE AFFORDABLE CARE ACT

The ACA makes substantial changes in public and private coverage and how they work together, and also contains provisions to improve care and outcomes. The ACA's changes include a number of provisions related to oral health or dental care, such as provisions supporting dental public health programs, oral health education campaigns, and improvements to the information collected about oral health in national epidemiological surveys. The most significant dental coverage-related provision is that pediatric dental benefits are required as part of a set of 10 essential health benefits that all non-grandfathered small group and individual insurance plans offered inside and outside the marketplace must generally offer. The marketplaces are online organizations where individuals can purchase coverage, with subsidies available for applicants between 100 and 400 percent of the Federal Poverty Level (FPL). The following sections briefly review the ACA's essential health benefit provision and describe how dental insurance products are being offered both inside and outside the marketplace. (See Appendix B for a summary of federal guidance related to dental benefits.)

ESSENTIAL HEALTH BENEFITS AND THE MARKETPLACE

The ACA requires that health insurance plans sold to individuals and small businesses provide a minimum package of services in ten categories, called “essential health benefits” (EHB). Beginning in 2014, EHB are applicable to most individual and small group health plans sold both inside and outside the marketplace; plans for certain new groups of Medicaid enrollees; and Basic Health Program plans.¹⁸ As defined by the law, the ten EHB categories are: (1) ambulatory patient services, (2) emergency services (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care.¹⁹ The final category mandates dental services for children; dental services for adults are not included as part of EHB. Federal cost-sharing subsidies that are available to lower-income individuals in the marketplace are only applicable to benefits under a state's EHB package and not to additional benefits—such as adult dental—offered by plans. The ACA also requires states to cover the costs of state-mandated benefits that exceed EHB requirements.²⁰

The ACA directed the Secretary of Health and Human Services to more specifically define the scope of benefits to be covered under EHB. Rather than establishing a new national standard, the Center for Consumer Information and Insurance Oversight issued a bulletin in December 2011 allowing each state flexibility to define its own EHB by selecting from a number of possible “benchmark” and supplementing benefits as needed to cover essential benefits.²¹ These policies were finalized in a February 2013 rule.²² In order to define EHB, states chose from one of the following federally-defined “benchmark plans”: (1) the three largest small group market plans in the state (2) the three largest state employee health plans (3) the three largest federal employee health plans or (4) the state's largest commercial non-Medicaid HMO plan. The default benchmark plan for states that opted not to select one was the largest small-group plan in the state. This benchmark approach allows states a path to keep from paying for state-mandated benefits that exceed EHB—if a state chooses a benchmark plan that is subject to state mandates, such as a small group market plan, those state mandates (enacted prior to 2012) would be included as part of the state's EHB package.²³ Most states (43, including DC) chose or defaulted to a small group plan in their states.²⁴ EHB-benchmark plans, selected by states in 2012, will remain in place for coverage years 2014 and 2015. The Centers for Medicare & Medicaid Services (CMS) has indicated that it will re-evaluate this method for defining EHB for 2016.²⁵

If a selected benchmark plan does not include one or more of the 10 categories of benefits, the state must supplement the plan with the missing categories using another benchmark option. Pediatric dental services, along with habilitative and vision services, are benefits most frequently missing from state benchmark plans. Therefore, federal guidance outlined options for supplementing these required benefits—states could select or default to the Federal Employee Dental and Vision Insurance Program (FEDVIP) or choose the state’s separate CHIP program.²⁶ Both options generally include a broad base of dental benefits but there is some variation from state to state with coverage for medically necessary orthodontia—for instance, Arkansas, Colorado, Michigan, and Utah chose CHIP supplemental benchmarks that do not cover medically necessary orthodontia.²⁷ Twenty-five states and the District of Columbia chose FEDVIP to supplemental their benchmark plan and 24 states chose CHIP dental benefits. One state, Utah, went with the dental benefit that was already included in its benchmark plan, the catastrophic plan for state employees known as Utah Basic Plus, which covers routine exams, cleanings, x-rays, and dental sealants but not restorative treatments like fillings, crowns, and root canals.^{28,29} Benchmark decisions determine the scope of services that will be included and not the cost-sharing structure, which is largely driven by actuarial value standards. The next section will describe how state and federally-facilitated marketplaces have translated the benchmark standards into offerings that consumers can purchase.

OFFERING PEDIATRIC DENTAL BENEFITS IN THE MARKETPLACE

The ACA includes some provisions specific to dental coverage that create unique complexity in how these benefits are packaged and delivered to consumers. The ACA requires marketplaces to allow carriers the option to offer pediatric dental coverage as a separate policy.³⁰ In addition, qualified health plans (QHPs) are not required to include pediatric dental benefits if at least one stand-alone pediatric dental policy is offered in a marketplace.³¹ Due to these provisions, states have opted to solicit plans meeting the pediatric dental requirement in three ways—as a benefit embedded in a medical health plan, as a bundled package of medical and dental plans, or as a stand-alone dental product. The structure of pediatric dental benefits in the marketplace has important implications for how accessible and affordable these benefits will be for families. Due to IT system limitations and differences under the ACA in how consumer protections and federal subsidies apply, each benefit structure differs in important ways:

- 1) Embedded Benefit:** Medical QHP issuers can choose to include, or “embed,” pediatric dental benefits to create a comprehensive single plan. Medical QHP issuers can contract with a dental issuer to offer the pediatric dental benefit, but in an embedded benefit, the medical issuer assumes all risks and liabilities of covering the dental benefit under one contract.³² This is similar to prescription drug coverage, which is frequently administered through a specialized third party administrator.^{33,34} In an embedded QHP, the pediatric dental benefit appears to consumers like any other benefit covered in the plan and is included under a single premium. An embedded QHP must comply with all market reform and rating rules, such as guaranteed availability, a ban on lifetime and annual limits, dependent coverage up to age 26, limits on out-of-pocket maximums, medical loss ratio, and limits on allowable rating factors.³⁵ QHPs, including those that embed pediatric dental benefits, are required to meet actuarial value levels corresponding to metal tiers: platinum (90 percent), gold (80 percent), silver (70 percent), or bronze (60 percent). With an embedded dental benefit, pediatric dental spending typically counts toward a single shared deductible and out-of-pocket maximum for medical and dental care. In addition, cost-sharing reductions (discussed further in the next section) will be available to eligible families purchasing a comprehensive QHP.

Meeting participants acknowledged that embedded plans are simpler for states to administer and may be more affordable for consumers. However, they also identified some concerns with embedding pediatric dental benefits. A main concern is that families of children with high needs for dental care, but low needs for other medical care, may be disadvantaged by a single shared deductible and out-of-pocket spending limit, which could require substantial out-of-pocket spending before insurance would begin paying dental claims. Meeting participants also discussed whether embedding pediatric dental into all QHPs unfairly passes on the cost of pediatric dental benefits to individuals without children. However, Connecticut shared that the state has not received any pushback from consumers to its approach to embedded plans and consumers seem pleased to have one less thing to worry about. In addition, an American Dental Association analysis of a sample of plans in 25 federally-facilitated marketplace states calculated the average monthly cost of dental benefits embedded in a silver plan to be relatively low, at \$5.11.³⁶

- 2) Stand-Alone Dental Policy:** The ACA allows dental benefits to be sold separately from medical benefits in the marketplaces as certified stand-alone dental policies. To be certified, stand-alone dental policies must offer pediatric dental services as included in the state’s chosen dental benchmark and must abide by applicable QHP certification standards including ensuring a provider network that is sufficient in number, type, and geographic distribution of providers. In addition, pediatric dental benefits offered in a stand-alone dental policy must be offered without annual and lifetime limits.³⁷

However, many provisions of the ACA applicable to medical QHPs were modified or deemed inapplicable to stand-alone dental plans. For example, federal guidance established a separate approach for calculating actuarial value for stand-alone dental plans, categorizing plans as “high” (85 percent) or “low” (70 percent) for 2014.³⁸ In addition, dental benefits provided through a stand-alone dental plan are considered “excepted benefits” under section 2791 (c) of the Public Health Service Act, and therefore are not subject to many consumer protections that do apply to embedded plans. Stand-alone dental policies are not subject to ACA requirements related to medical loss ratio requirements, protection against denials for pre-existing conditions, fair insurance premiums based only on age and geography, and guaranteed premium rates.³⁹ However, meeting participants noted that commercial dental products typically have not exercised denials of coverage for preexisting conditions, or used rating based on health status. Stand-alone dental plans can also have a separate out-of-pocket limit on cost sharing, which is stacked on top of the limit established in the ACA for medical plans. Finally, federal guidance does not allow federal cost-sharing reductions to apply to these plans.⁴⁰

Federal guidance does not preclude states from opting to apply market reforms to stand-alone dental policies and some states have already taken action to apply these protections. States can use marketplace application processes to extend age and geographic rating standards to stand-alone dental products or to guarantee rates. California’s marketplace chose to apply nearly all consumer protections to stand-alone dental policies via contract requirements in 2014.⁴¹ In February 2014, a bill was also introduced in California that would apply medical loss ratios to dental issuers.^{42,43} The federally-facilitated marketplace requires stand-alone dental plans to publicly display whether their rates are guaranteed or not, which could help provide transparency for the consumer and may help incentivize stand-alone dental plans to hold rates steady.⁴⁴ The National Association of Dental Plans reports that in 2014, all stand-alone dental policies on the federally-facilitated marketplace guaranteed their rates.

- 3) Bundled Benefit:** A QHP that does not include the pediatric dental EHB may contract with a separately licensed dental issuer to sell the two distinct policies together as a package. In this case,

individuals cannot mix and match different medical QHPs with different stand-alone dental policies, nor can they enroll in one product without the other. While the enrollee would pay a single combined premium, the dental issuer and medical issuer would each assume the risks and liabilities associated with providing coverage under its plan only—differentiating a bundled benefit from an embedded one.⁴⁵ While offering a full set of benefits like embedded policies, bundled dental policies are treated like stand-alone dental products with regard to out-of-pocket limits on cost sharing and market reform rules, and face many of the same challenges. Bundled benefits are not being offered in any marketplace in plan year 2014. The federally-facilitated marketplace, operating in 35 states, decided not to allow bundled benefits in 2014 because it did not yet have the IT capacity to list dental and medical deductibles and out-of-pocket maximums separately.⁴⁶ Some states with state-based marketplaces also chose to not offer bundled benefits, while other state-based marketplace states solicited bundled benefit plans and simply did not receive any submissions from issuers.

For 2014, most marketplaces, including in states with a federally-facilitated marketplace, solicited for both stand-alone dental plans and embedded plans. Across all states operating a federally-facilitated or partnership marketplace, 34 percent of QHPs embed pediatric dental benefits. The prevalence of embedded plans varies greatly by state—Alabama and West Virginia have embedded pediatric dental in nearly all QHPs, whereas less than five percent of QHPs embed pediatric dental in Texas and Iowa.⁴⁷ For plan year 2014, California and Washington decided to only allow the offer of stand-alone products. However, California plans to offer embedded dental products side by side with stand-alone dental policies beginning in plan year 2015 (see text box on page 18).⁴⁸ While some states solicited for bundled plans, no state is offering this type of plan in 2014. Connecticut is the only state requiring all issuers participating in the marketplace to embed pediatric dental benefits in medical QHPs that they offer.⁴⁹ (In 2014, Connecticut did not offer stand-alone dental products directly on their marketplace due to IT systems limitations. The state is soliciting stand-alone pediatric and family dental products for the 2015 plan year, but is not permitting medical QHPs to be offered via the marketplace without embedded pediatric dental.⁵⁰ Dental plans have raised concerns about how this requirement comports with ACA provisions related to stand-alone dental policies.⁵¹) Several states have indicated that they are reconsidering their plan solicitations for 2015 due to a variety of reasons, including increased IT capabilities or stakeholder pressure. A full summary of 2014 state decisions regarding pediatric dental offerings in the marketplace can be found in Appendix C.

OFFERING ADULT DENTAL BENEFITS IN THE MARKETPLACE

Adult dental benefits are not part of EHB and therefore there is no federal requirement that QHP issuers offer these benefits in the marketplace. However, carriers can choose to offer dental products for adults. Adult dental benefits can be included as part of a family stand-alone dental policy or embedded within a medical policy. The difference is that all stand-alone dental plans must include the pediatric dental benefit—even if the policy is intended for adults—but a QHP could offer embedded adult dental without including pediatric dental coverage. (Note that if a marketplace doesn't include stand-alone policies, then all QHPs would be required to embed pediatric dental.)

Many marketplaces in states represented at the meeting offered stand-alone family dental products that include adult and pediatric coverage. Regardless of the structure, federal cost-sharing subsidies cannot be applied to adult dental benefits.⁵² In addition, adults purchasing dental coverage through the marketplace will still be subject to annual limits, which are common in private dental insurance, and typically range between \$1,000 and \$2,000 annually.⁵³ While most consumers currently enrolled in dental insurance do not reach the annual maximum, meeting participants suggested that the population newly eligible for

coverage under the ACA may have greater pent-up dental needs than the currently insured population. They also expressed concern that lower-income individuals who enroll in adult coverage may be at greater risk of dropping coverage partway through the plan year. Participants indicated that it will be important for states to monitor patterns in service utilization and premium payment among adults gaining dental coverage through the marketplace.

(See text box on page 21 for an example of how adult dental benefits are working in Nevada).

DENTAL BENEFITS OUTSIDE THE MARKETPLACE

For people purchasing individual coverage outside of the marketplace, there is an additional layer of complexity related to pediatric dental coverage. The preamble to the February 2013 federal rule on essential health benefits states that all plans bought on the individual and small group market *outside* of the marketplace must offer all ten EHB—including pediatric dental—unless an issuer can be “reasonably assured” that an individual has purchased a marketplace-certified stand-alone pediatric dental policy elsewhere.⁵⁴ This means that some consumers purchasing coverage outside of the marketplace may have to enroll in and pay for coverage that includes pediatric dental benefits whether they have children or not.

State participants expressed a desire for greater consistency in the treatment of dental benefits inside and outside the marketplace, since differing rules increase the complexity of program administration. To address this concern, many state insurance departments have exerted their authority to regulate their insurance markets outside of the marketplace by issuing guidance to more concretely define what constitutes “reasonable assurance.”

Colorado has taken a unique approach to meeting “reasonable assurance” requirements while also allowing opportunities for adults to avoid paying for unnecessary pediatric dental coverage. Colorado worked with dental issuers to offer “child-only” pediatric dental policies at low or no cost to enrollees without children—these products allow adults to obtain the coverage for the full set of ten EHB “in full knowledge that [the pediatric dental] benefit will never be needed or used.”⁵⁵

The bullets below, adapted from a Delta Dental Plans Association analysis, summarize other state actions taken either by bulletin or through legislation to ensure individual and small group markets outside the marketplace are “reasonably assured” that consumers have purchased all ten EHB categories:

States indicating that a disclosure by the carrier that its plan does not include pediatric dental benefits constitutes “reasonable assurance.”

- Arkansas⁵⁶
- Idaho⁵⁷
- Iowa⁵⁸
- Montana⁵⁹
- New Hampshire⁶⁰
- New Mexico⁶¹
- Virginia⁶²
- Wisconsin⁶³

States requiring an attestation by the consumer that EHB pediatric coverage has been obtained/purchased from another carrier.

- Colorado⁶⁴
- Hawaii⁶⁵
- Massachusetts⁶⁶
- Michigan⁶⁷
- Oregon⁶⁸

States restating the language on “reasonable assurance” from the preamble of the federal EHB final rule and citing issuer responsibility.

- Kentucky⁶⁹
- New York⁷⁰
- Ohio⁷¹
- South Dakota⁷²

POLICY OPTIONS FOR ADDRESSING ISSUES WITH DENTAL BENEFIT STRUCTURE UNDER THE ACA

Below is a list of actions identified by meeting participants that state and federal policymakers could take to address issues with dental benefit structure. Depending on the authority that a marketplace has in a given state, some actions could require legislative or regulatory action. (Note that these are not consensus recommendations; the inclusion of a policy does not mean that all in the group agreed with the option.)

- Evaluate 2014 experience with embedded and stand-alone dental offerings to determine how many children enrolled in dental coverage, which benefit design approach worked best for consumers, and whether dental products offered in 2014 met the marketplace’s goals.
- Examine ways that marketplaces could solicit and offer stand-alone dental products to provide coverage for individuals without dental insurance, including adults inside and outside the marketplace, or families with employer-sponsored medical insurance but no dental coverage.
- Monitor patterns in service utilization and premium payment among adults to determine if those gaining dental coverage through the marketplace are keeping it through the year.
- Explore options to encourage issuers to offer embedded pediatric dental products.
- Consider state legislation or regulation to apply insurance reforms (e.g. guaranteed issue, medical loss ratio) to stand-alone dental products.
- Consider plan certification requirements that extend consumer protections like age and geographic rating factors and guaranteed rates to stand-alone dental products.
- Develop a state approach to “reasonable assurance” of essential health benefit coverage for adults outside the marketplace that promotes consistency and ease of administration.
- At the federal level, consider expanding the ten essential health benefit categories to include adult dental.

AFFORDABILITY OF DENTAL BENEFITS IN THE MARKETPLACE

The ACA and subsequent guidance create different rules for how affordability provisions—particularly advanced premium tax credits, cost-sharing reductions, and annual limits on cost-sharing—apply to pediatric dental benefits if offered as a stand-alone dental product. Therefore affordability of pediatric dental coverage in the marketplace will be a concern for many lower-income families.

PREMIUMS

The Children’s Dental Health Project conducted an analysis of premium rates for stand-alone dental plans in states with federally-facilitated and partnership marketplaces and found a wide range in premiums from state to state. West Virginia had the lowest rates, with low-cost plans averaging about \$15 per child per month and high-cost plans averaging \$19. In contrast, Alaska (a state with a high cost of living) was found to have the highest rates, with low-cost plans averaging \$53 per child per month and high-cost plans averaging \$77. The national average for stand-alone dental policies in federally-facilitated and partnership marketplaces is \$30 for low-cost options and \$37 for high-cost options.⁷³

It is likely that dental coverage offered as an embedded benefit will be priced lower than dental coverage offered as a stand-alone dental product. An American Dental Association analysis of a sample of plans from 25 federally-facilitated states found the average premium for stand-alone dental plans to be \$30.98 – \$38.80 (for low and high actuarial value plans respectively) as compared to the average estimated cost of dental benefits embedded in a silver plan at \$5.11.⁷⁴ Meeting participants indicated that the low cost might be due to the effect of spreading pediatric dental costs across the entire marketplace population. There is no federal requirement for states to display the portion of premium allocable to dental benefits when offered as part of an embedded or bundled plan, making it difficult for consumers to compare and decide on one of many plans that will be offered in a marketplace—particularly in states where stand-alone and embedded products are both available. Making the dental portion of a total premium explicit could help consumers make more informed decisions about the best option for them and their families.

ADVANCED PREMIUM TAX CREDITS

The Advanced Premium Tax Credit (APTC) is a federal subsidy available to assist consumers purchasing coverage in the marketplace by reducing monthly premium amounts. APTC is available to U.S. citizens and legal residents with household incomes between 100 and 400 percent FPL and without access to affordable minimum essential coverage. The IRS will calculate tax credits based on the second-lowest cost silver plan in a marketplace, *regardless of whether this plan includes dental benefits*. If the second-lowest cost silver plan in the marketplace does not include dental benefits, the cost for dental coverage will not be counted in the tax credit calculation.⁷⁵ QHPs that embed dental benefits will have a single premium to which the premium tax credit will apply. For stand-alone and bundled dental plans, premium tax credits will first be applied to a family’s medical QHP premium and any remaining tax credit amount will then be applied to a stand-alone dental policy premium.⁷⁶ It is likely that the tax credit amount will not be enough to fully cover pediatric dental benefits, whether offered through a bundled or stand-alone plan. Meeting participants suggested that in states where the second-lowest cost silver plan does not include dental, a change in federal policy to calculate APTC based on the combined cost of the medical plan and a stand-alone dental product would be useful.

Adult dental benefits are not part of EHB, therefore APTC cannot be used to subsidize dental benefits for adults. If a medical QHP or stand-alone dental plan offers dental coverage that an adult opts into, the adult must pay in full the portion of the total premium for the adult dental benefit. State and federal marketplaces will need to design systems that can accommodate this rule by properly calculating the separate allocation of premium tax credits.

COST SHARING

In addition to premium tax credits, the ACA introduces cost-sharing reductions for individuals with incomes up to 250 percent FPL purchasing a silver-level plan in the marketplace. Cost-sharing reductions are designed to limit the amount an individual has to pay out-of-pocket to receive health care services covered by a plan. However, guidance from the Center for Consumer Information and Insurance Oversight (CCIIO) states that while cost-sharing reductions will apply to an embedded benefit, they will not be applied if the pediatric dental benefit is provided through a stand-alone dental plan.⁷⁷ Researchers at the George Washington University School of Public Health and Health Services have raised some questions about this policy—asking whether federal guidance is at odds with the original intent of the law and how states will operationalize this policy to ensure proper allocation of federal subsidies—which remain unanswered.⁷⁸

In most states (28 plus the District of Columbia) children up to 250 percent FPL or higher are covered by CHIP.⁷⁹ However, CHIP funding past 2015 is uncertain and if funding is not reauthorized, eligible children will likely obtain coverage through the marketplace where coverage may no longer be affordable. Meeting participants identified this as an issue with important consequences that requires further clarification and action, particularly at the federal level.

The ACA also requires that certain preventive services recommended by the Health Resources and Services Administration's (HRSA's) *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* must be covered without cost sharing. This is intended to encourage individuals to seek early preventive care. The regulations that implemented the definition of "preventive services," however, left out many dental services—including professionally-applied fluoride and dental sealants—that are key to preventing dental disease. The regulations on preventive services only reference the Bright Futures periodicity schedule (a document that lists services that children should receive from pediatric medical providers at certain ages). In terms of preventive dental coverage, the periodicity schedule only includes referral to a dental home and fluoride supplements (e.g., tablets) for children living in areas without community water fluoridation. Supplements to the Bright Futures guidelines mention additional preventive dental care such as fluoride applications and sealants. Typically, dental insurance products have not required cost-sharing for preventive dental services, but some meeting participants suggested that federal officials revisit the rules to guarantee that evidence-based preventive dental services for children are available without cost-sharing.

ANNUAL LIMITS ON CONSUMER OUT-OF-POCKET COSTS

Federal guidance establishes an annual maximum out-of-pocket cost-sharing limit for QHPs—\$6,350 for an individual and \$12,700 for a family in 2014—but allows a separate annual limit for stand-alone dental policies.⁸⁰ In 2014, state-based marketplaces were responsible for determining an annual maximum out-of-pocket limit for stand-alone dental policies that is "reasonable." The federally-facilitated marketplace set this annual limit at \$700 for one child enrollee and \$1,400 for two or more child enrollees for plan year 2014 and many state-based marketplaces followed its example (see Appendix C for state-based marketplace information).⁸¹

However, in February 2013, the Internal Revenue Service issued guidance allowing issuers to delay implementing the annual limit on out-of-pocket costs in cases where benefits are administered by multiple service providers (e.g. separate administrators for medical, behavioral, dental, and/or pharmacy benefits) until 2015.⁸² The delay may affect some plans where dental benefits are embedded but administered through a third-party administrator.

In addition, CMS issued a proposed rule in December 2013 to lower the annual out-of-pocket maximum for stand-alone dental products and eliminate actuarial value standards for plan year 2015.⁸³ Final guidance, issued in March 2014, established the annual out-of-pocket maximum at \$350 for one child and \$700 for two or more children, and maintained that stand-alone dental plans must meet either “high” or “low” actuarial value standards in all marketplaces in plan year 2015.⁸⁴

At the time of the expert meeting, the federal rule proposing to lower the dental out-of-pocket maximum and eliminate actuarial value standards for stand-alone dental products had not yet been finalized. Some state marketplace leaders represented at the meeting stated that their states already struggled to meet the 2014 out-of-pocket maximum and actuarial value standards and were concerned about the lower standards. State marketplace leaders and industry experts represented at the meeting agreed that the most likely result of the proposed changes would be an increase in dental premium rates, an increase in dental deductibles, or potentially the imposition of cost-sharing for preventive services. Meeting participants expressed significant concern that higher premium rates could further deter consumer purchase of dental benefits. In addition, state marketplaces that currently require purchase of pediatric dental benefits (discussed further in the following section) expressed the possibility of reversing their decision to require purchase if the higher premiums proved enough of a barrier to enrollees. Meeting participants agreed that further monitoring and evaluation of consumer utilization in this area is necessary.

Having a separate annual maximum out-of-pocket limit for dental benefits that sits on top of one for a family’s medical QHP means that families purchasing stand-alone dental policies may be responsible for more total out-of-pocket costs than families enrolled in plans with embedded dental benefits. However, meeting participants noted that children in embedded plans could also face issues related to out-of-pocket costs, particularly as it relates to annual deductibles. Certain out-of-pocket spending applies towards reaching an annual deductible—once the deductible is met, consumers generally only pay a copayment or coinsurance for all covered services for the remainder of the year until reaching the out-of-pocket maximum. Embedded plans may have a single deductible to which medical and dental spending counts—in this case, children with high dental needs (e.g., a child with needs for extensive medically-necessary orthodontic care) but relatively modest medical needs must meet the higher combined deductible before the plan would begin to cover dental expenses and therefore be disadvantaged. The American Dental Association found that in a sample of plans drawn from 36 states, 42 percent of plans offering embedded pediatric dental benefits had separate medical and dental deductibles and the average amount (\$34.21) was comparable to the average deductible for stand-alone dental policies (\$41.10). Thirty-four percent of embedded plans, however, used a combined medical and dental deductible, and among these plans, the average amount was more than \$2,900. (Among the remaining 24 percent of embedded QHPs surveyed, it was unclear whether there was a separate dental deductible.)⁸⁵

California enacted a law that caps out-of-pocket spending at a single level across all medical and dental benefits. How this law affected the state’s decisions about plan offerings and its approach to dental out-of-pocket spending are described in the text box below.

California: Changes for the 2015 Plan Year

California opted to offer dental benefits only through stand-alone policies for the 2014 plan year, with a separate out-of-pocket maximum of \$1,000 for one child and \$2,000 for two or more children. In September 2013, as a result of concern among children’s advocates about the affordability and uptake of pediatric dental coverage, California Governor Jerry Brown signed SB 639, which caps the sum of separate out-of-pocket maximums for medical and dental coverage at the federal limit for QHPs—\$6,600 for an individual and \$13,200 for a family for 2015.⁸⁶ In August 2013, Covered California, the state marketplace, embarked on a comprehensive review of dental coverage options for the 2015 plan year and engaged Wakely Consulting Group to assess its future options. Wakely’s report resulted in a recommendation to Covered California’s Board that California embed pediatric dental in all plans in the marketplace while also implementing an integrated or “protective” dental out-of-pocket maximum inside the overall out-of-pocket limit. Under this scenario, all dental and medical charges would count towards a single out-of-pocket maximum, but out-of-pocket spending for pediatric dental services would be capped.⁸⁷ (See endnote for an example of how this protection would work.)

For 2015, the Covered California Board opted to offer QHPs with embedded dental side by side with stand-alone dental policies.⁸⁸ While the state marketplace is still accepting QHPs without a pediatric dental benefit, it is encouraging issuers to offer embedded pediatric dental benefits in medical policies in 2015.⁸⁹ Through a stakeholder review process, Covered California determined that implementation of a “protective” dental out-of-pocket maximum was not possible for the 2015 plan year. Instead, Covered California lowered the out-of-pocket maximum for medical QHPs—with or without embedded dental—to \$6,250, allowing consumers who purchase a stand-alone dental product (with a separate \$350 out-of-pocket maximum) to remain under the limit of \$6,600 set by SB 639.⁹⁰

POLICY OPTIONS FOR ADDRESSING ISSUES WITH AFFORDABILITY

As noted throughout this section, many of the identified issues with respect to the ACA’s affordability provisions would require action at the federal level.

- Revisit federal APTC guidelines to include the cost of dental benefits in the calculation of APTC for all who purchase pediatric dental benefits.
- Revisit preventive services guidelines to exempt routine preventive dental services from cost-sharing.
- Monitor the effect of any changes to dental out-of-pocket maximums on dental product premiums and consumers’ uptake of coverage.
- Plan ways to ensure that affordability protections extend to children covered in the marketplaces, especially any children who move from CHIP to the marketplace should CHIP funding not be extended beyond FFY 2015.
- In states offering embedded pediatric dental benefits, consider implementing a “protective” dental deductible and/or out-of-pocket maximum inside the overall cost-sharing limits.

THE CONSUMER EXPERIENCE OF DENTAL BENEFITS

Consumers shopping in the marketplace face a complex and potentially confusing set of choices related to dental coverage. As noted elsewhere in this report, both embedded and stand-alone products present issues related to transparency—consumers purchasing embedded plans may struggle to find clear information on covered dental benefits and dental deductibles, and consumers purchasing stand-alone products may find it challenging to understand how federal subsidies do or do not apply. States and the federally-facilitated marketplace can take steps to ensure consumers are able to navigate their options, make informed decisions, and seek assistance when needed. This section discusses key issues and state strategies related to ensuring transparency and assistance for consumers.

PURCHASING PEDIATRIC DENTAL BENEFITS

There is no federal requirement that consumers shopping on the marketplace purchase stand-alone pediatric dental coverage. Combined with potential additional costs for dental coverage, this may mean that some families will opt to forego dental coverage for their children. Early data from California’s marketplace, which offered (but did not require purchase of) stand-alone pediatric dental policies in 2014, demonstrate that only some families will take up this coverage. Of the 56,535 California children enrolling in a marketplace QHP between October 2013 and February 2014, only 36 percent (20,317) also enrolled in a stand-alone dental policy.⁹¹ Some states have chosen to implement requirements to purchase pediatric dental coverage in 2014:

Nevada weighed the pros and cons of different options for offering pediatric dental in its marketplace and decided to require that families with children purchase pediatric dental coverage for their children.⁹² Following the purchase of a QHP, all applicants are directed to a screen that allows the consumer to choose and purchase a stand-alone dental product. Adults have the option to purchase dental coverage, but enrollees under age 19 are required to purchase a stand-alone dental product in order to complete their purchase.⁹³ (see text box on page 21 for more information on adults)

Kentucky. With strong support from advocate and lobbying groups, Kentucky enacted an emergency administrative regulation requiring the Kentucky Health Benefit Exchange to ensure that individuals up to age 21 enroll in pediatric dental coverage.^{94,95} Families with children under 21 purchasing a QHP that does not offer pediatric dental benefits are prompted to purchase a stand-alone dental product, which is required in order to complete the transaction.

Washington also took a similar approach—the Washington Health Benefit Exchange board decided to ensure children receive all ten EHBs in the individual marketplace by requiring all families with children under 19 who do not qualify for CHIP to purchase dental benefits.⁹⁶

Meeting participants identified a requirement to purchase pediatric coverage as a way to effectively spread costs across a broader group and keep dental coverage more affordable. Both Kentucky and Nevada shared that requiring purchase in their states has not resulted in consumer pushback, even though federal subsidies do not apply to the stand-alone dental policy. Both states emphasized that the requirement to purchase only applies to children and pediatric dental benefits.

Meeting participants discussed several other actions states could take to improve the experience of purchasing pediatric dental benefits. For example, one concern was whether marketplaces are well-equipped to adequately display information on dental benefits, allowing consumers to compare embedded with stand-alone policies in states that offer both options, and make an informed purchasing decision. The American Dental Association’s survey of marketplace dental offerings identified inadequate detail on covered services and cost-sharing

in embedded policies as a concern.⁹⁷ Meeting participants suggested states could address this by implementing a more robust requirement for plans to report benefit information in a standardized manner and by programming marketplace systems to display dental benefits in a comparable way. Participants also suggested that state and federal agencies regularly report on uptake of dental benefits as a way to determine whether children are obtaining dental coverage.

PURCHASING ADULT DENTAL BENEFITS

States can include adult dental benefits in the marketplace as part of a stand-alone family dental policy or embedded in a medical policy. However federal subsidies are not applicable to adult dental benefits and states opting to include them have to build systems that properly allocate subsidies and implement policies that ensure adequate transparency for consumers. For plan year 2014, there is great variety in what adult dental benefits states are including in their marketplace and how they are being offered. Meeting participants indicated in January 2014 that adult dental offerings appear to be attractive to shoppers. Data released by the Department of Health and Human Services in March 2014 support this claim—21 percent of individuals enrolling in coverage through a federally-facilitated marketplace also purchased stand-alone dental plans. Of these individuals, 95 percent are over the age of 18, and 24 percent are over the age of 55.⁹⁸ However, meeting participants suggested that it remains too early to tell whether the current framework for adult dental benefits in the marketplace—voluntary purchase of unsubsidized products in states that allow it—will meet the needs of marketplace customers. Below are some examples of state approaches to adult dental benefits, and a look at how Nevada is using its marketplace to offer dental benefits to Medicaid-eligible adults.

Connecticut is offering adult dental plans as part of a stand-alone family dental product, primarily to target adults with employer-sponsored insurance that does not include dental coverage. In 2014, Connecticut's stand-alone dental product is not being sold directly through the Access Health CT site—instead the marketplace website directs individuals seeking adult dental coverage to a separate Anthem Blue Cross Blue Shield website where coverage can be purchased for about \$40-\$60 per month.⁹⁹ These stand-alone family dental products are reviewed and certified by Access Health CT.

Maryland. Adult dental coverage in Maryland is offered as part of a stand-alone family dental product. All adult consumers purchasing this product are notified that adult dental coverage is not part of the EHB and thus not eligible for subsidies.¹⁰⁰ As of September 2013, Maryland's marketplace is offering 20 stand-alone dental policies, eight of which will offer pediatric benefits only and 12 will offer family dental coverage.¹⁰¹

Washington is considering offering plans that include adult dental benefits in the marketplace in 2016 or later. In March 2014, the state's marketplace board discussed how to implement adult dental benefits in future years and expects that significant changes to its marketplace web portal may be necessary.¹⁰² To implement these changes, Washington was awarded enhanced funding through a federal Level One Establishment Grant in January 2014. In addition, Washington intends to conduct analyses in 2014 to compare and explore the feasibility of various adult and family dental options.¹⁰³

Nevada: Marketplace Dental Coverage for Adults in Medicaid

Health Link Nevada is one of three state-based marketplaces that requires customers to purchase stand-alone dental coverage for eligible children. (Nevada allowed plans to offer embedded or bundled dental benefits, but none did in 2014.) The state also allows dental plans to offer adult coverage, and has designed its website to ask shoppers who have not selected a dental plan whether they would like to add it to their “shopping cart” prior to checkout. The state does this for all adults, including those who are determined to be eligible for Medicaid. This has proved to be an unexpectedly attractive option for adults enrolling in Medicaid, which does not include a comprehensive adult dental benefit. It is still too early to know whether low-income individuals enrolling in this coverage will continue to pay monthly premiums of \$20-60 and copayments for services in order to maintain it through the course of the plan year. However, the initial enrollment suggests a level of desire among enrollees for dental coverage (and potentially, of unmet needs for dental care).

CONSUMER ASSISTANCE FOR DENTAL BENEFITS

The ACA supports a variety of consumer assistance entities, such as Navigators, In-Person Assisters, Certified Application Counselors, and agents and brokers, to help consumers understand their coverage options and whether they qualify for federal subsidies. The federal government establishes standards for training assistance entities working in federally facilitated marketplaces (to which states can add), whereas state-based marketplaces may follow the federal marketplace’s guidance or can establish their own. Meeting participants were concerned about the level of training that consumer assistance entities receive specifically related to dental benefits. Some states have taken extra steps to ensure that consumer assistance entities are trained on the specifics of dental coverage in their states in order to adequately help consumers make informed decisions. For example, the Children’s Dental Health Project (CDHP) has partnered with state officials in Connecticut to help develop dental training modules and quick reference materials for the state’s marketplace navigators and in-person assisters.¹⁰⁴ CDHP has also participated in web-based trainings sponsored by the federal Health Resources and Services Administration (HRSA) to educate stakeholders about pediatric dental benefits under the ACA and provide information designed to inform navigators and assisters.¹⁰⁵ To better inform their training efforts, Rhode Island provided an opportunity for each medical carrier to describe its products to state officials, and dental carriers were afforded the same opportunity. This process has helped ensure that adequate information about dental benefits is incorporated into training protocols in Rhode Island. Meeting participants identified a need for established mechanisms for obtaining feedback from navigators and other assister entities.

POLICY OPTIONS FOR ADDRESSING ISSUES WITH CONSUMER EXPERIENCE

Meeting participants identified a range of potential actions, many of which are applicable to both states and federally-facilitated marketplaces.

- Provide dental training for navigators and other consumer assistance entities to ensure they understand the specifics of dental benefits in their state’s marketplace.
- Utilize feedback from navigators and other consumer assistance entities to address consumer concerns and improve the provision of dental benefits.
- Develop relationships with other state entities that have expertise with oral health programs—including Medicaid, CHIP, Title V, and state dental directors—to partner around efforts to monitor uptake of dental insurance, measure access to care, and conduct dental-specific outreach.

- Monitor uptake, purchasing demographics, and any issues with access to care among the newly insured in order to identify issues and create targeted solutions. Provide periodic data reports to stakeholders.
- Require more robust and standardized benefit, premium, and cost-sharing information to enable comparisons of dental coverage between plans.
- Ensure that marketplace websites are designed to display clear information and messaging about dental products and options; highlighting the use of the Summary of Benefits and Coverage form to identify whether dental is included in a medical plan or not.
- Design websites to present adults shopping for Qualified Health Plans (and potentially Medicaid) with the option to purchase dental coverage prior to checkout.
- At the state level, require families with children to purchase pediatric dental in a state offering stand-alone dental products.

CONCLUSION

The ACA includes important dental coverage provisions that, when added to Medicaid and CHIP coverage, move the country closer toward ensuring dental coverage for all children. The inclusion of dental benefits in marketplace offerings also appears to have opened up new opportunities for adult dental coverage. However, states face unique challenges in offering dental benefits in the marketplace. The decisions states make will greatly impact consumers. In most states, consumers will encounter a wide variety of insurance options—including plans with embedded benefits, plans offering dental and medical benefits separately, and potentially plans that are a hybrid option. However, consumers in most states are not required to purchase dental benefits and may opt to forgo dental coverage entirely, particularly if coverage is not affordable. Consumers in different states may face vast differences in premiums, availability of Advanced Premium Tax Credit, limitations on annual out-of-pocket maximums, and availability of adult coverage. In addition, due to limitations in federal and state IT systems, dental offerings in the marketplace may lack transparency for the consumer. While these challenges are realities of the current environment, state and federal policymakers have the opportunity to reevaluate policies and implement program design changes to make dental benefits more accessible and affordable to marketplace consumers over the next several years. This report includes a number of suggestions for such policy and program changes, based on early state experience and expert opinion, that we hope will be useful to states and the federal marketplace as they work to evaluate and improve plan offerings and consumer experience in obtaining dental benefits.

APPENDICES

APPENDIX A. EXPERT MEETING PARTICIPANT LIST

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 APPENDIX B. SUMMARY OF FEDERAL GUIDANCE RELATED TO DENTAL BENEFITS

Summary of Federal Guidance Related to Dental Benefits
 (As of March 2014)

Date	Type	Title and Citation		Key Points Related to Dental
23-Mar-10	Statute	Patient Protection and Affordable Care Act (ACA) Section 1302(b)(1)(J)		<ul style="list-style-type: none"> Includes “pediatric services, including oral and vision care” as part of the Essential Health Benefits (EHB).
23-Mar-10	Statute	ACA Section 1311(d)(2)(B)(ii)		<ul style="list-style-type: none"> Allows marketplaces to offer pediatric dental benefits as stand-alone products.
23-Mar-10	Statute	ACA Section 1302(b)(4)(F)		<ul style="list-style-type: none"> Allows qualified health plans (QHPs) to be certified even if they do not include pediatric dental benefits, as long as one stand-alone pediatric dental product is offered in the marketplace.
23-Mar-10	Statute	ACA Section 1311(d)(3)		<ul style="list-style-type: none"> Requires states to cover the costs of state-mandated benefits that exceed EHB requirements.
23-Mar-10	Statute	ACA Section 1402(c)(5)		<ul style="list-style-type: none"> For individuals enrolled in a QHP and a stand-alone dental product, cost-sharing reductions shall not apply to the portion properly allocable to pediatric dental benefits.
16-Dec-11	Sub-Regulatory Guidance	Essential Health Benefits Bulletin	Center for Consumer Information and Insurance Oversight	<ul style="list-style-type: none"> Gives states flexibility for 2014-2015 to define an EHB package based on one of four benchmark plans: (1) the three largest small group market plans in the state (2) the three largest state employee health plans (3) the three largest Federal Employees Health Benefit Program plans or (4) the state’s largest commercial non-Medicaid HMO plan.
27-Mar-12	Final Rule	Patient Protection and Affordable Care Act: Establishment of Exchange and Qualified Health Plans; Exchange Standards for Employers	Department of Health and Human Services FR 77, no. 59	<ul style="list-style-type: none"> Clarifies that cost-sharing limits and restrictions on annual and lifetime limits apply to stand-alone dental products for coverage of the pediatric dental EHB. Clarifies that states can choose to require QHPs to separately offer and price pediatric dental coverage if they find it in the best interest of the consumer, but there is no federal requirement. Clarifies that stand-alone dental products are considered a type of QHP and therefore must meet applicable QHP certification standards and allows states to establish certification standards that are unique to stand-alone dental products. Directs states to consider during the certification process whether stand-alone dental products in the marketplace will provide “sufficient access” to the pediatric dental EHB to all potential child enrollees.
23-May-12	Final Rule	Health Insurance Premium Tax Credit	Department of the Treasury FR 77, no. 100	<ul style="list-style-type: none"> Establishes that Advanced Premium Tax Credits will be computed based on the second-lowest cost silver plan and that tax credits will be first applied to a QHP and any remaining credit will apply to a stand-alone dental product.

Date	Type	Title and Citation	Key Points Related to Dental
25-Feb-13	Final Rule	Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation	Department of Health and Human Services FR 78, no. 37 <ul style="list-style-type: none"> • States in the preamble that issuers <i>outside</i> the marketplace must be “reasonably assured” that an individual (with or without a child) has obtained all 10 EHB, including pediatric dental coverage. • Outlines two options for states to supplement base-benchmark plans to meet the pediatric dental EHB requirement: (1) Federal Employees Dental and Vision Insurance Program or (2) Separate-CHIP. • Clarifies that states must offer all 10 EHB to individuals purchasing coverage <i>inside</i> the marketplace, however there is no requirement for an individual (with or without a child) to purchase pediatric dental coverage. • Allows for a separate out-of-pocket maximum for stand-alone dental plans and gives marketplaces the responsibility in 2014 for determining a “reasonable” out-of-pocket maximum for stand-alone dental plans. • Establishes a “high” and “low” approach for the actuarial value calculation of stand-alone dental plans, with “high” meaning 85 percent and “low” 70 percent.
25-Feb-13	Sub-Regulatory Guidance	FAQs about Affordable Care Act Implementation Part XII	Departments of Labor, Health and Human Services, and Treasury <ul style="list-style-type: none"> • Delays the limitations on annual out-of-pocket maximums in cases where multiple service providers help administer benefits (e.g. separate administrators for medical, behavioral, dental, and/or pharmacy benefits) until 2015.
5-Apr-13	Sub-Regulatory Guidance	Letter to Issuers on Federally-facilitated and State Partnership Exchanges	Center for Consumer Information and Insurance Oversight <ul style="list-style-type: none"> • Establishes that the Federally-facilitated Marketplace (FFM) will not include bundled plans in 2014 nor will it require embedded plans to offer and price the pediatric dental EHB separately in 2014. • Requires stand-alone dental plans to publicly display whether their rates are guaranteed or not. • Cites ACA 1402(c)(5) to mean cost-sharing reductions can only be applied to pediatric dental benefits if offered through an embedded plan (not stand-alone or bundled). • Sets the limit on annual out-of-pocket maximums in the FFM at \$700 for one child and \$1,400 for two or more children for 2014. • Outlines which QHP certification standards are applicable to stand-alone dental products—including actuarial value (modified), inclusion of Essential Community Providers, service area requirements, non-discrimination, and network adequacy standards--and which are not applicable.

Date	Type	Title and Citation		Key Points Related to Dental
15-Jul-13	Final Rule	Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment	Centers for Medicare & Medicaid Services FR 78, no. 135	<ul style="list-style-type: none"> Establishes the process for state selection of EHB benchmarks for Medicaid Alternative Benefit plans.
30-Oct-13	Final Rule	Patient Protection and Affordable Care Act: Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014	Centers for Medicare & Medicaid Services FR 78, no. 210	<ul style="list-style-type: none"> Reiterates that while stand-alone dental products are a type of QHP, they are not subject to all requirements that apply to QHPs (as stated in the March 2012, Exchange Establishment Rule). Specifically, since dental benefits provided through a stand-alone product are considered "excepted benefits" under 2791 (c) of the Public Health Service Act, they are not subject to rating rules, medical loss ratio standards, or prohibition against denials for pre-existing conditions, though states or issuers have the option to apply these standards.
4-Feb-14	Sub-Regulatory Guidance	2015 Letter to Issuers in the Federally-facilitated Marketplace (FFM)	Center for Consumer Information and Insurance Oversight	<ul style="list-style-type: none"> Generally upholds the approaches outlined in the 2014 Letter to Issuers as it relates to stand-alone dental policy standards.
11-Mar-14	Final Rule	Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2015	Centers for Medicare & Medicaid Services FR 79, no. 47	<ul style="list-style-type: none"> Finalizes the annual limit on cost-sharing for stand-alone dental products at \$350 for one child and \$700 for two or more children, applicable to all marketplaces in the 2015 benefit year. Maintains that stand-alone dental plans must meet either "high" or "low" actuarial value standards (70 and 85 percent respectively) for plan year 2015.

APPENDIX C. INDIVIDUAL MARKETPLACE PEDIATRIC DENTAL BENEFIT DECISIONS FOR 2014

Individual Marketplace Pediatric Dental Plan Decisions for 2014

(As of March 2014)

Source documents are embedded in the chart as links

State	Marketplace Type	Stand-Alone Dental Policy (SADP)	Embedded (QHP includes pediatric dental benefits)	Bundled (QHP contracts with a dental issuer)	Requirement to Purchase Pediatric Dental (inside the marketplace)	2014 Annual Out-Of-Pocket Maximum for SADP	Pediatric Dental Benchmark Selection
All Federally-Facilitated Marketplace (FFM) States		✓	✓		No	\$700 for one child enrollee or \$1,400 for two or more child enrollees.	Varies by state: 12 CHIP, 22 FEDVIP, 1 Included
California	State-Based Marketplace (SBM)	✓			No	\$1,000 for one child, \$2,000 for two or more children.	CHIP
Colorado	SBM	✓	✓	S	No	\$700 for one child, \$1,400 for two or more children.	CHIP
Connecticut	SBM		✓		N/A	N/A	CHIP
District of Columbia	SBM	S	✓	S	No	\$1,000 for one child, \$2,000 for two or more children.	FEDVIP
Hawaii	SBM	✓	✓		No	\$700 for one child, \$1,400 for two or more children.^[1]	CHIP
Idaho	SBM	✓	✓		No	\$1,000 per person.	FEDVIP
Kentucky	SBM	✓	✓		Yes	\$1,000 for one child, \$2,000 for two or more children.	CHIP
Mass.	SBM	✓	✓		No	\$1,000 for one child, \$2,000 for two or more children.^[1]	CHIP

State	Marketplace Type	Stand-Alone Dental Policy (SADP)	Embedded (QHP includes pediatric dental benefits)	Bundled (QHP contracts with a dental issuer)	Requirement to Purchase Pediatric Dental (inside the marketplace)	2014 Annual Out-Of-Pocket Maximum for SADP	Pediatric Dental Benchmark Selection
Maryland	SBM	✓	✓	S	No	\$1,000 for one child, \$2,000 for two or more children.	CHIP
Minnesota	SBM	✓	✓	S	No	\$700 for one child, \$1,400 for two or more children. ^[1]	FEDVIP
New York	SBM	✓	✓		No	\$700 for one child, \$1,400 for two or more children.	CHIP
Nevada	SBM	✓	S	S	Yes	\$700 for one child, \$1,400 for two or more children.	CHIP
Oregon	SBM	✓	✓		No	\$1,000 per person.	CHIP
Rhode Island	SBM	✓	✓ (Individual market only)		No	\$700 for one child, \$1,400 for two or more children. ^[1]	FEDVIP
Vermont	SBM	S	✓	S	No	N/A	CHIP
Washington	SBM	✓ (Individual market only)			Yes	No imposed dollar amount – OOP deemed ‘reasonable if EHB is covered and actuarial value is met.’ ^[2]	CHIP

Key

✓ = State is offering this type of product in plan year 2014

S = State solicited for this type of dental offering but did not receive any submissions and is not offering this type of product in plan year 2014

^[1] Information obtained through correspondence with the National Association of Dental Plans

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