How Will the Affordable Care Act Affect Pediatric Dental Practices?

by Mary Essling and C. Scott Litch[1]

Overview

This question was the key focus of the AAPD's Sept. 28, 2013, conference on *The Impact of the Affordable Care Act on the Pediatric Dental Practice*. This article provides a brief overview of key issues.

Two key components of the Affordable Care Act (ACA), the employer mandate and the individual mandate, were scheduled to go into effect Jan. 1, 2014. However, enforcement of the employer mandate was recently postponed until Jan. 1, 2015. The employer mandate requires business owners with more than 50 full-time employees to provide health insurance or pay the government a $2,000-$3,000 penalty per employee. (Small businesses, i.e., those with less than 50 employees, are not required to offer health insurance coverage.) The individual mandate requires all Americans to obtain health care insurance by Jan. 1, 2014. As of press time, the individual mandate has not been postponed.

Beginning Oct. 1, 2013, small employers and millions of individual Americans may start shopping online for health care benefits through insurance exchanges—online portals (websites) offering essential health benefit packages that comply with the ACA.

Dental insurance carriers expect a lot of confusion for patients and for dental practices. This is because many consumers have never had dental insurance before. Many uninsured families do not speak English as their first language. Many will not understand the various dental plans available to them and how they will affect pediatric dental care. There is also concern that state and federal exchange portals may not offer adequate information to help a wide variety of consumers understand what they are buying.

The good news for pediatric dentists is that there will be more children with dental benefits and therefore more potential patients. A consultant's analysis prepared for the ADA estimated that 8.7 million children could gain extensive dental coverage through the ACA by 2018: 3.2 million under state Medicaid expansions, 3 million via health insurance exchanges or marketplaces, and 2.5 million via employer-sponsored insurance.

Some potential bad news for general dentists is that dental carriers expect to see some adults drop their dental coverage for financial reasons in order to obtain mandated pediatric dental benefits. A National Association of Dental Plans survey revealed that up to 50 percent of parents may drop their dental coverage if their children have dental coverage under medical policies.

Dental practices will also be affected as small employers because most have less than 50 employees. The ACA exempts employers with fewer than 50 full-time workers from the mandate to offer health insurance. While small employers are eligible for tax credits to help purchase insurance, most experts predict the credit will not significantly impact the offer of health insurance. If a dentist provides health insurance for employees, she will be able to purchase coverage for employees through a state or federal exchange. There will likely be more standardization in the medical plans available to small employers (i.e., less choice in plan design), and rates will be determined separately for each employee.

There are some burdens on small businesses under the ACA. All employers covered by the Fair Labor Standards Act (which includes any dental offices with employees) must furnish each employee with a notice about new health insurance marketplace coverage options available by Oct. 1, 2013. Some ACA revenue-raising taxes will likely be passed along as cost increases to the patient/family or dentist, such as the new tax on health insurers (which may impact premiums) and the new tax on medical devices (this tax includes dental devices) which may impact dental overhead costs.

Goal of the ACA

The goal of the ACA is to make health insurance more affordable for individuals and small businesses and to expand access to quality health care coverage. Despite the political rhetoric, it is not expected to prevent the ongoing rise in medical health care costs. The ACA requires all Americans to obtain health insurance (or pay a penalty) by Jan. 1, 2014. This so called "individual mandate" requires the purchase of "minimum essential coverage" via one of four options:

1. An individual or small group plan, which may be purchased in an exchange or outside an exchange;
2. A large group plan, which may be a medical plan provided by an employer;
3. A grandfathered plan (individual, small, or large group that existed on or before 3/23/10 and has had no change in benefits or carrier); or
4. A government program (Medicaid, CHIP, TRICARE, etc.).

Note that the requirements for minimum essential coverage are not the same as the components of an Essential Health Benefits package.

Health insurance purchased through insurance exchanges across the country must provide the following 10 essential health benefits:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices

- Laboratory services
- Preventive/wellness services and chronic disease management
- **Pediatric services, including oral and vision care.**

Among other things, the ACA prohibits discrimination against children with pre-existing medical conditions, which expands to adults after 2014. It also prohibits annual and lifetime maximum medical insurance limits beginning in 2014. Preventive care must be covered at 100 percent of the insurance plan's allowable fee, and young adults must be eligible for coverage on their parents' medical policies up to age 26.

In March 2013, D-HHS clarified that the pediatric dental benefit is mandated for children up to age 19. However, to be consistent with medical coverage, some dental insurers may voluntarily provide coverage up to age 26 for young adults who are on their parents' dental plans.

Insurance Exchanges

An insurance exchange is a Web portal for buying health insurance online. The federal government (D-HHS) has developed extensive rules regulating exchanges. Insurance exchanges went live Oct. 1, 2013, for individuals and small employers who choose to offer coverage to their employees. Large employers will not be able to purchase benefits through an insurance exchange until 2017. Until then, they will continue to purchase coverage as they do now. Coverage for essential health benefits purchased through insurance exchanges is scheduled to begin Jan. 1, 2014.

Each state must either set up its own insurance exchange or participate in a federal health insurance exchange. Eighteen states have decided to set up their own exchange. The remaining states will participate in one of two types of federal insurance exchanges: a Federally Facilitated Exchange—in which HHS performs all of the functions—or a Federal-Based Partnership model—in which the state has the option to certify which carriers will be permitted on the exchange and can manage customer service functions. Detailed information for each state exchange can be found at *www.healthcare.gov/marketplace/individual*.

Stand-alone Pediatric Dental Plans and other permutations

Stand-alone pediatric dental plans offered in state and federal exchanges cannot have annual or lifetime maximum dollar limits of coverage. However, plans can establish restrictions or limits on which types of dental procedures are covered. ACA regulations set out-of-pocket maximums (OOP), which is a new concept in dental insurance. This means there will be an OOP maximum for patients under age 19 when covered by an individual or small group standalone pediatric dental plan purchased through an exchange. However, patients/families will need to understand that OOP maximums only apply to services provided by in-network dentists. (Patients can go out of network to satisfy deductibles but out-of-network costs do not apply to OOP limits.) States that participate in federal insurance exchanges will likely have a $700 pediatric dental OOP maximum per child, capped at $1,400 for two or more children. The OOP maximum in state-run exchanges may be up to $1,000. Once the patient's OOP maximum is satisfied, any remaining dental treatment is covered at 100 percent of the carrier's allowable fee.

D-HHS has identified two benchmarks for stand-alone pediatric dental care benefits: the Children's Health Insurance Plan (CHIP) and the MetLife High Option Federal Employee Dental and Vision Insurance Plan (FEDVIP). A benchmark only defines the scope of benefits that must be offered. It does not define exactly what the plan must look like in terms of deductibles, copayments, frequency limitations, and all the variations that concern dental practices when trying to determine how much they are going to be paid for services they provide. States that have chosen to create their own insurance exchange could select either CHIP or FEDVIP as their benchmark for pediatric dental coverage. FEDVIP will be the default benchmark for states that have chosen to participate in a Federally Facilitated or Federal Partnership exchange but did not make a choice about the dental benchmark.

There are three ways that pediatric dental benefits may be offered through insurance exchanges:

1. Through a stand-alone dental plan. Similar to most dental insurance plans available today, a true stand-alone plan can be "coupled" with any medical plan that parents have (i.e., one company provides the medical insurance and a separate company provides the dental insurance). When essential pediatric dental benefits are sold as a standalone plan, consumers will have a high option (85 percent actuarial value) and a low option (70 percent actuarial value). Actuarial value refers to the overall ratio of covered services that are paid by the plan versus those that are paid by the patient. As noted above, stand-alone pediatric dental plans will have a separate OOP maximum.
2. Through a "bundled" stand-alone medical and stand-alone dental plan. Bundled means that the medical policy and dental policy are tied together. Although separate, the dental plan can only be coupled with a specific medical plan (e.g., a Kaiser Health plan that is bundled with a Delta Dental plan). In other words, the bundled stand-alone dental policy can only be purchased with a specific medical plan.
3. Through an "embedded" qualified health plan. "Embedded" means there is only one policy, which includes both medical and dental coverage. Because there is only one policy, there is typically only one cost-sharing limit that applies to both the medical and dental benefits that affects the patient's total coverage. In other words, the patient may have a $2,000 deductible for ALL benefits. If a child receives no medical care during a year, it is possible that there may be NO coverage for dental services until the $2,000 deductible is satisfied, which can be satisfied by paying $2,000 out-of-pocket for medical and /or dental services.

At this time, no one knows exactly how medical plans will manage their dental benefits when they are embedded in a medical policy. However, it is expected to be much less expensive for medical plans to embed dental benefits under a single combined OOP maximum and a single deductible, so a combined medical/dental OOP maximum and deductible is a strong possibility. Furthermore, it is likely that many patients will have embedded pediatric dental plans because they are expected to be cheaper than purchasing a stand-alone dental plan. This has the potential to become a significant challenge for dental teams because parents

may not understand that embedded pediatric dental benefits may not be available until a large combined medical/dental deductible is first satisfied.

Treatment of General Anesthesia Coverage Laws

Per the Nov. 20, 2012, federal proposed regulations on *Essential Health Benefits, Actuarial Value, and Accreditation Standards: Ensuring Meaningful, Affordable Coverage*, an essential health benefit will include all state health insurance mandates enacted prior to Dec. 31, 2011. This means that general anesthesia coverage for dental services will be an EHB in plans offered under health insurance exchanges in those states that have passed such laws (see: *http://www.aapd.org/advocacy/general_anesthesia_legislation/).* The only general anesthesia mandate that misses this deadline is in Pennsylvania, where the law was enacted in 2012.

Resources

The AAPD has created a website page that collects important materials concerning implementation of essential health benefits state-by-state under the ACA, including key regulations and other guidance. Go to *http://www.aapd.org/member/login/?Redir=%2fadvocacy%2fessential_health_benefits%2f*, then log in with your member ID and password. This page will be frequently updated, so we encourage members to bookmark and check periodically.

The ADA has produced a series of four ACA summaries that are extremely useful and cover a number of issues discussed in this article.

http://www.ada.org/news/9043.aspx

http://www.ada.org/news/8991.aspx

http://www.ada.org/news/8935.aspx

http://www.ada.org/news/8873.aspx

Conclusion

Expect more pediatric patients to have dental insurance, potentially fewer adults with dental coverage, and plenty of confusion. There will be a wide variety of pediatric dental plans sold on exchanges throughout the country. Initially, state and federal Web portals may not provide sufficient information to help new health insurance consumers understand what they are buying. Many patients and dentists will be confused due to the way that deductibles and OOP maximums are handled by embedded versus stand-alone dental plans. Furthermore, pediatric dentists need to be aware that they may need to contract with a medical PPO or HMO in order to receive embedded dental benefits so that the OOP maximum applies.

Obviously there are intense politics swirling around ACA implementation. Lower health care costs and insurance premiums are based on the assumption of everyone becoming insured. If insurance exchanges don't work well, i.e. premiums are too high or claims are not paid as expected, people may drop their insurance altogether and pay the penalty instead. ACA critics are predicting that the ACA will not work as well as originally planned, because unless the covered individual is at the poverty level or just above, the subsidies are not going to make insurance more affordable for most Americans. In fact, those who do not qualify for Medicaid or Medicare may find that their health care insurance premiums increase. Only time will tell if the ACA is a worthwhile endeavor.

In the meantime, Americans in the individual and small-employer markets will start shopping for pediatric dental benefits beginning Oct. 1, 2013. Try to anticipate the questions that your dental team will soon receive from parents and guardians. Proactively educate staff so they are prepared to help families understand the various options available for pediatric dental coverage and the impact that their choice of plans will have on their out-of-pocket expenses.

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New Privacy Practice Notices Required - ADA Updates HIPAA Manual

Model Notices of Privacy Practices are available from the U.S. Office for Civil Rights for use by HIPAA-covered health care providers and health plans. Most covered entity dental practices must provide notices explaining how the practice may use and disclose patient information and some of the rights patients have to control their information. For more information, go to *http://www.ada.org/news/9053.aspx*.

The ADA Complete HIPAA Compliance Kit (J598) describes changes under the HIPAA omnibus final rule and offers tools to help dentists design and implement a comprehensive HIPAA compliance program. To purchase the kit visit *http://www.ADAcatalog.org* or call the ADA member service center at (800) 947-4746.

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