

# Children's Dental Health Project

# ISSUE BRIEF

MARCH 2012

## Making CHIP Work for Kids: Changes in State CHIP Dental Coverage Subsequent to CHIPRA

### CHANGES IN PEDIATRIC DENTAL COVERAGE IN THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Despite major policy changes in the past five years, startling disparities in the oral health of children remain in the United States. With dental disease in children maintaining the unfortunate top position among chronic conditions in children, there is growing pressure to ensure that children at greatest risk for dental caries (the disease that causes cavities) have assistance in paying for necessary care. While the Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit includes comprehensive dental services, until recently, Medicaid's sister program, the Children's Health Insurance Program (CHIP), was not required to provide dental services. However, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) amended the 1997 law to mandate dental coverage for all child beneficiaries in CHIP. Currently, 12 states implement CHIP through a Medicaid expansion that automatically meets this requirement as their dental benefit is provided through the EPSDT benefit package. However, the remaining states with combination and separate CHIP programs are now required to revisit their dental plan design to ensure that it meets CHIPRA dental coverage requirements. In addition, the new Patient Protection and Affordable Care Act (ACA) also included a pediatric dental benefit in the required Essential Health Benefit Package. In a December 16, 2011 Bulletin on the Essential Health Benefit Package the Department of Health and Human Services outlined proposed benchmarks for meeting the pediatric dental component which include, but are not limited to, the state's separate CHIP dental benefit. While regulations on the CHIPRA pediatric dental benefit are currently being drafted, this document provides background information and resources for state policymakers to review what has been done to date in specific states and better understand the opportunities in CHIPRA and ACA to improve access to and affordability of dental coverage for working families.

### CHIPRA DENTAL BENEFIT

CHIPRA instructs states to provide dental services "necessary to prevent disease and promote oral health, restore oral structures to health and function and treat emergency conditions" and authorizes dental benefits to be provided through existing commercial benchmark plans regardless of whether they provide coverage as outlined in the definition. States with separate CHIP plans are provided the option to implement their dental benefit by either providing "dental coverage that is equivalent to a benchmark dental benefit package" or by establishing a "state-defined benefit" that meets the statutory definition of necessary coverage. The three benchmark coverage options are: "(1) the supplemental dependent dental plan most frequently selected under the Federal Employees Health Benefit Plan in the past two years (MetLife); (2) the State employee dependent dental benefit that has been selected most frequently by employees seeking dependent coverage in the past two years; and (3) the dental benefit plan provided by the State's largest insured commercial non-Medicaid plan of

For more information on pediatric dental benefits under CHIPRA and ACA, visit [www.cdhp.org](http://www.cdhp.org) or contact the Children's Dental Health Project at [cdhpinfo@cdhp.org](mailto:cdhpinfo@cdhp.org).



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dependent covered lives that is offered in the State involved.”<sup>1</sup>

In October 2009, the Centers for Medicare and Medicaid Services (CMS) notified State Health Officials that those electing to develop a “state-defined benefit option” must (1) cover all medically necessary oral health services and (2) provide services within each of the American Dental Association’s nine categories of dental service.<sup>2</sup> States electing benchmark-equivalent coverage need not provide all medically necessary oral health services if the benchmark does not do so. CMS is expected to issue formal rules regarding the CHIPRA dental benefit in 2012.

An examination of a survey conducted by the National Academy for State Health Policy (NASHP) before the passage of CHIPRA reveals that many states with separate CHIP programs would not meet the new CHIPRA mandate and would need to expand the range of covered services, remove dollar-caps, do both, or select a different type of plan in order to comply.<sup>3</sup> To understand this finding requires familiarity with the difference in design between commercial-style dental coverage, the CHIP dental benefit, and Medicaid, coverage as well as an appreciation for the legislative history of the dental mandate.

## PEDIATRIC DENTAL COVERAGE

Commercial group dental coverage, exemplified by the three benchmarks, is predicated on a business model of shared prepayment rather than on the basis of shared risk as is typical in medical insurance. Dental coverage typically pays 100% for preventive services, 80% coverage for basic reparative services, and 50% coverage for complex reparative services based on procedure-specific dollar allowances. Plans typically feature annual dollar caps, lifetime dollar caps, service exclusions, substitutions, and a variety of other cost-control measures. Two particularly costly items, orthodontic coverage and coverage for extraction of third molars (wisdom teeth), are tightly capped in order to limit the cost to the dental plan. Importantly, covering only “medically necessary” has not yet become a for commercial dental plans though doing so would reduce the burden of these costly services.

In sharp contrast, Medicaid EPSDT requires comprehensive coverage including medically necessary orthodontics and third molar extraction at no cost to beneficiaries’ families for any and all necessary care as well as regular and ongoing dental services provided at intervals that are established in consultation with pediatric dental authorities in the state.<sup>4</sup> In formulating the CHIPRA dental benefit, Congress sought to ensure that coverage is sufficiently comprehensive to meet children’s needs (therefore the language calling

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for “prevention,” “restoration” and “emergency services”) yet reflective of the commercial market (therefore listing “benchmark options”). CMS, through its State Health Official letter, has similarly sought to respect the legislation’s articulation of a required benefit while also accommodating the allowance of benchmarks.

## REVIEW OF STATE CHIP DENTAL PLANS

While awaiting final rules from CMS, states may voluntarily submit their CHIP dental plan for approval through the State Plan Amendment (SPA) process. As of May 2011, nine states had received SPA approval for CHIP dental benefits from CMS and five additional states had submitted dental SPAs for consideration. Examination of these initial SPAs provides the best assessment of how states are likely to pursue the new requirement and what CMS accepts as meeting their initial guidance.

In December of 2011, the National Maternal and Child Oral Health Policy Center (Policy Center) released CHIP Dental Coverage: An Examination of State Oral Health Benefit Changes as a Result of CHIPRA, a brief reviewing the approved and pending SPAs as of May 2011. It examined the SPAs for evidence of changes made to comply with CHIPRA and sought to elucidate factors that may affect state decisions, now and in the future. This document is meant to be a response to the Policy Center brief and provides recommendations to CMS for ensuring that future SPAs adhere to the requirements of comprehensive dental coverage as defined in the 2009 statute.

By May 2011, CMS had approved eight CHIPRA Dental SPAs. Six SPAs were from states that adopted state-defined benefit designs (AL, IA, FL, MI, NV, WA, WY) and two were from states that adopted the state employee benefit benchmark (MT, TN). Four additional SPAs were under consideration of which three adopted state-defined benefit designs (MA, NJ, TX) and one adopted a benchmark plan (PA). Additional details on each SPA can be found in Table 1 of the Policy Center document.

Among the approved SPAs, the seven states with state-defined dental plans all comply with the two CMS requirements of providing medically necessary care and addressing all nine of the standard dental categories of treatment (diagnosis, prevention, restoration, endodontics, periodontics, prosthodontics, oral surgery, orthodontics, and emergency services). In three of these states (FL, NV, WA) there is no annual dollar limit. In the remaining four states (AL, IA, MI, WY) annual dollar limits ranging from \$1000-\$1500 can be overridden as needed for medically necessary care. Similarly, two of the four states with pending SPAs for state-defined dental plans ( MA, NJ) propose full benefits and assure affordability while the fourth (TX) may be incompatible with CMS guidance as it appears to limit orthodontic coverage only to children with craniofacial malformations (through payment by its health plan) in addition to placing a maximum annual limit of \$1000.

In contrast to approved SPAs from states with state-defined plans, the two states with approved SPAs that elected benchmark plans do not assure the availability of all outlined medically necessary care and costs are capped. Montana excludes all orthodontic care and establishes an annual dollar cap of \$2588 while Tennessee limits orthodontics to medically necessary care for children who have been enrolled for at least one year and establishes an annual dollar limit of \$1000 (exclusive of orthodontics with an additional \$1250 lifetime limit). Pennsylvania, the only state with a pending SPA for a benchmark plan, has a nominal annual limit of \$1500 (and a lifetime orthodontic benefit of \$5200) and does allow care beyond the annual cap when needed for medically necessary care.

While there are still too few SPAs to fashion a national picture of dental plans post-CHIPRA, comparing and contrasting approved and pending SPAs reveals a number of consequential variations that will impact families:

1. CHIPRA has successfully ensured coverage that better meets children's needs. In particular, CHIPRA has resulted in increased dollar limits in many states so that children can have more insurance-funded care during a year, including orthodontic coverage.
2. While children's needs do not vary between states, there remains significant variation across states in benefit design, nominal and hard dollar limits, prior authorization and appeals processes that result in markedly different experiences for children and families depending upon their state of residence.
3. There appears to be far greater consistency across states in coverage for diagnostic, preventive, and reparative

services than for orthodontic services which range from quite limited (e.g. craniofacial malformations) to reasonably broad (e.g. "orthodontic needs" in IA).

4. The CHIPRA legislative mandate that coverage must meet the preventive, restorative, and emergency needs of children to ensure their health and function appears to be circumvented or diminished when states elect benchmark plans as exemplified by MT's and TN's hard dollar limits and MT's exclusion of orthodontic care.
5. To date, more states elect state-defined plans over benchmark plans, perhaps because the statutory out-of-pocket limits (5% of family annual income), negate the cost-savings value of cost sharing that is typical of commercial/benchmark plans.

## CHIP BENCHMARKS IN THE ESSENTIAL HEALTH BENEFITS

In December, the Department of Health and Human Services (HHS) issued preliminary guidance to states on the definition of the Essential Health Benefits Package, specifying that a benchmark plan approach, similar to CHIPRA is likely to be utilized for the purpose of providing services equivalent to those covered by a typical employer-sponsored plan.<sup>5</sup> In structuring this approach, HHS identified four benchmark plans states may adopt for offering on the Exchanges:

- the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market;
- any of the largest three State employee health benefit plans by enrollment;
- any of the largest three national Federal Employees Health Benefits Plan (FEHBP) options by enrollment; or
- the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.

However, HHS recognized that only a small percentage of individual and small-group market plans cover "pediatric oral and vision services" and is considering allowing states to utilize the Federal Employees Dental and Vision Program (FEDVIP) or the state's CHIP dental benefit for those states with separate CHIP programs. The bulletin goes on to propose that non-medically necessary orthodontics would not be covered. CDHP analysis of both the FEDVIP plans and the approved CHIP dental plans demonstrates a great deal of variability both in terms of medically necessary services covered and out of pocket costs to families. With less than a dozen states having approved SPAs for the CHIP dental benefit, it is unclear whether states will choose the FEDVIP or CHIP plans as the

benchmark for the pediatric dental portion of the Essential Health Benefits and whether the CHIP plans would provide a benefit robust enough to meet the requirements of the ACA. This uncertainty underscores the importance of clear guidance from CMS on the CHIP benefit as does the fact that many children are likely to move between CHIP, Medicaid, and the Exchanges. Creating relative consistency of benefits across these programs is critical to ensuring that children receive comprehensive care regardless of the mechanism through which they obtain coverage.

## LOOKING FORWARD

As CMS continues to review CHIP dental SPAs and deal with the disparities in the coverage and dollar limits that are evident between state-defined plans and benchmark plans, it will gain substantive information that can inform its final rulemaking. Future oversight should promote consistency across states and assure comprehensiveness of coverage by clearly addressing caps and medically necessary services. We therefore put forth the following recommendations to CMS:

**Provide clear and consistent guidance and oversight on benefit design and exclusions of services that meet the definition of dental benefits in CHIPRA.** Families eligible and enrolled in CHIP are by definition at higher-risk than a child on a typical employer sponsored plan with less financial means, therefore imposing annual caps that are found in typical employer sponsored plans (e.g., \$1,000) are likely to limit the delivery of services in a manner contrary to the statutory definition. Creating a mechanism for the coverage of medically necessary services regardless of plan caps and limits would increase the likelihood that children, especially those in the high risk category, receive the full benefit of their dental coverage through CHIP.

**Provide clear guidance and oversight on acceptable cost-sharing, financial benefit limits and tracking of medical and dental expenses.** It is critical that CMS provide the guidance and oversight needed to ensure that families have affordable dental coverage. Regulations should provide clarification as to who is responsible for tracking out-of-pocket expenses and informing families, providers and insurers when limits have been reached.

**Encourage cost-effective risk-based pediatric dental benefits. Providing regulatory clarity for existing models of dental coverage is essential.** However, we also recommend that CMS allow for flexibility to provide cost-effective risk-based pediatric dental benefits. On September 27, 2011 Children's Dental Health Project forwarded a letter

to Secretary Sebelius signed by 55 organizations and 39 dental benefit companies supporting the use of pediatric dental benefit that reflects current science, best practices and professional recommendations as the foundation for the essential pediatric dental benefit in the Affordable Care Act.<sup>6</sup> Such a benefit supports early, timely, and ongoing oral health care (preventive and restorative) that is tailored to a child's level of risk and needs. Future CHIP regulations should acknowledge and incentivize a benefit design that aligns with current professional standards, is more cost effective and attends to the health of children, eliminates procedures that use excessive resources and lack an evidence-base, and can provide more cost effective care to this higher risk population.

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## CONCLUSION

While both CHIPRA and the ACA represent marked improvement in terms of expanding coverage and improving affordability for families, much work will need to be done by federal and state officials to realize the full promise of both laws. Regulations should provide clear guidance to states on how to guarantee families access to comprehensive dental coverage across programs. Additionally, plan development and program implementation requirements should address the clinical needs of children as well as the financial situation of families in order to fully meet the requirements of the statutes.

## END NOTES

[4] Issue Brief: *Making CHIP Work for Kids: Changes in State CHIP Dental Coverage Subsequent to CHIPRA*

# Issue Brief

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<sup>1</sup> CMS CHIPRA State Health Official Letter #1, April 9, 2009

<sup>2</sup> CMS CHIPRA State Health Official Letter #7, October 7, 2009.

<sup>3</sup> Catherine Hess, et al., Charting CHIP IV: A Report on State Children's Health Insurance Programs Prior to Major Federal Policy Changes in 2009 and 2010 (Washington, DC: National Academy for State Health Policy) 81.

<sup>4</sup> CMS Guide to Children's Dental Care in Medicaid, 2004. ("Section 1905(r)(3) of the Social Security Act specifies that dental services: 1) are to be provided at intervals that meet reasonable standards of dental practice, as determined by the state after consultation with recognized dental organizations involved in child health care; 2) are to be provided at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and 3) shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.")

<sup>5</sup> EHB Bulletin available at [http://cciio.cms.gov/resources/files/Files2/12162011/essential\\_health\\_benefits\\_bulletin.pdf](http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf)

<sup>6</sup> Essential Health Benefit sign-on letter. September 2011, available at: [http://www.cdhp.org/resource/dental\\_benefit\\_consensus\\_letter\\_secretary\\_sebelius](http://www.cdhp.org/resource/dental_benefit_consensus_letter_secretary_sebelius).



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CDHP's mission is that of creating and advancing innovative solutions by engaging a broad base of partners including professionals, communities, policymakers, and parents. We work to eliminate barriers to preventing dental disease across the age span and, in particular, to ensure that all children enjoy the benefits of robust oral health so that they can grow, learn, and smile their way to their full potentials.