ACCESS TO CHILD-ONLY SUPPLEMENTAL DENTAL COVERAGE THROUGH CHIPRA:

A Handbook for Advocates and Policymakers

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Overview & Background

The 2009 reauthorization of the Children's Health Insurance Program (CHIPRA) for the first time specifically addressed the oral health of children. CHIPRA's many dental provisions established a new and comprehensive approach to oral health for beneficiaries by providing a dental benefit, public information about available providers, increased accountability, among others. In addition, CHIPRA added the ability for states with separate CHIP plans to provide supplemental dental coverage to children that would otherwise be eligible for CHIP, but for their private medical coverage disqualified them from any CHIP coverage prior to the new CHIPRA law. This new child-only supplemental dental coverage allows families to maintain their private/employer-sponsored health insurance that may have limited or no dental coverage to enroll in CHIP supplemental dental coverage.

CHIPRA has allowed states with a separate CHIP plan to adopt the supplemental dental coverage since April 2009, prior to the Patient Protection and Affordable Care Act (ACA) – the new health reform law, which will provide dental coverage for children thorough plans offered in the state-based Exchanges when they are rolled-out in 2014. ACA also extended CHIP until 2019 (with funding extended from the end of CHIPRA in 2013 through 2015) which maintains the option for states to provide the supplemental dental coverage to working families while maintaining their employer-sponsored health coverage. States have significant decisions to make about the implementation of ACA in the coming years – including specifics about pediatric dental benefits. While the design of the supplemental dental coverage may change as additional coverage requirements and coverage options are shaped, this option remains available to states to address the overwhelming disparities in access to oral health care in the United States.

The structure of dental care in the United States relies on a historic disconnect between medical and dental care. These separate health benefits systems, medical insurance and dental coverage, has been maintained with little overlap of the two even at times when they reside within the same corporate entity. Unfortunately, this arrangement of separate coverage has created a society wherein fewer individuals have dental coverage than medical coverage due to numerous financial and other circumstances that have made dental coverage less accessible to many families. According to the 2004 federal Medical Expenditure Panel Survey (MEPS), for the US population in general 54% had private dental coverage (vs. 64% private medical), 12% had public coverage (vs. 19% public medical) and 35% had no dental coverage (vs. 17% medically uninsured). While children were more likely to have public dental coverage (26%) compared to adults (5% non-elderly population) – 20% of children remained without dental insurance, primarily from low-income families.[i]

A review of the CHIPRA Law

As of October 1, 2009, states were required to provide CHIP enrolled children a dental benefit that either meets the definition of "…coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions" or provide benefits equivalent to those found in one of the identified benchmark dental benefit package which include a) the most frequently selected coverage in the federal employees health benefit package, b) the most frequently selected state employee dependent dental coverage in the last 2 years, or c) the largest (most covered lives) commercial non-Medicaid dependent dental plan in the state. This new mandate provides families the stability of dental coverage within the CHIP program that previously did not exist when dental benefits were optional.

In addition to stabilizing the dental benefit, the CHIPRA legislation included a state option as of April 1, 2009, to provide child-only supplemental dental coverage. The statute states, *"…in the case of any child who is enrolled in a group health plan or health insurance coverage offered through an employer who would, but for the application of paragraph (1)(C), satisfy the requirements for being a targeted low-income children under a state child health plan that is implemented under this title, a State may waive the application of such paragraph to the child in order to provide --- (i) dental coverage consistent with the requirements… (ii) cost-sharing protection for dental coverage consistent with such requirements…"*[ii]

Step-by-Step Guide for States

States that are debating whether to provide child-only supplemental dental coverage are likely to seek specific data to make that determination. The following information provides a framework for thinking through the options and requirements of the child-only supplemental dental coverage.

Step 1: Why would my state want to implement the child-only supplemental dental coverage option?

Providing the child-only supplemental dental coverage is an option for states therefore significant consideration will be taken to determine if the gains outweigh the cost to the state. The fundamental issues that a policymaker is likely to be balancing are a) the number of children that need dental coverage vs. the ability of supplemental dental coverage to reduce the burden of unmet dental needs and b) the cost of providing the additional coverage vs. any averted costs by providing dental coverage to families that are able maintain their health coverage in the private market.

- Reducing Unmet Dental Need: Nationally, dental care tops the list of parent reported unmet needs. Child-only supplemental dental coverage provides an opportunity provide access to dental care to families for which dental coverage is out of reach. Parents report unmet dental needs three times more often as medical care, four times that of vision care and tops the list of unmet health care for families of children with special needs – surpassing mental health, home health, hearing aids and all other services.[iii,iv] Dental caries, the chronic and infectious disease that leads to cavities, is progressive if not addressed early. Children that have ongoing untreated dental disease suffer from pain and infection that can hinder their ability to learning in school and if it remains untreated can cause oral health problems into adulthood. States such as California and Maine have begun to document the impact of unmet dental needs through the use of emergency departments. Specifically, Maine has reported that dental disease was the top diagnostic reason for an emergency department visit among uninsured and publicly insured young adults.[v] Additionally, California reports statewide emergency department visits (not resulting in hospitalization) were higher for dental conditions than for diabetes.[vi] The consequence of untreated dental disease in young children reaches beyond childhood into disruption in future employment and health status.
- Maintaining Families on Private Medical Coverage: Anecdotal information has been collected about families dropping employer coverage that lacked or provided limited dental coverage in order to obtain comprehensive (medical & dental) public coverage to access essential dental care for their child. In fact, a recent California HealthCare Foundation study found that "nearly 60 percent of those who failed to get the dental care they needed last year said that they couldn't afford it. An additional 17 percent cited lack of dental insurance as the reason." Maintaining families' enrollment in a private and/or employer-based medical plan may be optimal if comprehensive coverage is available. However, although employers often recognize the importance of providing dental coverage, in recent years employers have begun to shift a greater portion of the cost of dental insurance to employees to maintain the benefit. Reports have confirmed that families are less incline to have coverage or take on the additional cost when employers raise the contribution necessary to keep coverage.[vii] Therefore, if a state has a goal of promoting CHIP-eligible families in private/employer-sponsored insurance, providing supplemental dental coverage may create a less costly option, for families and the state to achieve access to comprehensive health coverage for children in working-poor families.

Step 2: Is my state eligible for the option?

Only states that provide CHIP coverage through a separate, non-Medicaid expansion program are eligible to provide the child-only supplemental dental coverage option. States that provide CHIP coverage through a Medicaid expansion are required to provide EPSDT benefits (including dental benefits). In fact, children with private coverage cannot be denied Medicaid enrollment. Thus, children with no or limited dental coverage, can be enrolled in Medicaid and receive dental benefits and other important health services not covered by their private insurance.

States that provide separate CHIP coverage must also meet a set of core criteria to seek approval from the federal Centers for Medicare and Medicaid Services (CMS) to provide supplemental dental coverage. Those criteria include the following:

- Eligibility Standard: The state CHIP program must be providing coverage for children at the level permitted by the state as of January 1, 2009 (e.g., if the state's CHIP eligibility was 200% FPL on 1/1/09 then the state's current CHIP eligibility must be at least at 200%). The state cannot set a higher eligibility level for children applying for the supplemental dental coverage than for children eligible for full CHIP enrollment.

- No Limitations on New Applications: The state CHIP program must currently have no limits on accepting new applications for CHIP enrollment including, but not limited to, instituting waiting lists or any other limitations on CHIP enrollment.

- Benefits to Eligible Applicants: The state CHIP program must provide benefits to all children who apply for and meet eligibility standards for the supplemental dental coverage. If a child applies and meets the eligibility standards, benefits must be provided.

- Benefits & Cost Sharing: The state CHIP program must provide children in the supplemental dental coverage the same benefits as children receive in the full CHIP program, including cost-sharing requirements. Children in the supplemental dental plan cannot receive more favorable treatment, including coverage, cost-sharing, etc. versus children in the full CHIP program.

For more details on each of these criteria, CMS released their initial guidance regarding the child-only supplemental dental coverage option in a Dear State Health Officials letter on October 7, 2009.[viii]

Step 3: How does the supplemental dental coverage work?

Children are eligible if they would otherwise meet the CHIP income eligibility standards and either has no dental coverage through a private insurance or has limited dental coverage that falls below that of the CHIP dental benefit package. For children with limited private group dental coverage, the supplemental dental coverage provides benefits (including cost-sharing protections) up to the CHIP dental benefit level for which the CHIP supplemental coverage serves as a secondary payor subsequent to the private group plan.

The state must determine how a family can apply for child-only supplemental dental coverage, whether the application is part of the full CHIP program application or if a separate application process is required. In addition, as was done in Iowa, families can be determined eligible for the supplemental dental coverage immediately as children with private coverage or no health coverage (those seeking to enter the full CHIP program) are eligible immediately for the dental coverage.

States that opt to provide the supplemental dental coverage are required to comply with the cost sharing requirements that limit a family's cost-sharing for medical and dental care to 5% of the family income. Therefore, the state must identify a system to monitor the amount a family pays out of pocket expenses (premiums, co-pays, deductibles, etc.) to ensure they do not exceed 5% of their family income. In addition, states can waive CHIP waiting periods for children to enter of supplement dental coverage.

Step 4: Estimating the potential number and cost of enrollees

A consequence of dual health insurance systems has been a nation in which nearly one-in-five children have medical insurance, but no dental coverage. That figure grows to one-in-three for children in working-poor families. The method however for deciphering dentally uninsured and dentally underinsured children may be a challenge for states. The following methods were developed to estimate the number of dentally uninsured children in a given state to assist in determining the potential human and financial impact of implementing this new policy. The three methods outlined below have been taken a) from a national extrapolation of data; b) Iowa's estimates based on state data available (the first state to enact the child-only supplemental dental option in 2009); and c) estimates developed by the University of California Los Angeles (UCLA) and Children Now to identify the potential eligible population in California.

National Estimate:

According to the National Medical Expenditure Panel Survey (MEPS) there are an estimated 20% of children that have private coverage (i.e. employer sponsored insurance through their parents' employer) that lacks dental coverage. However,

children in the CHIP targeted income range (100%-200% FPL) 33% are estimated to have medical, but no dental coverage. A state estimate could be calculated using these national estimates, but would lack specificity of a State's CHIP eligibility (if beyond 200% FPL) or the likely percent of families that would chose to enrolled (based on current enrollment rates). However, to identify a rough estimate and potential budget impact the following calculation could be completed.[ix]

Dentally Uninsured Calculation:

Total # of children 100-200% FPL x 33% = Estimated number of children with incomes between 100-200% FPL with medical and no dental coverage.

Cost Calculation: As with any of the models, the approximate cost per member per month (PMPM) would need to be determined to multiply the number of dentally uninsured eligible children. In addition to PMPM rates, budget estimates should include initial start-up costs and projections for the number of children that will enroll in a given budget year. Enrollment numbers should include the projections for ramping-up the coverage – it is unlikely that all eligible children would enroll in the first year, but much can be learned about the state's CHIP enrollment trends from the start. To finish an estimate, the state must further take into consideration the federal matching rate to determine the percent that will be covered by the federal government (the supplemental dental coverage would receive the same CHIP matching rate as other services) and that required to be covered by the state.

Limitations: This method of using national data to determine state estimates provides a relatively simple calculation; however is the least reliable for actual cost. The ability to identify regional, or better yet, state data to predict the dentally uninsured rate would provide more accurate and reliable estimates from which policymakers could make decisions.

Iowa Estimate:

Iowa was the fist state in 2009 to receive approval to implement the supplemental dental coverage which began March 1, 2010 for their CHIP program (hawk-i). In order for Iowa to determine the potential impact, the Iowa Department of Human Services (IDHS) was asked to estimate the total number of children that may be eligible for supplemental dental coverage and the "take-up" rate (the likely number of children to enroll) in order to provide cost estimates. The IDHS determined the following.[x]

Iowa has a standing Child and Family Household Health Survey that asks families to self-report health information, including medical and dental insurance and family demographics, including income. Therefore, Iowa was able to determine the rate of dentally uninsured children within their CHIP income eligible range, which was expanded to 300% of the federal poverty level (FPL) as of July 1, 2009. The survey findings revealed that of the children in families between 133-200% FPL, 22-23% had medical, but no dental insurance – or approximately 30,000 children. The same percentage (22.5%) was used for to calculate the number of children between 201-300% FPL for an additionally 30,000 children for total of 37,007 children in Iowa that are potentially eligible for the supplemental dental coverage.

Take-up Rate: The initial assumption was that 75% of eligible children (50,537) would enroll in the dental supplement over a three-year period with 16,861 children anticipated to enroll in the first year.

Iowa Dentally Uninsured Calculation:

[135,000 children 133-200% FPL x 22.5% = 30,375 CHIP income eligible children with medical, but no dental insurance] + [164,754 children 201-300% FPL x 22.5%= 37,007] = 67,382

California Estimate:[xi]
In response to a 2009 California Senate Bill (SB 311) that proposed to implement the supplemental dental coverage option, among other CHIP provisions, Children Now and UCLA estimated the potential enrollment in supplemental dental coverage using the 2007 California Health Interview Survey. California's CHIP program (Healthy Families) provides coverage to children at varying income levels based on age.

Healthy Families Eligibility:
0-1 year olds: 200-250% FPL
1-5 year olds: 133-250% FPL
6-19 year olds: 100-250% FPL

Using the California Health Interview Survey data, it was estimated that about 106,000 children were eligible for Healthy Families, between the ages of 1-18 with teeth, lacking dental insurance, and enrolled in private or employer-based medical coverage.

California Calculation:

Total # of children eligible for Healthy Families (<250% FPL) with teeth, no dental coverage, and private or employer-based health insurance x 69% = 73,000 with medical and no dental coverage.

Take-Up Rate: The assumption was that 69% of eligible children (106,000) would enroll in supplemental dental coverage each year, therefore it was determined that about 73,000 children would be likely to enroll in a given year.

Step 5: What must be done to establish a supplemental dental benefit in my State?

CMS provides the final approval for the implementation of the supplemental dental coverage option in a state, however the process within a given state to making changes to their CHIP plan differs significantly among states and may differ depending on the changes being made.

Educating Consumers, Providers and Policymakers: Obtaining support from potential beneficiaries, dental and medical providers and policymakers is essential for approval and implementation. Educating all involved parties on the need and the short and long-term gains from opting for supplemental dental coverage is critical, especially if states are facing budget shortfalls. In addition, planning outreach activities to enroll eligible families if the supplemental coverage is adopted is also critical for the successful implementation.

State Approval: Prior to seeking federal approval, a state CHIP agency may be able to propose the change or may need legislature approval to submit a State Plan Amendment (SPA). Often the budget implications will dictate the involvement of legislatures, governors or agency staff.

CMS Approval: Ultimately, regardless of how state-level decisions are made regarding CHIP benefits, federal CMS approval is required in the form of a SPA to implement the supplemental dental coverage option. CMS provides a State Plan Amendment Template as part of the October 7, 2009 Dear State Health Official guidance that outlines all the information a state needs to provide.[xii]

Conclusion

The inclusions of dental coverage for children in both CHIPRA and ACA marks a significant milestone for the health of children, however for many working-poor families dental coverage remains out-of-reach despite their success in obtaining employer-sponsor health coverage. Although the reach of the pediatric dental benefit in ACA remains uncertain for a few more years, the ability for states to act immediately to secure dental benefits for working-poor families is certain through the new supplemental dental coverage option in CHIPRA.

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About CDHP

The Children's Dental Health Project is a national non-profit organization with the mission of creating and advancing innovative solutions to achieve oral health for all children so that they reach their full potential.

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