

**THE EFFECT OF STATE HEALTH INSURANCE SELECTION ON THE
PEDIATRICRAL HEALTH BENEFIT**

A Thesis

by

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Submitted to the Office of Graduate and Professional Studies of
Texas A&M University
in partial fulfillment of the requirements for the degree of

MASTER OF SCIENCE

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December 2014

Major Subject: Oral Biology

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ABSTRACT

To compare the impact of health care reform on the pediatric dental benefit across state health insurance Exchanges through the focused evaluation of (1) existing plan designs, (2) legislative processes through which these plans are selected and regulated, and (3) the role of the pediatric dental profession. Three states were selected based on type of Exchange implemented, identified as State-Based (SB), State-Partnered (SP), and Federally-Facilitated (FF). Data were collected through public record investigation and health policy expert interviews. A cost-analysis was completed for a total of 10,427 insurance plans from the three states. Sixteen confidential health policy expert interviews were conducted at state and federal levels. Individual monthly premium costs for embedded plans were found to have minimal differences when compared to the combined monthly premium costs of medical plans and stand-alone dental plans purchased separately ($p=0.11$). Financial implications of cost-sharing designs for embedded plans are limited, restricting consumer protections for the dental patient in comparison to medical coverage. Policy change for the federal regulation of dental insurance is markedly more challenging than for medical insurance given existing barriers resultant from the historical separation of the dental insurance industry from traditional medical insurance. Despite comparable premium costs across varying plan designs, the true affordability and quality of the state's pediatric dental benefit requires greater transparency and consistent policy standards.

DEDICATION

“There can be no keener revelation of a society’s soul than the way in which it treats its children.” Nelson Mandela. This project is dedicated to the children who touch our lives, who inspire by teaching us the beauty and simplicity of love.

ACKNOWLEDGEMENTS

I would like to thank my committee chair and co-chair, Dr. N. Sue Seale and Dr. Paul Casamassimo, along with my committee members, Dr. Alton McWhorter, and Dr. Carolyn Kerins for their guidance and support throughout the course of this research.

My appreciation is also for the friends and colleagues and the department faculty and staff for making my time at Texas A&M University Baylor College of Dentistry Pediatric Department an unforgettable period of personal growth and inspiration. I also want to extend my gratitude to the American Academy of Pediatric Dentistry (AAPD) and their Pediatric Oral Health Research and Policy Research Center for allowing me the opportunity to serve as the 2013-2014 Samuel D. Harris Health Policy and Research Fellow. I would like to especially thank Dr. John Rutkauskus, Scott Litch, Dr. Paul Reggiardo, Jan Silverman and the Academy's exceptional team members and staff. I would also like to thank the confidential interview participants from federal and state governments and professional organizations.

Finally, thanks to my loved ones for their patience and love.

NOMENCLATURE

AAPD	American Academy of Pediatric Dentistry
ACA/PPACA	Patient Protection and Affordable Care Act
ADA	American Dental Association
AV	Actuarial Value
CMS	Centers for Medicare and Medicaid Services
DQA	Dental Quality Alliance
EHB	Essential Health Benefits
FF	Federally-Facilitated Health Insurance Exchange
QHP	Qualified Health Plan
SADP	Stand-Alone Dental Plan
SB	State-Based Health Insurance Exchange
SP	State-Partnered Health Insurance Exchange

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CHAPTER I

INTRODUCTION

BACKGROUND

Private dental insurance is becoming integrated with medical insurance as an unintended result of the inclusion of the pediatric dental benefit in the Affordable Care Act (ACA). The pediatric dental benefit was selected as one of the ACA's ten Essential Health Benefits (EHB) mandated for individuals to purchase.¹ The non-partisan advocacy effort required to include pediatric dental services in this law has been overshadowed by confusion surrounding the significance of placing dentistry amidst the controversy of the health care reform.²

An aspect of health care reform that will affect the quality of the pediatric dental benefit is the state health insurance Exchange for the individual market.³ Every state was mandated to create a health insurance Exchange. This is an online tool used by individuals to purchase commercial (private) health insurance. The Congressional intent of the Exchange was to create a competitive market based on economic principles that will provide consumers purchasing insurance with greater protections.^{3,4} States chose to implement one of three types of Exchanges, depending on varying preferred levels of control. The three Exchange categories fall within a regulatory spectrum of state and federal control, distinguished as State-Based (SB), State-Partnered (SP), and Federally-Facilitated (FF).⁵ The SB Exchanges have the greatest local autonomy, assuming the

greatest responsibility in implementing and managing the Exchange, instead of existing federal agencies. The SB states are required to create a new governmental agency to operate the Exchange. On the opposite end of this Exchange spectrum, the FF Exchanges have the least amount of local control, with the majority of operational responsibility lying with the federal government. Lastly, the SP exchanges have “partnered” with the federal government to share management and fiscal responsibilities, often with the longer-term goal of eventually adopting a more independent model (e.g., the SB Exchange).⁶⁻⁸

The commercial insurance sector has targeted a new market for consumerism in the Exchange by providing patients with the option of purchasing medical plans with “embedded” or “bundled” dental benefits. Both plan designs include coverage for all ten essential health benefits, but their payment structures differ. The embedded plan design has a single policy and a single, combined medical and dental deductible.^{9,10} Controversy has surrounded the embedded plan design, as patients are experiencing a very high single deductible that can render dental coverage ineffectual.¹¹ The bundled plan design is essentially two separate medical and dental policies with two separate deductibles, packaged and sold together. Understanding how pediatric dental services are offered through varying plan designs across state Exchanges is necessary in evaluating the quality of the pediatric dental benefit.⁴

The Affordable Care Act’s (ACA) inclusion of pediatric dental benefits as one of the ten EHBs has historic relevancy to pediatric dentistry.^{12,13} The potential magnitude of federal policy change affecting the pediatric dental patient through insurance reform is

unparalleled. The quality of the pediatric dental benefit can be measured by cost and comprehension of covered oral health services, accessibility of dental care, and the legislative feasibility in supporting necessary improvements for ongoing oral health policy development.¹³ The legislative differences across states will have an effect on the implementation of this benefit and navigating the political challenges is essential in advocating for child rights. One aspect of the ACA that is closely tied to the quality of the pediatric dental benefit and inherently demonstrates these differences can be found in the state health insurance Exchange for the individual market.^{3,4}

Although the purchase of medical insurance is a mandatory component of the ACA, there is not a legal requirement to do so through the Exchange. Therefore, private insurance companies are not limited to selling plans only through this online marketplace and have the option of providing their products inside and/or outside the Exchange. Analogously, although individuals are required to purchase medical insurance, there is not a legal requirement to do so through the Exchange and they are given the same option to purchase plans inside and/or outside of the Exchange.^{9,14}

The Exchange is, however, the only conduit whereby individuals who qualify for income-based governmental subsidies can receive tax credits to help cover their monthly medical premium costs.¹⁵⁻¹⁷ These new “premium tax credits” are a result of the ACA and are to be distinguished from existing public assistance medical coverage provided through Medicaid or CHIP. In fact, health care coverage offered through these two public programs remains largely untouched by the ACA’s implementation of the Exchange. The main effect that the Exchange is predicted to have on Medicaid and

CHIP programs is the indirect increase in enrollment due to increased public awareness.^{18,19} Those seeking coverage are becoming aware of their own income-based qualification for public assistance programs through the Exchange website's online educational prompts.

Measuring the quality of the pediatric dental benefit requires comprehension of plan design, regulation, and cost.¹³ The implementation of the state Exchange provides a platform to compare pediatric dental stakeholder influence amidst health care reform. This research evaluates the impact of health care reform on the pediatric dental benefit through analysis of existing plan designs, legislative processes through which these plans are selected and regulated, and the role of the pediatric dental profession.

CHAPTER II
IMPACT OF HEALTH CARE REFORM:
THE PEDIATRIC DENTAL BENEFIT

PURPOSE

How will medical and dental plan designs and regulations differ depending on the type of state Exchange selected? How will the cost of the pediatric dental benefit vary by plan design across state Exchanges? This research aims to address these questions through investigation of the impact of health care reform on the quality of the pediatric dental benefit.

MATERIALS AND METHODS

Data/Sample

States included in this study were selected based on the type of state health insurance Exchange implemented and the accessibility of local personnel and resources. The selected states were identified through their categorization of Exchange model, including: State-Based (SB), State Partnership (SP), and Federally-Facilitated (FF). Data were collected using two mechanisms: public record investigation and health policy expert interviews. The confidentiality of the personally identifiable information of the

interviewer and represented state will be maintained throughout the research and thereafter.

The cost analysis was based on 2014 insurance plan data from healthcare.gov for the SP and FF Exchanges, and 2014 state health insurance Exchange agency data provided for the SB Exchange. Data from the Centers for Medicare and Medicaid Services (CMS) healthcare.gov website was downloaded for the selected SP and FF state Exchanges. Data for the SB Exchange was accessed through the individual state agency website. Databases from the selected state Exchanges provided cost information for SADPs (N=6,700), traditional medical plans (N=2,773), and embedded plans (N=954). A total of 10,427 insurance plans were analyzed using SPSS Statistics software.

Variables

A variable representing the summation of randomly selected SADP premium costs and traditional medical plan premium costs from Exchange data was created as an aggregate estimate for the combined traditional pediatric coverage cost. The aggregate measure of total pediatric coverage premium cost was created in order to compare its average cost to that of the embedded plan. In the bivariate statistical analysis, the difference among actuarial values (AV) between medical and dental plans was controlled by selecting the low stand-alone dental plan (SADP) and silver medical plan, both designs with 70% AV.^{20,21}

Statistical Methods

Exchange characteristics and cost-sharing frequencies were analyzed. One-way ANOVA with Bonferroni correction was completed across state Exchanges, evaluating

mean differences in SADP pediatric costs for premiums and deductibles. With multiple comparisons, the Bonferroni correction controls the probability of falsely assuming significant differences across state Exchanges by providing paired state statistics. T-test statistics were completed to compare randomly selected embedded plan costs to an aggregate measure of total pediatric coverage premium cost through combining the mean SADP premium costs with those of traditional medical plans. Embedded plans are not permitted on selected SB Exchange and are excluded from this analysis.

Interviews

Information gathered through health policy expert interviews served as this study's second level of data collection, providing answers to regulatory and plan design characteristics unavailable through public records. In each state, there was a minimum of four expert interviews conducted, including the state's representing American Academy of Pediatric Dentistry (AAPD) Public Policy Advocate (PPA).²² Additional governmental and non-governmental health policy experts were identified following consultation with selected members within the state's local governmental, the AAPD, and the American Dental Association (ADA). Data gathered at state and federal levels were obtained through expert interviews scheduled at specified governmental agencies. No personally identifiable information is included in the final results of this study, including those specific state government and/or agency represented. A total of sixteen (16) health policy experts participated in semi-structured interviews.

RESULTS

Pediatric Dental Benefit Variation in Design, Regulation and Cost

Medical and dental plan design characteristics (Table 1) and frequencies (Table 2) across states were analyzed. One-way ANOVA was completed to compare the effect of Exchange selection (SB, SP, or FF) on premium and deductible costs for SADPs (N=6,700). There was a significant effect of Exchange selection on premium costs at the $p<0.05$ level for the SADP [$F(2,6697)=217.64, p<0.001$]. Post hoc comparisons using the Bonferroni correction reveal that the mean scores for the premium costs in the SB Exchange (M=19.59, SD=8.1), the SP Exchange (M=30.98, SD=5.3) and the FF Exchange (M=27.64, SD=6.3) were significantly different. There was also a significant effect of Exchange selection on deductible costs at the $p<0.05$ level for the SADP [$F(2,1799)=8.92, p<0.001$]. Post hoc comparisons using the Bonferroni correction reveal that the mean score for the deductible costs in the FF Exchange (M=70.00, SD=30.0) was significantly different from the SB Exchange (M=60.00, SD=0.0) and the SP Exchange (M=66.43, SD=13.6). The mean scores for deductible costs between the SB and the SP Exchanges did not have statistically significant differences. The SB Exchange exhibits the lowest premium and deductible average costs, however no causal association can be determined given multiple geographic variables.

The mean cost differences between the SADPs offered through the SP and FF Exchanges (premium: \$3.34, deductible: \$3.57) were smaller in magnitude than those found with the SB Exchange. Cost differences across Exchanges were identified, as consistent with literature on geographic plan variation. However, data demonstrated

greater similarities between offerings within the SP and FF Exchange, in contrast to those found in the SB Exchange.

An independent samples t-test was conducted to compare monthly premium costs of purchasing a separate SADP with a traditional medical plan and the purchase of the new insurance design, the embedded plan. The SB Exchange did not have embedded plan offerings and was excluded from this t-test analysis. To obtain a randomized data sample that included all offered plan types from both the SP Exchange and the FF Exchange, thirty-five (35) embedded premium costs were selected for comparison with thirty-five (35) combined medical and dental premium costs (represented as aggregate estimates), for a total of seventy plan comparisons (N=70) across the two Exchange categories. Statistically significant differences in monthly premium costs were not found between the embedded plan (M=173.70, S.D.=21.0) and the combined aggregate estimate (M=168.49, S.D.=16.6); $t(138)=1.63$, $p=0.11$. The embedded plans from this randomized sample were \$5.21 more expensive on average. The mean premium costs for all plans offered within each of the SP and FF Exchanges were also calculated (Figure 1). Inside the SP Exchange, the embedded plan cost was \$0.99 less than the cost of purchasing traditional medical and SADPs separately. In the FF Exchange, the average premium cost for the embedded plans was \$7.77 more expensive. Results from these cost analyses suggest that there are nominal differences in the average premium costs when purchasing pediatric dental coverage offered through the embedded plan design compared to the combined pediatric average premium costs for stand-alone dental plans and traditional medical plans.

Relationship between State Exchange and the Pediatric Dental Benefit

No direct relationship was observed between the selection of SB, SP or FF Exchanges and cost of SAMP premiums or deductibles. However, trends in regulatory operations are revealed through plan characteristics affiliated with Exchange selection. The SB Exchange exhibits the greatest local autonomy and must assume complete responsibility in implementing and managing the pediatric dental benefit. The FF Exchange has the least amount of regulatory control, operating under the assumption that the majority of management responsibility for the pediatric dental benefit lies with the federal government. The SP Exchange shares more management and fiscal responsibilities than in the FF Exchange, with a system in place to eventually adopt the more independent SB Exchange category.

SP and FF Exchanges demonstrate greater similarity in regulations when compared to those found in the SB Exchange. With the SB Exchange's greater control of public data, the plan information is more privately regulated in comparison to the SP and FF Exchanges. The SB exchange analyzed in this study elected to restrict pediatric dental benefits from being offered through embedded plan designs for 2014. In both the SP and FF Exchanges, embedded plans are permitted. Bundled plans are not offered in the SP and FF Exchanges, resulting from the limitations experienced nationwide with technical website support. The website interface to purchase insurance plans has not been developed sufficiently to permit the dual purchase of the bundled medical and dental plans.

Regulatory obstacles are encountered by all three state Exchange categories. Despite Congressional intent for the pediatric dental benefit to be a mandated purchase, it is only a mandated offering. There are no penalties enforcing families to purchase pediatric dental insurance, unlike those required for the purchase of medical insurance. States do not have adequate infrastructure to support premium subsidy calculations to count toward pediatric dental benefits. Instead, families can receive income-based premium subsidies for medical plans only, despite the pediatric dental benefit being one of the ten EHBs. Quality control measures for dental plans have not been established for the monitoring and regulation of the pediatric dental benefit on the Exchange. There are no financial solvency requirements for dental insurance carriers offering pediatric dental services. In addition, no criteria exist for the regulation of dental provider network adequacy or fee scheduling.

DISCUSSION

The purpose of this research was to determine how health insurance plan designs and regulations differ depending on the type of state Exchange selected. Cost comparisons across state exchanges exhibit statistically significant differences. The average monthly premium cost of the pediatric dental benefit when offered through embedded plans demonstrates no statistical significance when compared to an aggregate measure of total combined traditional medical and stand-alone dental premium costs. Plan designs vary across state Exchanges, with greater regulatory autonomy experienced

in the SB Exchange as evidence by its prohibition of an embedded plan offering. The SP and FF Exchanges offer the same plan designs and face similar regulatory restrictions given greater state control by the federal government. From a dental provider standpoint, those living in states operating SB Exchanges have greater potential to influence policy regulations that will ensure that their pediatric patients have adequate coverage options.

Limitations

This research, while novel in its exploration of the pediatric dental benefit, has several limitations. Further analysis is required to analyze the total number of state Exchanges to account for the geographic differences incurred. Results from this study are not generalizable to every state Exchange. Variation in cost-sharing frequencies between state Exchanges will exist given geographic differences in cost calculations affecting health care pricing.^{23,24} Monitoring nationwide trends given regional differences will help in predicting the impact that varying state regulations have on insurance costs.²⁵ This research design, while consistent with statistical standards, is ill suited to make strong claims concerning the causality of a specific Exchange category selection on all offered pediatric dental benefit plan designs, regulations, or coverage costs.²⁶ In addition, this study does not address dimensions on the specific pediatric dental services covered in each plan design, all of which are likely to have a significant impact on the quality of this benefit.^{10,11}

Market Activity Predictions

With the creation of the insurance Exchange, health economists predict that there will be greater competition in the medical insurance market.²³ Less attention has been

given to the predictive effects on the dental insurance market. However, greater competition appears also to be the result for the dental insurance market, given the inclusion of medical plans offering embedded dental benefits. With these market shifts, the bargaining power of both medical and dental insurance companies is theoretically lowered in comparison to that of the medical and dental provider. In economic principle, this effect can subsequently lead to lower prices and decreased utilization of individual insurance plans.²³ By integrating dental benefits into medical insurance, dental coverage has greater potential to operate as true economically-defined “insurance”, with the aim of pooling risk to off-set expensive medical payments.²⁷ Traditional dental insurance coverage functions more closely to a pre-payment structure, offering less protection toward higher-cost services.

Insurance Trends and Future Implications

Inherent to the pediatric dental specialty affording these services, the combination of medicine and dentistry leads to complexity in insurance regulation. The pediatric dental benefit is the EHB most uniquely challenged by insurance reform given the integration of completely separate insurance infrastructures. The coordination between medical and dental insurance companies for special needs and medically compromised patient care is not a new concept to the pediatric dentist. Pediatric dentists offering behavioral services, like full-mouth dental rehabilitation under general anesthesia, have navigated the traditionally separate insurance systems.² Pediatric dentists working on craniofacial teams also require coordination with payment structures integrating the care of plastic and oral surgeons, psychologists, speech pathologists, and

orthodontists.^{28,29} These examples of integrative care demonstrate the pediatric dentist's liaison positioning in understanding the regulations required for patients covered by medical and dental insurance. With the implementation of Accountable Care Organizations (ACOs) as part of the infrastructure reform branch of the ACA, more integrative health care system changes are likely to occur.³⁰⁻³² Pediatric dentists have an opportunity to be at the forefront of this health care trend, advocating for cost-structure designs that incentivize disease prevention.^{33,34}

Improving the quality of the pediatric dental benefit is the responsibility of the pediatric dental profession, and should not be limited to only those dental providers accepting third-party payments.³⁵ Consumer protections for the pediatric dental patient are not as robust as those implemented for medical care, and these patients are at risk of incurring hidden costs.^{9,10,14} The plan designs resulting from this health care reform require greater transparency. Cost-sharing features of embedded plans require greater analysis as to whether offering a separate but integrative dental deductible will protect patients from greater out-of-pocket costs. Pediatric dental patients can also experience greater consumer rights by qualifying to receive premium subsidies.¹⁵⁻¹⁷ Lastly, further policy development is required to incentivize the purchase of pediatric dental coverage through penalties and create quality control standards for both medical and dental plans offering the pediatric dental benefit.^{13,36}

Reforming the current United States health care system to improve quality and cost of care is a bi-partisan effort, irrespective of one's political support for or against the ACA. The ACA has initiated the integration of medical and dental benefits and the

opportunity for policy development is now. Comprehensive, national data on pediatric dental benefit design, regulation and cost must be analyzed in order to provide regionally-specific medical and dental insurance plan comparisons. Providers will need to understand how pediatric dental coverage will be provided and by whom, to help inform patients of what changes may occur with payments and why.³⁷ Monitoring local market activity will help identify insurance sources of new and existing patients.^{3,38} The pediatric dentist will have a unique opportunity to serve as child advocate by representing patients and the profession on the boards and commissions that oversee the governance of state insurance Exchange policies.³⁹

CONCLUSIONS

Assuring a quality standard for the Affordable Care Act's pediatric dental benefit across state health insurance Exchanges will require non-partisan support by the pediatric dental profession to ensure patient rights through insurance reform.

This requires an understanding of the correlations that exist between the category of state Exchange selected and regulatory challenges experienced. SB Exchanges have more regulatory autonomy in comparison to the SP and FF Exchanges. However, there is no guarantee that state policies will protect the pediatric dental patient. Irrespective of the type of Exchange selected, each state is subject to barriers in improving the quality of the pediatric dental benefit due to a lack of defined policy parameters. Further policy development is necessary in evaluating the effectiveness of plan designs, as illustrated in

the embedded plans. Despite embedded premium costs appearing comparable to that of estimated total premium costs for pediatric coverage, the pediatric dental services provided by these plans requires greater transparency.

With variation in plan design, regulation, and cost of the pediatric dental services offered across state Exchanges, further development of cost-structure systems must occur, including those that integrate both medical and dental benefits.⁴ Greater plan transparency is also necessary to help patients make informed decisions regarding the cost and benefits of their health care coverage options. Requirements for the quality control, financial solvency, and network adequacy of insurance plans offering pediatric dental benefits must be established. Without further legislative maturation, the realized affordability and quality of the pediatric dental benefit will continue to present violations of consumer rights.

CHAPTER III
IMPACT OF HEALTH CARE REFORM:
LEGISLATIVE ADVOCACY

PURPOSE

How has the implementation of the varying types of state insurance exchanges defined the pediatric oral health benefit? Are there opportunities for the pediatric dental profession to advocate for policy development amidst the reform? These are important questions that this study aims to address with the hope of encouraging further investigation and active participation in the policy decision-process affecting pediatric dental patients.

MATERIALS AND METHODS

Data were collected through public record investigation and sixteen confidential health policy expert interviews conducted at state and federal levels. Participating state informants were selected based on type of represented Exchange implemented, identified as State-Based (SB), State-Partnered (SP), and Federally-Facilitated (FF).

Following the completion of initial public data investigation and guidance from a health policy advisory group, information was used to develop the action steps and

considerations included in the AAPD ACA Advocacy Tool. This product will serve as a template to compare policies affecting pediatric dental stakeholder influence and outline a principled guide to action for pediatric dental patient advocates through the focused evaluation of the legislative challenges in defining the ACA's pediatric dental benefit and the advocacy role of the pediatric dental profession.

Interviews

A total of sixteen (16) health policy experts participated in semi-structured interviews. The confidentiality of the personally identifiable information from the interviewer and represented state or federal entity will be maintained throughout the research and thereafter. In each state, there were at least four expert interviews conducted, including representative AAPD Public Policy Advocates (PPA).²² Data gathered at the federal level required expert interviews scheduled at specified governmental agencies. Experts were initially contacted by phone or email using a scripted recruiting template. They were provided with information regarding the purpose of the study and informed that their identity will remain confidential following data collection. The interview script facilitating discussion was created based on results from initial public record investigation, tailored specifically to each individual state or federal agency role. No audio recordings of the interview were taken. Following data collation and review by an independently-created health policy advisory group, a policy tool was created to compare legislative differences affecting pediatric dental stakeholder influence.

RESULTS

Navigate Political Barriers

Unique legislative and regulatory challenges exist for child advocates supporting pediatric oral health policies amidst the health care reform. The identification of both federal and state-level policies and their constraints will facilitate progress in protecting the rights of the pediatric dental patient. For example, a dental organization residing in a state with policies requiring children to receive medical coverage but not dental, can advocate for policy change that supports the mandatory purchase of pediatric dental benefits.

The legislative intent for the pediatric dental patient to be protected by equal insurance reform standards experienced by the medical patient is challenged by unforeseen implementation limitations. Given the United States' history of dental insurance being largely an independent entity from that of medical insurance, the existing health care infrastructure has inherent barriers to policy change unique for the pediatric dental advocate.⁴⁰ Furthermore, the oral health policies that previously dictated insurance regulation continue to control operations within a federal system that has not adapted to the ACA.^{25,41} In 2010, many legal sections regarding dental insurance regulation within the ACA were direct amendments to the 1944 Public Health Service Act (PHSA).⁴² This legislative precursor categorized dental coverage as an "excepted benefit", defined as those "not subject to requirements if offered separately," including "limited scope dental or vision benefits".⁴³ This distinction from the legislation existing prior to the ACA implementation has led to the unintended exemption of dental benefits

offered through stand-alone dental plans from aspects of market reforms.^{1,10} Specifically, the federal agencies responsible for insurance regulation are bound by these policies and any advocacy recommendation to permit clearer federal regulatory standards for stand-alone dental plans cannot be circumvented without Congressional action.

There exists a misunderstanding of responsibility between federal and state dental insurance regulation. Within the SP and FF Exchanges this confusion appears to be the result of the dichotomizing nature of splitting responsibilities between the local state government and the federal agencies involved. States selecting SB exchanges appear to have an advantage in this regard, as an established state agency is the identifiable contact when pursuing advocacy support. In the SP and FF Exchanges, local policy officials defer to regulatory standards adopted by federal agencies with the perspective that any policy change will have to occur on a federal level. However, when interviewing representatives from various federal agencies, the general recommendation is that any policy improvement will be most likely to actualize through state-level advocacy, irrespective of the type of Exchange selected by a state. Distinguishing accountability between state and federal regulation will be directly related to the feasibility of oral health policy change. Without such, advocacy groups are unable to determine which governmental entity is responsible or capable of making changes.

Understanding fiscal sensitivity among state governmental departments is crucial in navigating the most appropriate and effective avenue for advocacy efforts.⁴⁴ Key state governmental departments with direct responsibility toward child advocacy efforts, and more specifically child health care and commercial insurance regulation, must be

identified by local leaders of organized dentistry.³⁵ With the pediatric dental benefit as the essential aspect pertaining to the dental profession amongst insurance reform, there exists an enhanced intersection and importance between child health advocacy and private insurance. One of the largest commercial dental insurance carriers operating in the Federally-Facilitated state has experienced pediatric dentists in company leadership positions. This example demonstrates the importance held by private insurance companies to foster relationships with pediatric dental providers, and this trend will likely develop with further health care reform progression. With more private insurance companies working directly with pediatric dentists, there can be greater receptiveness to advocacy efforts in promoting coverage of particular dental benefits for the pediatric population.

Understanding What to Advocate For

The ACA's Congressional intent was for the ten purposefully selected essential health benefits (EHB) to be included in every qualified health plan (QHP) purchased through the Exchange.⁴¹ Because stand-alone dental plans cannot offer coverage for other medical benefits, the unplanned exclusion of dental insurance from the Exchange resulted. An unprecedented amendment to the law then occurred, arguably influenced by the advocacy efforts by dental insurance companies. Now, stand-alone dental plans are exempt from this aspect of the ACA's original intent.^{45,46} Consequently, medical plans sold through the Exchange do not have to offer dental coverage as long as there is at least one stand-alone dental plan being offered.¹⁴ This has led to the unintended consequence that families are not penalized for the non-purchase of pediatric dental

coverage. Thus, the Exchange's pediatric dental benefit is not a mandatory purchase for pediatric patients, but rather a mandatory "offer".^{9,10} The lack of an enforced mandate has resulted in more consumers foregoing the selection of dental benefits for their children when purchasing medical plans. Economic theory predicts that incentivizing the purchase of a pediatric dental benefit can occur by through the policy creation of a mandatory penalty for its non-purchase.³⁹ Increasing public awareness through campaigns to promote the prevention of pediatric oral disease can also be an effective strategy to incentivize the purchase of the pediatric dental benefit.

Following the implementation of the Exchange, insurance regulators at the state and federal level were faced with unexpected infrastructure barriers when integrating traditional medical and dental coverage. One such barrier uniquely affecting pediatric dental patients is the inability to allocate subsidies toward individuals purchasing dental plans. Patients qualifying for income-based tax credits can receive financial assistance in covering the cost of monthly medical premiums, but they are not able to apply this subsidy toward pediatric dental premiums.^{16,17} This challenge facing policymakers in adapting the health care reform standards to dentistry's unique infrastructure is due to the historical separation from medicine. Despite legislation requiring stand-alone dental plans to have "cost-sharing reductions for low-income families", the pediatric dental patient is uniquely unprotected by this consumer right.²

Providing greater patient (consumer) protection when purchasing health insurance is a core objective of the ACA.^{12,47} Commercial (private) medical and dental insurance companies are required to meet regulatory standards in order to sell their

products (plans) on the Exchange market.³⁸ The legislative amendment permitting the inclusion of stand-alone dental plans on the Exchange requires that these plans “comply with any relevant consumer protections”.^{45,46} However, pediatric dental patients are uniquely unprotected by legislative requirements related to the cost-sharing structure and network adequacy of dental plans in comparison to medical plans.²

An instructive display of the unequal protections provided for dental services can be seen in the study of a new medical plan design that offers “embedded” dental benefits. The cost-structure of the embedded plan includes a single, combined medical and dental deductible. Controversy surrounds this plan design, as its aggregated deductible amount is clearly greater than any average dental-only deductible and must be paid in full prior to the patient becoming eligible for either medical or dental benefits.¹¹ Regulators have not yet required sufficient transparency standards for these medical plans when informing patients of the differing cost-structure as it relates to dental coverage. As a result, many of these plans do not have clear plan policy information accessible to patients. Patients are subsequently enrolling in these embedded plans, unaware of their potential for incurring greater out-of-pocket costs in receiving routine pediatric dental care.

In a separate cost-sharing issue, regulators prohibit medical plans from placing annual and lifetime dollar limits, but exempt all dental plans from this protective requirement.² There also exists no regulatory mechanism to ensure that dental plans offered through the Exchange have adequate networks. Dental coverage purchased for pediatric patients through the Exchange has no protection against plans with insufficient

number of providers so no assurance of access to pediatric dental services without unreasonable delay or sufficient choice of provider type exists.⁴⁸

Strengthen Networks

Rooted and purposeful formalized networks are essential components of policy change. The American Academy of Pediatric Dentistry (AAPD) is uniquely positioned to provide network support for local pediatric dental advocates, in particular general dentists and pediatric dentists.⁴⁹ Advocacy support can be established through the nomination of a state AAPD Public Policy Advocate (PPA).²² This individual's goal of service will be to act as liaison between the national leaders at the AAPD and the local pediatric dental advocates. For states that do not have a state AAPD operation, a PPA representative can function through the local American Dental Association (ADA) component or equally established dental organization.⁵⁰ The network of national PPAs is one that can provide guidance across state Exchanges to actualize policy change.

In addition to pediatric dentists, key stakeholders that invest resources into child rights must be identified. Dental organizations and child advocacy groups are uniquely positioned to affect policy related to pediatric dental care amidst health care reform. The ADA Dental Quality Alliance (DQA) is one such initiative with particular focus in performance measures, leading a collaborative advocacy approach among member organizations within organized dentistry.⁵¹ Fostering shared political agendas between members of state dental and medical organizations, such as a local chapter of the ADA and the American Academy of Pediatrics (AAP), will strengthen negotiating power in advocacy efforts. Assigning or creating committee and board member positions for

members of outside organizations will facilitate communication between interests groups. Establishing a Government Affairs Committee will facilitate direct discussions between interests groups and policy officials.

The influence of the insurance industry in pediatric dental services has increased with insurance reform.⁵² Understanding key stakeholder influence in insurance regulation with public programs such as Medicaid and CHIP has been essential in advocating for pediatric dental care.¹⁹ With the implementation of the ACA's Exchange, building relationships with the private insurance industry will be a proactive step toward strengthening political influence, from both the provider and the patient perspective. Contacting commercial carriers regarding opportunities to provide expert opinion is one avenue to breach communicative barriers. From a governmental standpoint, identifying which regulatory agencies are responsible for public and private insurance regulation will allow interest group members to seek out opportunities to serve on existing governmental committees. With the ACA, pediatric dental providers have a new role in educating the private insurance industry on the significance of those services requiring coverage. States that have set examples for the nation include Kentucky, Nevada and Washington, where each have implemented policies to enforce the mandated purchase of the pediatric dental benefit. The Exchanges in Connecticut, the District of Columbia, Vermont and West Virginia, raise policy standards further by promoting the purchase of pediatric dental care by only offering medical plans that embed or bundle pediatric dental benefits.⁵³

Inform the Public and Policymakers

Pediatric dental advocates must raise public awareness in order to harness organized support to discuss policy recommendations with legislators. Collaborative conferences are an effective means of informing the public while simultaneously increasing collaboration between interest group members.

In addition to informing the public, policymakers must be directly educated on the challenges facing pediatric dental patients. Utilizing lobbyists through organized dentistry to inform and develop relationships with legislators will increase potential for policy change. Should resources be limited in the acquisition of a formal lobbyist, interest groups must provide training for member(s) to step into this role. In addition, establishing relationships with district representatives is an indirect method of harnessing lobbying power that requires minimal training or resources.

Advising state officials of oral health policy recommendations proactively will increase the likelihood of improving current inequalities experienced by the pediatric dental population.⁵⁴ Organizing fundraisers for active legislative supporters of issues relevant to pediatric dentistry is an important opportunity to gain the attention of legislators while informing them of the specific support needed.⁵⁵ Results from this study were used to create the AAPD ACA Advocacy Tool (Figure 2).

DISCUSSION

The ACA's focus on patient protection through insurance reform subjects pediatric dental patients to new consumer protection standards similar to those provided for medical insurance, but unfortunately, not equal.^{2,39,41,56} Due to the difficulty regulators face when enforcing policy standards to dental insurance payment structures, dental coverage does not have the same consumer protection guarantees experienced with medical coverage.^{10,11} Stakeholders invested in pediatric dentistry are positioned to uniquely shape policy with the potential to participate in the reformation of the American health care system's dental infrastructure.

The advocacy recommendations provided are based on data with inherent limitations. Key elements of the policy tool are based on states that will have geographic differences. Legislative generalizations made when comparing Exchanges will not equally apply to every state's political environment. Because states have the option of harnessing more local control by changing their Exchange category, it is important to realize that any existing trend experienced in Exchange regulations is subject to legislative change.^{5,17} There are state governments that have already taken political initiative through penalizing the non-purchase of dental coverage for children¹¹. It is the advocate's responsibility to understand the intricacies of his or her state's policy needs and adapt these guidelines accordingly. There is no guarantee that informing policymakers of specific policy recommendations will lead to change. However, persistent and adaptive leadership within the pediatric dental profession will engage public support and serve as the impetus for historic development.

An unconventional leadership role has emerged for pediatric dentistry because of the pediatric dental benefit's incorporation in the ACA. Prevention and integrative medicine are key principles of the pediatric dental specialty and, likewise, critical features of Accountable Care Organizations (ACOs)³⁰. A feature of the ACA largely untouched by dentistry but with potential for great infrastructural change, ACOs operate under value-based purchasing arrangements using global payments.⁵⁷ This model for health care financing is gradually transforming medicine toward greater population health accountability^{31,32}. This incentive-based health care system approach has controversial implications for dentistry, given its inherent differences from the traditional fee-for-service payment structure.^{40,58} Dental services offered through hospital systems are more likely to be affected by this financing trend, in particular those offered by oral surgeons and pediatric dentists. The approximation to medicine in these specialties results in a unique potential for advocacy coordination, should both interest groups develop shared political agendas.

There will also be increased priority for payment incentives tied to disease prevention through further implementation of the ACA.³³ Pediatric dentistry's clinical focus in caries risk assessment and disease prevention provides this dental specialty with a unique opportunity to collaborate with health care financing stakeholders in developing payment structures that would benefit the patient, provider, and third-party payer.^{34,59,60} Increasing coordination with insurance carriers is a necessary step in positioning pediatric dentistry at the forefront of this health care reform instead of becoming a reactionary interest group. Action is required to ensure that the influence of the provider

is not replaced by that of the insurance representative. Pediatric dentistry has the opportunity to be a leader in reshaping preventive incentive financing that would benefit both pediatric and adult populations.⁶¹

CONCLUSIONS

The pediatric dental advocate's ability to impact insurance reform is challenged by unforeseen infrastructure barriers largely due to dental insurance existing historically as a separate entity from that of medical insurance. As a result, existing consumer protections for the dental patient are more limited in comparison to those established for medical coverage.

Policy change for the federal regulation of dental insurance is also markedly more challenging than for medical insurance. It is unclear how effective national lobbying efforts can be in changing insurance policy unless there are technical corrections made to the actual law. With unidentified federal and state regulatory accountability, the greatest potential for policy influence is at the state level, despite confusion about which political/legislative entity is responsible for the policy changes.

When comparing legislative differences across the states, State-Partnered and Federally-Facilitated Exchanges are operating under the assumption that the federal government will dictate their state's reform progress. However, federal agencies suggest that these states have the ability to control progress. In fact, they are more likely to correct problems through state legislature rather than waiting for changes to the ACA.

State-Based Exchanges appear to have greater potential for policy change regarding dental issuer and benefit requirements.

Achieving true affordability and improving the quality of the ACA's pediatric dental benefit is possible through the creation of consistent policy standards and greater transparency. Despite political challenges, pediatric dentistry is uniquely positioned to lead change in oral health policy.⁶²

CHAPTER IV

CONCLUSIONS

Assuring a quality standard for the Affordable Care Act's pediatric dental benefit across state health insurance Exchanges will require non-partisan support by the pediatric dental profession to ensure patient rights through insurance reform. With variation in plan design, regulation, and cost of the pediatric dental services offered across state Exchanges, further development of cost-structure systems must occur, including those that integrate both medical and dental benefits.

The pediatric dental advocate's ability to impact insurance reform is challenged by unforeseen infrastructure barriers resulting from dental insurance existing as a historically separate entity from that of medical insurance. Additionally, confusion resulting from unidentified federal and state regulatory responsibilities suggests that the greatest potential for policy influence across Exchanges will be at the state level. Despite these challenges, achieving true affordability and improving the quality of the ACA's pediatric dental benefit is possible through the creation of consistent policy standards and greater plan transparency.

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APPENDIX A
FIGURES & TABLES

Figure 1: Pediatric Premium Cost (\$) Comparisons between Embedded Plans and the Aggregate Estimate of the Combined Costs of Stand-Alone Dental Plans with Traditional Medical Plans

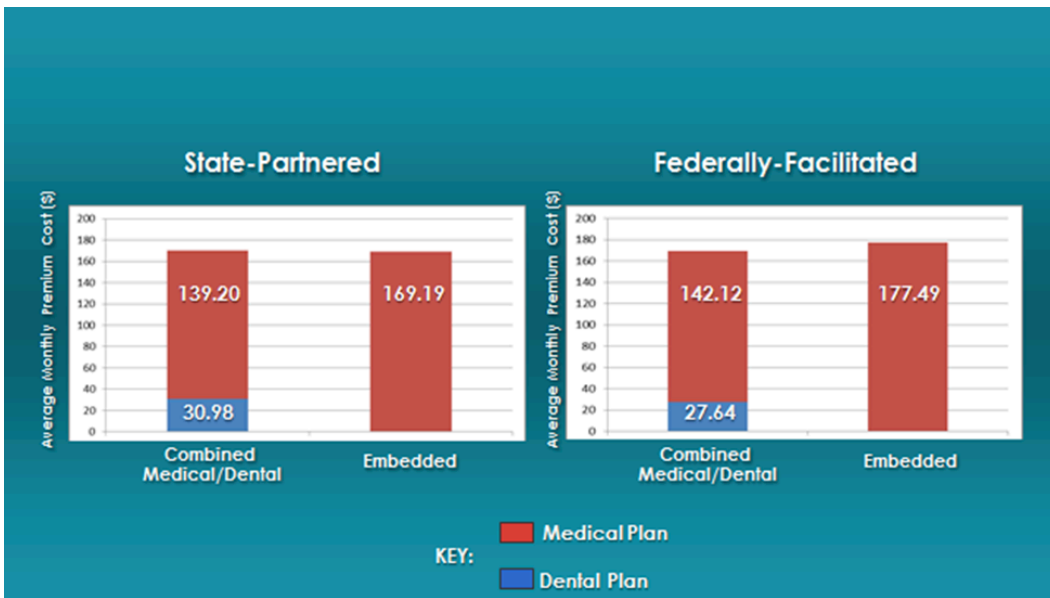


Figure 2: American Academy Pediatric Dentistry (AAPD) Affordable Care Act (ACA) Advocacy Tool

Advocacy Tool

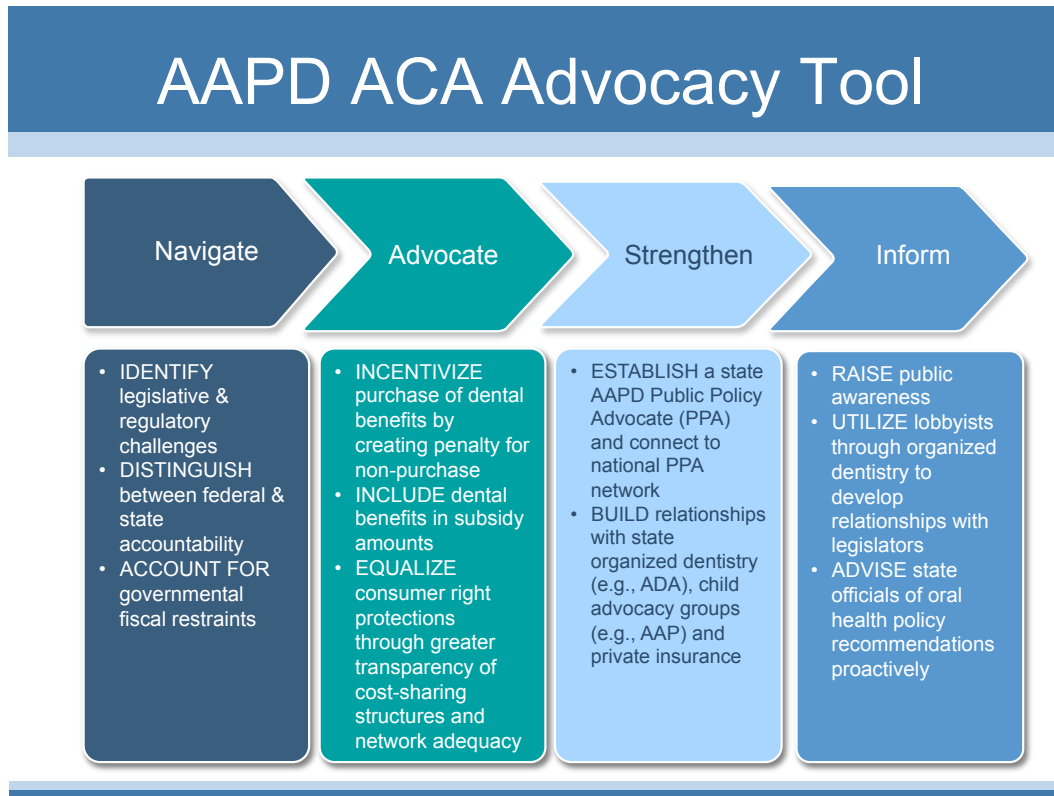


Table 1: State Insurance Exchange Plan Characteristics

<i>Insurance Designs</i>	<i>State-Based (SB)</i>	<i>State-Partnered (SP)</i>	<i>Federally-Facilitated (FF)</i>
Medical Plans	Traditional (100%)	Traditional (40%) Embedded (60%)	Traditional (98%) Embedded (<1%)
Plans Offering Pediatric Dental Benefits	Stand-Alone Dental Plan Bundled Plans	Stand-Alone Dental Plan Embedded Plan	Stand-Alone Dental Plan Embedded Plan
<i>Regulations</i>	<i>State-Based (SB)</i>	<i>State-Partnered (SP)</i>	<i>Federally-Facilitated (FF)</i>
Mandated Purchase: Pediatric Dental Benefit	No Penalty	No Penalty	No Penalty
Qualification for Premium Subsidies	Medical Benefits Only	Medical Benefits Only	Medical Benefits Only
Solvency & Provider Network Criteria	Medical Plans Only	Medical Plans Only	Medical Plans Only

Table 2: State Insurance Exchange Cost-Sharing Frequencies
Stand-Alone Dental Plans

Premium	<i>Mean (\$)</i>	<i>SD</i>
State-Based (SB)	19.59	8.1
State-Partnered (SP)	30.98	5.3
Federally-Facilitated (FF)	27.64	6.3
Deductible	<i>Mean (\$)</i>	<i>SD</i>
State-Based (SB)	60.00	0.0
State-Partnered (SP)	66.43	13.6
Federally-Facilitated (FF)	70.00	30.0
Out-of-Pocket Maximum	<i>Mean (\$)</i>	<i>SD</i>
State-Based (SB)	1000.00	0.0
State-Partnered (SP)	700.00	0.0
Federally-Facilitated (FF)	700.00	0.0

*N=6,700

Traditional Medical Plans

Premium	<i>Mean (\$)</i>	<i>SD</i>
State-Based (SB)	N/A	N/A
State-Partnered (SP)	139.20	15.8
Federally-Facilitated (FF)	142.12	17.5
Deductible	<i>Mean (\$)</i>	<i>SD</i>
State-Based (SB)	N/A	N/A
State-Partnered (SP)	4,686.42	1,232.2
Federally-Facilitated (FF)	4,074.50	1,785.3
Out-of-Pocket Maximum	<i>Mean (\$)</i>	<i>SD</i>
State-Based (SB)	N/A	N/A
State-Partnered (SP)	6,185.14	445.0
Federally-Facilitated (FF)	6,224.98	219.0

*N=2,773

Embedded Plans

Premium	<i>Mean (\$)</i>	<i>SD</i>
State-Based (SB)	N/A	N/A
State-Partnered (SP)	169.19	16.6
Federally-Facilitated (FF)	177.49	24.6
Deductible	<i>Mean (\$)</i>	<i>SD</i>
State-Based (SB)	N/A	N/A
State-Partnered (SP)	2,762.82	1,181.1
Federally-Facilitated (FF)	3,500.00	0.0
Out-of-Pocket Maximum	<i>Mean (\$)</i>	<i>SD</i>
State-Based (SB)	N/A	N/A
State-Partnered (SP)	5,887.46	454.4
Federally-Facilitated (FF)	6,350.00	0.0

*N=954

** Not offered on SB Exchange