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Does Health Care Reform Mean More Covered Children in your Chair?

Think again.

There's a lot of talk about more children gaining access to dental coverage thanks to the Affordable Care Act (ACA). How this new coverage plays out at the dentist office, however, may come as an unpleasant surprise to both dentists and patients. Since dentist offices typically fall into the small business category, health care reform will affect dentists on two levels — by limiting the types of health insurance plans they can buy and by resulting in large out-of-pocket costs for their patients.

Changing Rules

Dentist practices with fewer than 50 employees are considered small groups from the ACA. Groups with up to 100 employees will also be defined as small. Groups with 50 or fewer employees are free to offer or not offer benefits to their employees without fear of fines. Since 2016, groups with 51-100 employees are not only required to offer benefits to employees as part of the ACA's shared responsibility provisions (commonly known as the employer mandate), but since they will be defined as small groups, they will have fewer plan options.

Why will small groups have more limited choice?

While the ACA does not require individuals or groups to purchase specific benefits (but will bestow a tax penalty if you don't have minimum essential coverage), it forces carriers to include certain benefits as part of plans offered in small group and individual markets. It's as if the government said to an individual, you are not required to purchase a car with an infant car seat, but then the government turns around and tells all car manufacturers, "you must include a

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car seat in every car sold to an individual." You don't have to buy it, you just can't not buy it.

From the small group and individual insurance market perspectives, there are 10 car seats — called "essential health benefits." Half of one of those 10 car seats is pediatric dental benefits, and these benefits are treated differently from the rest.

Legislation Eases the Burden in Virginia

For groups headquartered in Virginia (and a handful of other states), the rules are a bit friendlier when it comes to dental benefits.

In 2014, the Virginia General Assembly passed legislation clarifying that a carrier offering plans in the small group or individual market is allowed to offer health plans without pediatric dental benefits so long as two conditions are met: first, there must be a qualified dental plan available for purchase and, second, the carrier must disclose that the pediatric dental benefits are not included in the health plan.

Since exchange certified dental plans are offered on and off of the exchanges in Virginia, groups and individuals are free to shop for their dental benefits like always. This applies to small groups, those that aren't required to purchase any benefits for employees (under 50) and groups that must offer benefits (51-100).

Great news, right? Maybe not. As it turns out, almost all medical carriers are forcing small groups to include pediatric dental benefits in their health plans despite the fact the carrier is not required to do so and small groups may already have a dental plan they prefer. Like the car seat analogy, you just can't not buy it.

In some cases, the resulting pediatric dental portion of the health plan premium is small since the dental benefits are subject to a combined medical and dental deductible. Dentists need to understand the implication of a patient's dental benefits being subject to a high medical deductible. In such cases, a parent may take a child to the dentist believing they are covered only to be billed for 100 percent of the bill since they have not met a huge medical deductible.

Other insurance carriers are charging a bit more premium to provide what looks like a traditional dental benefit. But buyer beware. Often, even

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when diagnostic and preventive dental services such as exams and cleanings are covered without having to meet the medical deductible, the other categories of benefits such as basic (including such common services as fillings) and major services are subject to the medical deductible.

Additionally, any orthodontia benefit must meet strict medical necessity criteria. The coverage levels are not as high as a typical 100/80/50 dental plan. They often look more like a 90/60/50 plan and, in reality, play-out more like a 90/0/0 plan.

Estimating the costs of treating a child who visits the dentist twice in a year and receives common procedures such as cleanings, X-rays, fluoride, sealants, a couple fillings and a pulled tooth reveals that the person in a plan where the dental is subject to the medical deductible would owe 100 percent of the $746 bill (assuming the high medical deductible had not been met).

The person in an embedded medical plan that covers diagnostic and preventive dental services without having to first meet a medical deductible would owe $407. A person in a traditional standalone dental plan would owe $140. Even when taking into consideration the difference in the costs of premium, the person is better off in a traditional standalone dental plan.

It's unfortunate big health insurance companies are forcing small groups and individuals to buy something they don't need. As small employers, dentists who shop for health coverage will be forced to purchase pediatric dental benefits whether or not they or their employees have children, and many of their patients are likely to pay much more out-of-pocket for their children's care.

As groups, brokers and dentists understand what is and is not required, market pressure will be applied and the result will be consumers having the freedom to shop for what they want and need. In the meantime, many groups and individuals will be left with having to purchase duplicative coverage in some cases and will be paying more premium and out-of-pocket costs than necessary.