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CHIP Dental Coverage: An Examination of State Oral Health Benefit Changes as a Result of CHIPRA



Introduction

Oral health remains a serious concern for the health and well being of children, and especially those who are low-income. In recent years, a focus on children's oral health has taken a more prominent role, particularly after the preventable death of a young Maryland boy due to an abscessed tooth.¹ Although states struggle with low utilization of dental services by children enrolled in public programs, since the passage of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), all children in the Children's Health Insurance Program (CHIP) will have a base level of dental coverage included in their benefit package.

CHIPRA's dental benefit mandate was effective as of October 1, 2009; however, because the Centers for Medicare and Medicaid Services (CMS) have yet to release regulations, most states have not yet submitted

state plan amendments (SPAs) to CMS with proposed dental benefit changes. Still, some states are moving forward in seeking CMS approval for voluntarily changing their dental benefits to meet current guidance. This brief examines the benefit and coverage limits of those states that have voluntarily sought and received federal approval for their CHIP dental benefit. In addition to examining changes in benefits and coverage limitations, this brief also reviews states' procedures for allowing children to obtain services beyond any stated benefit maximums.

Dental Coverage Before CHIPRA

By 2009, when CHIPRA mandated dental coverage, all states had established some level of dental coverage in CHIP; however, no federal standard existed. Since CHIP's creation in 1997, states that operate Medicaid expansion (M-CHIP)² programs were required to provide dental coverage as part of the Early and Periodic Screening, Diagnostic, and Treatment Program (EPSDT) mandated benefits offered to children. However, prior to CHIPRA, separate CHIP (S-CHIP) programs had the option, but were not required, to provide dental services to targeted low-income children enrolled in CHIP. In late 2008, the National Academy for State Health Policy (NASHP) conducted a survey of state CHIP programs and found that 39 out of the 40 responding S-CHIP programs provided oral health preventive, emergency, and treatment benefits³, but only 16 states provided coverage for orthodontic services. Fourteen S-CHIP programs also placed an annual cap on dental benefits, and one state imposed a \$600 deductible.⁴ While states offered dental benefits prior to the passage of CHIPRA, coverage varied widely from state to state.

CHIPRA's Oral Health Requirements

CHIPRA's dental mandate was intended to level the playing field so that children in both M-CHIP and S-CHIP programs and across states would have a more consistent level of dental coverage. Section 501 of CHIPRA added section 2103(c)(5) to Title XXI of the Social Security Act that requires S-CHIP programs to provide dental services to targeted low-income children that are "... necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions." The law states, "A State may elect to meet the requirement of [the statutory definition] through dental coverage that is equivalent to a benchmark dental benefit package..."⁵

On October 7, 2009, CMS issued CHIPRA State Health Official (SHO) letter number 7, which provides guidance on the dental benefit requirements. SHO number 7 clarifies that effective October 1, 2009, states are required to offer either a dental benchmark plan outlined in the law, or a state-defined dental benefit package that meets the statutory definition of necessary coverage.⁶ The SHO further explains that states using a state-defined dental benefit package must cover medically necessary oral health services, regardless of whether they are specified as a covered benefit. Since EPSDT is required of M-CHIP state programs, M-CHIP states are considered to be compliant with CHIPRA requirements. Although CMS provided guidance through the SHO, regulations are not anticipated for release until 2012.

In order to make the necessary changes to their CHIP programs, states must submit a SPA to CMS for approval, though states are not required to make changes until after CMS issues final regulations. These SPAs outline necessary changes to benefits, limits, and financial caps. CMS makes a determination on the SPA following a review process that includes any clarifications from state officials.

Changes as a Result of CHIPRA

As of September 2011, CMS has approved nine SPAs (Alabama, Florida, Iowa, Michigan, Montana, Nevada, Tennessee, Washington, and Wyoming) that include changes to dental benefits.⁷ Seven of the nine states with approved SPAs chose to use the state-defined benefit package to cover children's dental benefits. The two remaining states use the benchmark state employee benefit package.

State Defined Benefit Packages

States may elect to use a state-defined benefit package to meet the statutory definition of required services, provided that the benefit package includes dental services necessary to "prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions." CHIPRA SHO number 7, developed by CMS in consultation with various dental organizations and using the American Dental Association's (ADA) Current Dental Terminology (CDT) code of dental procedures and nomenclature, specifies the nine benefit categories states must provide in order to meet the definition. The nine benefit categories that are required to be covered by a state-defined benefit package include:

1. Diagnostic (CDT codes D0200-D0999);
2. Preventive (CDT codes D1000-D1999);
3. Restorative (CDT codes D2000-D2999);
4. Endodontic (CDT codes D3000-D3999);
5. Periodontic (CDT codes D4000-D4999);
6. Prosthodontic (CDT codes D5000-D5899, D5900-D5999, and D6200-D6999);
7. Oral and maxillofacial surgery (CDT codes D7000-D7999);
8. Orthodontics (CDT codes D8000-D8999); and
9. Emergency dental services.

State programs are not required to cover all services in each category, though states may not impose any limits that would preclude children from receiving benefits defined by the statute.⁸ CHIPRA's requirement that states selecting state-defined benefit packages cover medically necessary services, even if the services are not specifically listed as covered benefits, was significant, particularly for orthodontic services, as prior to CHIPRA, many states provided no orthodontic services, regardless of medical necessity.

Covered Benefits

The seven states with approved state-defined benefit packages appear to have a more uniform benefit structure than prior to CHIPRA because of the nine mandated benefit categories. More specifically, three states (Iowa, Michigan, and Wyoming) provide orthodontic coverage not previously included in their CHIP benefits, four states (Iowa, Michigan, Nevada, and Wyoming) amended their state plans to add benefits, and three states (Florida, Michigan, and Nevada) increased or removed benefit limits.

Of those states with state-defined benefit packages, Nevada and Washington cover full dental EPSDT benefits. In particular, Nevada made more significant changes by reinstating full EPSDT coverage and orthodontic benefits and removing its \$600 annual cap. EPSDT requires

coverage of dental services, including any medically necessary care or treatment needed to correct illness, even if not specifically listed as a covered benefit. Under EPSDT, the frequency of dental care covered must “meet reasonable standards of dental practice” and must also include coverage for maintenance, pain and infection relief, tooth restoration, and other medically necessary care.⁹

Benefit Limits, Exceptions and Prior Authorization Requirements

Although the states offering state-defined benefit packages now offer relatively similar benefits, the limits on benefits vary. Four of the nine states with approved SPAs (Alabama, Iowa, Michigan, and Wyoming) impose annual benefit maximums ranging from \$1,000 to \$1,500 per child. In addition, the process for providers or families to request medically necessary treatment beyond the maximums differs among those four states.

States must comply with existing federal CHIP regulations that set forth limits on cost sharing. State-defined and benchmark packages alike may not impose any cost sharing on preventive or routine diagnostic services, including routine or diagnostic dental services, with a cumulative limit (including copayments, coinsurance, deductibles, or other cost sharing) of five percent of family income across all services, including dental and medical.¹⁰

Alabama

Alabama’s ALL Kids program has a \$1500 annual benefit maximum for dental services, which does not include preventive and diagnostic care. The state has a contract with BlueCross and BlueShield of Alabama (BCBS Alabama), which acts as a third party administrator for all benefits, including dental.

For approval of services beyond the annual benefit maximum, providers are responsible for submitting the prior authorization form required by the program. BCBS Alabama handles authorization requests and makes an initial determination. Because ALL Kids is self-insured, BCBS Alabama then e-mails the ALL Kids program to ensure that the program will approve payment. There is also a clinical appeals process



through BCBS Alabama, which is the same as the appeals process for non-dental services. There are multiple levels of appeal, the last one being with the BCBS Alabama Medical Director.

Alabama did not change its benefit package as a result of CHIPRA. Orthodontics are covered for craniofacial malformation, including cleft lip and cleft palate.

Iowa

Iowa's CHIP program, *hawk-i*, has a full-risk contract with Delta Dental of Iowa (Delta Iowa) to provide its dental benefits. The benefit has a \$1000 annual maximum, not including orthodontic services, with prior authorization from Delta Iowa required to obtain benefits in excess of this amount.

Delta Iowa reviews prior authorization requests and makes determinations in consultation with *hawk-i*. In the event that a prior authorization request is denied, a family could appeal through Delta Iowa, with the final level of appeal being with the state Insurance Commissioner. Review time frames are not established.

Providers submit requests for orthodontic services on behalf of their patients and are paid an up-front fee of \$4300 for approved benefits. Delta Iowa approves services for patients with a Salzmann Index¹¹ score of 26 or higher that is used to determine if the services are medically necessary.

Michigan

Prior to CHIPRA, Michigan's MICHild program had a \$600 annual maximum. Currently the benefit maximum is \$1500 a year, and children can obtain benefits in excess of this amount if medically necessary. Michigan's approval process for orthodontics differs from that for other dental services.

Delta Dental of Michigan (Delta Michigan) provides all dental benefits and two additional insurers provide only orthodontic coverage. For prior approval of services in excess of the benefit maximum other than orthodontics, the provider submits a request to Delta Michigan, which makes the authorization determination. If Delta Michigan denies services, the family may appeal through Delta Michigan or to a state administrative tribunal.

Orthodontic care must be medically necessary based on a cleft lip, cleft palate, or orthognathic abnormality. In order to receive orthodontic treatment, the child must first be deemed eligible for Michigan's Title V Children's Special Health Care Services (CSHCS) program, based on an application the family submits to the Michigan Department of Community Health (the Title V agency). Once the child is approved for the program, a nurse, physician, or dentist review panel will then determine if orthodontic services are medically necessary. Orthodontic services are subject to a \$4000 lifetime benefit maximum, which is separate from the \$1500 annual cap for all other dental services.

Wyoming

Wyoming's Kid Care CHIP program has a \$1000 annual benefit maximum, which does not include preventive and diagnostic services. Children may receive additional treatment beyond the \$1000 maximum if the treatment is medically necessary. Wyoming has a full-risk insurance contract with Delta Dental of Wyoming (Delta Wyoming). Delta Wyoming must approve or deny the treatment request within two weeks, but the process rarely takes this long and can be expedited if a provider needs an immediate decision.

If Delta Wyoming denies treatment based on lack of medical necessity, families can appeal directly to Delta Wyoming either by telephone call or in writing. If Delta Wyoming receives an appeal, then the Delta Wyoming CEO meets with the Wyoming CHIP Director to make a determination within 10 business days. This is the final level of appeal.

Wyoming covers orthodontics if medically necessary or due to craniofacial orthopedic deformity. Orthodontists must use a malocclusion index and submit referral and evaluation forms, evaluation narrative, photographs, and X-rays to Delta Wyoming. The Delta Wyoming Orthodontic Consultant will review the information and make a determination.

States with Benchmark Benefit Packages

As set forth in the law and CMS guidance, in addition to using a state-defined benefit package, states may elect to provide dental coverage that is equivalent to a benchmark dental plan. The three benchmark options available for selection are:

1. A dental benefit plan under the Federal Employee Health Benefit Plan (FEHBP) that has been selected most frequently by employees for dependent coverage in either of the previous two plan years;
2. A state employee dental benefit plan that has been selected most frequently by employees for dependent coverage in either of the previous two plan years; or
3. A commercial dental benefit plan that covers the largest insured, non-Medicaid, dependent population in the state.¹²

Unlike states' options with CHIP health benefit packages, CHIPRA requires benchmark dental coverage to be equivalent, not actuarially equivalent, and all benefits must be equal to the scope, level, and type of services offered in the benchmark plan. States that use a benchmark plan cannot remove any benefits from the package and may, but are not required to, add any benefits that are not included in the benchmark plan. Thus, if specific benefits, such as orthodontics, are not included in the benchmark plan, the program is not required to offer these services to its enrollees.

Benefit Limits and Orthodontics

Two of the nine states with approved SPAs, Montana and Tennessee, elected to offer a plan equivalent to the state employee dental benefit plan. Unlike the state-defined package, neither state that chose to use a benchmark dental benefit package was required by CMS to have an exception to its annual limits for medically necessary services.

Montana increased its basic dental benefit package from \$412 to \$1412 per year. The plan has the flexibility to provide an additional \$1176 per year (total of \$2588) if the child exceeds the basic benefit and is determined to have significant dental needs. Medically related dental emergencies are reimbursable under the CHIP medical benefits; however, because Montana's state employee health package does not cover orthodontic services, these services are not available in its CHIP program. The only exception for orthodontic coverage is for a cleft palate or craniofacial malformation.

Tennessee's SPA increases the annual limit on services from \$600 to \$1000. Although Tennessee does provide medically necessary orthodontic care, it is subject to a \$1250 lifetime cap and a child must be enrolled in CHIP for 12 months before being eligible for the orthodontic benefit.

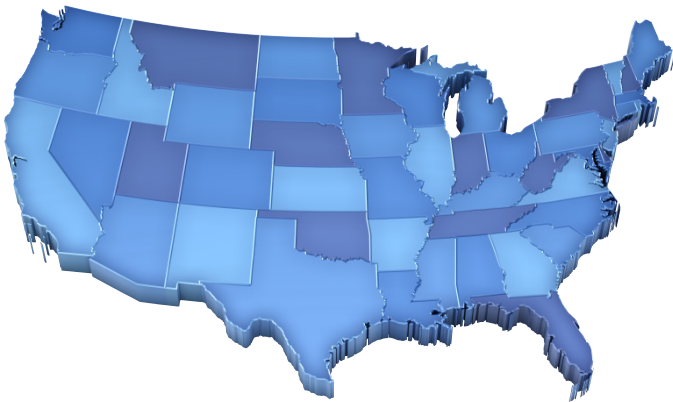
Dental-Only Supplemental Coverage

CHIPRA not only mandates dental benefits, but it also provides states with S-CHIP programs the option of using CHIP funds to provide stand-alone, dental-only services to CHIP-eligible children who have private health insurance but have no or inadequate private dental coverage. To qualify for this option, the state must adhere to all of the CHIP program's cost sharing requirements, be void of any waiting lists or caps on enrollment in its CHIP program, and not provide more favorable treatment to children under the supplemental dental benefit than provided to other CHIP enrollees.¹³

Iowa is currently the only state that offers supplemental coverage and as of September 2011 had over 3,000 children enrolled in the dental-only program. Children enrolled either have no other dental coverage or are underinsured with regards to their other dental coverage, in which case the state plan acts as a secondary payor. The state enrolls a child in the CHIP program solely for the dental benefits portion of the program, and families pay up to \$15 per month for one child, but no family pays more than \$20 per month in total.

Trend in and Possible Rationale for Benefit Package Selection

Of the nine states with approved SPAs, seven offer state-defined benefit packages and two offer benchmark packages. Given the small subset of states, it may be premature to assess whether this demonstrates a definite trend in how states will choose to define their CHIP dental benefit; however, this sample may provide insight into states' likely preference for the CHIP dental benefit packages.



At first glance, it may seem that selecting a benchmark plan would be less costly than a state-defined benefit package, since states adopting benchmark plans do not have to cover services from all nine categories of benefits and are not required to cover medically necessary orthodontics if not already in the benchmark benefit package. However, it may actually be less costly for states to provide a state-defined benefit package. CHIPRA states that benchmark coverage must be “equivalent to a benchmark dental benefits package,”¹⁴ and CMS has clarified this to mean that an actuarially equivalent benefit package does not meet this requirement.¹⁵ Private dental insurance plans generally require enrollees contribute through copayments, co-insurance and deductibles before the plan will start paying for covered services. For example, the FEHBP benchmark (MetLife Dental Plan High Option) requires a 30 percent co-insurance for dental fillings and 50 percent co-insurance for crowns, root canals, bridges, and orthodontic services. These levels of cost sharing greatly exceed those permitted in CHIP. Since CHIP programs are statutorily prohibited from imposing cost

sharing above five percent of a family's income, and benefit packages cannot be reduced when using a benchmark plan to offset the low level of cost sharing,¹⁶ this precludes programs from taking cost sharing into account, and adjusting benefits and limits when designing dental benefit packages. Therefore, when choosing how to design their dental benefits, CHIP programs may see a state-defined benefit package as the more cost-effective option to administer. This could explain the potential preference for the state-defined benefit package by state CHIP administrators.

Conclusion

CHIPRA's dental mandate is a significant development in ensuring that children have coverage for needed dental services, regardless of the state in which they live. As of September 2011, 13 states with S-CHIP programs voluntarily submitted SPAs to CMS, the majority of which chose to implement a state-defined dental benefit package. States may wish to draw from the experiences of the nine states with approved SPAs when examining whether their current dental benefits meet CHIPRA's requirements or if changes are needed to provide coverage that meets children's needs and complies with CHIPRA. Policymakers can glean information from these states' choices and CMS' approvals to help them decide whether a state-defined or benchmark package will best meet children's needs and create benefit packages and policies that will promote good dental health.

Selected Information on States with Approved SPAs

State and Program Name	Benefit Package Selection	Periodicity Schedule	Administration	Benefit Limits	Copayments	Prior Authorization	Appeals	Orthodontic Coverage
Alabama – ALL Kids	State defined	AAPD*	BC/BS Alabama third party administrator (state retains risk)	\$1500 annual cap for non-diagnostic and non-preventive procedures; state can authorize coverage beyond the cap	Non-preventive services: \$3.00/visit 150% FPL and below; \$5.00/visit over 150% FPL	Required for services over the capped amount; retrospective authorization is accepted	Tiered process initially through TPA with final level of appeal with state Medical Director; no designated timeframe	Craniofacial malformations including cleft lip and cleft palate
Florida – Healthy Kids	State defined	AAPD	MCNA Dental Plan and DentaQuest full risk contracts	No annual cap	None	Required for referrals and treatment provided by endodontists, periodontists, oral surgeons, and orthodontists, except in emergency situations; retrospective authorization is accepted, primarily in emergency situations	Formal and informal appeals including expedited appeals through MCNA and DentaQuest; state will intervene if family or provider requests a review, especially when access or contract standards unmet	If condition creates medical disability and impairment to overall physical development (defined in Florida Medicaid Dental Services Coverage and Limitation Handbook)

*American Academy of Pediatric Dentistry

State and Program Name	Benefit Package Selection	Periodicity Schedule	Administration	Benefit Limits	Copayments	Prior Authorization	Appeals	Orthodontic Coverage
Iowa – hawk-i	State defined	AAPD	Delta Dental Iowa full risk contract	\$1000 annual cap excluding orthodontics; Delta Dental can authorize coverage beyond cap with state input	None	Required for services over the capped amount	Tiered process initially through Delta Dental with final level of appeal with state Insurance Director; no designated timeframe	Salzmann Index of 26 or higher with advance payment of \$4300
Michigan – MICHild	State defined	State defined	Delta Dental Michigan (orthodontics administered by Delta Dental, BC/BS, and Golden Dental) full risk contract	\$1500 annual cap; Delta Dental can authorize coverage beyond the cap	None	Required for services over the capped amount	Tiered starting with optional appeal to Delta Dental, ultimately to state administrative tribunal	Cleft lip, cleft palate, or other orthognathic abnormality; services and payment provided through state's Title V program
Montana – Healthy Montana Kids	State employee	AAPD	Affiliated Computer Service/Xerox third party administrator (state retains risk)	\$1412 annual cap with additional "extended benefit" to maximum of \$2588	None	Required for the extended benefit	Tiered starting with Healthy Montana Kids Fair Hearings Program Officer	Cleft palate or craniofacial anomaly
Nevada – Nevada Check Up	State defined	State defined (state provides EPSDT benefits)	Health Plan of Nevada or Amerigroup full risk HMOs with orthodontics carved out as fee for service	None	None	Required for orthodontics	Tiered process, ultimately to state hearing staff, using same timeframes and processes as for medical coverage	Covered with a score of 26 or higher on handicapping labiolingual deviation index

State and Program Name	Benefit Package Selection	Periodicity Schedule	Administration	Benefit Limits	Copayments	Prior Authorization	Appeals	Orthodontic Coverage
Tennessee – Cover Kids	State employee	AAPD	DentaQuest full risk contract	\$1000 annual cap with additional \$1250 lifetime orthodontic cap; no coverage beyond cap	Non-preventive services: \$5.00/visit 150% FPL and below to \$15 annual max; \$25.00/visit over 150% FPL to \$75 annual max	None	Tiered process initially through DentaQuest, ultimately to state; expedited 72-hour review available if child's health could be in jeopardy; normal timeframes are 20 or 30 days	All orthodontics covered once enrolled for at least 12 months, up to benefit limit
Washington – Apple Health for Kids	State defined	State defined (state provides EPSDT benefits)	State-administered fee for service	None	None	Required for certain services	Administrative appeal	Craniofacial anomalies and conditions receiving score of 25 or higher on Washington Modified Handicapping Labiolingual Deviation Index ; other malocclusions covered on a case-by-case basis
Wyoming – Kid Care CHIP	State defined	State defined	Delta Dental Wyoming full risk contract	\$1000 annual cap for non-diagnostic and non-preventive services; Delta Dental can authorize coverage beyond cap	Non-preventive services: \$5.00/visit from 101-150% FPL to \$15 annual max; \$25.00/visit from 151-200% FPL to \$75 annual max	Required for services over the capped amount	Appeal to Delta; adjudicated by Delta CEO and state CHIP Director; decision in 10 business days	Covered if medically necessary or due to craniofacial orthopedic deformity

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The National Academy for State Health Policy (NASHP) is an independent academy of state policymakers working together across branches and agencies of state government to identify emerging issues and develop health policy solutions. NASHP is a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice.

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

About the Policy Center

The National Maternal and Child Oral Health Policy Center was created in 2008 as a collaborative effort of the Association of Maternal and Child Health Programs (AMCHP), the Association of State and Territorial Dental Directors (ASTDD), the Medicaid/SCHIP Dental Association (MSDA), and the National Academy for State Health Policy (NASHP) with funding from the federal Maternal and Child Health Bureau of the Department of Health and Human Services, Health Resources and Services Administration, Department of Health and Human Services. The Policy Center promotes the understanding of effective policy options to address ongoing disparities in children's oral health.

The three-year initiative has set out to map a course for improving family oral health by building knowledge and skills of professionals with the ability to steer systems changes.

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References

¹Mary Otto, "For Want of a Dentist," *The Washington Post*, February 28, 2007.

²Federal law gives states the option of operating a separate CHIP program, which has more flexibility; a Medicaid expansion program, which expands the state's existing children's Medicaid program to cover children who otherwise would not be eligible due to income; or a combination program that includes both a separate and a Medicaid expansion program.

³Louisiana covered oral surgery for impacted tooth removal and dental services secondary to cancer, accidents or temporomandibular joint disorder (TMJ), but did not provide preventive or treatment services.

⁴Catherine 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.

⁵The Children's Health Insurance Program Reauthorization Act (CHIPRA), Public Law 111-3, 11th Cong., 1st Sess. (4 February 2009), §501.

⁶Centers for Medicare and Medicaid Services (CMS), "Dear State Health Official Letter," October 7, 2009 (SHO # 09-012, CHIPRA #7).

⁷As of publication, CMS was reviewing SPAs that included dental coverage submitted by Massachusetts, New Jersey, Pennsylvania, and Texas.

⁸CMS, "Dear State Health Official Letter," October 7, 2009.

⁹Social Security Act, Title XIX, §905(r).

¹⁰CMS, "Dear State Health Official Letter," October 7, 2009.

¹¹The Salzman Index is one of several screening indices used to assess the degree to which a patient has malocclusion. Many state CHIP programs have adopted the Salzman Index or another index when determining whether or not to authorize orthodontic services.

¹²CHIPRA §501(a).

¹³CHIPRA §501(b).

¹⁴CHIPRA §501.

¹⁵CMS, "Dear State Health Official Letter," October 7, 2009.

¹⁶42 CFR §457.560(a).