Affordable Care Act 101

The Affordable Care Act (ACA) was passed with a goal of making healthcare more accessible and affordable for all Americans. The ACA requires that all Americans have health coverage and identifies the quality of coverage that must be obtained. One requirement is that all plans must provide coverage for essential health benefits (EHB). There are currently ten items considered to be EHB, including pediatric services. This is an important provision for dental practices because this pediatric coverage includes dental care.

TYPES OF COVERAGE

There are three ways to obtain pediatric dental benefits.

Stand-alone Dental Plan

A standalone plan is similar to a traditional dental plan. There are two types of ACA stand-alone plans: the high option and the low option.

The difference is the percentage of treatments that the plan will pay. (Note: This type of plan typically has out-of-pocket maximums.)

Bundled Stand-alone Medical and Dental Plan

Bundled plans are separate medical and dental plans that are coupled together. With a bundled plan, a given dental policy may only be bundled with the corresponding medical plan. Even though the plans are bundled, monthly premiums are paid separately. To date, bundled plans appear to be more of a theory than a practical offering.

Embedded Dental Plan

When dental coverage is embedded in the medical plan, the insured is only covered by one plan that provides both medical and dental benefits. Under this type of plan, there is sometimes only one deductible that applies to all benefits. Dental benefits in embedded plans may be subject to the global deductible.

Since embedded plans are typically less expensive than other plans, many individuals choose this type of coverage. However, families that do not meet the single deductible may not actually receive any dental benefits.

COVERED PROCEDURES

Dental coverage varies among plans. Furthermore, coverage can differ between different types of plans (i.e., medical policies with embedded dental benefits versus stand-alone dental plans). The following routine procedures are typically covered as preventive treatments:

- Sealants for first and second permanent molars (typically covered only for patients 6 to 15 years of age; benefits vary).
- Space maintainers (typically must have missing first or second primary molars).
- Consultations.
- Palliative emergency treatment (for pain relief).
- Pulp vitality tests.

Reimbursement for covered procedures varies among plans. Some medical plans with embedded dental benefits require that preventive services be subject to the medical deductible. Once the medical deductible is met, some plans may require the patient to pay a copayment, such as 25 percent. There are also plans that have copayments for preventive visits.

LIMITATIONS AND MAXIMUMS

Plans have historically featured annual or lifetime limits on benefits. Under the ACA, plans are not allowed to place limits on EHB, including preventive care and pediatric benefits. However, plans may place limits on procedures that are not designated as EHB.

Another new feature for pediatric dental benefits is the out-of-pocket maximum. When a plan features an out-of-pocket maximum, once the maximum is met, all treatments are covered at 100 percent of the plan's allowable fee. Stand-alone dental plans purchased on the federal exchange must have an out-of-pocket maximum of $350 for one child and $700 for two or more children. (Note: This feature only applies to treatments provided by in-network doctors.)

PEDIATRIC DENTAL BENEFITS

Under the ACA, all children under the age of 19 must be covered by dental insurance. The coverage comes primarily from public programs, including the Children's Health Insurance Plan (CHIP) and Medicaid. Some coverage also comes from stand-alone plans or may be embedded in a medical plan.

This pediatric coverage requirement dramatically increased the number of children with dental coverage, and thus the demographics of pediatric patients within the dental market. However, dental coverage is not required for adults. Research shows that many adult patients have not obtained dental coverage, and some have even dropped existing dental coverage. This is especially true for families who purchase a medical plan that features embedded pediatric dental benefits.
ORTHODONTIC BENEFITS

Orthodontic benefits are also included in the pediatric EHB. Pediatric orthodontic benefits are typically covered when the treatment is considered medically necessary and the proper documentation is submitted.

Each payer defines its requirements for medical necessity and documentation. For orthodontic treatment, severe orthognathic problems, such as cleft palate or severe occlusion issues, typically meet medical necessity requirements. However, esthetic misalignment where the teeth have a stable occlusion does not qualify. Practically speaking, routine esthetic orthodontic cases are not covered.

While orthodontic documentation requirements vary by plan, many plans require the following:

- Documentation that establishes medical necessity.
- A written report from a qualified orthodontic specialist.
- Orthodontic records with a complete diagnosis (e.g., intraoral and extraoral photographs, panoramic radiographic images, study models, etc.).
- Orthodontic treatment plan or contract, including the anticipated initial placement of the appliance(s) and the length of treatment.

It is highly recommended that orthodontic benefits always be verified before treatment is provided, as coverage often varies from plan to plan and some plans have waiting periods. Furthermore, many plans require prior authorization for orthodontic benefits.

ICD-10-CM CODES

*Note: The current diagnostic (ICD) code set is ICD-10-CM.*

Medical claims are filed using both CPT and ICD codes. CPT codes are similar to CDT codes in that they report the procedure that was performed. ICD codes, or diagnoses codes, provide detail as to the necessity of the procedure. The additional information provided by ICD codes is appealing to claims processors and government entities for benchmarking and other purposes.

The 2012 ADA Dental Claim Form provides four boxes to report ICD codes. Some state Medicaid and ACA plans are currently requiring ICD codes to be reported on dental claims, and some have announced that they will require ICD codes in the future. Others have announced that all claims must be filed using the current 2012 ADA Dental Claim Form, indicating that they may be moving toward the ICD code requirement. Some predict that all plans will require ICD codes to be reported in the future.

COORDINATION OF BENEFITS

Coordination of benefits (COB) occurs when a patient is covered by more than one dental plan. One payer is identified as the primary payer. A claim is sent to the primary payer first, which will determine benefits based on its plan document. After the primary payer provides reimbursement, the claim is then filed to the secondary payer for consideration. Under this arrangement, the practice may receive up to its full practice fee for the procedure performed in some circumstances. However, under non-duplication of benefits, the secondary payer might not provide any benefits based on the primary payer’s level of reimbursement.

COB is a very difficult part of insurance administration and creates confusion for many practices. It is important to understand COB and to have all of the information needed to determine the proper coordination of benefits for each patient.

The ACA impacts COB in two ways, both of which concern the ordering of submitted claims. Medical plans are almost always primary to dental plans. Therefore, when a patient has a medical plan with embedded dental benefits and a stand-alone dental plan, the medical plan with embedded dental benefits will be primary to the stand-alone plan. However, if more plans are involved, determining the primary payer can be even more complicated.

The ACA provides that children up to age 26 may be covered under their parents’ health insurance. While dental coverage is only required up to age 19, some payers voluntarily offer coverage up to age 26 to provide consistency between the dental and medical coverage. Therefore, patients who are working adults may be covered under their employer plan and their spouse’s employer plan, while still being covered under one or more of their parents’ plans. This is an equation that previous COB models did not have to consider. These additional coverages further complicate COB.

Due to the complexity of the ACA, many employers, individuals, dentists, patients, etc. have experienced confusion and frustration. With the implementation of the required pediatric dental benefit, this confusion has been felt across the dental industry as well. Be aware that this article provides an overview of the ACA’s impact on dental practices and is not intended to provide a comprehensive and complete analysis of the ACA.

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