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Pediatric Dental Care Coverage

Under the Affordable Care Act (ACA), pediatric dental services are considered an "essential health benefit" that all non-grandfathered plans in the individual and small group markets must offer. This requirement applies to plans offered inside and outside of the Exchanges, which are scheduled to become effective in 2014. Self-insured group health plans, health insurance coverage offered in the large group market and grandfathered plans are not required to cover essential health benefits.

All qualified health plans (QHPs) must also provide essential health benefits. This generally includes coverage for pediatric dental services, unless a qualified, stand-alone dental plan is also offered in the Exchange.

Adult dental services and non-medically necessary orthodontia are *not* considered essential health benefits, and the ACA does not require any issuers to provide these services (even if the state benchmark covers them). Additionally, an individual does *not* have to obtain dental coverage in order to avoid a penalty under the individual mandate.

OVERVIEW OF ESSENTIAL HEALTH BENEFITS

Beginning in 2014, the ACA requires non-grandfathered plans in the individual and small group markets to offer a comprehensive package of items and services, known as essential health benefits (EHBs). The ACA requires EHBs to reflect the scope of benefits covered by a typical employer and to cover at least 10 general categories of items and services, including pediatric dental services.

The ACA provides that EHBs must include items and services within at least the following 10 categories:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder benefits, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

The ACA also directed HHS to more specifically define the items and services that comprise EHBs. On Dec. 16, 2011, HHS released an informational bulletin (Bulletin) outlining its proposed approach for defining EHBs. It was expected that HHS' guidance would detail the items and services that must be covered as EHBs. Instead, HHS' proposed approach deferred to the individual states by giving them flexibility to select their own benchmarks for defining EHBs. On Feb. 17, 2012, HHS also issued a series of FAQs to supplement the Bulletin's guidance.

On Feb. 25, 2013, HHS released a final rule regarding the ACA's essential health benefits requirement. The final rule confirms HHS' prior guidance defining EHBs based on a state-specific benchmark plan.

HHS Approach for Defining EHBs

HHS has finalized its **benchmark approach** for defining EHBs. Under this approach, each state selects a benchmark insurance plan that reflects the scope of services offered by a typical employer plan in the state. States can select their benchmark plan from the following options:

- One of the three largest small group plans in the state by enrollment;
- One of the three largest state employee health plans by enrollment;
- One of the three largest federal employee health plan options by enrollment; or
- The largest HMO plan offered in the state's commercial market by enrollment.

If a state does not select a benchmark plan, the default benchmark selected by HHS is the small group plan with the largest enrollment in the state.

The items and services included in the selected benchmark insurance plan comprise the essential health benefits package. However, if a state's benchmark plan does not cover the 10 categories of care specified under the ACA, the state or HHS will supplement the benchmark plan in that category.

More information on the benchmark plans, including the benchmark plan for each state, can be found on the Center for Consumer Information & Insurance Oversight (CCIIO) website.

PEDIATRIC DENTAL SERVICES AS AN EHB

Pediatric dental services are considered an "essential health benefit" that all non-grandfathered plans in the individual and small group markets must offer. Adult dental services and non-medically necessary orthodontia are not considered essential health benefits, and the ACA does not require these services to be covered by any plan.

Under the final rule, "pediatric services" means services for individuals under the age of 19 years. However, states have the flexibility to extend pediatric coverage beyond the 19-year age baseline.

In general, a plan may not exclude an enrollee from coverage in any category of EHB, regardless of whether those limits exist in the EHB-benchmark plan. However, this rule does not apply to coverage for pediatric services, including pediatric dental care.

Although all non-grandfathered plans in the individual and small group markets generally must offer pediatric dental coverage, the final rule provides that plans offered outside of an Exchange may exclude pediatric dental coverage if the issuer is reasonably assured that coverage is only sold to individuals who purchase Exchange-certified stand-alone dental coverage that covers the pediatric dental EHB requirement. This assurance could be obtained by requiring proof of coverage from the individual or establishing a method of confirming coverage directly with the stand-alone dental plan. The method of obtaining assurance is at the discretion of the issuer.

Supplementing State Benchmark Plans

HHS noted that pediatric dental services were not covered under the benefit packages of a number of potential state benchmarks. Under the final rule, states have two options for supplementing base-benchmark plans that do not include benefits for pediatric dental care coverage. Pediatric dental services can be supplemented with either:

- The pediatric coverage included in the FEDVIP dental plan with the largest enrollment; or
- The benefits available under that state's separate CHIP program, if one exists, to the eligibility group with the highest enrollment.

HHS will supplement pediatric dental services in the default benchmark plan with the first of the following options that offers pediatric dental benefits:

- The largest plan by enrollment in the second largest product by enrollment in the state's small group market;
- The largest plan by enrollment in the third largest product by enrollment in the state's small group market;
- The largest national FEHBP plan by enrollment across states that is offered to federal employees; or
- The pediatric coverage included in the FEDVIP dental plan with the largest enrollment.

PEDIATRIC DENTAL BENEFITS UNDER QUALIFIED HEALTH PLANS

A "qualified health plan" (QHP) is an Exchange-certified health plan that provides an essential health benefits package and is offered by a health insurance issuer that meets certain requirements. All plans that are offered through an Exchange must be a QHP; however, QHPs may be offered both inside and outside of an Exchange.

In general, all QHPs must provide essential health benefits, including pediatric dental coverage. However, QHPs are permitted to exclude pediatric dental coverage in certain circumstances.

- **QHPs offered inside the Exchange**—All QHPs offered through an Exchange must include coverage for pediatric dental services, unless a qualified, stand-alone dental plan is also offered in the Exchange. QHPs offered through an Exchange may omit the pediatric dental coverage if a stand-alone dental plan in that Exchange offers the required pediatric dental benefit.
- **QHPs offered outside of the Exchange**—Outside of the Exchanges, QHPs generally must cover pediatric dental services. However, QHPs offered outside of the Exchange may offer an essential health benefits package that excludes pediatric dental coverage only if the issuer is reasonably assured that coverage is only sold to individuals who purchase Exchange-certified stand-alone dental coverage that covers the pediatric dental EHB requirement. This assurance could be obtained by requiring proof of coverage from the individual or establishing a method of confirming coverage directly with the stand-alone dental plan. The method of obtaining assurance is at the discretion of the issuer.

HHS determined that a stand-alone dental plan will be available in every federally-facilitated Exchange (FFE) or state-partnership Exchange. As a result, QHP issuers in all FFEs can omit pediatric dental care from their benefits package.

Requirements for Stand-Alone Dental Plans

Under the ACA, all essential health benefits packages are required to limit cost-sharing and meet certain levels of actuarial value. However, the requirements for stand-alone dental plans vary slightly.

In order to be certified by the Exchange, a stand-alone dental plan must cover the pediatric dental EHB, as required by the ACA. A stand-alone dental plan may also offer additional benefits, which could include adult dental coverage; however, only the pediatric dental benefit would be subject to EHB standards.

Stand-alone dental plans cannot use the actuarial value (AV) calculator that HHS has provided to determine the plan's AV. Instead, the plan must be certified by an actuary as either:

- A high plan (with an AV of 85 percent, plus or minus 2 percent); or
- A low plan (with an AV of 70 percent, plus or minus 2 percent).

In addition, a stand-alone dental plan is allowed a separate annual limitation on cost-sharing from QHPs covering the remaining EHBs. The plan must demonstrate that it has a reasonable annual limitation on cost-sharing, as determined by the Exchange. This annual limit on cost-sharing will be applicable to in-network services only.

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