

Pediatric Dental Benefits Requirements

February 8, 2013

Arkansas Plan Management Advisory Committee



Issues

- (1) Should the Arkansas Insurance Department (AID) allow individual and small group health plans offered by issuers outside the Exchange to not include pediatric dental benefits to the extent that such benefits are separately available through stand-alone plans?
- (2) Should AID require issuers of individual and small group plans outside of the Exchange to structure their products to allow the pediatric dental portion to be removed to allow consumers to substitute with a stand-alone plan?
- (3) Should Arkansas require consumers to purchase pediatric dental benefits as a condition of meeting their individual mandate?
- (4) This paper will clarify the issue of the applicability of advance premium tax credits to pediatric dental benefits.
- (5) The FFE will not require consumers to purchase pediatric dental benefits inside the Exchange.
- (6) CCIIO has stated that the FFE portal technology cannot support a requirement to purchase pediatric dental benefits.

Background

Section 1302(b)(4)(F) of the Affordable Care Act permits qualified health plans to not offer pediatric dental benefits to the extent that those benefits are available through stand-alone plans inside the Exchange. This provision reads as follows:

(F) provide that if a plan described in section 1311(b)(2)(B)(ii) (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph (1)(J);

In the final Exchange rule published in the Federal Register on March 27, 2012, HHS replied to comments that individual and small group health plans sold outside of the Exchange should also be permitted to not offer pediatric dental services if they are otherwise available to consumers as stand-alone offerings. HHS indicated that such a request was outside the scope of the rule and affirmed that the exemption for plans to not offer pediatric dental was specific to QHPs inside the Exchange.

That language reads as follows:

Comment: A few commenters urged HHS to allow health plans outside of the Exchange to have the same exemption as QHPs inside the Exchange, in that health plans would not have to cover pediatric dental if a stand-alone plan existed in the market.

Response: This request is outside the scope of this final rule, which addresses explicitly the standards for QHPs. Section 1302(b)(4)(F) of the Affordable Care Act specifically addresses the exemption in terms of QHPs offered through an Exchange.

Last July, the Arkansas Plan Management Advisory Committee recommended that Exchange QHPs be required to structure their products to allow the pediatric dental portion to be removed to allow consumers to substitute with a stand-alone plan.

With regard to issue 3, advocates for expanded dental coverage for children are concerned that consumers will not be required to buy pediatric dental and benefits as a condition of meeting their individual responsibility mandate. The advocates believe this contradicts the intent of the Affordable Care Act. However, qualified health plans are allowed to not include pediatric dental when these benefits are separately available through stand alone products. The individual responsibility mandate is tied to enrollment in a “qualified health plan.” Therefore, the language appears to permit consumers to meet their mandate without purchasing these benefits.

Coverage advocates have commented to HHS that they should clarify that pediatric dental coverage is a requirement to meet the individual mandate. CCIIO has responded to AID that the requirement is to purchase a QHP and not specific benefits. Therefore, they cannot create that requirement. In addition, CCIIO has indicated that AID could pass legislation that would create a requirement that would require individuals to purchase certain benefits. However, CCIIO has also informed AID that they would be unable to assist in enforcing that requirement.

Finally, this paper seeks to clarify whether or not the cost of pediatric dental is eligible to be subsidized via federal tax credits.

Discussion, Issues 1 and 2

- Issuers of stand-alone products argue that by not exempting plans outside the Exchange from the requirement to include pediatric dental as an embedded benefit, stand alone products will have no capacity to compete in this market. This could jeopardize the viability of stand-alone products and impact their availability inside the Exchange.
- The vast majority of dental benefits offered in the small and individual markets are currently provided through stand alone products. Requiring health plans to embed these benefits will create a disruption in the current market.

- In general, assuring a “level playing field” between the individual and small group markets inside and outside the Exchange has been a priority for Arkansas. Aligning stand alone plan policies across both markets would be consistent with this objective.
- Section 1302(a) of the Affordable Care Act indicates that “essential health benefit” requirements apply to “any plan.” The exemption from offering pediatric dental at 1302(b)(4)(F) has been confirmed by HHS as applying only to Exchange plans. Therefore, any action taken by AID may conflict with federal law.

Options, Issues 1 and 2

- Option 1 – Recommend that the Insurance Commissioner extend the exemption from offering pediatric dental benefits to individual and small group plans sold outside of the Exchange where stand alone plans are available for substitution.
- Option 2 – Same as option 1, but also require health plans sold outside the Exchange to stratify pediatric dental offerings to allow comparability of prices and benefits with stand alone products and to allow for potential consumer substitution.
- Option 3 – Do nothing; which will result in small group and individual health plans outside the exchange being required to embed pediatric dental in their benefits.

Discussion, Issue 3

- To address pediatric dental coverage concerns, Arkansas could establish through legislation an individual responsibility mandate that requires parents with children to purchase pediatric dental.
- Arkansas may wish to exert its opinion that the ACA intended to require purchase of these benefits and that stand alone offerings were never meant to be a way around this.
- The instrument for enforcement of any such provision, however, is the Exchange eligibility portal. CCIIO has stated that they will not make any changes to the Exchange portal to prevent a purchase of a QHP unless a consumer also initiates the purchase of pediatric dental. Therefore, it is not clear how Arkansas would enforce this.
- It is not clear how this requirement may only be applied to parents without effectively establishing two coverage mandates for two groups of individuals.

Options, Issue 3

- Option 1: Recommend AID create legislation that Arkansans must purchase pediatric dental benefits.
- Option 2: Do nothing.

Clarification, Issue 4

Since pediatric dental benefits may be separately offered in an Exchange, there is some confusion about the eligibility of these separate benefits for advance premium tax credits. Section 1401 of the Affordable Care Act includes the following language, which clarifies that while the portion of a premium allocable to pediatric dental will be treated as a premium for purposes of computing tax credits, any other additional non-EHB benefits, including adult dental benefits that are part of a stand-alone plan, will not be counted as premiums when computing the tax credits.

ADDITIONAL BENEFITS.—If—

“(i) a qualified health plan under section 1302(b)(5) of the Patient Protection and Affordable Care Act offers benefits in addition to the essential health benefits required to be provided by the plan, or“(ii) a State requires a qualified health plan under section 1311(d)(3)(B) of such Act to cover benefits in addition to the essential health benefits required to be provided by the plan, the portion of the premium for the plan properly allocable (under rules prescribed by the Secretary of Health and Human Services) to such additional benefits shall not be taken into account in determining either the monthly premium or the adjusted monthly premium under paragraph (2).

“(E) SPECIAL RULE FOR PEDIATRIC DENTAL COVERAGE.— For purposes of determining the amount of any monthly premium, if an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii)(I) of the Patient Protection and Affordable Care Act for any plan year, the portion of the premium for the plan described in such section that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J) of such Act shall be treated as a premium payable for a qualified health plan.

These issues will be presented and discussed at the February 8, 2013 Plan Management Advisory Committee.

