Regulatory Treatment of Pediatric Dental Coverage outside Exchanges

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The Affordable Care Act (ACA) includes coverage for pediatric oral health services in the small group and individual market as part of the Essential Health Benefits (EHB) package. Recognizing that 99% of Americans with dental coverage prior to the ACA obtained that coverage separate from their medical policy on a standalone basis, Congress directed that the ACA allow separate dental policies to provide the essential pediatric dental coverage. However, the ACA as enacted, explicitly provided this choice only inside the Marketplaces (or Exchanges).

INSIDE of a state or federal Exchange families can obtain dental coverage in two ways mirroring the pre-ACA market:

Stand-Alone Dental Plan (SADP)

Recognizing that dental policies are offered and purchased separately, the ACA allows dental carriers to offer dental policies and for consumers to purchase these policies separately from their medical plan, just as is commonly done in the commercial market today.

Embedded Medical Plan

Medical carriers can offer Qualified Health Plans (QHPs) that include coverage for pediatric dental services. With these plans, dental and medical benefits are integrated into one policy from the same carrier.

OUTSIDE of a state or federal Exchange, the ACA requires that medical carriers include pediatric dental coverage in policies offered in the small group and individual market.

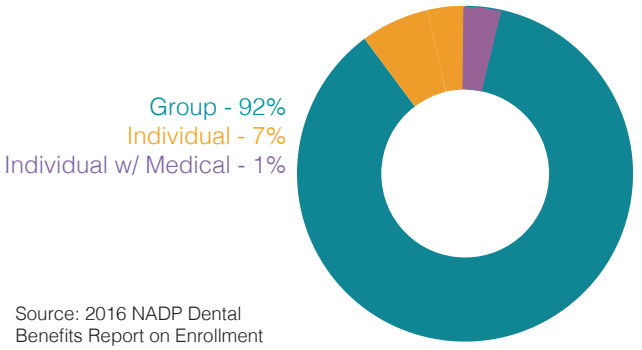
HHS provided an option for medical carriers to offer policies without pediatric dental coverage if two conditions were met:

1. the medical carrier is "reasonably assured that an individual has obtained such coverage" and
2. the coverage be an "Exchange-certified stand-alone dental plan" offered outside an Exchange

While this option was intended to eliminate market disruption and allow the same choices of dental coverage offered in exchanges, the regulation utilizes terminology that is not otherwise defined in the ACA or other federal guidance. Varying interpretations of "reasonable assurance" by state insurance regulators and medical carriers have complicated and ultimately limited the offer of pediatric dental coverage in the small group and individual market outside of exchanges.

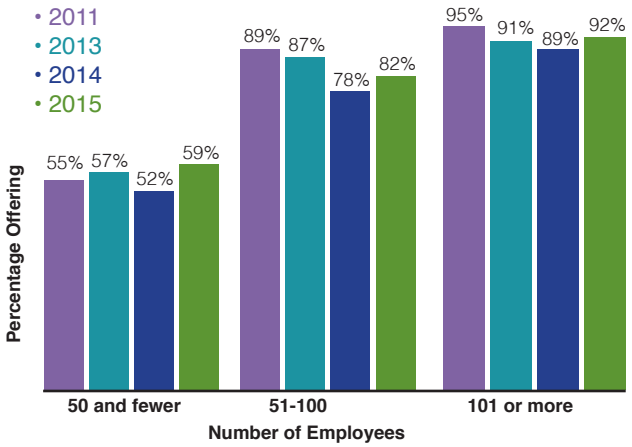
The information outlined here specifically addresses the phrase, "reasonably assured" and outlines how states are implementing and addressing HHS regulations.

Sources of Private Dental Coverage



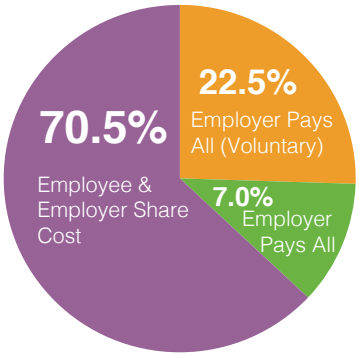
Source: 2016 NADP Dental Benefits Report on Enrollment

Dental Benefits by Employer Size



Source: 2015 NADP Survey of Employers

Group Policy Funding



Source: 2016 NADP Dental Benefits Report on Enrollment

Premium Facts
per Enrollee Per Month

employer size	DHMO	DPPO	Indemnity
< 50	$15.85	$28.38	$34.99
50-99	$14.35	$29.28	$29.72

Source: 2016 NADP Dental Benefits Report: Premium and Benefit Utilization Trends, Feb 2017

IMPLEMENTING "REASONABLE ASSURANCE"

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Several states are concerned with the ambiguity of the federal guidance and have taken steps to define "reasonable assurance" for health carriers offering medical policies within their state. As addressed in memorandums and insurance bulletins, state leaders are concerned about disrupting dental coverage within their state and want to support a competitive dental marketplace.

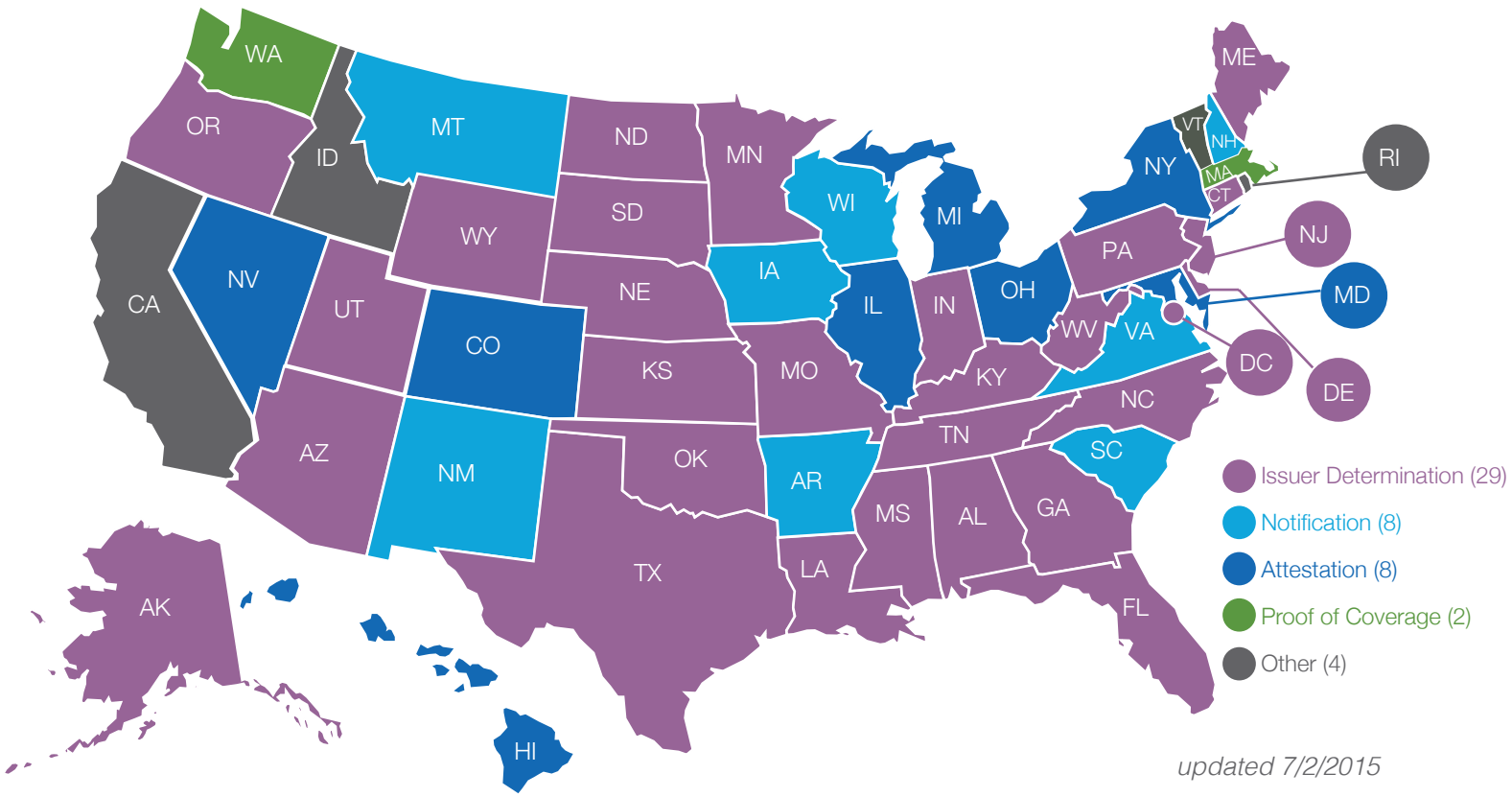
States have taken a variety of approaches clarifying federal reasonable assurance guidance. Four general approaches have been taken in the states that have provided guidance:

Notification: Many states which have taken action are requesting medical issuers provide notification to enrollees that their policy (if appropriate) does not include an approved pediatric dental benefit. The consumer is free to make their own choice for dental or medical carrier for the purchase of dental benefits.

Attestation: Another approach allows for the medical issuer not to embed pediatric dental as long as the consumer attests they have such coverage. Enrollment documents could direct the consumer to attest that he/she has or will obtain separate coverage for pediatric dental benefits. If the enrollee had not obtained such coverage, the medical issuer could offer a medical policy that covers the pediatric dental benefits and/or direct the enrollee to the Exchange to find an Exchange-Certified SADP.

Proof of Coverage: Two states require medical carriers obtain from the consumer or his/her dental carrier some proof that the consumer has obtained the pediatric dental coverage at the time of applying for medical coverage.

Issuer Determination: The remaining states have either declined to clarify the federal standard or have restated the federal standard without interpretive guidance. In these cases, the method of obtaining assurance is at the discretion of the medical issuer, who could employ any or all of the approaches listed here.



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