

A Q&A with Dental Select's General Counsel, Dana M. Smith



Dana M. Smith serves as General Counsel to Dental Select. In this role, she oversees all aspects of the company's regulatory, compliance, and transactional matters. Ms. Smith is a member of the Government Relations Commission of the National Association of Dental Plans (NADP) and is a participant of workgroups and task force teams of the Utah Legislature Health Reform Task Force. Ms. Smith received her Juris Doctor from the J. Reuben Clark Law School at

Brigham Young University and a Bachelor of Arts in English from the University of Utah. Ms. Smith is a current member of the Utah State Bar and the Association of Corporate Counsel.

Essential Health Benefits

What is an EHB and do all health plans have to cover the EHBs?

The *Essential Health Benefits (EHBs)* are 10 benefit categories that must be made available by all non-grandfathered medical plans to individuals and small employer groups. Medical plans sold to large groups and self-funded plans are not required to cover the EHBs. The 10 EHBs include benefits such as emergency services, prescription drugs, and pediatric dental and vision services.

The EHB categories seem to be pretty broad. Are there certain services that must be covered under each category?

Yes, and the services vary by state. The law requires each state to select a plan, from a pool of existing and popular plans, to serve as that state's "benchmark plan." The benchmark plan acts like a baseline, in that it establishes which services must be covered under each EHB category.

Issuers are allowed some latitude to substitute benefits within categories, so long as it is a reasonable substitution with equivalent actuarial value.

What happens when a state's benchmark plan doesn't cover children's dental services?

In those instances, HHS recommends the Federal Employees Dental and Vision Insurance Program (FEDVIP) or the state's Children's Health Insurance Program (CHIP) be used as the state's supplemental benchmark plan.

Just as the benchmark plan establishes which services must be covered under the other EHB categories, the state's supplemental benchmark plan determines which pediatric dental services must be covered.

Do all dental plans have to cover the pediatric dental EHB services?

No. Only dental plans that are Exchange-certified or offered on an Exchange must cover the pediatric dental EHB services. Traditional stand-alone dental

plans are not required to cover the pediatric dental EHB services, nor are they restricted by the plan design limitations placed on Exchange and Exchange-certified plans.

Exchange & Exchange-Certified Dental Plans

What is a "stand-alone" plan?

A stand-alone plan is a plan designed to cover only a specific risk or cost. A stand-alone insurance policy is typically used to augment a comprehensive policy; or, as is often the case with dental insurance, used to buy only the type of coverage you need without paying more for coverage you don't want.

When a stand-alone dental plan is offered separately from a comprehensive medical plan, it may also be called an *excepted benefit*. Excepted benefits are unique, in that they are often exempt from certain requirements of health-related laws. For example, stand-alone dental plans are exempt from many of ACA's market reform provisions, such as: guaranteed availability, renewability of coverage, medical loss ratio standard, rating standards related to age, family size, rating area, and tobacco.

When a stand-alone dental plan is Exchange-certified or offered on the Exchange, certain market reforms do apply, albeit in a modified version.

What changes are necessary when a dental plan is offered on the Exchange or Exchange-certified?

When a stand-alone dental plan is offered on the Exchange or as an Exchange-certified plan, the plan becomes subject to certain strict ACA requirements. In these instances, a dental plan must: (a) Cover the pediatric dental EHB services; (b) Have reasonable cost-sharing values; (c) Have an actuarial value of either 70% or 85%; (d) Be offered without annual and lifetime limitations for in-network pediatric dental EHB services; and (e) Extend pediatric dental EHB coverage for dependents up to age 19.

What's the difference between Exchange and Exchange-certified dental plans?

Not much, actually. Under the healthcare reform law, Exchanges are allowed to offer only certain types of plans at specified levels of coverage. These plans are referred to as qualified health plans *QHPs* and qualified dental health plans *QDHPs*.

Both *QHPs* and *QDHPs* must meet strict requirements of plan design and

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coverage levels. In addition, they are fixed plans; meaning, they cannot alter benefits, plan design, actuarial value, etc., without risking loss of Exchange participation or loss of designation as an Exchange-certified plan. Simply put, the primary difference between a dental plan offered on the Exchange and an Exchange-certified dental plan is merely where the QDHP is offered – on or off the Exchange.

Can a carrier be Exchange-certified?

Exchange-certification is a plan-specific designation, not an issuer or company designation. It is possible for an issuer to offer plans on the Exchange and/or offer Exchange-certified plans, but the issuer cannot itself be designated as “Exchange-certified.”

Pediatric Dental Coverage and Reasonable Assurance

Is my medical plan required to cover dental services for my children?

All non-grandfathered health plans offered to individuals and small groups (those with 50 or fewer employees) are required to cover all 10 EHBs, including pediatric dental services. Whether or not such medical plans must embed coverage for pediatric dental services largely depends on where you’re shopping for medical coverage:

On Exchange: Health plans offered on Exchanges may exclude coverage for pediatric dental services if one or more stand-alone dental plans are offered on the Exchange.

Off-Exchange: Health plans offered outside Exchanges must offer the full set of EHBs unless the carrier obtains reasonable assurance the applicant already has pediatric dental EHB coverage through an Exchange-certified stand-alone dental plan.

What does it mean for a carrier to have “reasonable assurance?”

Reasonable assurance relates to medical policies sold outside of Exchanges, and refers to the degree of certainty an issuer must have before it may offer an Off-Exchange medical plan to individuals or small groups, without embedding pediatric dental EHB coverage.

When an issuer is reasonably assured that an individual has purchased stand-alone pediatric dental coverage offered by an Exchange-certified dental plan, the issuer can offer the individual a policy that, when combined with the stand-alone dental plan, ensures full coverage of the EHBs.

HHS has not determined what, exactly, constitutes “reasonable assurance.” A few states have passed laws defining what constitutes “reasonable assurance” for carriers selling medical plans within their state boundaries. Until federal or state legislation provides otherwise, the medical plan issuer has business discretion to determine what evidences (e.g., applicant or employer signed attestation form, notice of coverage exclusion, certificate of credible coverage, summary of plan benefits, etc.) provide sufficient reasonable assurance.

Could you give a few examples of how states are defining reasonable assurance?

Each state has authority to regulate issuers operating within their state

boundaries and selling insurance plans to their residents, including (due to ACA’s silence on the topic and HHS’s failure to issue specific guidance), legislatively determining what constitutes “reasonable assurance.”

A handful of states have determined an issuer may exclude pediatric dental EHB from the medical policy so long as the issuer provides written notice of such exclusion to the applicant. In some states, the health plan issuer must receive a signed attestation from the individual (or employer) certifying the individual (or employee) has purchased stand-alone pediatric dental coverage from an Exchange-certified plan.

In nearly 40 other states, the question of what constitutes reasonable assurance is left – at least for the time being – to the issuer’s business discretion. In these states, the medical carrier may determine the form and content of notice it must provide to applicants (or, the documentation/attestation it must receive from applicants) in order to properly exclude pediatric dental EHB coverage.

Minimum Essential Coverage for Individuals

The ACA requires most Americans to maintain “minimum essential coverage.” What does that mean?

Under the Affordable Care Act, individuals must maintain minimum essential coverage for themselves and their dependents. An individual who fails to comply with this mandate will be assessed a penalty. **Minimum essential coverage** includes any of the following:

- Medicare, Medicaid or CHIP
- TRICARE or VA Health Care
- Job-based coverage (employer’s health plan)
- Individual market policies
- Certain other coverage (e.g., grandfathered plans, state high risk pools, etc.)

Am I required to have coverage for all 10 EHBs in order to avoid paying the penalty?

This is a common misconception. Minimum essential coverage is not the same thing as essential health benefits. Minimum essential coverage refers to the type of coverage an individual needs to have to meet the individual responsibility requirement under the ACA. [See previous question.] The essential health benefits (EHBs) are the 10 benefit categories that must be included with medical plans offered to individuals and small groups (up to 50 employees).

Are individuals required to have pediatric dental EHB coverage to avoid paying the ACA penalty?

No. According to Healthcare.gov, starting in 2014, individuals “must have health coverage, or pay a fee. But this is not true for dental coverage. You do not need to have dental coverage to avoid the penalty.” Bear in mind, some state-based Exchanges do require the purchase of pediatric dental coverage for children enrolling for health coverage. Check with your Exchange to see if this applies in your state.

Affordable and Minimum Value Coverage Offered by Employers

What is the ESRP and when does it go into effect?

Starting in 2015, large employers (50 or more full-time employees or its equivalent) will be subject to ACA's Employer Shared Responsibility provisions. Large employers who do not offer affordable health coverage that provides at least a minimum level of coverage to their full-time employees and their dependents may be subject to an [Employer Shared Responsibility Payment \(ESRP\)](#) when one or more of its full-time employees receives a premium tax credit for purchasing individual coverage on the Exchange. Liability for the ESRP tax is only triggered when a full-time employee receives a premium tax subsidy.

While the ESRP will generally apply starting in 2015, it will not apply until 2016 for employers with at least 50 but fewer than 100 full-time employees, so long as these employers timely file the informational annual certification form with the IRS in 2015. No ESRPs will be assessed for 2014, regardless of the employer's size.

Do the Employer Shared Responsibility provisions apply only to large, for-profit companies?

No. The Employer Shared Responsibility provisions apply to all large employers (those with 50 or more full-time employees or its equivalent), including for-profit, not-for-profit, federal and state government entities, and Indian tribal government employers. The only employers not subject to the provisions are those who employ fewer than 50 full-time employees. Dental Select recommends employers speak with their trusted tax advisors or legal counsel for assistance in determining whether or not their business qualifies as a large employer under the ACA.

So, small employers aren't required to offer health insurance to their employees?

That's correct. The ACA does not require employers with less than 50 full-time employees (or its equivalent) to offer health insurance coverage. If a business of this size does offer health insurance to its employees, the business may qualify for a small business tax credit in certain situations. Employers should speak with an insurance broker and a trusted tax advisor to discuss all available options.

When is a group plan considered to be "affordable," and have "at least a minimum level of coverage?"

A group plan is considered to be [unaffordable](#) if the employee's cost for employee-only (EO) coverage exceeds 9.5% of the employee's household income. Of course, most employers will not know their employees' household income, so employers can take advantage of certain affordability safe harbors set forth by the IRS. Employers should speak with their trusted tax advisor for details.

A plan provides [minimum value](#) if it covers at least 60% of the total allowed cost of benefits that are expected to be incurred under the plan. HHS and the

IRS created a minimum value calculator, which is available at IRS.gov. In addition, the Treasury and the IRS have proposed other methods available to employers for determining minimum value.

Does a plan have to include all 10 EHBs to be considered of "minimal value?"

No. Remember – the EHBs must be included with medical plans offered to individuals and small employer groups (up to 50 full-time employees). The minimal value determination only applies to large employer plans (those with 50 or more full-time employees). Medical plans sold to large employer groups are not required to cover the EHBs.

Pediatric Dental EHB Coverage and Dental Select Plans

What services are included in the pediatric dental EHB?

Plan designs vary, according to each state's benchmark (or supplemental benchmark) plan. Although the covered services can vary from one state to the next, the pediatric dental EHB services typically include: oral exams, x-rays, cleanings and fluoride, sealants, fillings, crowns, and some endodontics and periodontics services.

When a state's supplemental benchmark plan is a CHIP plan, chances are it also includes coverage for medically-necessary orthodontia. At least one state (Utah) selected a benchmark plan that covers only preventive services: exams, cleanings and fluoride, x-rays, and sealants.

What is medically-necessary orthodontia, and how is it different from cosmetic orthodontia?

Medically-necessary orthodontia is very different from the type of orthodontia benefit found in traditional dental insurance plans. [Medically-necessary orthodontia coverage](#) is limited to children with severe or handicapping bite impairment or congenital deformities, such as cleft lip and palate. Medically-necessary orthodontia is diagnosed by a dental professional, using an index of severity and degree of impact on a child's quality of daily life. The most commonly-used diagnosis tool is the Salzmann Index.

When traditional dental insurance includes an orthodontia benefit, the plan generally covers all commonly-performed orthodontia treatments, regardless of the degree of malocclusion (bad bite) or severity of medical necessity. When the malocclusion is not serious enough to qualify as medically-necessary, the orthodontia benefit available through traditional dental insurance often provides coverage for treatments more cosmetic in nature, such as correcting tooth position and adjusting bite alignment – slight adjustments that can improve the child's appearance and self-esteem.

What is the dependent max age for pediatric dental EHB coverage on Exchange and Exchange-certified plans?

The ACA requires Exchange and Exchange-certified plans to cover pediatric dental EHB services for children up to age 19.

When pediatric dental EHB is embedded in a comprehensive medical plan, does the medical deductible apply or is there a separate dental deductible?

The answer wholly depends on the person's medical plan. When the pediatric dental EHB is embedded in a medical plan, and if the dental services are subject to the medical accumulators (deductibles and out-of-pocket maximums), there is no plan payment for dental services until the person's contribution requirements are met. In other words, the individual could be 100% responsible for all dental charges until the medical deductible has been met.

Individuals covered under a high-deductible health plan with an embedded pediatric dental EHB could find themselves paying in full for dental services that may have otherwise been covered at 100/80/50 cost-sharing levels under a stand-alone dental plan.

Any individual who is considering the purchase of a medical plan with an embedded pediatric dental benefit should review the plan documents very carefully to determine which services are subject to the medical deductible.

What is a MOOP?

MOOP stands for **Maximum Out-Of-Pocket** (also referred to as an out-of-pocket maximum). A plan's MOOP is the annual cost-sharing limit that caps the out-of-pocket expense a consumer will spend for covered services. Beyond that limit, the insurer pays for all covered dental services for the remainder of the year. A MOOP is not the same thing as a deductible, which is the amount a consumer must pay before a carrier pays for any portion of covered services.

Disclaimer: *The information contained herein is intended for general informational purposes only. This does not constitute legal advice and is not intended to constitute advertising or solicitation for legal services. Dental Select recommends individuals and employers speak with their trusted tax advisors or legal counsel for assistance in determining their duties and potential liabilities under the ACA.*

I've heard Dental Select say its group plans include coverage for the pediatric dental EHB services. Is there a difference between that, and Exchange or Exchange-certified dental plans?

Nearly all Dental Select employer plans include coverage for the pediatric dental EHB services (i.e., the list of services that must be covered by Exchange and Exchange-certified dental plans). We say "nearly all," because Dental Select's plans are ultimately customizable. If your employer group plan is an atypical, "preventive only" plan, or a plan that provides non-traditional coverage, then such a plan would likely not include coverage for all pediatric dental EHB services.

Even though a group plan may cover all of the pediatric dental EHB services, however, it doesn't mean it's an "Exchange-certified" plan. Remember, when a dental plan is offered on the Exchange or as an Exchange-certified plan, the plan becomes subject to strict ACA requirements, including annual and cost-sharing limitations, and actuarial value restrictions.

Dental Select is only offering Exchange and Exchange-certified plans in the State of Utah for the 2014 plan year. We are looking to greatly expand this offering in numerous states in 2015.