



July 12, 2013

To: Policymakers and interested stakeholders
From: Deborah Kelch, Health Insurance Alignment Project
Subject: Pediatric Dental Essential Health Benefits FAQ

Attached please find for your review and background Frequently Asked Questions relating to pediatric dental essential health benefits in California. The Health Insurance Alignment Project (Alignment Project) developed this background to inform and support the current policy discussions the state is having relating to how best to offer this benefit in the context of the federal Affordable Care Act and state law.

The Alignment Project is funded by a grant from the California Healthcare Foundation to conduct independent research and technical assistance aimed at advancing effective state implementation of the federal Affordable Care Act (ACA) health insurance market reforms, with a focus on supporting consistency and uniformity in consumer protection and public accountability across state agencies responsible for market oversight.

The attached FAQs include detailed questions relating to the applicable federal laws and policies (Questions 1-13) and California law and policy (Questions 14-17). Question 18 lays out for consideration some of the key issues and questions for policymakers as they deliberate on this issue given the framework of state and federal law and policy.

We hope you find it useful and informative.

Frequently Asked Questions (FAQs)

Pediatric Dental Coverage in California Under the ACA

Under the federal Affordable Care Act (ACA), pediatric oral care is an essential health benefit,¹ one of ten essential health benefits which, starting in 2014, must be included by health insurance issuers selling non-grandfathered individual and small group coverage.² Inclusion of pediatric EHB dental coverage, mandated as an essential component of the broader package of core essential health benefits, represents a change to the existing market for dental insurance coverage where dental coverage is typically sold and purchased as a separate product, distinct and apart from medical coverage.³

This series of Frequently Asked Questions (FAQs) outlines key provisions of federal and state law and policy (as they are known as of this writing) that affect coverage for pediatric dental services in California in two sections, highlighting federal law and policy, and then following with relevant California law and policy applicable to the California Health Benefit Exchange ((California Exchange), branded as Covered California).

Federal Law and Policy

1. Is pediatric dental coverage required to be covered as an essential health benefit?

Yes. Under the ACA, pediatric oral care (along with pediatric vision care) is one of ten essential health benefits that are minimum requirements for non-grandfathered coverage sold in the individual and small group markets.⁴ The ACA requires the Secretary of the Department of Health and Human Services (DHHS) to define the scope of the essential health benefits and ensure that the benefits are equal to the benefits provided under a “typical employer plan.” The ACA also requires the Secretary to ensure that if a stand-alone dental plan is offered in an Exchange, qualified health plans (QHPs)⁵ without pediatric dental coverage will still be allowed.⁶

¹ ACA essential health benefits include at least the following ten general categories: Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, 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.

² “Grandfathered” coverage refers to individual and small group coverage in effect as of March 23, 2010, which continues to meet specific federal requirements, including limited benefit and coverage changes. Grandfathered plans are exempt from some of the ACA requirements that generally apply in the individual and small group markets, including the essential health benefits requirement.

³ National Association of Dental Plans (NADP) and Delta Dental Association. *Offering Dental Benefits in Health Exchanges: A Roadmap for Federal and State Policymakers*. September 2011. Available online at:

<http://www.nadp.org/advocacy/HealthCareReform/ExchangeWhitePaper.aspx>

⁴ 42 United States Code (USC) §18022(b).

⁵ Under the federal ACA, a QHP is a health coverage product or plan certified by an exchange to provide coverage for individuals or small employers who choose to buy coverage in the exchange. In federal law, the health insurance company or entity that offers the QHP is referred to as the QHP issuer. In this FAQ, use of the term QHP refers specifically to coverage of the full scope of essential health benefits, even though dental plans in the Exchange will also be certified as QHPs.

⁶ 42 USC §18022(b).

Pursuant to federal guidance,⁷ and subsequent federal rules,⁸ states can choose from among ten designated “benchmark” or reference plan options to define essential health benefits, including policies sold in the state to small and large employers and coverage provided to federal and state employees in that state.

If the benchmark the state chooses does not include coverage for pediatric oral care, states must “supplement” or add a pediatric oral benefit based on either the pediatric dental benefits available to federal employees or dental benefits available to children enrolled in a state’s separate Children’s Health Insurance Plan (CHIP).⁹

2. What is meant by the term “9.5 plan”?

The term has emerged as shorthand for coverage that includes all ten essential health benefits except for pediatric dental coverage.

3. What provisions of the ACA apply to pediatric dental coverage?

Applicability of ACA provisions to dental coverage depends on whether the coverage is offered as an integral part of a health insurance plan or policy covering medical care (health plan) or as a separate or “stand-alone” dental plan.

When provided under a separate policy, certificate, or contract of insurance, or when they are otherwise not an integral part of a health plan, in federal law limited dental benefits are considered “excepted benefits”¹⁰ and thus are not subject to many of the ACA insurance market reforms, such as guaranteed availability (guaranteed issue), guaranteed renewability of coverage, the prohibition on pre-existing condition exclusions and ACA rating rules.¹¹

In a health plan that integrates health and dental coverage into one policy, the health plan is subject to the insurance market reforms of the ACA based on the market for the policy (i.e., individual, small group, large group, etc.).

⁷ Centers for Consumer Information and Insurance Oversight (CCIIO). *Essential Health Benefits Bulletin*. December 16, 2011.

⁸ 45 Code of Federal Regulations (CFR) §155.100.

⁹ 45 CFR §156.110(b)(2).

¹⁰ 45 CFR §146.145(c)(3)(i).

¹¹ Centers for Medicare and Medicaid Services (CMS). *Affordable Exchanges Guidance: Letter to Issuers on Federally-facilitated and State Partnership Exchanges*. April 5, 2013. See also: CMS. *Qualified Health Plan Webinar Series FAQ #10: Selected Responses*. May 9, 2013.

4. What federal requirements apply to the offering of pediatric dental coverage in state-administered Exchanges?¹²

Exchanges must do all of the following relating to pediatric dental coverage in the Exchange:

- ◆ Allow QHP issuers¹³ in the Exchange to offer a health plan that does not cover pediatric dental as an essential health benefit.¹⁴
- ◆ Allow an issuer of stand-alone dental to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the dental plan provides pediatric dental benefits that comply with the pediatric essential health benefits dental requirement (pediatric EHB dental)¹⁵ and the dental plan: (a) Includes and imposes no annual or lifetime limits on pediatric EHB dental; (b) Meets the Exchange certification standards except for those QHP standards that cannot be met by dental plans; and (c) Otherwise complies with applicable federal laws relating to excepted dental benefits.¹⁶
- ◆ Consider the collective capacity of stand-alone dental plans to ensure sufficient access to pediatric EHB dental coverage.¹⁷
- ◆ Collect and display premium rate information for QHPs and dental plans offered in the Exchange, in a standardized and comparable way, and provide specified information including, for example, premium rates and cost sharing, actuarial values, summary of benefits and specified information on quality and consumer satisfaction.¹⁸

Exchanges may:

- ◆ Allow stand-alone dental plans to be offered separately or in conjunction with a QHP;¹⁹
- ◆ *If* an Exchange determines that it is in the [best] interest of consumers, as a condition of certification, Exchanges can require QHPs to offer and price the pediatric EHB dental separately. However, absent the best interest determination by the Exchange, federal law does not allow an Exchange to require QHPs to separately price and offer the pediatric EHB dental.²⁰

¹² State-administered Exchanges, federally-facilitated Exchanges and state partnership Exchanges are generally required to comply with the same federal rules and standards regarding the selection, certification and offering of QHPs and stand-alone dental plans. This FAQ focuses on California which has established a state-administered Exchange.

¹³ QHP issuers in the California Exchange must be either health insurers subject to the jurisdiction of the California Department of Insurance (CDI) or health care service plans licensed by the Department of Managed Health Care (DMHC).

¹⁴ 45 CFR §155.1065(d).

¹⁵ 42 USC §18031(d)(2)(B)(i).

¹⁶ 45 CFR §155.1065(a).

¹⁷ 45 CFR §155.1065(c).

¹⁸ 45 CFR §155.205(b).

¹⁹ 45 CFR §155.1065(b). In the Preamble to the Exchange final rule, (Federal Register, Volume 77, No. 59, March 27, 2012, p. 18411) CMS states that this means independent of a QHP or as a subcontractor to a QHP issuer, and limit stand-alone dental products to only one of these options.

²⁰ 45 CFR §155.1000(c) codifies the standard where the exchange must determine that offering any QHP is in the interests of individuals and small employers [in the Exchange]. In the Preamble to the Exchange final rule (Federal Register, Volume 77, No. 59, March 27, 2012, p. 18411), CMS states that if an Exchange determines that having QHPs separately offer and

5. In addition to offering the pediatric EHB dental through a stand-alone plan independent of any QHP what options are there for Exchanges to offer the pediatric EHB dental “in conjunction with” QHP coverage?

Subsequent to the final Exchange rules issued in 2012, the Centers for Medicare and Medicaid Services (CMS) identified two options for Exchanges to offer pediatric EHB dental coverage in conjunction with a QHP—either embedded or bundled with a QHP.

According to CMS, the pediatric EHB dental benefit is *embedded* in a QHP when it is offered in the same way as all of the other benefits in the plan, financed by a single aggregated premium, and used by the issuer to calculate the actuarial value (metal tier) of the QHP coverage.²¹ Therefore, even if the QHP issuer contracts with a dental issuer for the benefit, the QHP issuer assumes the risks and liabilities for all of the coverage, including the dental benefit, and presents consumers with one evidence of coverage (coverage contract or policy) for all ten essential health benefits. This is similar to instances where an issuer subcontracts with specialized health plans for administration of mental health or prescription drug benefits but retains the ultimate risk and legal responsibility for the covered services. For purposes of the annual out-of-pocket maximum, in an embedded offering there would be just one annual maximum applicable to all ten essential health benefits, including the pediatric EHB dental.

CMS describes a *bundled* pediatric EHB dental as one where the QHP issuer pairs with a separate stand-alone dental plan to offer pediatric EHB dental coverage. In a bundled arrangement, the QHP issuer would assume the risk for all essential health benefits except for the pediatric EHB dental (9.5 plan) and the stand-alone dental plan would separately assume the risks and liabilities for the pediatric EHB dental (.5 plan). Each offering would be considered a separate plan and the bundled dental plan would be considered an excepted benefit, a stand-alone. Each of the two plans would be held to the applicable standards for the type of plan, QHP or stand-alone dental, including on issues such as out-of-pocket maximums and actuarial value requirements which are discussed in more detail below.²² This means, for example, that as a stand-alone plan the bundled dental plan could have a separate out-of-pocket maximum for the pediatric dental EHB.

6. So there are three options for Exchanges to offer the pediatric EHB dental?

Yes. The pediatric EHB dental can be offered by Exchanges through some combination of the following structures:

- ◆ Embedded in a QHP that covers all ten EHBs however the dental benefit is provided, including a subcontract with a dental issuer (issuer option);
- ◆ In a stand-alone dental plan bundled with a QHP (issuer option); or
- ◆ In a stand-alone dental plan entirely separate and independent of any QHP.

price pediatric dental coverage is in the interest of the consumer the Exchange may do so, but federal rules do not require (or otherwise allow Exchanges to require) that QHPs separately price and offer pediatric EHB dental coverage. The CMS April 5 guidance repeated the same standard for Exchanges related to the pediatric EHB dental with the addition of best interests of consumers [Emphasis added].

²¹ CMS. *Qualified Health Plan Webinar Series FAQ #10: Selected Responses*. May 9, 2013.

²² Ibid.

7. What federal requirements apply to stand-alone dental plans when offered in Exchanges?

Stand-alone dental plans seeking to participate in Exchanges must meet the QHP certification standards for participation in an Exchange, unless the certification requirement cannot be met because the plan only covers dental benefits.²³ In addition, stand-alone dental plans in Exchanges are subject to the following federal rules:

- ◆ Prohibition on annual and lifetime limits. As an essential health benefit, pediatric EHB dental coverage must be offered without annual or lifetime limits.²⁴
- ◆ Different out-of-pocket limits. Out-of-pocket limits differ if the pediatric EHB dental is embedded or stand-alone (including a bundled stand-alone dental plan). In a QHP with the pediatric EHB dental included (embedded), the ACA limits an individual Exchange enrollee’s annual share of costs (copayments, deductibles and coinsurance, etc.) to the federal out-of-pocket limit for Health Savings Accounts, or \$6,350 for 2014.²⁵ For a stand-alone dental plan covering the pediatric EHB dental, federal rules allow for a separate “reasonable” annual limit on cost sharing (above what applies in the QHP the individual selects) applicable to in-network dental services, as reasonable is defined by the Exchange.²⁶
- ◆ No cost-sharing reductions. Pediatric EHB dental benefits provided through a stand-alone dental plan are not subject to the cost-sharing reductions—which reduce consumer copayments, deductibles and coinsurance—that are otherwise available for eligible individuals in a QHP.²⁷ The cost-sharing reductions would be applied to the pediatric EHB dental if “embedded” in a QHP covering all ten essential health benefits.
- ◆ Dental-only actuarial value requirements. Exchange QHPs must characterize the coverage they offer based on four categories of actuarial value,²⁸ sometimes referred to as metal levels or coverage tiers, as follows: bronze (60% actuarial value), silver (70%), gold (80%) and platinum (90%); QHP issuers may also offer a catastrophic plan which allows for specific benefit limitations and is available only to adults under 30 and individuals with affordability exemptions from the federal individual coverage requirement. Stand-alone dental plans must offer coverage for pediatric dental EHB at 70% or 85% actuarial value.²⁹
- ◆ Premium tax credit portion allocated to dental. Advanced payments of the federal premium tax credits for individuals and families must first apply to QHP premiums. Tax credits can only apply to stand-alone pediatric EHB dental if, after the amount of the tax credit which an individual or family is eligible for is first applied to the QHP coverage they choose, there remains a credit to apply to the stand-alone dental coverage.³⁰

²³ 45 CFR §155.1065(d).

²⁴ 45 CFR §155.1065(2)(a) referencing 45 CFR §147.126.

²⁵ 45 CFR §147.126.

²⁶ 45 CFR §156.150(a).

²⁷ 45 CFR §156.440(b).

²⁸ Actuarial value is a measure of the percentage of expected health care costs a specific policy or plan will cover, with the remainder to be covered by the enrollee.

²⁹ 45 CFR §156.150(b) California law imposes additional requirements on the coverage tier offerings of issuers in the Exchange and outside of the Exchange which are outlined below in the section on California law.

³⁰ 45 CFR §156.340(e).

Federal rules establish a formula for determining the portion of the advance payment of the premium tax credit that would be allocated to the pediatric EHB dental benefit in stand-alone plans for federally facilitated Exchanges.³¹ State Exchanges may adopt the federal methodology for allocating the premium tax credits to stand-alone dental policies or “a reasonable and consistent” methodology determined by the Exchange.³²

Note: There are significant implications for the application of the premium tax credits for eligible low income families in the California Exchange, depending on state policy choices made regarding pediatric EHB dental coverage. These impacts are important considerations beyond the scope of this FAQ which should be considered by policymakers and may be the subject of a future Alignment Project FAQ.

8. What federal requirements apply to the offering of pediatric EHB dental coverage and stand-alone dental plans outside Exchanges?

The ACA does not allow for the exclusion of the pediatric EHB dental from coverage outside of the Exchange and issuers must offer the full ten benefits in non-grandfathered, non-Exchange coverage plans.³³ Outside of an Exchange, issuers must offer and sell individuals and families coverage of all ten essential health benefits.

Federal rules allow, however, at the issuer’s option, in cases where an individual has purchased stand-alone dental coverage that is Exchange-certified and the issuer is “reasonably assured” that the individual has such coverage, the issuer to meet the EHB requirement by offering coverage that combines a health plan (9.5 plan) with the pediatric EHB dental coverage (.5 plan) the individual already has purchased.³⁴ In this case, the stand-alone pediatric EHB dental benefit need not be purchased in the Exchange but must be certified by the Exchange to ensure that it covers the pediatric EHB.

Although this question summarizes the relevant federal law, California law prohibits offering any coverage outside of the Exchange with less than all ten EHBs (see Question 15). According to Department of Managed Health Care (DMHC), the CMS Center for Consumer Information and Insurance Oversight (CCIIO) has indicated that federal law does not prohibit states from requiring issuers outside of the Exchange to offer all ten essential health benefits without the reasonable assurance option described above.³⁵

As discussed above, stand-alone dental plans offered outside of the Exchange are excepted benefits under

³¹ 45 CFR §155.340(f).

³² 45 CFR §155.340(e)(2). For further discussion and examples of how the tax credits might be applied see the Preamble to the final rule on Benefit and Payment Parameters (Federal Register, Vo. 78, No.47, March 11, 2013, pp. 15475-15477).

³³ Preamble to the Essential Health Benefits final rule (Federal Register, Volume 78, No. 37, February 25, 2013, p. 12853).

³⁴ Ibid. Note that the discussion in the Preamble of the Essential Health Benefits final rule has not been reduced to regulation and state regulators and stakeholders continue to seek clarification on its meaning and interpretation.

³⁵ Conference call between the DMHC and CCIIO on June 6, 2013, as reported by the DMHC on June 7, 2013 through a background set of FAQs regarding stand-alone dental plans (DMHC FAQs) provided to legislative staff.

federal law (see question #3 for discussion of excepted benefits).

9. Can states require QHP issuers in the Exchange to offer all ten essential health benefits in the Exchange?

Federal law and regulation require Exchanges to allow QHP issuers in the Exchange to offer coverage with or without the pediatric EHB dental,³⁶ at the issuer's option, as long as consumers have a stand-alone dental option in the Exchange.

10. Are Exchanges required to mandate that QHPs only offer coverage that excludes pediatric EHB dental so that dental coverage is only available through stand-alone dental plans?

No. Issuers may choose to offer QHPs without the pediatric EHB dental in the Exchange; Exchanges must allow QHPs with or without pediatric EHB dental and Exchanges must allow the offering of stand-alone dental plans covering the pediatric EHB dental.³⁷ In 2012, CMS stated that Exchanges generally cannot limit the offering of the pediatric EHB dental benefit to just one option (only embedded or only as stand-alone).

11. Are individuals who purchase coverage in the Exchange required by federal law to purchase a stand-alone dental plan if the QHP coverage they purchase does not include the pediatric EHB dental?

No. CMS has stated that "in an Exchange, someone (with a child or without) can purchase a QHP that does not cover the pediatric dental EHB without purchasing a stand-alone dental plan."³⁸ Proposed rules issued in February 2013 by the Department of the Treasury, Internal Revenue Service, do not require coverage that includes all essential health benefits in order to qualify as minimum essential coverage. For example, coverage that typically does not include all EHBs, such as grandfathered health plans, will constitute minimum essential coverage for purposes of the federal coverage requirement.³⁹ The essential health benefits requirement in federal law (and California law) is a requirement on the issuer to include the ten EHBs in any new health plans offered starting in 2014 to individuals and small employers, including coverage through Exchanges. The EHB requirement is not a requirement imposed on the purchasers of coverage or on individuals subject to the federal minimum essential coverage requirement.

12. Can states require individuals in the Exchange to purchase all ten essential health benefits, either through one embedded QHP product or through the combination of a QHP without dental and a stand-alone dental plan?

Yes. There is nothing in federal law that would prohibit a state from requiring that individuals purchase coverage for all ten essential health benefits, including the pediatric EHB dental, in the Exchange.⁴⁰

³⁶ 45 CFR §155.1065(d).

³⁷ Ibid.

³⁸ Preamble to the Essential Health Benefits final rule (Federal Register, Volume 78, No. 37, February 25, 2013, p. 12853).

³⁹ 26 CFR Part 1 (Proposed), §1.5000A-0 through §1.5000A-5. IRS proposed rules entitled, *Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage*. (Federal Register, Vo. 78, No. 22, February 1, 2013).

⁴⁰ According to the DMHC FAQs, in the June 6, 2013 conference call CCIIO confirmed that states could impose this requirement.

13. What policy choices did CMS make that will apply to stand-alone dental plans offered in federal and partnership Exchanges?

For the 2014 coverage year, CMS will not require QHP issuers providing the pediatric EHB dental in the federal and partnership Exchanges to offer and price that benefit separately from the rest of the QHP coverage.⁴¹ According to CMS, the federal Exchange will not have the capacity in 2014 to display dental benefits as a “separate or severable benefit” so that the pediatric EHB dental will have to be offered either embedded with a QHP or in a stand-alone dental plan.

CMS set the “reasonable” annual limit on cost sharing for the pediatric EHB dental at or below \$700 for a plan with one child enrolled and \$1,400 for a plan with two or more enrolled children. CMS will display basic, comparable rate information for stand-alone dental plans on the web portal and for eligible individuals and families will calculate the advance payment of the premium tax credit according to the formula for federally-facilitated Exchanges outlined in regulation.⁴²

To allow QHP issuers to exercise the federal statutory option to omit pediatric EHB dental from QHPs in Exchanges where stand-alone dental plans will be available, CMS established a voluntary reporting program for dental issuers planning to seek certification of stand-alone dental plans in federal and partnership Exchanges. CMS reported that the results of the voluntary reporting mean that stand-alone dental plans will be available in every state with a federal or partnership Exchange, so QHP issuers will have the option (but not the requirement) to omit coverage for the pediatric EHB dental.

California Law and Policy

14. How does California law address the issue of pediatric dental as an essential health benefit?

California passed state implementing legislation in 2012 that requires all non-grandfathered health plans sold to individuals and small employers, to include coverage for all ten essential health benefits, including pediatric dental coverage.⁴³ California selected as the benchmark plan (base benchmark) the Kaiser Foundation Health Plan Small Group HMO 30 (Kaiser Benchmark). Since the Kaiser Benchmark does not include pediatric dental coverage California chose to supplement the benchmark with the dental benefit provided to children enrolled in the 2011-12 state Children’s Health Insurance Program (CHIP) program, the Healthy Families Program in California, including medically necessary orthodontic care as required in the 2009 federal CHIP reauthorization.

⁴¹ CMS April 5, 2013 letter.

⁴² 45 CFR §155.340(f).

⁴³ CA Health and Safety Code (HSC) §1367.005 and CA Insurance Code (CIC) §10112.27 (AB 1453, Chapter 854, Statutes of 2012 and SB 951, Chapter 866, Statutes of 2012 respectively.)

15. How does California law impact pediatric EHB dental coverage inside and outside of the California Exchange?

California's essential health benefits law applies equally to issuers inside and outside of the California Exchange.⁴⁴ Both issuers in the Exchange and outside of the Exchange are required under California law to cover all ten essential health benefits, including pediatric dental. California's Exchange enabling law also requires that all issuers in the Exchange who elect to also sell coverage outside of the Exchange offer and sell all of the QHPs they offer in the Exchange in the outside market as well.⁴⁵ Issuers not participating in the Exchange must offer at least one of the standardized benefit plans adopted by the Exchange in each of the coverage tiers, if the California Exchange adopts standardized benefits (which it did).⁴⁶

16. The federal requirement that Exchanges allow QHPs to offer coverage that either includes or excludes the pediatric EHB dental, at the issuer's option, seems to be in conflict with the California law requiring issuers to cover all ten essential health benefits, whether in the exchange or outside the exchange. How can this be resolved?

Federal law does require Exchanges to allow at least some QHPs to exclude pediatric EHB dental coverage. Given the California law requiring issuers in the individual and small employer markets to cover all ten EHBs in new coverage, DMHC sought federal clarification on these issues and determined the following:⁴⁷

- ◆ State Exchanges must allow QHP issuers to sell coverage without pediatric EHB dental (9.5 plans) at the issuer's option. States cannot require QHP issuers in the exchange to offer all ten essential health benefits.
- ◆ States can require consumers purchasing coverage in an Exchange to buy all ten essential health benefits, as long as the consumer has a stand-alone dental plan choice.
- ◆ California's essential health benefits law includes language that "nothing in this section shall be implemented in a manner that conflicts with a requirement of the Patient Protection and Affordable Care Act (PPACA)" and also that the provisions of the state EHB law "shall be implemented only to the extent essential health benefits are required pursuant to PPACA."⁴⁸ DMHC interprets these provisions to require that as a regulator DMHC must allow issuers seeking to be in the Exchange to offer a plan without pediatric dental, a 9.5 coverage plan, to comply with federal law.
- ◆ Under federal law, issuers outside of an Exchange do have to offer all ten essential health benefits, including pediatric EHB dental coverage; unless the plan obtains an assurance that the individual has pediatric coverage through a stand-alone dental plan.⁴⁹ However, states may require issuers outside the Exchange to cover all ten essential health benefits without the reasonable assurance exception.

⁴⁴ CIC §10112.27(f) and HSC §1367.005(f).

⁴⁵ CIC §10112.3 (c)(1)(A) and HSC §1366.6(c)(1)(A).

⁴⁶ CIC §10112.3(e) and HSC §1366.6(e). This requirement only applies if the Exchange Board adopts standardized benefit plans. California Exchange did adopt standardized benefit plans through regulations (10 CA Code of Regulations (CCR) §6426).

⁴⁷ DMHC FAQs, June 7, 2013.

⁴⁸ CIC §10112.27(j) and HSC §1367.005(j).

⁴⁹ The stand-alone dental plan must obtain an Exchange certification to ensure that it covers the pediatric EHB dental.

CDI and DMHC interpret the combined state and federal law to require issuers in California to offer all ten benefits outside the Exchange without the reasonable assurance exception.

- ◆ Issuers participating in the Exchange who also offer coverage outside the Exchange must add pediatric EHB dental coverage to Exchange QHPs when sold in the outside market in order to comply with both the requirement to cover all 10 and the requirement to offer all Exchange QHPs outside of the Exchange.

In 2014, based on decisions made by the California Exchange to date, issuers in the Exchange will administer two separate out-of-pocket maximums (one for medical (\$6,350) and one for dental (\$1,000)). According to CDI and DMHC, in recent discussions CMS indicated that under federal law issuers outside the Exchange would also be able to administer two separate out-of-pocket maximums but further analysis of relevant state law is pending.

Both CDI⁵⁰ and DMHC⁵¹ recently adopted emergency regulations implementing essential health benefits which allow qualified health plans in the California Exchange to offer both 9.5 and 10 benefit plans at their option if specified conditions are met.

17. What policies related to pediatric EHB dental have to date been adopted by the California Exchange?

Based on review of reasonably available California Exchange Board agendas, minutes, plan solicitation documents / communications and Board-adopted regulations, the following California Exchange policies were adopted or discussed regarding pediatric EHB dental coverage:

- ◆ Require [initially] QHP issuers to submit bids for all ten essential health benefits, including pediatric EHB dental and vision care, and to also submit a separate bid reflecting the exclusion of the pediatric EHB dental. Pediatric vision care will be included as an embedded benefit in QHPs.⁵²
- ◆ Allow bids from stand-alone plans offering pediatric EHB dental in both the individual and Small Business Health Insurance Options Program (SHOP) exchanges.⁵³

⁵⁰ 10 CCR §2594.3. CDI regulations excerpt:

Essential health benefits are defined to include all of the following: (1) Health benefits within the ten categories of essential health benefits enumerated in subdivision (a)(1) of section 10112.27. Provided that a standalone pediatric dental plan is certified to be offered on the Exchange pursuant to section 1302(b)(4)(F) of PPACA (42 USC §18022(b)(4)(F)), a health insurer participating in the Exchange may, but is not required to, omit coverage of the pediatric oral essential health benefit in a health insurance policy sold on the Exchange. A health insurance policy sold on the Exchange shall not omit coverage of the pediatric oral essential health benefit when sold outside of the Exchange pursuant to subdivision (c)(1) of Insurance Code section 10112.3 or otherwise.

⁵¹ 28 CCR §1300.67.005. DMHC regulations excerpt:

If a stand-alone dental plan described in the PPACA at section 1311(d)(2)(B)(ii) (42 USC §18031 (d)(2)(B)(ii)) is offered on the California Health Benefit Exchange (Exchange), then, pursuant to the PPACA section 1302(b)(4)(F) (42 USC § 18022(b)(4)(F)), health plan contracts offered in the Exchange may, but are not required to, omit coverage of pediatric dental care benefits described in Health and Safety Code Section 1367.005(a)(5). A health plan shall not omit coverage of the pediatric dental EHB for health plan contracts sold outside the Exchange.

⁵² California Exchange. *Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability: Options and Recommendations*. August 23, 2012. Adopted by the California Exchange Board.

- ◆ Adopt emergency regulations establishing QHP standard benefit designs for all ten essential health benefits (including child dental and vision care) but incorporate the federal definition of QHP that allows a QHP to exclude pediatric EHB dental.⁵⁴
- ◆ Adopt emergency regulations establishing standard benefit designs for pediatric EHB dental coverage⁵⁵ and require the standard dental benefits to be provided whether embedded in a QHP or offered in a stand-alone dental plan in both the individual and SHOP exchanges. Adopt federal actuarial value requirements of 70% and 85% for the pediatric dental EHB. Require guaranteed issue of pediatric EHB dental in the Exchange although not required in federal law.⁵⁶
- ◆ Adopt emergency regulations⁵⁷ requiring that the California Exchange conduct the QHP solicitation process according to the QHP solicitation incorporated in the regulations, which requires QHP bidders to include pediatric dental, subject to a requirement to separate that may occur and “will be prescribed through the administrative rulemaking process at a later date” depending on future federal guidance and rules.⁵⁸
- ◆ Adopt a QHP Model Contract (final May 21, 2013) which requires QHPs to provide essential health benefits consistent with applicable laws, including specific reference to the state essential health benefits requirements in law, but also allow for QHPs that do not cover pediatric EHB dental coverage
- ◆ Adopt emergency regulations incorporating the solicitation for stand-alone pediatric dental plans and establishing the bid requirements and selection criteria.⁶⁰

In addition to the regulations and policy decisions described above, the California Exchange has provided the following relevant information and communications regarding pediatric EHB dental:

- ◆ Confidential communication to QHP bidders revising the QHP solicitation requirements relating to pediatric EHB dental as follows: (1) Every QHP must bid the pediatric EHB dental benefit as a bundled option through partnering with a stand-alone pediatric dental plan; (2) Embedded pediatric EHB dental is prohibited; (3) QHPs will be required to generate a single invoice for the bundled product; (4) Federal rules require one out-of-pocket maximum for QHPs with embedded dental but allow a separate annual maximum if the benefit is provided through stand-alone dental plans (including bundled); (5) The revised approach [in the letter to bidders] permits separate annual out-of-pocket maximums for medical and dental; and (6) The separate out-of-pocket maximum for stand-alone pediatric EHB dental in the California Exchange will be \$1,000 in 2014.⁶¹

⁵³ Ibid. Staff presentations to the Board at the September 2012 and October 2012 meetings relating to the qualified health plan solicitation content and timeline reaffirmed these policies.

⁵⁴ 10 CCR §6410.

⁵⁵ 10 CCR §6446.

⁵⁶ California Exchange. *Solicitation HBEX 15: Vendor Inquiry Responses (v1.0), Question D102*. February 1, 2013.

⁵⁷ 10 CCR §6410, §6420, §6422, §6424, §6440, §6442, and §6444. Adopted as emergency regulations 1/17/13 and readopted by the Board 6/25/13.

⁵⁸ California Exchange. *2012-13 Initial Qualified Health Plan Solicitation to Health Issuers*. Final December 28, 2012.

⁵⁹ California Exchange. *Final Qualified Health Plan Model Contract*. May 21, 2013.

⁶⁰ 10 CCR §6446.

⁶¹ California Exchange. *Rules for QHP bidders for Submission of Pediatric Dental Essential Health Benefit Dental Plans in conjunction with Qualified Health Plans which provide all essential health benefits other than the Pediatric Dental EHB*. April

- ◆ Supplemental vision and dental plans (other than pediatric EHB dental coverage) will not be offered in 2014 and further analysis is required to determine how such benefits might be offered through the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) in the future.⁶²
- ◆ California Exchange staff presented the following at the June 20, 2013 Board regarding pediatric EHB dental: (1) Adopted standard dental plan designs allow for separate out-of-pocket maximum for pediatric EHB dental (\$1,000); (2) The purchase of pediatric dental for 2014 is voluntary and any stand-alone dental plan can be purchased with any QHP; (3) Every QHP is required to partner with a stand-alone pediatric dental plan using a “bundled” approach; and (5) Selection of pediatric dental plan bidders will be announced June 25, 2013.
- ◆ California Exchange announced the selection of six pediatric EHB dental plans offering three different product types (HMO, PPO and EPO plans) with rates ranging from \$9 per month to \$44 per month, depending on the benefit plan design, the issuer and the geographic rating region.⁶³ The Exchange notice of the selected children’s dental plans stated that the “purchase of the children’s dental health insurance plan is not required.” All of the announced dental plan offerings are stand-alone dental plans and no embedded offering of all ten essential health benefits was selected.⁶⁴

18. What is the status of the pediatric EHB dental in the California Exchange? What are some of the issues and policy questions for policymakers and the Exchange Board related to the offering of this benefit in the California Exchange?

As of this writing, all of the QHP offerings in the California Exchange exclude pediatric EHB dental (no embedded offerings), the pediatric EHB dental will only be available in stand-alone dental plan offerings, and purchase of the pediatric EHB dental benefit is voluntary for individuals enrolling in the Exchange. The Exchange Board has scheduled a special Board meeting for August 8, 2013 which will include a focus on and discussion of the pediatric EHB dental benefit.

Stakeholders and policymakers have raised questions and concerns on the proposed structure and design of this benefit offering in the Exchange, including, for example, concerns that all children may not end up with the coverage and that getting the coverage may be an affordability challenge for families since the premium in the offered pediatric EHB dental plans is higher than the premium likely would have been for coverage embedded in a QHP purchased by all individuals in the Exchange.

The questions above highlight the complex array of state and federal laws that apply to this policy choice. Any reconsideration or changes made to how the California Exchange offers the pediatric dental EHB need to be made in that context, but it may be helpful to evaluate options and next steps in three categories:

3, 2013. (This communication was obtained in hard copy and was referenced in the June 4, 2013 Assembly Health Committee analysis of AB 18 (Pan) but at the time of this analysis a reasonable search of the California Exchange web site www.healthexchange.ca.gov did not yield an electronic version posted on the site.)

⁶² California Exchange. *Notice to Supplemental Dental and Vision Bidders: Supplemental Benefits*. February 26, 2013. Staff presentation at April 23, 2013 Board meeting.

⁶³ California Exchange. *Children’s Dental Insurance Plan Rates, 2014*. June 25, 2013.

⁶⁴ The Health Net dental coverage offering is bundled with Health Net medical coverage but will not be available as a stand-alone dental plan with other QHPs in the Exchange.

- ◆ *Structure of Benefit Offering.* As described above, Exchanges have three options for providing coverage for the pediatric EHB dental– embedded with a QHP, or through a stand-alone dental plan bundled with a QHP or a stand-alone independent of any QHP – in some combination that ensures that consumers have a stand-alone dental option. On the structure question, decision makers will necessarily need to consider and assess:
 - The impact on premium and coverage (expected take-up) for pediatric EHB dental with the current structure and the potential impacts of making changes to the offerings, which could include allowing issuers that want to resubmit QHPs with embedded pediatric EHB dental to do so.
 - The advisability and feasibility of conducting a timely re-bidding or revision to the QHP and/or stand-alone dental offerings in the Exchange for 2014, including the operational and CalHEERS impacts affecting the scheduled October 1, 2013 open enrollment date.
 - Whether there would be adequate time for regulatory review and approval by CDI and DMHC of any new/revised product offerings and rates.

- ◆ *Purchase of Pediatric EHB Dental.* The current policy of the California Exchange would make purchase of the pediatric EHB dental benefit voluntary. The purchase rules affect the pricing of the benefit offering and the anticipated number of children who are likely to end up with dental coverage. On the purchase question, decision makers will need to consider and assess:
 - Whether the purchase of pediatric EHB dental should be voluntary or mandatory and what state and federal laws and authority need to be considered to implement either choice. If mandatory, who should be required to purchase the benefit, all purchasers in the Exchange, or only families with children under age 19?
 - Affordability of the dental EHB coverage depending on how it is offered and who is required to purchase it. For example, leaving the purchase voluntary would likely lead to adverse selection, and potentially higher premiums, if families with children who may have high dental needs disproportionately choose the benefit. At the same time, limiting a purchase requirement to families with children, rather than embedding the coverage in QHPs purchased by all individuals buying Exchange coverage, also potentially increases the premiums for families with children.
 - What is the impact on overall affordability for families from the different out-of-pocket maximums for embedded coverage and stand-alone coverage? Impacts related to the level of premium tax credits that will be available for low-income families in California as a result of the structure of the dental offering? Assessment of these and other impacts could be accomplished through development of specific examples and scenarios for individuals and families in different circumstances making different coverage choices.
 - What assistance will be available for families purchasing pediatric EHB dental? Federal rules allow for some allocation of premium tax credits to dental plans as determined by the Exchange but it would be helpful to understand how that might work on a practical level for families in California for each of the structure and purchase requirements under consideration.
 - The premium assumptions incorporated by bidding QHPs and dental plans regarding who would be buying pediatric EHB coverage and how those assumptions (and the resulting

premium rates) would change if policies in the Exchange are changed.

- ◆ *Evaluation.* Whatever the final structure and requirements applicable to pediatric EHB dental in the California Exchange in 2014, policymakers and the Exchange Board should develop clear processes for tracking and evaluating the take-up rates and experience with pediatric EHB dental to inform future state decisions on this issue.

For 2015, policymakers, including the Exchange Board, may wish to engage stakeholders early in 2014 in analysis and public discussion of the most effective approaches to offering pediatric EHB dental coverage in the Exchange so as to both maximize the numbers of children covered and ensure the affordability of the coverage. Future discussion of the policy options and implications should include a thorough public vetting of those options in advance of the QHP solicitation and re-certification process for the 2015 coverage year.

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