

Important Consumer Considerations in Design of Pediatric Dental Benefits

Pediatric dental benefits are essential health benefits (EHBs) under federal and state law.¹ Both inside and outside of the Exchange, non-grandfathered health plans in the individual and small group markets have to provide all ten EHBs, including pediatric dental health benefits.

Federal law requires Exchanges to *allow* Qualified Health Plans (QHPs) to offer the pediatric dental EHB through stand-alone plans. Outside of the Exchange, however, pediatric dental EHBs must be provided in all plans; they cannot be offered as stand-alone products.²

The Centers for Medicare and Medicaid Services (CMS) permits Exchanges to offer pediatric dental EHBs exclusively in stand-alone plans, but only if the Exchange determines that this is in the **best interest of consumers**.³

It is not in the best interest of California consumers to offer *only* stand-alone pediatric dental plans in Covered California and to fail to offer “embedded” pediatric dental benefits.⁴ First, offering only stand-alone pediatric dental benefits has serious implications for the affordability of the pediatric dental EHB. Second, important consumer protections that govern QHPs do not apply to stand-alone pediatric dental plans, but do apply to embedded plans. Third, the differences in affordability and consumer protections between Exchange products and those offered outside the Exchange violates one of the fundamental policy premises of California law, that the rules for products inside and outside the Exchange should be the same.

¹ Kelch, Deborah, Pediatric Dental Essential Health Benefits FAQ, Health Insurance Alignment Project, pages 1 and 9, July 12, 2013.

² “The ACA does not provide for the exclusion of a pediatric dental EHB outside of the exchange as it does ... for QHPs. Therefore, individuals enrolling in health insurance coverage not offered on an Exchange must be offered the full ten EHB categories, including the pediatric dental benefit.” Preamble to the Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule Federal Register, Volume 78, No. 37, p. 12853, February 25, 2013. The only exception is when an outside plan can provide reasonable assurance that the enrollee is covered through a stand-alone dental plan certified by the Exchange.

³ 45 C.F. R. §155.1000(c). See also, Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers 77 FR 59, page 18411, March 27, 2012; Letter to issuers on federally-facilitated and state partnership exchanges, page 32, April 5, 2013.; and Preamble to newly proposed regulations on risk corridors. Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, Premium Stabilization Programs, and Market Standards; Proposed Rule 78 FR 118, page 37041, fn 18, June 19, 2013.

⁴ See Kelch, page 5 for definition of “embedded.”

1. Affordability of pediatric dental EHBs:

It is not in the best interests of consumers to offer pediatric dental benefits only through stand-alone plans. It greatly impacts the availability of premium tax credits to enrollees eligible for tax credits.

The premium tax credits consumers would be eligible for in the Exchange will not be increased as a result of purchasing stand-alone pediatric dental plans. (See Attachment A regarding how the advance premium tax credit is calculated). As a result of increased costs related to offering stand-alone dental plans for children to access dental coverage, consumers may opt out of purchasing the pediatric dental EHBs entirely.

Premiums for stand-alone pediatric EHB products are not included when calculating the advance premium tax credits. Because stand-alone plans are not part of a full QHP package, but are separate, the premiums for the pediatric dental are not considered part of the second lowest silver plan, used to calculate premium tax credits, but instead are considered separately. Thus, the portion of the premium purchased separately for the stand-alone pediatric dental EHB cannot be used in the premium calculation equation.

What does this mean for Californians eligible for help paying for coverage? This means that families eligible for tax credits who purchase stand-alone pediatric dental alongside their QHP will have to pay a higher percentage of their income for such coverage than families with the same exact income who choose not to purchase the pediatric dental EHB.

Covered California staff has asserted that even when pediatric dental benefits are “embedded” in a QHP—i.e. are part of a fully integrated QHP—the premium associated with those benefits is not included in the advance premium tax credit calculation. This assertion is incorrect. As CMS has stated:

When the pediatric dental benefit is embedded in a health insurance plan subject to standards set forth in §§156.130 and 156.140, we do not distinguish it from other benefits with respect to AV and cost-sharing requirements.”⁵

The IRS regulations affirm that the second lowest silver plan premium is “adjusted only for the age of each member of the coverage family.”⁶ Therefore, it is not adjusted based on whether the QHP includes all 10 EHBs, or excludes pediatric dental coverage (also known as “9.5 plans”).

⁵ Federal Register, Volume 78, No. 37, p. 12853, February 25, 2013.

⁶ 26 C.F.R. §1.36B-3.

By allowing only stand-alone pediatric dental plans in Covered California, the families of more than one hundred thousand children who are low- and moderate-income⁷ may be forced to pay more than 9.5 percent of their family income—the percentage above which consumers become exempt from having to get mandated coverage—in order to access both a QHP and pediatric dental EHBs.

The scenarios below illustrate the practical, detrimental effect of stand-alone pediatric dental plans on affordability. In Scenario 1, the hypothetical Chin family, consisting of two parents and two children living in Vacaville, has an annual income of \$64,000, less than 300% FPL.

Scenario 1 shows the additional financial resources that will be required for the Chin family to purchase dental benefits for their two children if only stand-alone dental plans are available. Based on the second lowest silver plan in their region (which does not include pediatric dental), they are entitled to \$6,232 in advance premium tax credits. However, because the dental coverage is in a stand-alone plan, the family would have to pay out-of-pocket an additional \$27/month for each of their two children (in the lower-priced and lower actuarial value Anthem PPO 70% AV plan), which would increase the total amount they would have to pay \$6,728, which is 10.5% of their income.



Chin Family – Vacaville, CA – Scenario 1
(stand-alone, separate dental premium at 70% AV)

Two adults – John (40 yrs) & Susan (40 yrs)

- Amy – 12 years
- Mark – 10 years

Family income - \$64,000 (<300% FPL)

QHP – Anthem PPO w/o embedded dental

Expected annual contribution: 9.5% = \$6,080 (\$507/month)
 Adult benchmark plan: \$8,232/yr (\$343/month x 2); Child benchmark plan \$4,080/yr (\$170/month x 2)
 Total family benchmark plan: \$12,312/annual (\$1,026/month)
 Premium credit: \$12,312 - \$6,080 = **\$6,232** (\$519/month) – 51% of total premium
 Total family cost: \$6,080 (\$507/month)
9.5% of MAGI

Dental – Anthem DPPO (70% AV)

Child dental plan: \$648/yr (\$27/month x 2)
 Total premiums: \$12,312 + \$648 = \$12,960
 Premium credit: **\$6,232**
 Total family cost: \$6,728 (\$561/month) = \$6,080 (9.5% of income) + \$648 additional/year (\$27/month x 2)
10.5% of MAGI

⁷ CalSIM version 1.8 Statewide Data Book 2014–2019, page 6, March 2013.

In contrast, as shown in Scenario 2, if pediatric dental were embedded in the second lowest silver plan, at the rate of \$15 additional monthly premium,⁸ the Chin family would only be required to contribute \$6,080 toward their premiums and be able to get full dental coverage for both of their children.



Chin Family – Vacaville, CA – Scenario 2
(embedded dental benefits)

Two adults – John (40 yrs) & Susan (40 yrs)

- Amy – 12 years
- Mark – 10 years

Family income - \$64,000 (<300% FPL)

QHP – Anthem PPO with embedded dental adding to base premium \$8/month

Expected annual contribution: 9.5% = \$6,080 (\$507/month)

Adult benchmark plan: \$8,592/yr (\$358*/month x 2) Child benchmark plan \$4,440/yr (\$185*/month x 2)

Total family benchmark plan: \$13,302/annual (\$1,108/month)

Premium credit: \$13,302 - \$6,080 = **\$7,222** (\$519/month) – 54% of total premium

Total family cost: \$6,080 (\$507/month)

9.5% of MAGI

* includes additional \$15/month for each dental embedded in the plan

Table 1 below summarizes the financial impacts on the Chin family when only stand-only dental plans are offered in the Exchange. In order to have dental coverage for their children, their monthly premiums are much higher than they would be if the dental benefits were embedded. They will have less advance premium tax credit to use to shop in Covered California. In order to keep their premiums no more than 9.5% of their income, they may be forced to choose a lower monthly cost bronze plan that would increase their exposure to out-of-pocket costs and deductibles.

⁸ We understand from plans that embedded pediatric dental would increase the QHP premiums by \$6 to \$12 per person, per month. In order to be conservative, we created this scenario assuming that the embedded pediatric dental would increase the base QHP premium by \$15 per person, per month.

Table 1:

	Scenario 1	Scenario 2
Total credit	\$6,232	\$7,222
Cost to family	\$6,728	\$6,080
Out-of-pocket max (total)	\$8,350*	\$6,350
Family deductible	\$2,120**	\$2,000
Premium % of MAGI	10.5%	9.5%

* Family OOP max: \$6,350 + separate dental \$1,000 x 2 (per child)

** Family deductible: \$2,000 deductible + separate dental \$60 deductible x 2 (per child)

Thus, Covered California’s decision to prohibit QHPs from offering embedded pediatric dental coverage would result in higher out-of-pocket costs, and in some cases, would thrust families over the 9.5% income threshold and into an exemption from the mandate to have coverage, leaving families with the option not to purchase health insurance at all. For some, the additional costs associated with the stand-alone dental plans will put them in an untenable position and will force them to forego dental coverage for their children.

Tax credit subsidies can be used to pay for stand-alone dental plans if, after a family purchases their QHP health plans, they have some of the tax credit left over.⁹ However, the federal regulations make clear that stand-alone dental plans must be able to process and accept advance payments of the premium tax credit, so that consumers don’t have to wait until tax time to avail themselves of the credit.¹⁰ We are not aware of whether the current bidders of pediatric dental stand-alone plans have this capacity. Further, as shown by the scenarios above, in most situations, the amount of premium tax credit available to families is likely to push low- and moderate-income families into situations where they are only able to afford bronze level plans, in order to be able to purchase stand-alone pediatric dental benefits and remain below the 9.5% income affordability threshold.

⁹ This comes from the final regulations on Benefit and Payment Parameters addressing §155.340(e), which focuses on the allocation of a tax credit when individuals in the tax filers’ tax household are enrolled in more than one QHP or stand-alone dental plan. The process requires that first the subsidy allocation be spread across the multiple QHPs (if family members are enrolled in more than one QHP plan), “to ensure that the majority of the tax credit is allocated to the most costly portion of an individual’s coverage.” 78 FR 47, page 15477, March 11, 2013.. Section 155.340(e)(2) states that “any remaining advance payment of the premium tax credit must be allocated among the stand-alone dental policies in a reasonable and consistent manner specified by the Exchange.” See 78 F.R. 47, page 15533. ¹⁰ 78 FR 47, page 15477.

2. Important consumer protections do not apply to stand-alone plans:

It is not in the best interest of consumers to allow only stand-alone plans since such plans are not required to meet many of the most fundamental consumer protections of the ACA. Under California law, these consumer protections apply to full service health care service plans, but not to specialized plans. Consumers purchasing embedded coverage would receive these protections while those purchasing a stand-alone dental benefit would not.

Federal rules and California law do not apply these key consumer protections to stand-alone pediatric dental plans offered by specialized health plans:

- Guaranteed issue: the requirement that coverage be sold regardless of pre-existing conditions or health status;
- Limits on pre-existing condition exclusions and waivers;
- Modified community rating, which bases premiums on age, family size and geographic region rather than health status or pre-existing condition;
- Rate review;¹¹ and
- Medical loss ratio rules.

All of these consumer protections apply to pediatric dental coverage when offered by a health care service plan which is not a specialized plan and thus apply to pediatric dental benefits offered outside the Exchange. The lack of guaranteed issue and community rating of pediatric dental benefits is especially troublesome since it directly affects the affordability of the benefit.

In the past, dental benefits have been supplemental or incidental benefits. The enactment of the essential health benefits requirements in both federal and California law move pediatric dental from a supplemental benefit to a core benefit. It is unfortunate that existing California law does not provide the same consumer protections to stand-alone dental benefits offered by specialized health plans. In the absence of a change in California law, the only way to provide these important consumer protections is to provide pediatric dental benefits through health plans or insurers subject to the more comprehensive consumer protections.

Some protections do apply regardless of the plans' stand-alone status. For example, cost-sharing limits and restrictions on annual and lifetime limits apply to stand-alone dental plans for coverage of the pediatric dental EHB.¹² And, contrary to statements made by Covered California staff, stand-alone plans must meet QHP certification

¹¹ 45 C.F.R. §146.145(c)(3).

¹² 45 C.F.R. section 146.145(c)(3); Section 155.1065(a)(3) (See also, 77 F.R. 59, page 18411, March 27, 2012.)

standards, such as network adequacy.¹³ Specialized plans that are regulated by DMHC are subject to network adequacy and timely access requirements under existing law.

3. Comprehensive Benefits, Not Partial Benefits

Under both federal and state law, pediatric dental is one of the ten essential benefits. It is not a supplemental or incidental benefit. Comprehensive benefits, by their nature, include benefits that many enrollees will never use: some of us will never need maternity coverage, others among us will never need prostate cancer screening; and children need neither, yet all of our QHP offerings include both benefits. The list of benefits that many of us hope we never need is even longer: coverage for numerous diseases and conditions is part of the core benefits that everyone pays for.

Pediatric vision has been included without question in the coverage to be sold to all consumers both inside and outside the Exchange. Pediatric dental should not be treated differently than pediatric vision.

4. Market Impacts: Same Rules Inside and Outside the Exchange

A guiding principle of the California legislation enacted to implement and improve on the federal Affordable Care Act has been that the rules for the insurance market should be the same inside and outside the Exchange. California has a long history with the market-distorting effects of allowing different parts of the market to play by different rules. An earlier effort at a small group purchasing pool collapsed due to adverse selection because risk rating was different for the purchasing pool than the outside market. The California individual market shifted from 80% of the covered lives with maternity benefits to only 20% in less than five years because premiums without maternity coverage are cheaper than premiums for more comprehensive coverage.

Allowing individuals to purchase coverage without pediatric dental benefits is no different than allowing individuals to purchase coverage that does not include maternity benefits (or prostate cancer or childhood immunizations): it will impact the market. If all of those in the individual market outside the Exchange are required to purchase all ten benefits, while those purchasing individual coverage through the Exchange have the option to decline pediatric dental coverage, it will create market distortions between the outside market and the Exchange.

If those purchasing through the Exchange can obtain coverage without pediatric dental benefits, that will drive up the cost of pediatric dental benefits for those families purchasing through the Exchange who choose to purchase pediatric dental benefit, since the cost (and risk) of the pediatric dental benefit will not be spread across the entire Exchange population. Further, treating pediatric dental as a supplemental or

¹³ See 77 F.R. 59, page 18412.

optional or incidental benefit ignores the policy principle that health coverage should cover a comprehensive set of benefits rather than a pick and choose menu of what consumers think they might need or might be able to afford. California has consistently improved on what the federal law permits or requires.

Conclusion

Stand-alone pediatric dental plans that are an optional purchase in the Exchange cost consumers more, reduce the *value* of the available tax credit to families, push some consumers above the 9.5% affordability threshold, offer fewer consumer protections and undermine insurance market rules. Providing stand-alone dental benefits as the only option is not in the best interests of consumers. Embedded products should also be offered, if at all possible for the 2014 rate year, if not as a policy direction for the 2015 rate year.

Attachment A:

Figuring out Advance Premium Tax Credits

Advance premium tax credits are determined by looking at two things:

- The individual or family's modified adjusted gross income (MAGI), based on the number of people in the family; and
- The cost of second lowest silver tier plan premium in their geographic region for each family member's age (think of this as the "benchmark" premium for each person).

Step 1: Determine the maximum amount the family will be required to pay in premiums

The ACA established an income cap (a percent of income) for each income level between 139% to 400% of the federal poverty level (FPL). The first step is to establish what the percentage cap is for the individual or family's income level. The income cap is never more than 9.5% for those eligible for premium tax credits. If expenditures exceed the 9.5% cap, the family is exempt from the "individual mandate" to have coverage.

For example, suppose Rachel Smith makes \$33,000 annual modified adjusted gross income. The most she will have to pay toward her annual premium is 9.5% of her modified adjusted gross income, which would be \$3,135.

Step 2: Determine what the benchmark premium is for her age.

To find the benchmark premium for each person, you look at the geographic region where she lives, her age bracket, and find the second lowest cost silver plan premium amount for her age.

Suppose that Rachel Smith is 40 years of age and lives in Vacaville, which is in Solano County. If you use Covered California's booklet for Region 2 (Napa, Sonoma, and Solano County),¹⁴ you will see five silver tier plans offered in the region for a 40 year old single adult.

¹⁴ Covered California, Health Insurance Companies and Plan Rates for 2014, page 25 (May 23, 2013, updated June 28, 2013).

Pricing Region 2

Napa, Sonoma, Solano,
Marin

40-YEAR-OLD				
Plan	Bronze	Silver	Gold	Platinum
Anthem PPO	\$259	\$343*	\$416	\$482
Blue Shield EPO	\$282	\$338	\$402	\$461
Health Net PPO	\$348	\$396	\$450	\$507
Kaiser Permanente HMO	\$275	\$365	\$448	\$482
Western Health Advantage HMO	\$257	\$369	\$434	\$471

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The second lowest silver tier plan is the Anthem PPO product. The unsubsidized premium per month for the Anthem product is \$343 per month (annual \$4,116).

Step3: Figure out the amount of the premium tax credit.

To figure out the amount of the tax credit, subtract the family's maximum premium contribution from the total annual premium of the lowest cost silver plan:

Annual premium for second lowest silver plan	\$ _____
Subtract maximum family contribution	- \$ _____
Federal tax credit	\$ _____

For Rachel Smith (above) who is 40 years old, single, and lives in Vacaville (Region 2) the equation would be:

Annual premium for Anthem PPO (\$343/month)	\$4,116
Maximum contribution (9.5% MAGI)	- \$3,135
Federal tax credit	\$ 981

For the Chin family, a family of four (2 children and 2 adults) living in Vacaville with \$64,000 in modified adjusted gross income (MAGI), the equation would be based on the family premium rate for Region 2:

Pricing Region 2

Napa, Sonoma, Solano,
Marin

FAMILY OF FOUR				
Plan	Bronze	Silver	Gold	Platinum
Anthem PPO	\$774	\$1,026*	\$1,245	\$1,444
Blue Shield EPO	\$844	\$1,012	\$1,204	\$1,379
Health Net PPO	\$1,041	\$1,187	\$1,347	\$1,518
Kaiser Permanente HMO	\$823	\$1,092	\$1,341	\$1,443
Western Health Advantage HMO	\$769	\$1,106	\$1,300	\$1,410

Family of four = two parents age 40 and two children under the age of 21

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The Anthem PPO is the second lowest silver plan for a family of four. Hence, the Chin family calculation of advance premium tax credits would be:

Annual premium for Anthem PPO (\$1,026/mo)	\$12,312
Maximum contribution (9.5% MAGI)	- \$6,080
Federal tax credit	\$6,232