access health CT
Connecticut's Health Insurance Marketplace

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To: Access Health CT Board of Directors

From: Virginia A. Lamb
General Counsel Access Health CT

Re: Pediatric Dental Benefits

Issue: **The National Association of Dental Providers (NADP), the trade association for 26 member dental carriers has challenged the Exchange's 2013 decision to embed pediatric dental benefits in its standard plan designs for 2014. The Association asserts that the Exchange's requirement to embed the pediatric dental benefit in the standard plan designs fails to comply with federal and state law which require that when a qualified stand-alone dental plan is available, the Exchange must allow health carriers to choose how they will provide the pediatric dental benefit. In other words, health carriers may provide this benefit integrated with the other essential health benefits, or in conjunction with a qualified stand-alone dental provider.** The NADP characterizes those Qualified Health Plans (QHPs) that do not integrate (i.e. embed) the pediatric dental benefit as a 9.5 plan.

Exchange Response: The Exchange believes that the NADP has read the language of the Affordable Care Act (ACA) and federal regulations, as well as the Exchange's own enabling legislation, too broadly. Specifically, the NADP fails to recognize certain exceptions provided in the federal law and regulations and in state law that allow the Exchange to require that the pediatric dental benefit be embedded in all its standard plan designs.

The Exchange does not dispute that the Patient Protection and Affordable Care Act (ACA) allows for stand-alone dental plans. Section 1311(d)(2)(B)(ii) of the ACA states, in pertinent part:

> (ii) OFFERING OF STAND-ALONE DENTAL BENEFITS.—Each Exchange within a State shall allow an issuer of a plan that only provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J)).

State law also requires the Exchange to allow carriers to offer qualified limited scope stand-alone dental plans. Conn. Gen. Stat. 38a-1085 and 38a-1086. But there is nothing in federal or state law that requires that limited scope stand-alone dental plans be the only vehicle to offer the pediatric dental benefit.

This provision is further clarified in the final regulations issued by the Department of Health and Human Services (HHS) in March 2012. Section 155.1065 states:

> § 155.1065 Stand-alone dental plans.
> **(a)** ***General requirements.*** The Exchange must allow the offering of a limited scope dental benefits plan through the Exchange, if—
> **(1)** The plan meets the requirements of section 9832(c)(2)(A) of the Code and 2791(c)(2)(A) of the PHS Act; and
> **(2)** The plan covers at least the pediatric dental essential health benefit as defined in section 1302(b)(1)(J) of the Affordable Care Act, provided that, with respect to this benefit, the plan satisfies the requirements of section 2711 of the PHS Act; and
> **(3)** The plan and issuer of such plan meets QHP certification standards, including § 155.1020(c), except for any certification requirement that cannot be met because the plan covers only the benefits described in paragraph (a)(2) of this section.

The Exchange currently offers qualified dental plans on a stand-alone basis on the Exchange and plans to continue to do so in 2015, providing an even more robust on Exchange shopping experience in 2015 than in 2014. Accordingly, the Exchange is in compliance with these requirements.

Subsection (b) of 45 CFR § 155.1065 addresses offering options and states that these plans can be offered on a stand-alone basis or in conjunction with a QHP.

> **(b)** ***Offering options.*** The Exchange may allow the dental plan to be offered—
> **(1)** As a stand-alone dental plan; or
> **(2)** In conjunction with a QHP.

For 2015, it is the Exchange's intent to allow qualified dental plans to be offered, either on a stand-alone basis or in conjunction with any one of the carrier's optional non-standard plan designs at all metal tiers. In practice, the decision regarding integration of the pediatric dental benefit into the QHP would be the carrier's choice for all non-standard plan designs. Accordingly, the Exchange is in compliance with the offering options.

However, it is the Exchange's intent to continue to require that the pediatric dental benefit be embedded in all of the Exchange's standard benefit designs at all metal tiers for 2015. This Exchange decision is supported by subsection (d) of 45 CFR § 155.1065 and subsection (c) of 45 CFR § 155.1000, as well as by state law. Subsection (d) states that where there is a qualified stand-alone dental plan available, the Exchange cannot deny a QHP certification "solely" [emphasis added] because it does not offer coverage of benefits offered through the stand-alone plan.

> **(d)** ***QHP Certification standards.*** If a plan described in paragraph (a) of this section is offered through an Exchange, another health plan offered through such Exchange must not fail to be treated as a QHP solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under section 1302(b)(1)(J) of the Affordable Care Act.

The Exchange's decision regarding certification of the standard plan designs would not be "solely" based on the lack of integration for the pediatric dental benefit but would be because this failure to integrate the benefit undercuts in a material way the ability of the Exchange to offer its customers a fully comparative shopping experience. Early on, the Exchange Board established this fully comparative shopping experience as a key goal of the Exchange. To meet that goal, the Exchange developed standard benefit designs, so that consumers could more easily evaluate which health plan offered them the best value. By holding covered benefits, deductibles, co-payments, co-insurance, and out of pocket maximums constant across the standard plan designs, consumers are able to make informed decisions.

The Exchange's requirement for an integrated pediatric dental benefit in its standard plan designs is also consistent with the duty imposed on the Exchange by Conn. Gen. Stat. 38a-1084 (24) to "Seek to include the most comprehensive health benefit plans that offer high quality benefits at the most affordable price in the exchange." In practice, embedding pediatric dental makes this service available at almost no additional cost to the consumer. The Exchange's actuaries have estimated the costs as adding about $5 to $6 to the premium dollar per month for the standard plan designs. This cost contrasts to the estimated cost of a standalone pediatric benefit of $25 to $35 per month for services. Admittedly, the stand-alone dental plan, would in all likelihood be offering more services for this additional price. But that in itself will make it difficult, if not impossible for the consumer to have a fully comparable shopping experience. It is unclear how a stand-alone dental plan could separately price the same benefit.

Subsection (d)(4) of Conn. Gen. Stat. Sec. 38a-1086 provides that

> (d) (4) Health carriers may jointly offer a comprehensive plan through the exchange in which dental benefits are provided by a health carrier through a qualified dental plan and health benefits are provided by another health carrier through a qualified health plan, provided the plans are priced separately and are also made available for purchase separately at the same such prices.

Federal regulations also recognize the need for the Exchange to act in the best interests of its customers. Subsection (c) of 45 CFR §155.1000 requires the Exchange to make available plans that are in the interest of qualified individuals and qualified employers. The Exchange believes the standard plan designs with the embedded pediatric dental benefit are in the best interest of qualified individuals and employers. The standard plan designs provide a cost effective option and a fully comparable shopping experience. Embedding the pediatric dental benefit also ensures that this essential health benefit is available and remains available without additional action on the part of the consumer. It is included in the plan's premium. And, it is a benefit that

will stay available so long as the consumer purchases the plan and pays their premium. In addition, embedding the pediatric dental benefit allows the consumer to qualify for the full APTC in one transaction. This simplicity is especially important for many of the Exchange's consumers, who are not experienced with health insurance and for whom tax credits are in all likelihood a foreign concept.

Finally, there are only three absolute conditions set out in federal regulation that the Exchange cannot use to exclude a health plan. Lack of an embedded pediatric dental benefit, is not one of those limitations.

> (c) *General certification criteria.* The Exchange may certify a health plan as a QHP in the Exchange if—
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> (2) The Exchange determines that making the health plan available is in the interest of the qualified individuals and qualified employers, except that the Exchange must not exclude a health plan—
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> (i) On the basis that such plan is a fee-for-service plan;
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> (ii) Through the imposition of premium price controls; or
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> (iii) On the basis that the health plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

The Exchange believes the ACA and state law provide the Exchange the flexibility to act in the consumers' best interest, by integrating the pediatric dental benefit in the standard plans designs. This integration allows consumers to have a comparative shopping experience, a more cost effective option and a simple transaction with full APTC credit. It also ensures that this essential health benefit will continue to be available so long as the consumer has medical coverage.