Bernie Lowe & Associates, Inc.
"Beyond the Product"

Health Care Reform Update

IMPORTANT NOTICE REGARDING HEALTHCARE REFORM

Update 23 **August, 2013**

Essential Health Benefits - Pediatric Dental and Vision

The Affordable Care Act (ACA) requires Americans to purchase qualified health coverage in 2014 and thereafter or pay a fine. For small groups and individuals, the ACA sets a specific group of benefits, Essential Health Benefits (EHB), as the minimum health coverage that can be offered both on and off the Health Insurance Marketplace (the Public Exchange). Included in this set of benefits are pediatric services, including pediatric dental and pediatric vision care.

The EHB requirements apply only to individuals and groups with 2 to 49 employees

While the ACA defines small group as 100 or fewer, states defined their small group markets as under 50 full-time equivalent employees and can keep this threshold until 2016, if they choose to. Therefore for 2014, EHB will be offered at minimum to individuals, to employers under 50 and to anyone purchasing coverage through the Health Insurance marketplace.

The definition of pediatric dental and vision services for Iowa will be based on the FedVIP plan and will include coverage for all children up to the age of 19 with no lifetime or annual maximums. Dental benefits will include all pediatric services and medically necessary orthodontia. Vision benefits will include coverage for vision exams, eyeglasses and other materials. At this time the law states the limiting age for pediatric benefits is to age 19, however, states have the option of increasing the limiting age. We believe the State of Iowa will increase the limiting age to age 21.

Pediatric Dental Coverage:

For pediatric dental coverage, carriers can offer plans in two different ways, i.e., as part of the medical plan (embedded) or as a separate plan from medical (standalone).

Embedded Plan: Pediatric benefits are offered as part of the medical plan. This means an embedded plan will only cover pediatric charges and medically necessary orthodontia for children under age 19. Adult coverage will not be included. The pediatric benefits, in most cases, will be offered subject to the medical plan deductible, out-of-pocket and coinsurance limits. With this option the out-of-pocket expense to the member may be higher as medical plans will have larger deductibles and out-of-pocket limits.

Standalone Plan: With this option the plan is purchased separately from the medical plan. The regulations set an annual pediatric dental out-of-pocket limit at $700 per child and $1400 per family. This includes only charges for children under age 19 and includes only "medically necessary" orthodontia. Note, charges for adults and "corrective orthodontia" for all members including those under 19, will be subject to standard dental plan limits, i.e., annual limits can be applied.

Exchange-Certified dental plans offered must meet one of two required actuarial value levels (70% or 85%) for pediatric dental coverage. The 70% plan is referred to as the low option and the 85% the high option. Either plan will meet the EHB requirements for small group and individual.

Qualified medical plans offered in the individual and insured small group market must either include pediatric dental benefits, or follow these rules for the provision of pediatric dental benefits as a stand-alone dental plan:

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On the Health Insurance Marketplace (the Public Exchange):

- If a stand-alone pediatric dental option is available from any carrier on the Health Insurance Marketplace, pediatric dental coverage can be excluded from the EHB package provided by the medical plan.

- There is no requirement for an individual or family (with a child or without) to purchase a stand-alone plan if the Health Insurance Marketplace medical plan does not cover the pediatric dental.

Outside the Health Insurance Marketplace:

- Pediatric dental coverage can be excluded from the medical plan if that carrier is reasonably assured that the individual has obtained pediatric dental coverage by an exchange-certified stand-alone dental plan. An exchange-certified stand-alone dental plan does not have to be purchased through the Health Insurance Marketplace.

- An individual or family must be offered coverage of all ten categories of EHBs, either through one policy, or through a combination of a medical policy and an exchange-certified stand-alone dental plan.

HHS final EHB rules were not specific about what constitutes reasonable assurance. Some states are defining reasonable assurance as a notice to consumers while others indicate that an attestation on applications or some other form is needed.

Self-funded and large group plans do not have to offer the pediatric dental benefit.
Only plans that are "excepted benefits" can impose annual or lifetime dollar limits for pediatric dental EHBs for anyone under 19. By maintaining excepted benefit status, dental benefits are exempt from PPACA and HIPAA requirements that are applicable to medical plans.

Pediatric Vision Coverage:

Pediatric vision plans offered in the non-grandfathered individual and non-grandfathered insured small group market must cover pediatric vision services beginning January 1, 2014. Services will include vision exams, eyeglasses and other materials.

Self-funded and large group plans do not have to cover the pediatric vision benefit.
However, if they have a vision plan that is not an "excepted benefit," annual & lifetime dollar limits are banned for persons under 19 on the services deemed pediatric vision EHBs .

Excepted Benefits:

Insured plans

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- Dental and vision benefits offered under an insurance policy that is separate from other medical coverage are "excepted benefits" and not subject to PPACA health insurance reform provisions such as the Essential Health Benefits (EHB) mandate.

- Dental and vision benefits that are incorporated into the insured medical plan are not "excepted benefits" and therefore are subject to the PPACA EHB requirement.

Self-funded plans

- Dental and vision benefits are treated as "excepted benefits" only if:
  1.) Individuals can separately elect or reject the dental/visions benefits, and
  2.) An additional contribution is required for the cost of the dental/vision benefits.

- Dental and vision benefits are not "excepted benefits" if employees enrolling in medical automatically get the vision/dental benefits and/or pay no additional contribution.

So what is BLA's plan of action regarding this component of the law?

We are currently working diligently with the Dental Insurance Carriers, the State of Iowa and the Federal Government to understand the impacts and to provide our clients with their options.

Some of these options may include:

- For groups **with** a current dental plan: Offer a Pediatric Dental option embedded in the current dental plan, or strictly as a stand-alone plan offered to dependent. These offerings could be on an employer paid or cost sharing basis.

- For groups **without** a current dental plan: Offer a standalone Pediatric dental to dependents on a cost sharing basis.