DELTA DENTAL®

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Delta Dental of Michigan, Ohio, and Indiana

Affordable Care Act FAQs

1) Are dental benefits subject to Affordable Care Act (ACA) requirements?

Most dental plans issued by a stand-alone dental carrier like Delta Dental are exempt from many of the ACA's requirements. A complete answer, however, depends on how your dental plan is structured. This FAQ document may help you determine the ACA's impact on your dental plan.

2) How do I determine if my dental plan is structured in a way that exempts it from most ACA requirements, such as the market reforms?*

The answer depends on whether your plan is *fully insured or self-funded.*

Fully insured dental plans administered by a stand-alone dental carrier like Delta Dental are "excepted benefits" and are therefore exempt from ACA requirements. However, if your group is part of the small group insurance market, you will only be able to purchase health coverage off the exchange that includes all 10 Essential Health Benefits, including pediatric dental services. See Question 6. In most states, an employer is considered part of the small group market if the employer has 50 or fewer employees.

Self-funded dental plans are "excepted benefits" if the dental benefits are not "integral" to the medical benefits. See Question 3 for an explanation of what constitutes "integral" medical and dental benefits.

3) How do I determine if my self-funded dental plan is "integral" to my medical benefits?

On October 1, 2014, the U.S. Departments of Health and Human Services, Labor and the Treasury issued a final rule that changes the analysis used to determine when dental benefits are not considered an integral part of a self-funded health plan. Prior to the final rule, dental benefits were not considered an integral part of a health plan so long as 1) participants had the opportunity to opt out of the dental coverage and 2) to the extent the participants elected dental coverage, they paid at least a nominal contribution toward that coverage. Under the final rule, so long as participants are either given the opportunity to opt out of the dental coverage or the dental coverage is being administered pursuant to an agreement that is separate from the claims administration for any other benefits covered under the plan, the dental coverage will not be considered integral to the health plan. Accordingly, if your dental plan is being administered by Delta Dental, your plan is an excepted benefit and is not subject to the ACA's market reform requirements.

4) My group is self-funded and we have a contract with Delta Dental to administer our dental benefits. Is my dental plan an "excepted benefit" because it is administered separately from my medical plan?

Yes, pursuant to the final rule issued on October 1, 2014, by the U.S. Departments of Health and Human Services, Labor and the Treasury, your dental plan is considered an excepted benefit so long as it is administered pursuant to an agreement that is separate from the claims administration for any other benefits covered under the plan. If your dental plan is being administered by Delta Dental, your plan is an excepted benefit and is not subject to the ACA's market reform requirements. See the answer to Question 3 above.

* *Health Insurance Industry Tax may apply*

5) What are Essential Health Benefits?

The ACA mandates that all policies issued in the small group and individual insurance markets provide coverage for certain benefits, which are commonly referred to as Essential Health Benefits (EHBs). Those benefits include the following:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including **oral** and vision care

The specific services that must be covered under each of the 10 general categories identified above vary on a state-by-state basis.

6) Does my group's dental plan need to include EHB-complaint pediatric dental benefits?

Self-funded dental plans

No. A self-funded dental plan does not need to cover EHBs. Under the ACA, only policies in the small group and individual insurance markets are required to cover EHBs.

Fully insured dental plans in the large group market (in most states, groups with more than 50 employees)

No. A fully insured dental plan covering a group in the large group market does not need to cover EHBs. Under the ACA, only policies in the small group and individual insurance markets are required to cover EHBs. In most states, the small group market is defined as groups that have 50 or fewer employees. (Please note that starting in 2016, the definition of small group will be expanded to include groups with 100 or fewer employees.)

Fully insured dental plans in the small group market (in most states, groups with 50 or fewer employees)

Technically, a fully insured dental plan in the small group market is not required to offer its employees health coverage under the ACA. However, if the group elects to purchase coverage off the exchange, it will only be able to purchase coverage that contains all 10 EHBs, including pediatric dental coverage. The group does not need to buy all 10 EHBs from its medical carrier but instead may purchase an EHB-compliant policy from its stand-alone dental carrier. In most states, the small group market is defined as groups that have 50 or fewer employees.

7) If my group has part-time employees, how do I determine whether my group is in the small or large group market?

You should consult an attorney, payroll advisor or other qualified professional.

8) If my group decides to offer EHB-compliant coverage, will Delta Dental help me?

Absolutely! If you determine that you must have an EHB-compliant plan, make sure to notify Delta Dental. Once Delta Dental knows of your need to comply, we will offer your group a fully compliant dental plan.

9) I've determined that my group has 50 or fewer employees, and I want to continue to provide dental benefits through Delta Dental to my employees. What benefit plan options are available to me?

Delta Dental will have EHB-compliant plans for your group. If you purchase an EHB-compliant plan through Delta Dental, you can be assured of meeting the ACA's EHB pediatric dental coverage requirement.

10) Up to what age are EHB-compliant pediatric dental benefits offered?

Generally, EHB-compliant pediatric dental benefits are provided up to age 19 unless a state selects a higher age. For example, the state of Kentucky mandates that EHB-compliant dental coverage must be provided up to age 21.

11) Does my group dental plan have to provide dependent dental coverage up to age 26?

Fully insured groups

No. Fully insured dental plans administered by a stand-alone dental carrier like Delta Dental are "excepted benefits" and are therefore exempt from the ACA market reforms, including the requirement to offer dependent coverage up to age 26.

Self-funded groups

So long as your dental plan is not "integral" to your medical plan, you will not have to provide dependent coverage up to age 26. However, if your dental plan is integral to your medical coverage (see Question 3), the group may have to comply with the ACA's market reforms, which includes a requirement that groups offer dependent coverage up to age 26.

12) Do I have to provide orthodontic coverage?

It depends on the EHB benchmark plan selected by the state.

Michigan—no, EHB coverage does not include orthodontia.

Ohio—yes, EHB coverage includes "medically necessary" orthodontia.

Indiana—yes, EHB coverage includes "medically necessary" orthodontia.

13) Will Delta Dental of Michigan, Ohio, and Indiana offer products on the exchange?

Not at this time.

14) What ACA taxes and fees affect my group? Which of those will apply to my group dental plan?

The ACA includes four new taxes/fees that may generate numerous questions. They are the Health Insurance Industry Fee, Medical Device Excise Tax, Comparative Effective Research Fee and the Transitional Reinsurance Fee.

Here is a summary of these four new taxes/fees:

Health Insurance Industry Fee (also called the ACA Tax): This fee assesses the health insurance industry for the money that will ultimately be used to pay the premium subsidies for eligible low-income individuals purchasing coverage on Health Insurance Exchanges. Beginning in 2014, those with incomes between 133 percent (138 percent with a 5 percent disregard) and 400 percent of the Federal Poverty Level (FPL) were able to access this newly available money. The Health Insurance Industry Fee DOES apply to stand-alone dental. The good news is that it only applies to risk business, and nonprofit carriers like Delta Dental get substantial tax relief. This tax will not appear as a separate line item on clients' monthly invoices.

Medical Device Excise Tax: This is a 2.3 percent excise tax on the sales price (that's gross sales, not profit) of taxable medical devices. As a result, some dentists may ask for slightly higher fees on services with lab charges attached (crowns, bridges, dentures, implants, etc.) because the lab may be passing on a portion, or the full amount, of the tax to those dentists using their services. There have been multiple calls to repeal the Medical Device Excise Tax over the past several years. The U.S. Senate, in an amendment to the Senate Democrats' budget, even voted 79–20 to repeal the tax in March 2013. While that budget didn't pass, it showed bipartisan disapproval of the revenue raising measure. Most dental plan sponsors will not need to worry about this tax.

Comparative Effectiveness Research Fee (CERF), also called the Patient-Centered Outcomes Research Institute (PCORI) Fee: This fee is intended to fund a research institute that will look into various issues around comparative effectiveness (for example, should patients with heart disease be treated with drugs or have surgery, and when does it make sense to shift from one treatment to another). The annual fee was $1 per covered life for policy years ending between October 1, 2012, and September 30, 2013. The fee increased to $2 annually for policy years ending between October 1, 2013, and September 30, 2014. The fee is indexed for policy years between October 1, 2014, and September 30, 2019. If a group is fully insured, its medical carrier will pay the fee on behalf of the plan. If the medical plan is self-insured, regulation requires the plan itself to perform the calculation and make the payment (that is, the carrier will not make the payment on behalf of the group). This fee does not apply to stand-alone dental as long as the dental plan retains its excepted benefit status.

Transitional Reinsurance Fee: This fee is intended to help offset the anticipated higher costs health plans will experience when health policies become "guaranteed issue" policies with no pre-existing condition exclusions. Essentially, many uninsured people (some with pre-existing conditions) are about to become insured. To help carriers partially offset this cost and let their rates and claims data catch up with the "new normal," the ACA established a fund that will effectively act like stop-loss reinsurance for medical plans The fee is $5.25 per member (not per subscriber) per month, which is a significant cost. The assessment declines over time (and is slated to disappear after 2016). For fully insured medical plans, the carrier will make the payment. For self-insured medical plans, the carrier most likely will make the payment, but the plan itself is ultimately legally liable for the fee. This fee does not apply to stand-alone dental as long as the dental plan retains its excepted benefit status.

15) Will Delta Dental offer "pediatric-only" plans on both an individual basis and a group basis?

Yes. Delta Dental will offer “pediatric-only” plans to both individuals and small groups with 50 or fewer employees.

16) I am an employer in the small group market, and I want to provide my employees with EHB-compliant pediatric dental coverage. My current plan with Delta Dental already covers pediatric dental services. Is my current policy’s coverage sufficient to meet the ACA’s requirements?

Most likely no. Despite the fact that your current policy with Delta Dental covers pediatric benefits, it is likely not compliant with the ACA’s requirements.

17) I have an employee who does not have children. Will he or she still have to purchase pediatric dental coverage?

It depends. If you are an employer in the small group market and you have elected to purchase health coverage for your employees, you will only be able to offer your employees coverage that contains all 10 EHBs, including pediatric dental coverage. However, if your employee is purchasing coverage through the exchange, he or she will have the option of not purchasing pediatric dental coverage.

18) I am an employer in the small group market. My broker (or medical plan carrier) told me that if I elect to purchase coverage for my employees I have to purchase EHB-compliant pediatric dental benefits from my medical plan carrier. Is that true?

No. Under the ACA, a small group employer is allowed to purchase EHB-compliant pediatric dental from a stand-alone dental carrier like Delta Dental. Medical carriers are not required to sell pediatric dental coverage to a small group employer so long as the carrier is reasonably assured that EHB-compliant pediatric dental coverage has been obtained from a stand-alone dental carrier.

19) Must all employees covered by an employer that needs an EHB-compliant plan enroll in an exchange-certified pediatric dental plan, even if they’re currently waiving the group dental plan? What if the member doesn’t have a spouse or dependent under age 19? What if the member is waiving the group dental plan currently and their dependents under age 19 are covered under a spouse’s exchange-certified pediatric dental plan?

Under the ACA, a medical carrier may only issue coverage that does not contain pediatric dental to an individual or small group employee if that carrier is “reasonably assured” that the individual or small group employee obtained certified pediatric dental coverage from a stand-alone dental carrier. However, because it is the medical carrier who is ultimately responsible for ensuring that appropriate coverage has been issued to an individual or small group employee, consulting with your medical carrier is the best way to determine how it is answering the specific questions above.

Each medical carrier may handle these situations slightly differently. Regardless of how your medical carrier chooses to address the above scenarios, rest assured that Delta Dental is ready and able to assist by providing you and your employees with the dental coverage you need.