COMMONWEALTH OF MASSACHUSETTS
Office of Consumer Affairs and Business Regulation
DIVISION OF INSURANCE
1000 Washington Street, Suite 810 • Boston, MA 02118-6200
(617) 521-7794 • http://www.mass.gov/doi

DEVAL L. PATRICK
GOVERNOR

GREGORY BIALECKI
SECRETARY OF HOUSING AND ECONOMIC DEVELOPMENT

BARBARA ANTHONY
UNDERSECRETARY OF CONSUMER AFFAIRS AND BUSINESS REGULATION

JOSEPH G. MURPHY
COMMISSIONER OF INSURANCE

BULLETIN 2013-07

TO: Commercial Health and Dental Insurers, Blue Cross and Blue Shield of Massachusetts, Inc. and Health Maintenance Organizations

FROM: Joseph G. Murphy, Commissioner of Insurance

DATE: June 19, 2013

RE: Pediatric Dental Benefits within Plans Offered to Eligible Individuals and Eligible Small Employers outside the Massachusetts Exchange

---

This Bulletin is issued by the Division of Insurance ("Division") to inform commercial health insurers, Blue Cross and Blue Shield of Massachusetts, Inc. and Health Maintenance Organizations (collectively, "Carriers") that write or intend to write health insurance plans subject to Massachusetts General Laws Chapter 176J regarding the offer of certain products to eligible individuals and eligible small employers with the implementation of the federal Patient Protections and Affordable Care Act ("ACA").

Requirement to Offer Coverage with Pediatric Dental Benefits

On and after January 1, 2014, Carriers that make health plans available to eligible individuals and eligible small employers must include in the health plans those Essential Health Benefits ("EHBs") that Massachusetts has selected to meet the benefit requirements outlined in the ACA, including coverage for pediatric dental benefits. These plans are referred to as Qualified Health Plans ("QHP"), and in offering such plans, Carriers must comply with the following federal requirements::

> "Section 1302 of the Affordable Care Act outlines the requirements for health plans to cover the ten categories of the essential health benefits. The only exception permitted under 1302 of the Affordable Care Act is for QHPs to exclude coverage of the pediatric dental EHB if there is a standalone dental plan offered in the Exchange. Section 1311 of the Affordable Care Act requires all Exchange stand-alone dental plans to cover the pediatric dental EHB. In this way, sections 1302 and 1311 of the Affordable Care Act require that the full set of [EHBs] be offered to people purchasing coverage through the Exchange. However, nothing in this rule requires the purchase of the full set of EHB if the purchase is made through an Exchange. Thus, 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.
>
> As noted above, outside of an Exchange, an individual or family must be offered coverage of all ten categories of EHB, either through one policy, or through a combination of a medical policy and an Exchange-certified stand-alone dental plan, as described above."

See Patient Protection and Affordable Care Act; *Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation*; Final Rule, page 12853 of the Federal Register published February 25, 2013 (hereinafter, the "Federal Rule").

It is the Division's understanding that the Federal Rule requires that each Carrier that is offering QHPs to eligible individuals and eligible small employers outside of the Exchange must offer coverage of all ten categories of EHBs. Carrier QHP form filings will only be approved by the Division if they include pediatric dental benefits within the evidence of coverage, or if the submission includes materials that describe the Exchange-certified stand-alone dental plan that will be required to be purchased with the Carrier's plan to satisfy the federal requirements.

Qualified Dental Plan Requirements for Carriers Offering Individual/Small Group Health Plans without Pediatric Dental Benefits outside the Massachusetts Exchange

When health plans are offered outside an Exchange, the federal Department of Health and Human Services has set forth the following requirements in the Federal Rule:

> "The Affordable Care Act does not provide for the exclusion of a pediatric dental EHB outside the Exchange as it does in section 1302(b)(4)(F) of the [ACA] for [QHPs]. Therefore, individuals enrolling health insurance coverage not offered on the Exchange must be offered the full ten EHB categories, including the pediatric dental benefit.
>
> However, in cases in which an individual has purchased stand-alone pediatric dental coverage offered by an Exchange-certified stand-alone dental plan off the Exchange, that individual would already be covered by the same pediatric dental benefit that is part of EHB. When an issuer is reasonably assured that an individual has obtained such coverage through an Exchange-certified stand-alone dental plan offered outside an Exchange, the issuer would not be found noncompliant with EHB requirements if the issuer offers that individual a policy that, when combined with the Exchange-certified stand-alone dental plan, ensures full coverage of EHB."

The Commonwealth Health Insurance Connector Authority ("Health Connector"), the designated Exchange for Massachusetts, will be making available certified stand-alone dental plans offered by Carriers, referred to as Qualified Dental Plans ("QDPs"). The Division is aware that some Carriers intend to offer dental plans outside the Exchange that incorporate, at a minimum, those benefits that

are found in the QDPs offered by those same Carriers inside the Exchange, and that those dental plans being offered outside the Exchange may include dental benefits in addition to those contained in the Carrier's QDP.

For purposes of identifying those plans that satisfy the above-noted Federal Rule, the Division will maintain a list on its website of each dental plan offered by a Carrier in Massachusetts that is either a QDP offered by the Carrier inside the Exchange, or is a dental plan offered by the Carrier only outside the Exchange that incorporates, at a minimum, the same benefits as the QDP being offered by the respective Carrier within the Exchange (the "Dental Plan List"). When a Carrier files a stand-alone dental plan with the Division intended to be offered outside of the Exchange, the Carrier must indicate in the filing whether the stand-alone dental plan incorporates, at a minimum, the same benefits as a QDP that the Carrier is offering within the Exchange, so that the Division may include the plan on its Dental Plan List.

As noted under the Federal Rule, a Carrier must be "reasonably assured" that an individual has already obtained coverage under a dental plan that is on the Division's Dental Plan List if that Carrier wishes to offer or renew a health plan to that individual that does *not* include the pediatric dental benefits required under the ACA. In order to be reasonably assured that an individual has, in fact, obtained the appropriate dental coverage required under the ACA outside the Exchange, a Carrier must obtain documentation with respect to each potentially covered person that demonstrates that, as of the date of the enrollment in the Carrier's health plan, each person being considered for the health plan *without* pediatric dental benefits is, in fact, already covered by or has coverage pending for a dental plan that is on the Dental Plan List with the same or a different Carrier. If the Carrier does *not* receive appropriate documentation with respect to each potentially covered person, then the Carrier may not issue or renew health coverage unless it includes pediatric dental EHB features.

Notices

All Carriers that are offering or renewing health plans must disclose, at the time of solicitation, whether a plan covers dental benefits at the pediatric dental EHB level. The Division recommends that Carriers use the following example of notification language for plans sold outside the Exchange that include the pediatric dental EHB:

> "This policy includes coverage of pediatric dental services as required under the federal Patient Protection and Affordable Care Act."

The Division recommends that Carriers use the following example of notification language for plans sold outside the Exchange that do not include dental benefits at the pediatric dental EHB level:

> "This policy DOES NOT include coverage of pediatric dental services as required under the federal Patient Protection and Affordable Care Act. It will only be offered when the Carrier is reasonably assured that an applicant is covered by a stand-alone dental plan with the required level of coverage for pediatric dental services."

The Division recommends that Carriers use the following example of notification language for plans sold inside the Exchange that do not include dental benefits at the pediatric dental EHB level:

> "This policy DOES NOT include coverage of pediatric dental services as required under the federal Patient Protection and Affordable Care Act. Coverage of the appropriate level of pediatric dental services may be purchased as a stand-alone plan. You can purchase an Exchange-certified stand-alone dental plan that includes the appropriate level of coverage for pediatric dental services from products offered by the Commonwealth Health Insurance Connector Authority."

If you have any questions about this Bulletin, please contact Nancy Schwartz, Director of the Bureau of Managed Care, at 617-521-7347 or by e-mail at nancy.schwartz@state.ma.us.