FAQ: Pediatric Oral Health Services in the Affordable Care Act (ACA)

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Tooth decay is widespread among children and teens, but it can be prevented, and treated. By including pediatric oral health in the ACA's 10 Essential Health Benefits (EHBs), Congress created a significant opportunity to expand dental coverage and consumer choice. Children with coverage are more likely to get the care they need.

How do children get dental coverage under the ACA?

Pediatric dental coverage must be offered to families buying private health insurance in the new state-based and federally-facilitated marketplaces (FFMs), and in the existing individual and small-group insurance markets in each state. Several plans may be available. In choosing coverage, families should assess their children's dental health needs and compare each plan's costs and benefits.

Pediatric dental benefits may be offered three different ways in the new marketplaces:

- Through a qualified health plan (QHP) that includes dental coverage (embedded)
- Through a stand-alone dental plan purchased in conjunction with a QHP
- Through a contracted/bundled plan (families pay one premium for separate medical and dental policies)

Do families have to buy pediatric dental coverage?

If a family buys coverage on their own outside of the state marketplace, then yes: pediatric dental must be purchased either as part of the medical plan or through a marketplace-certified stand-alone dental plan.

If a family is purchasing coverage inside the marketplace, the answer will depend on the state's requirements. If pediatric dental coverage is only available through a stand-alone plan, families may opt out of purchasing those benefits. Click here for the latest coverage options by state.

What services will be covered?

The ACA does not specify which tests, treatments, or services must be included in marketplace plans. States select their own "benchmark plan" for covered services. If that plan does not include pediatric dental coverage, the benchmark is supplemented with the dental services covered in either the state's Children's Health Insurance Program (CHIP) plan or the largest dental plan offered by the Federal Employee Dental and Vision Insurance Program.

Typically, dental insurance pays 100% for preventive and diagnostic services, 80% of minor restorative services, 50% of major restoratives and 50% of orthodontics. However, each plan may offer a slightly different menu.

Pediatric Dental Coverage Under the ACA

- Among the 10 Essential Health Benefits that must be offered
- Covers children up to age 19
- Applies to coverage in the small group (50 or fewer employees) and individual markets
- Requires the offering of child-only dental plans; standardizes covered services through state-selected benchmark plans
- Subsidizes dental purchase options through premium tax credits in some states
- Removes annual and lifetime dollar limits on coverage
- 3 million children/young people expected to enroll in ACA benefits by 2018 (Note: 43 million currently have public health coverage through Medicaid/CHIP)

How will families know about the benefits available to them?
The ACA created helpers called "navigators" and "assisters" to educate consumers about how to apply for coverage and assist them through the process. There is no cost for their services. These guides may be drawn from public and private agencies, unions, chambers of commerce, safety-net providers, etc.

Are families who buy dental coverage in the health insurance marketplaces eligible for tax credits?
Families earning up to 400% of the federal poverty level (FPL)[*] are eligible for a tax credit to lower the cost of their monthly premium. A family purchasing separate medical and dental coverage will have two monthly premiums. Current IRS policy suggests that a family's tax credit may not cover the cost of dental benefits if they are only offered separately in a marketplace.

What about deductibles and out-of-pocket costs?
In choosing dental coverage, families should know that cost-sharing (how much the plan pays for services) and the treatment of deductibles may differ from plan to plan.

The ACA seeks to limit how much a family will pay in out-of-pocket costs. The out-of-pocket limit for QHPs varies according to family income and is the same whether or not a plan includes dental coverage. Families purchasing stand-alone dental coverage will have an additional out-of-pocket limit that must be "reasonable." In states where the federal government is establishing the marketplace, the out-of-pocket limit for stand-alone dental plans is $700 for one child and $1,400 for multiple children. States establishing their own marketplaces may set their own standard for reasonable out-of-pocket limits for stand-alone dental plans. Again, families should consider their children's potential dental needs and how all costs are applied when evaluating plans.

What are the ACA consumer protections?
All plans providing EHB coverage are required to have an adequate provider network, limit out-of-pocket expenses, offer child-only plans, and eliminate annual and lifetime dollar limits. Stand-alone dental plans may choose to, but are not required to, provide the following protections:

- Denials for pre-existing conditions
- Guaranteed issue/renewal and guaranteed premium rates
- "Fair insurance premiums" (solely reflecting age, location and smoking status)
- Right to external appeals
- Medical loss ratio requirements

Where can I get updates on these benefits?
The Children's Dental Health Project closely monitors the ACA's pediatric oral health provisions. Sign up for updates here.

For additional discussion and background, see A Roadmap for Implementation Part II: Dental Care Provisions in Health Reform.

[*] 400% of the FPL for a family of four is an annual income of $94,200.