

Buying Dental Coverage on the Kansas Marketplace

FAQ

1. How is dental coverage offered on the marketplace?

The Affordable Care Act (ACA) requires that pediatric dental coverage must be offered on the marketplace either as part of a qualified health plan (QHP) or as a stand-alone dental plan sold separately. This means that any child or adolescent (ages 0-18) enrolling in health coverage on the marketplace is also eligible to enroll in dental coverage.

For the 2020 plan year, there is at least one QHP that includes pediatric dental coverage in each of Kansas' 105 counties. For every county but Johnson and Wyandotte, that issuer is **BlueCross and BlueShield of Kansas**. In Johnson and Wyandotte Counties, the only issuer offering a QHP that includes pediatric dental coverage is **Oscar Insurance Company**.

In addition to QHPs that include pediatric dental coverage, families have the option to purchase their children's health and dental coverage through separate plans. These stand-alone dental plans may also allow adults to purchase dental coverage for themselves at an additional cost. Every county has at least three dental insurers offering stand-alone dental plans.

2. Are families required to buy dental coverage for their children?

Under current law, children enrolling in a QHP that does not include pediatric dental coverage are not required to enroll in a stand-alone dental plan.

3. What services are covered?

The specific dental services that must be covered are based on the benefits outlined in the state's Children's Health Insurance Program, Healthwave. Any plan offering pediatric dental coverage must cover preventive and restorative services like cleanings, fluoride treatments, dental sealants, x-rays, and fillings. Orthodontic services like braces are typically only covered when medically necessary (e.g., if a child has trouble chewing or speaking). The full list of services is available at:

<https://www.insurekidsnow.gov/state/ks/index.html>

Each plan may have different rules for how frequently a patient can receive certain services, which providers a patient may see, and how much patients are required to pay out of pocket for specific services. These details should be available through the plan brochures and summaries of benefits.

Note: Some plans sold off the marketplace -- like short-term health plans or association health plans -- may not cover dental care or other essential health benefits. These off-marketplace plans also do not have to comply with the Affordable Care Act's consumer protections. Consumers should carefully review the benefits and protections of any insurance plan before purchasing.

4. How does dental coverage differ between QHPs and stand-alone dental plans?

When purchasing a dental plan separately from a QHP, families will be required to pay an additional monthly premium for that dental coverage. Furthermore, stand-alone dental plans have a separate out-of-pocket maximum of \$350 for one child or \$700 for two or more children. This means that out-of-pocket costs for dental services do not contribute to the patient's out-of-pocket limit on the medical side. As such, a family in this scenario would have a higher total out-of-pocket obligation.

However, QHPs in the Kansas marketplace do not have a separate deductible for dental coverage. This means that, for most pediatric dental services, families would have to pay out-of-pocket for the full cost of care until they met their health plan deductible. Stand-alone dental plans have much lower deductibles.

5. Are subsidies available to help purchase pediatric dental coverage?

Yes. As of plan year 2019, families purchasing both a QHP that does **not** include pediatric dental coverage *and* a stand-alone pediatric dental plan can receive a tax credit. If a consumer purchases a medical policy (without pediatric dental) and a separate dental policy AND the combined premiums are less than the calculated premium assistance based on the benchmark plan, then pediatric dental is specifically included in the tax credit. The amount of the tax credit will be based on the allocable premiums of both a benchmark health plan and a benchmark dental plan.

However, cost-sharing reductions for individuals and families at or below 250% of the federal poverty level (about \$30,000 per year for an individual and about \$61,000 for a family of 4) do not apply to stand-alone dental plans.

Additional resources: <https://www.cdhp.org/topics/affordable-care-act>

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