# SECTION 10: AFFORDABLE CARE ACT (ACA), ALSO KNOWN AS HEALTH CARE REFORM (HCR)

## A. ACA Plans - Benefits Overview

The Affordable Care Act (ACA), also known as health care reform, was signed into law in 2010. New health plans for individuals and small businesses (with 50 or fewer employees) must include 10 essential health benefits, including pediatric dental services. Many of HMSA's current commercial and traditional dental plans, including dental plans for large employer groups (with more than 50 employees), remain unchanged. We've updated our qualified dental plans (QDPs) to include pediatric services that comply with the ACA.

**Pediatric dental benefits,** as required by the ACA, cover children ages 0 through 18 years of age. Eligible services are covered at 100 percent once patients meet their maximum out- of-pocket costs ($375 per child, $750 for two or more children). For plan benefit details, refer to the current ACA PPO Plan Matrix and ACA CDT Manuals – located via the Plans, Manuals, and Training page of our provider dental website, hmsadental.com.

**Prior authorization is required for medically necessary orthodontic care.** Qualified patients must have cleft lips and palates or other severe facial birth defects or injuries that affect speech, swallowing, or chewing.

To provide our members with a consistent experience when they shop for coverage, HMSA ACA dental plans are being renamed using metal categories (Bronze, Silver, Gold, and Platinum). Renaming our dental plans allows us to align more closely with HMSA medical plans, which also use metal classifications, and it more clearly emphasizes the value of each plan. The chart below outlines the changes.

These new plan names are being introduced in conjunction with the existing names for 2021 plans, to aid with the transition. The new names will be filed as official plan names for the 2024 dental plans.

| Coverage Code | Current Plan Name | Official New Name for 2022 |
|---|---|---|
| **207** | HMSA Individual Dental PPO Basic | HMSA Individual Dental PPO Bronze |
| **211** | HMSA Individual Dental HMO Basic | HMSA Individual Dental HMO Silver |
| **220** | HMSA Individual Dental PPO Basic II | HMSA Individual Dental PPO Silver |
| **206** | HMSA Individual Dental PPO High I | HMSA Individual Dental PPO Gold |
| **D91** | HMSA Dental Plus Plan | HMSA Individual Dental PPO Platinum |
| **202** | HMSA Small Business Dental PPO Basic | HMSA Small Business Dental PPO Bronze 1000 |
| **208** | HMSA Small Business Dental HMO Basic | HMSA Small Business Dental HMO Silver |
| **209** | HMSA Small Business Dental HMO High I | HMSA Small Business Dental HMO Gold |
| **204** | HMSA Small Business Dental PPO High II | HMSA Small Business Dental PPO Gold 1500 |
| **216** | HMSA Small Business Dental PPO High V | HMSA Small Business Dental PPO Gold 1500 Plus |
| **203** | HMSA Small Business Dental PPO High I | HMSA Small Business Dental PPO Platinum 1000 |
| **214** | HMSA Small Business Dental PPO High III | HMSA Small Business Dental PPO Platinum 1000 Plus |
| **215** | HMSA Small Business Dental PPO High IV | HMSA Small Business Dental PPO Platinum 1500 Plus |

**Note:** Standard dental plans (coverage codes: L, V, C, D, and A) for large businesses (more than 50 employees) remain unchanged.

### B. ACA Plans – Pediatric Dental Benefits

All ACA dental plans were designed to qualify as stand-alone dental plans, which include pediatric dental benefits in compliance with the ACA. (Note that some of these services may not be covered when received from out-of-network providers.)

Effective Date: ACA plan coverage went into effect on January 1, 2014, for patients with individual plans and upon their plan renewal date for patients with group (small business) plans.

**Collecting Copayments and Cost Shares:** You must collect patient deductibles, copayments (fixed fee), and/or cost shares and coinsurance (percentage of cost) at the time of the visit. To check your patients' eligibility and coverage, go to mydentalcoverage.com/dentists or call HMSA Dental Customer Service at **948-6440** on Oahu or **1 (800) 792-4672** toll-free on the Neighbor Islands.

**Deductible and Maximum Out-of-Pocket (MOOP) Amount:** Patients with an ACA-compliant dental plan may have a deductible and a MOOP amount that includes dental costs. Once the deductible is met, patients pay copayments and coinsurance, according to their dental plan. Once the MOOP amount is met, HMSA pays 100 percent of the eligible cost.

**Reimbursement:** We'll pay HMSA participating dentists for pediatric dental benefits, using the fee you submitted or the Maximum Allowable Charge (MAC), whichever is less, minus the patient's deductible, copayment, or coinsurance.

**Claims Submission:** Continue to submit all claims for these services to:

- **Mail to** HMSA Dental, PO Box 69436 Harrisburg, PA 17106-9436
- **Electronically** through our free online claims processing system, on MyDentalCoverage, called **Speed eClaim®**
- **Electronic (837D)** Payer ID — HMSA1

## C. Submission Guidelines – Pediatric Essential Health Benefits under Healthcare Reform Plans

Orthodontic treatment is limited to medical necessity for all Healthcare Reform Plans. Members under age 19 who have a severe and handicapping malocclusion may qualify for orthodontic care under the Essential Health Benefit mandate if the member belongs to a plan that includes these benefits.

To qualify for medically necessary orthodontia services, treatment must result from congenital or developmental malformations related to or developed because of cleft palate, with or without cleft lip. Treatment must be rendered by an orthodontist and prior authorization and approval is required before services are rendered. Please go to **mydentalcoverage.com** to download the authorization form and instructions. Claim review is conducted by a licensed dentist who will review the clinical documentation submitted by the treating dentist.

Review of the Member's orthodontic benefits and treatment planning are essential to the timely and accurate payment of claims for Orthodontic treatment. Orthodontic treatment plans are based upon the type of dentition involved – transitional, adolescent or adult; as well as the treatment of a particular patient depending on circumstance:

**NOTE:** These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

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| Limited Orthodontic Treatment- treatment with a limited objective, not involving the entire dentition | |
| | Limited orthodontic treatment of the primary dentition |
| | Limited orthodontic treatment of the transitional dentition |
| Comprehensive Orthodontic Treatment Phase II - multiple phases of treatment provided at different stages of dentofacial development | |
| | Comprehensive orthodontic treatment of the transitional dentition |
| | Comprehensive orthodontic treatment of the adolescent dentition |
| | Comprehensive orthodontic treatment of the adult dentition |
| Other Orthodontics Services | |
| | Pre-orthodontic treatment visit |

## D. ACA Plans – Pediatric Dental Services Requiring Prior Authorization

There are select pediatric dental services that require prior authorization (PA) for patients ages 0 through 18. If you don't get a PA before you render these selected services, your patient will be financially responsible for the entire cost of the procedure.

To obtain this detailed list of CDT Codes Requiring a PA (for patients, ages 0 through 18), refer to our dental website, hmsadental.com under the Provider tab, within the Provider Secured Site, under the Healthcare Reform header. The HCR CDT Manuals also include this information.

For additional HMSA Healthcare Reform Plan resources: Please refer to our dental website, hmsadental.com. Here you will find HCR plan matrices, HCR CDT Manuals, and HCR Prior Authorization guidelines.

## E. The Essential Health Benefit Plans FAQs

**Question: How does Health Care Reform (HCR) affect dental providers?**

**Answer:**

Effective JAN 1, 2014, for individuals, and upon groups' renewal date, HMSA will include coverage for pediatric dental benefits (Essential Health Benefits or EHBs) for children ages 0 through 18 with our small group and individual plans. Members using these mandated benefits do not have to have dental insurance. They do need to have HMSA medical coverage to access these mandated benefits. Pediatric dental benefits for children ages 0 through 18 will include:

**Type 1 services:** Preventive and diagnostic services, including oral exams, x-rays, and routine dental care.

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**Type 2 services:** Basic restorative services, including fillings, root canals, stainless steel crowns, periodontal care, oral surgery, and dental prosthetic maintenance.

Medically necessary orthodontic services that have been prior-authorized and approved for qualified members. To qualify for medically necessary orthodontia services, treatment must result from congenital or developmental malformations related to or developed because of cleft palate, with or without cleft lip. Member must meet the 24-month waiting period. Treatment must be rendered by an orthodontist.

Please verify member's eligibility and benefits on **mydentalcoverage.com**, Essential Health Benefits (EHB) that cover dental services typically will have member co-insurance and member copays that are different than services covered under traditional dental plans. It will be important for the dentist to know the member's financial responsibility for services covered under EHB. Members covered for dental services under EHB will have a limitation on their financial responsibility after they have reached a dollar threshold in payment for services. Once the member's out of pocket maximum are met, claims pay at 100% of the dentist's charge or the HMSA dental allowance, whichever is lower.

**Question: How do pediatric dental benefits covered under a member's essential Health Benefits differ from traditional dental benefits covered under a dental insurance plan?**

**Answer:**

There are several significant differences between dental insurance benefits and the pediatric dental benefits covered under a member's medical plan:

**Maximum Out-of-Pocket.** Pediatric dental benefits covered under the member's medical plan include an annual in- network out-of-pocket maximum (the most a member could pay during the plan year for covered in-network services.) The in-network out-of-pocket maximum is $400.00 per member under age 19 and $800.00 for two or more members under age 19 enrolled under the same family plan.

**Medically necessary Orthodontic services.** To qualify for medically necessary orthodontic services, treatment must result from congenital or developmental malformations related to or developed because of cleft palate, with or without cleft lip. Only orthodontists are allowed to perform EHB orthodontic services. A prior authorization must be requested and approved.

**NOTE:** These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

### Question: I am an orthodontist. What do I need to know about providing medically necessary orthodontic services?

**Answer:**

To qualify for the medically necessary orthodontic services, a child must have a severe and handicapping malocclusion or misalignment of teeth. Only orthodontists are allowed to perform EHB orthodontic services. Prior authorization is required before the services are rendered.

Medically necessary orthodontic services rendered without obtaining a prior authorization approval may not be covered.

### Question: What orthodontic codes require prior authorization?

**Answer:**

The following codes are the only orthodontic services covered under the EHB plans and they all require prior authorization:

### Question: What is the process for requesting a prior authorization for orthodontic services?

**Answer:**

1. Submit the services requested on the most current version of the ADA dental claim form with the Pre-Treatment Estimate box checked.

   Include the appropriate documentation for review e.g., pre-treatment claim form, x-rays, study models, and photographs for orthodontic cases.

2. When your Pre-Treatment Estimate has been approved, you can consider this to be your approved prior authorization.
3. Send the prior authorization request electronically, if possible. Paper prior authorization requests should be mailed to:

   HMSA – Dental
   P.O. Box 69436
   Harrisburg, PA 17106-9436

All prior authorization requests will be reviewed for appropriateness and medical necessity. Prior authorized services will not be approved for payment until they are determined to meet the guidelines for coverage. Any required prior authorized service that does not have a prior authorization in HMSA's claim system will be denied and NO insurance payment will be made.

Please provide a self-addressed, postage paid envelope or packaging if you would like your x-ray, study models or other documentation returned.

**NOTE:** These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

### Question: How can I check to see if my request for prior authorization has been approved?

**Answer:**
To check if a Prior Authorization is approved, you can go online to MyDentalCoverage.com or call our **Dental Customer Service 948-6440 on Oahu** or **1 (800) 792-4672 toll-free on the Neighbor Islands** as you do today to verify eligibility and benefits.

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| D8050 | Interceptive orthodontic treatment of the primary dentition – once per lifetime |
| D8060 | Interceptive orthodontic treatment of the transitional dentition – once per lifetime |
| D8070 | Comprehensive orthodontic treatment of the transitional dentition – once per lifetime |
| D8080 | Comprehensive orthodontic treatment of the adolescent dentition – once per lifetime |
| D8210 | Removal appliance therapy |
| D8660 | Pre-orthodontic treatment visit |
| D8670 | Periodic orthodontic treatment visit (as part of contract) |
| D8680 | Orthodontic retention (removal of appliances, construction and placement of retainer(s)) |

### Question: Who is responsible for payment if prior authorization is not obtained?

**Answer:**
The member is held liable if prior authorization is not obtained or approved.

### Question: Will the appeals process be the same for HCR plans?

**Answer:**
Yes, all appeals should be sent to:

HMSA Appeals
P.O. Box 69437
Harrisburg, PA 17106-9437

**NOTE:** These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.