To our valued customers:

Health reform’s impact on your dental benefits

During the past year, Delta Dental actively engaged in the health care reform debate, providing input and advice on how dental coverage and costs might be affected. Now that the legislation has passed, a full assessment is underway. Although complete information is not yet available, our preliminary review leads us to offer the following points regarding some of the key provisions affecting dental plans and our customers:

Market Reforms and Benefit Mandates

First, from a stand-alone dental benefit plan perspective, it appears that a great deal will stay the same, especially for our customers with more than 100 employees. In the short-term, stand-alone dental benefits are not subject to most of the immediate insurance reforms enacted by the new law, such as no lifetime or annual maximums, and the extension of dependent child coverage to age 26. Should your organization wish to extend dental benefits, making them consistent with changes required of your other health benefits, your Delta Dental representative will be glad to discuss that with you.

Many of the reforms and benefit mandates contained in the new legislation target individuals and employers with 100 or fewer employees, with some reforms effective immediately or within 6 months, and others beginning in the year 2014. Larger groups governed by ERISA are also subject to most of these changes.

Insurance Exchanges

For smaller employers, the legislation’s impact on dental begins in four years. Existing coverage that individuals are enrolled in on the date of enactment (March 23, 2010) is "grandfathered" and is subject to some but not all of the insurance market reform changes. Generally speaking, smaller businesses and individuals will become subject to new benefit mandates as defined by an “essential health benefits package.” Under the mandates, groups with fewer than 100 employees will be required, among other things, to provide dental coverage for children up to age 21.

Essential benefits can be purchased inside or outside a state- or regionally-administered health exchange. These benefits must conform to an assortment of new market reforms including no annual or lifetime maximums, no copayments for some services, and an annual out-of-pocket maximum of $5,000 when combined with medical costs.

Details about the applicability of these market reforms to stand-alone pediatric dental plans will likely be written by the Secretary of Health and Human Services and are, as of now, unknown. Additionally, the final children’s dental benefit plan design is not yet defined, but Delta Dental will work with the Department of Health and Human Services during the rulemaking process to advocate designs that we know will be effective and affordable.

DISCLAIMER: This is information based on a preliminary analysis by the Delta Dental Plans Association and it should not be construed as legal advice.
Within the exchanges, individuals and smaller groups will be allowed to purchase stand-alone pediatric dental coverage from companies like Delta Dental, in combination with essential medical benefits. Clarification is needed to assure the same choice will be available to smaller businesses and individuals opting to purchase benefits in the private marketplace. In future years, larger employers will also have access to plans available through the exchanges.

A more detailed analysis is not yet available. We will provide you with relevant information as soon as it becomes available to help you make informed decisions about your dental plan.

As the nation enters this new era for health insurance, you can count on Delta Dental. We are the largest administrator of dental plans in the United States, covering more than 54 million people, and our expertise makes us uniquely qualified to help our customers navigate a changing benefit landscape – whether those changes come from an evolving marketplace or legislation.