DELTA DENTAL

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January 4, 2013

National Healthcare Operations, Healthcare and Insurance
U.S. Office of Personnel Management
Attention: RIN 3206-AM47
1900 E Street, NW
Room 2347
Washington, DC 20415

Re: Comments on Proposed Rule for Establishment of the Multi-State Plan Program

To Whom It May Concern:

I am writing on behalf of Delta Dental Plans Association ("DDPA") in response to the invitation for comments on the December 5, 2012, Proposed Rule for "Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges." We are pleased to offer comments on the proposed rule specifically relating to the role of stand-alone dental benefit plans in offering the pediatric dental essential health benefit in an Exchange and the relation to qualified health plans such as a Multi-State Plan.

Specifically, OPM has asked for comments on how stand-alone dental plans offered on the Exchanges should affect the ACA requirement for a qualified health plan that is a Multi-State Plan to provide the pediatric oral health benefit under section 1302(b)(1)(J). In addition, OPM has asked for comments on the advantages, disadvantages, and legal justification for the approaches to providing the pediatric dental essential health benefit. Finally, OPM has proposed as the "benchmark" for the pediatric dental essential benefit the FEDVIP program.

Qualified Health Plans: How Stand-Alone Dental Plans Affect Requirements

Because a Multi-State Plan is a qualified health plan under the ACA, the Multi-State Plan is afforded a "waiver" from the requirement to provide the pediatric dental essential benefit where a stand-alone dental benefit plan is participating on the Exchange. Accordingly, a Multi-State Plan may offer only the medical benefits specified in subsections (A) through (I) of section 1302(b) of the ACA. The "waiver" for qualified health plans is a "required element" in defining the essential health benefits. *See* ACA section 1302(b)(4)(F).

Consistent with Congress's intent, we urge OPM, when contracting with Multi-State Plans, to recommend that the plans be required to offer a "medical only" option. As described above, a Multi-State Plan need not offer the pediatric dental benefit required as part of the essential health benefits package to be certified as a qualified health plan, so long as that benefit is available from a limited scope dental plan. Stated another way, the scope of benefits required of a qualified health plan under ACA may be offered through a combination of separate medical and dental plans.

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Advantages: Stand-Alone Dental Benefits Reflect the Existing Marketplace

The advantage to this arrangement is that the Multi-State Plan will operate like the vast majority of large employer group health plans today. The typical employer-provided dental benefit is separately offered and priced from the medical plan using a dental specialty plan. In the case of a self-insured employer plan, the dental benefit is separately administered from the medical benefits plan and typically employs a separate administrator that is a dental benefits specialist.

As you know, the Federal employee benefit program for dental benefits is separate from the major medical plans, and is a model or an example of how to structure the Exchange insofar as providing the pediatric essential dental benefits. *See,* 5 U.S. Code, Chapter 89A.

Current Arrangements Are Stand-Alone. Allowing the offering of stand-alone dental plans independent of medical plans was intended by Congress to reflect current choices and preferences of consumers in the health care insurance market. *See,* Stabenow-Lincoln modified amendment C-7 to the Chairman's Mark. Today, 97 percent of Americans with dental coverage receive that coverage through separate dental policies, which reflects the value of stand-alone dental plans offered by specialty carriers having decades of experience, custom-tailored technology and relationships with the dental profession.

Only about 2 percent of the market offers dental without choice as "embedded" within medical benefits. Requiring "embedded" pediatric dental benefits, while not explicitly discussed in the federal law, would clearly frustrate the federal purpose of the Exchange. No other types of "essential health benefits" are permitted by statute to be offered by stand-alone plans. The pediatric dental benefit is unique among the "essential health benefits" in this regard. *See* ACA section 1302(b)(4)(F) (required elements).

Dental Plan Networks Exist. A stand-alone dental carrier will be available to offer coverage of the essential pediatric dental benefit in each and every one of the 50 States. Delta Dental member companies collectively provide a nationwide dentist network, and by deferring coverage of essential pediatric dental services to stand-alone dental carriers such as Delta Dental, Multi-State Plans could greatly maximize the choice of dentists for children covered through the Exchanges. Because of stand-alone dental plans, Multi-State Plan enrollees will be able to access a plan that allows them to retain their existing family dentist – an opportunity that could easily be lost with the smaller, more restrictive networks of many of the large full service medical plans.

Overall, the participation of stand-alone dental benefit plans would encourage more competition and greater consumer choices in the medical market. This is because the vast majority of dental benefits are offered as stand-alone arrangements. The existence of a stand-alone dental plan in each and every Exchange triggers the opportunity for more qualified health plan medical carriers that don't normally offer dental coverage to offer their medical-only products through the Exchanges.

Keep Existing Dental Plan Coverage. Millions of Americans currently have family dental plan coverage. Included in these plans are benefits for children. A major concern is that as the

essential health benefits package only includes a requirement for a pediatric dental benefit, families may be encouraged to drop their coverage because of this segmentation. Alternatively, families may be forced to split up coverage between adults and children with different carriers, lose access to their child's dentist due to switching networks, or purchase duplicative coverage to preserve the coverage that they already have and enjoy.

This appears to be an unintended consequence of a provision meant to extend and improve coverage. To avoid these complications for families, HHS appears to support the view that individuals may satisfy the pediatric essential dental benefit requirements by purchasing family dental coverage in the Exchange that includes benefits that meet the required pediatric essential dental benefit.

We note that separately in the Preamble for the HHS proposed rule entitled "HHS Notice of Benefit and Payment Parameters for 2014" (December 7, 2012) in describing the proposed rule for premium tax credits and the allocation of premiums the agency observes that stand-alone dental benefit plans must provide to an Exchange a dollar allocation of the expected premium for: (1) the pediatric dental essential health benefit; and (2) any benefits offered by the stand-alone dental plan that are not the pediatric dental essential benefit. *See* 77 Fed. Reg. 73117, at 73168.

Subsidies and Stand-alone Dental Benefit Plans. The tax credit subsidies applicable to the purchase of coverage in the Exchange specifically includes a requirement for determining that a portion of the credit is allocated for the pediatric dental benefit. *See* ACA sections 1401-02. As a result, the subsidy structure is intended to accommodate the separate offer and pricing of the pediatric dental benefit. Any other dental benefits would have to be separately offered and priced for the purpose of distinguishing these additional benefits from the pediatric essential dental benefits eligible for the subsidies.

As previously noted, the HHS proposed rule entitled "HHS Notice of Benefit and Payment Parameters for 2014" includes allocation rules for premium tax between the medical benefits offered by a qualified health plan and the pediatric essential dental benefits by the stand-alone dental benefit plan. *See* Proposed Sections 155.340 (e) (2), 156.470 (d) and (e); 77 Fed. Reg. 73117, at 73211-12 (December 7, 2012).

Separate Offer and Separate Pricing of Pediatric Dental Benefits. Comparison and choice are facilitated by the separate offer and pricing of the pediatric dental benefit. Consumer "choice" is not facilitated where the pediatric essential dental benefit is "embedded" in a "take all or leave all" arrangement. If the purchaser likes the qualified health plan's essential medical benefits but not the pediatric essential dental benefit, there is no "choice" unless it is separately offered.

Comparison is not easily facilitated if the "embedded" plan's dental benefit is not priced-out. The purchaser cannot easily compare benefits and price, and have a choice with "embedded" dental benefits. In the March 27, 2012, final rule establishing standards and guidance for Exchanges and Qualified Health Plans, the agency stated that the pediatric essential dental benefit is required to be offered and priced separately from the medical coverage where an

Exchange determines that it "is in the interest of the consumer". *See* 77 Fed. Reg. 18411 (right hand column response).

This is consistent with the legislative history of the ACA which even more emphatically states that the required pediatric dental benefits in the non-group and small group markets (in and outside an Exchange) may be *separately offered and priced* from other required health benefits." *See* Stabenow-Lincoln modified amendment C-7 to the Chairman's Mark.

Most recently, the American Dental Association and the American Academy of Pediatric Dentistry wrote in support of separate offer and price as "necessary to provide consumers with the tools and information they need to make informed dental coverage decisions". *See* comment letter to Mr. Michael Hash on Federally-Facilitated Exchanges, dated August 3, 2012.

Recommended Benchmarks for Pediatric Dental Benefits

We urge OPM to follow the provisions of the HHS proposed EHB NPRM at proposed section 156.110(b)(2) that specifies for the pediatric essential dental benefit the "supplemental" benchmarks of CHIP, and the Federal Employees Dental and Vision Insurance Program ("FEDVIP") as "benchmark" plans. We also request, that the agency further clarify in regulatory language that the FEDVIP benchmark relates only to the category of dental benefits of those programs that are typically provided to children rather than to adults.

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DDPA is the nation's largest, most experienced dental benefits system. Since 1954, DDPA has worked to improve oral health in the U.S. by emphasizing preventive care, and making quality, cost-effective dental benefits affordable to a wide variety of large and small employers and groups. A nationwide system of dental health service plans, DDPA offers custom programs and reporting systems that provide employees with quality, cost-effective dental benefit programs and services. Our nationwide network of 39 companies and 142,000 dentists, serves more than 59.5 million Americans in over 97,900 group plans across the nation.

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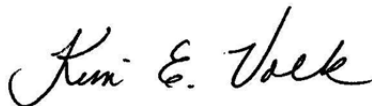
We very much appreciate the opportunity to submit comments on this important proposed rule. Please let me or my staff know if you have any questions.

Sincerely,



Kim E. Volk
President and CEO
Enclosure