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December 31, 2012

Centers for Medicare & Medicaid Services
ATTN: CMS-9984-P
U.S. Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Comments on the Proposed Rule for Benefit and Payment Parameters for 2014

To Whom It May Concern:

I am writing on behalf of the Delta Dental Plans Association ("DDPA") in response to the invitation for comments on the December 7, 2012, Proposed Rule for "Benefit and Payment Parameters for 2014." We are pleased to offer comments on the proposed rule specifically relating to the provisions for payment of the premium tax credit, and provisions for user fees for a Federally-Facilitated Exchange ("FFE"). We generally support the "pro rata" allocation method set for in the proposed rule for distribution of the premium tax credit.

Administration of Advance Payments of the Premium Tax Credit

Proposed section 155.340(e)(2) provides that "any remaining" advance payment of the premium tax credit must be allocated among the stand-alone dental policies (if any) in proportion to the respective portions of the monthly premiums for the pediatric dental essential health benefit offered by the stand-alone dental plan, and the other essential health benefits offered by a qualified health plan.

We recommend that the phrase "any remaining" be struck from the proposed regulatory language. This is because it could be read to authorize payment of an amount that is "left over" regardless of whether it is in proportion to the premium for the pediatric dental essential benefits and the premium for the other essential health benefits. Clearly the intent is to establish a "pro rata" distribution that reflects the proportional relationship between two equally "essential" benefits and would guarantee this "pro rata" amount for the pediatric dental essential benefit.

Allocation of Payments of the Premium Tax Credit

Proposed section 156.470(b) provides that a stand-alone plan must submit separate dollar amounts for the premiums for the pediatric dental essential benefits, and "any" other benefits offered that are not pediatric dental essential benefits. We read this regulatory language as the agency's interpretation that the ACA permits a stand-alone dental benefit plan to offer, for example, adult and family dental benefits in an Exchange so long as they are offered and priced separately.

Delta Dental Plans Association
1515 West 22nd Street, Suite 450
Oak Brook, Illinois 60523

Telephone 630-574-6001
Facsimile 630-574-6999

Proposed section 156.470(d)(3) provides that a dental benefit plan must establish that the dollar amount of the premium only for the pediatric dental essential benefit must be calculated under the "fair health insurance premium" standards except for "age" factors, the single risk pool factors, and the rating standards that otherwise apply to qualified health plans. We support this methodology with respect to the pediatric dental essential benefit in order to provide equal treatment with other essential health benefits, and we note that the agency recognizes that other dental benefits offered and that are not pediatric essential benefits are "excepted benefits".

Proposed section 156.470(d)(4) requires the use of a single age factor for an individual under age 19 and that does not vary. However, the proposed rule establishes that for persons over age 19 the dollar amount of the premium is equal to "zero". We recommend that where, as the agency has proposed to permit (in the Preamble discussion to the Essential Health Benefits NPRM dated November 26, 2012), a state defines "pediatric" to include persons over age 19, that the same rule applies as is proposed for persons under age 19.

User Fees for a Federally-Facilitated Exchange ("FFE")

Proposed section 156.50(c) imposes a "user fee" on FFE participating issuers that is levied on each family member in a policy ("billable" members) and up to three family members under age 21. Each "billable" member is then multiplied by the applicable monthly user fee rate, currently proposed at 3.5%. We recommend that this "user fee" be levied in the same manner as state insurance premium taxes so that it is a rate levied solely on the premium amount charged.

The Preamble describes the user fee for the 2014 benefit year as "a monthly user fee rate equal to 3.5% of the monthly premium charged by the issuer for a particular policy under the plan". See 77 Fed. Reg. 73117, at 73181. Otherwise, this proposed FFE user fee will more greatly burden families, especially those purchasing the "pediatric" dental benefit, as a 3.5% tax on at least each of three members of a family under age 21 would result in a real "tax" of 10.5% per policy.

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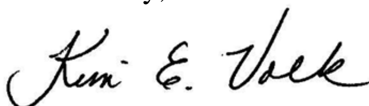
DDPA is the nation's largest, most experienced dental benefits system. Since 1954, DDPA has worked to improve oral health in the U.S. by emphasizing preventive care, and making quality, cost-effective dental benefits affordable to a wide variety of large and small employers and groups. A nationwide system 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.

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