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July 5, 2012

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9965-P
P.O. Box 8010
Baltimore, Maryland 21244-8010

Centers for Medicare &Medicaid Services
U.S. Department of Health and Human Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development, OMB/CMS-10320
Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Via: www.regulations.gov

Re: Comments on PPACA EHB Data Collection Proposed Rule

To Whom It May Concern:

I am writing on behalf of the Delta Dental Plans Association ("DDPA") in response to the agency's request for comments on the notice of proposed rule-making ("NPRM") published in the June 5, 2012, Federal Register (77 Fed. Reg. 33133). This NPRM would establish data collection standards necessary to implement aspects of the Patient Protection and Affordable Care Act ("PPACA") to support the definition of essential health benefits ("EHB") and includes a provision entitled the "Voluntary Data Collection From Stand-Alone Dental Plans" to collect information on stand-alone dental plan issuers that intend to participate in a state or federal Exchange.

We are also writing to offer comments on a related information collection request ("ICR") that the agency published on the same day entitled "Health Care Reform Insurance Web Portal Requirements" (77 Fed. Reg. 33221). This separate but related information collection request describes information entitled "Stand-Alone Dental Data Elements", "Instructions for Issuers that Intend to Offer Stand-alone Dental Coverage in the Exchange", and a "Notice of Intent to Provide Dental Coverage in the Exchange." These provisions would be used to report information to the agency to meet the voluntary requirements of the separately issued NPRM.

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

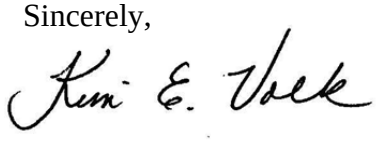
Delta Dental Plans Association
1515 West 22nd Street, Suite 450
Oak Brook, Illinois 60523

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

and services. Our nationwide network of 39 companies and 142,000 dentists, serves 60 million Americans in over 95,700 group plans across the nation.

We very much appreciate the opportunity to provide comments on these important matters. Our comments on the NPRM and the ICR as they relate to stand-alone dental plans are enclosed.

Sincerely,



Kim Volk
President and CEO

DDPA COMMENTS ON THE NPRM FOR DATA COLLECTION TO SUPPORT STANDARDS RELATED TO ESSENTIAL HEALTH BENEFITS

The NPRM establishes that a "voluntary" data collection from stand-alone plans is for the sole purpose of informing QHPs if the pediatric dental benefit "waiver" is operative. HHS proposes to collect this participation information on a "voluntary" basis to find out whether each state Exchange will have dental stand-alone plan options.

First of all, "voluntary" reporting alone will not make the "waiver" work well for the intended purpose. This reporting requirement should be mandatory for each stand-alone dental plan that intends to participate in a state or federal Exchange to offer "at least" the pediatric essential health benefit.

Second, there is no specification for the timeliness of such reporting so that QHPs have sufficient lead time to extract the pediatric dental benefit. We strongly recommend that a specific date established by which stand-alone dental benefit plans must report their intention to participate in a state or federal Exchange to offer "at least" the pediatric essential health benefit.

Third, the federal reporting must necessarily work in tandem and in a timely manner with each state Exchange's needs. We recommend that timely if not instantaneous reporting to each state or federally-administered Exchange of this intention to participate in a state or federal Exchange to offer "at least" the pediatric essential dental benefit is necessary.

Fourth, we recall that 45 CFR 155.1065(c) requires an Exchange "to consider the collective capacity of stand-alone dental plans during certification to ensure sufficient access to pediatric dental coverage." To meet that requirement, each Exchange will need data about the provider networks of all the issuers that report their intent to offer stand-alone dental products on the Exchange. Therefore, HHS should also require that each such report by a dental plan issuer include the issuer's provider network data for its intended service area.

In the Exchange NPRM, the agency requested comment on the need for notice to QHPs in advance of the QHP certification process in order to determine whether they must include the pediatric dental coverage in their EHBP or whether the pediatric dental coverage requirement is "waived" because a stand-alone dental benefit plan will offer the coverage in the Exchange.

DDPA replied that this important issue of advance "notice" can be addressed by requiring the Exchange to issue a request for information ("RFI") by some reasonable amount of time (at least six months) prior to the beginning of the certification process to identify whether any stand-alone dental plans will offer the required pediatric dental benefit.

Our member companies currently engage in a similar process with respect to private employer plan offerings and this same process could be imported into the Exchange.

DDPA COMMENTS ON ICR FOR
HEALTH CARE REFORM INSURANCE WEB PORTAL REQUIREMENTS

The ICR information proposed to be collected from stand-alone plans is for the sole purpose of informing QHPs if the pediatric dental benefit "waiver" is operative. This participation information would be collected on a "voluntary" basis to find out whether each state Exchange will have dental stand-alone plan options.

First, the separate information collection request includes "stand alone dental data elements" (issuer name, list of states, individual market, small group market, service areas) (Appendix G). The data elements appear to be repetitious with respect to the items numbered 2 and 3. One requires the list of states where the issuer intends to offer coverage, and another requires the issuer to identify from the list of states, the state in which the stand-alone plan would be offered.

Second, there is a simple draft "form" in the separate information collection request that is designed to facilitate this reporting (Appendix H4 "Instructions" and form at H5). This form and its data elements are derived from the "instructions" and are adequate except that it again repeats the list of states where the issuer intends to offer coverage, and again requires the issuer to identify from the list of states, the state in which the stand-alone plan would be offered.

This appears to be designed to accommodate circumstances where a stand-alone dental plan may participate in the individual market in some states but not in all states, or may participate in the small group market in some states but not all states. It may be more efficient for purposes of informing each state's Exchange to design the form as a uniform data collection form to be filed separately with each individual state or federally-administered Exchange.

Third, the "Insurance Issuer and Product Level Data" in the appendices makes reference to a "Dental check-up for children" (Appendix D, Benefits and Pricing, item HH), "Dental Benefits" (Appendix D, Benefits and Pricing, item I), "Routine Dental Services (Adult)" (Appendix G, Benchmark Plan Data Requirements, item 8), "Dental Check-Up for Children" (Appendix G, Benchmark Plan Data Requirements, item 45), "Dental Check-Up for Children (IN/OON)" (Appendix H, Benefits and Pricing Collection Tool). References to "limit of two Dental Check Up for Children per year) are also included in the "Instructions" at Appendix H4).

None of these terms or specific benefits is included in the list of essential health benefits that would become effective on or after January 1, 2014. This data collection appears to be applicable to health plans prior to January 1, 2014. However, some states are using this information with respect to defining essential health benefits for purposes of certifying qualified health plans in the state's Exchange.

The agency should clarify the intent of these references in this ICR and its application to the NPRM. See Revisions Crosswalk (Form CMS-855S); OMB 0938-1086 (references to the pediatric dental benefit in Issue #8, and stand-alone dental plans in Issue #17).