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August 16, 2012

Center for Consumer Information and Insurance Oversight
Centers for Medicaid and Medicare Services

Via email: FFEcomments@cms.hhs.gov

**Re: Comments on General Guidance on Federally-facilitated Exchanges Bulletin**

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 May 16, 2012 General Guidance on Federally-facilitated Exchanges Bulletin.

In general, DDPA supports a federally-facilitated exchanges (FFE) rule that further clarifies through additional guidance certain issues that the final exchange rule relegated to the states. Providing this clarity will improve participation on FFEs by stand-alone dental plans like Delta Dental member companies and create a more robust health insurance market.

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 60 million Americans in over 95,700 group plans across the nation.

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

Sincerely,

Kim E. Volk
President and CEO

Enclosure

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

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**DELTA DENTAL PLANS ASSOCIATION ("DDPA") COMMENTS ON GENERAL GUIDANCE ON FEDERALLY-FACILITATED EXCHANGES BULLETIN**

## Background

To ensure a competitive environment on FFEs, DDPA recommends establishing a level playing field among *all* carriers through transparent pricing. Essential to this aim, the pediatric dental essential health benefit ("EHB") must be separately priced by all carriers, whether they are qualified health plans ("QHP") or stand-alone dental plans, to allow for easy comparison by consumers. This will enable consumers to shop knowledgably for the dental coverage they want. We recommend a user interface design within each FFE which facilitates selection of either stand-alone dental or dental provided by the medical QHP.

## State Partnership in a Federally-facilitated Exchange

We note that there is no mention of the billing, collection, aggregation or distribution functions within a partnership or FFE (these functions are addressed for the federally facilitated-SHOP ("FF-SHOP"). DDPA recommends that all state Exchange partnerships and FFEs provide for premium collection through a central location – either the FFE itself or an aggregator. Centralized collection and aggregation with subsidies where appropriate will reduce administrative costs for carriers, particularly stand-alone dental plans collecting small premium amounts. It also allows FFEs to answer consumers' questions on payment status in a real-time basis.

This bulletin provides more specific guidelines for FF-SHOP when compared with those provided for FFEs. We recommend cross-supplying this level of specificity to the FFE in several key areas:

- Grace periods
- Maximum allowable waiting periods
- Quarterly changes in rates
- Premium aggregation
- Billing
- Payment
- Disbursement
- Reconciliation

Doing so will reduce uncertainty for carriers as they consider participation on exchanges, particularly those carriers which may consider offering coverage in exchanges in several different states.

## Approach to Key Exchange Functions in a Federally-facilitated Exchange

The FFE policy objective of "providing an attractive and viable market for insurers" will require full pricing transparency in order for stand-alone dental carriers to compete with full-service (dental and medical combined) carriers. This approach benefits consumers in a number of ways:

they are not forced to pick a dental plan that is embedded in a full-service plan; they have a greater chance of selecting a dental option that has the dentist they want "in-network;" and competition among dental plans and full-service plans for the dental market on FFEs will drive down the cost of dental. Full pricing transparency does not create an administrative burden for full-service plans; these plans routinely provide pricing transparency in the current health insurance market where 98 percent of dental is contracted separately.

Further, we believe that the limitations on the FFE's role and authority should not be interpreted to only allow the EHBs to be offered on an FFE. Buy-ups or dental adult wrap-around should be offered by QHPs and stand-alone dental plans on the FFE in addition to EHBs.

## Chart 2: High-level Overview of QHP Certification Process

In most cases, dental does not have standards in network adequacy, essential community providers or accreditation. As a result, we believe that these standards should only be applicable by some "reasonableness" standard. Additionally, we do not believe it is appropriate to apply standards for actuarial value and meaningful difference for stand-alone dental plans.

## Other Plan Management Functions

To alleviate confusion, HHS should confirm that "user fees" are payments by carriers and will not make products in the exchanges more expensive for consumers.

## Conclusion

Enclosed, please find the comments DDPA submitted on the 2011 exchange NPRM. In its final exchange rule, HHS left many issues on planning and implementation up to the individual state's discretion. The FFE, in our view, provides an opportunity for a more proactive approach, and many of the issues for stand-alone dental plans can be clarified appropriately in that environment. Also enclosed, please find DDPA comments on the EHB bulletin and actuarial value NPRM.

DELTA DENTAL

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October 31, 2011

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Attention CMS-9989-P
P.O. Box 8010
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Baltimore, Maryland 21244-1850

**Re: Comments on Proposed Rule for Exchanges and Qualified Health Plans**

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 Notice of Proposed Rulemaking ("NPRM") for the Establishment of Exchanges and Qualified Health Plans included in the *Federal Register* of July 15, 2011. Our comments consist of two enclosed documents: (1) formal comments on the proposed rule that include general comments, response to specific dental-related questions; section-by-section comments, proposed new Subpart L; and (2) a paper entitled "Offering Dental Benefits in Health Exchanges: A Roadmap for Federal and State Policymakers" (September 2011).

Delta Dental is the nation's largest, most experienced dental benefits system. Since 1954, Delta Dental 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, Delta Dental 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 135,000 dentists, serves more than 54 million Americans in over 93,000 group plans across the nation.

We very much appreciate the opportunity to submit comments on this important proposed regulation and your time and attention to the dental-related issues. Please let me or my staff know if you have any questions.

Sincerely,

Kim E. Volk

Kim Volk
President and CEO

Delta Dental Plans Association
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About Delta Dental

Delta Dental is the nation's largest and most experienced dental benefits system. Its member plans serve nearly one-third of the estimated 166 million Americans with dental insurance, providing coverage to more than 56 million people in 95,700 groups across the nation. Since 1954, Delta Dental has worked to improve oral health in the U.S. by emphasizing preventive care and making dental coverage affordable to a wide variety of employers and groups.

Enclosures

**DELTA DENTAL PLANS ASSOCIATION ("DDPA") COMMENTS ON NOTICE OF PROPOSED RULEMAKING ("NPRM") FILE CODE CMS-9989-P: ESTABLISHMENT OF EXCHANGES AND QUALIFIED HEALTH PLANS**

## In General

As an overview of our comments to the July 15, 2011, proposed rule for the "Establishment of Exchanges and Qualified Health Plans", the Delta Dental Plans Association ("DDPA") must emphasize the significant difference in both the nature and structure of dental benefits from medical benefits, and the legal treatment of stand-alone dental benefits and dental benefit plans.

Dental benefits provided by stand-alone dental benefit plans are treated as "excepted benefits" under federal law and as a result are not regulated in the same manner as comprehensive, major medical coverage. This was established in the 1996 HIPAA amendments to the PHSA, ERISA, and the IRC, and the ACA builds upon those provisions and continues the exception for "excepted benefits".

For these reasons we urge the agency to establish a separate subpart in the final rule for pediatric oral health benefits and the offering of those benefits by qualified health plans and stand-alone dental benefit plans. We offer suggested language for addition to the final rule as new "Subpart L" discussed below in the section-by-section comments.

## 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 because the essential health benefits package only includes a requirement for a pediatric dental benefit that is yet undefined, that families may be encouraged to drop their coverage because of this segmentation.

HHS should provide that individuals may satisfy essential health benefit package requirements by demonstrating to the Exchange that existing family dental coverage includes benefits that meet the required pediatric essential health benefit.

## Outside the Exchange

A concern of the DDPA member plans relates to the operation of the qualified health plan "waiver" in the market outside the Exchange. Section 155.1065 (c) of the Exchanges and Qualified Health Plans rule provides that a qualified health plan offered through an Exchange will not fail to be certified by an Exchange as a qualified health plan if a stand-alone dental plan in the Exchange offers the required pediatric dental benefit.

The ACA is silent with respect to the treatment of a qualified health plan offered outside an Exchange because an Exchange does not certify a qualified health plan in that market. The existing market already relies upon freely available stand-alone dental plans in all States, and those stand-alone plans are expected to be the usual suppliers of the required pediatric dental

benefit for purposes of meeting the essential health benefit package in the individual and small group insurance market outside an Exchange.

Accordingly, State regulators should not have to require a qualified health plan to offer the essential pediatric dental benefit in those markets or be faulted for failing to enforce such a requirement.

HHS should include a statement in the preamble discussion to the final rule that the legislative history of the Senate-passed provision authorizing stand-alone dental benefit plans to offer the pediatric dental benefit states as its purpose "to allow stand-alone dental plans to offer the required pediatric dental services and to be offered in the individual and small group markets including within the insurance exchanges." [Emphasis added].

In addition, HHS should clarify that it is not necessary for State regulators to require qualified health plans to cover the essential pediatric benefit unless the benefit is not available from a stand-alone dental benefit plan. This would apply the qualified health plan "waiver" in the market outside the Exchange market in the same manner that the qualified health plan "waiver" operates inside the Exchange market as intended by the Stabenow Amendment.

## Response to Specific Questions

### Relevant and Necessary Certification Standards

The NPRM requests comment on whether some of the proposed certification and consumer protection requirements for QHPs should also apply to stand-alone dental plans. HHS suggests that these might include: quality reporting; transparency measures; summary of coverage information; provider network standards; and standards regarding the consumer's experience in comparing and purchasing dental plans.

Legislative history of the Senate-passed provision authorizing stand-alone dental benefit plans to offer the pediatric dental benefit states that dental plans would comply with any "relevant" consumer protections required for participation in the Exchange. These consumer protections are intended, as HHS correctly notes, to mean requirements for participation in the Exchange and not insurance market reforms.

We have considered each of the suggested QHP proposed certification and consumer protections suggested by HHS under a "relevant" (meaning "relates to" dental plans) analysis:

1. Quality reporting measures do not exist in dental care and so no uniform, national standards exist at this time;

2. Transparency measures (reporting, plain language, cost sharing, and performance) are specific to medical plans and measures that take into account the unique characteristics of dental benefits would have to be developed;

3. Summary of coverage information and uniform definitions have been developed by the NAIC but are not appropriate for dental plans to use and would have to be developed;

4. Provider network standards for dental provider networks do not exist as a national standard but some states have developed standards applicable to dental provider networks.

Accordingly, because the ACA does not establish certification and consumer protection standards for dental benefit plans these requirements would be developed on a state-by-state basis by each Exchange. We ask that HHS provide guidance to the Exchanges that these "relevant" standards must be limited to Exchange "participation" requirements and are not insurance market reforms that would be applied to "excepted benefit" coverage.

## Operational and Administrative Minimum Standards

**Tax Credit**. The NPRM requests comment on whether specific "operational" minimum standards should be established and provides examples such as: allocating advance payment of the premium tax credit and calculating actuarial value when stand-alone dental plans segment the pediatric dental coverage of the EHBP.

Each Exchange should be required to determine the average premium for "qualified health plan" coverage without the pediatric dental benefit, and the average premium for the pediatric dental benefit coverage. The proportional ratio of those two premiums would be used to calculate the allocation of the tax credit between the medical and dental coverage segments.

**Advance Notice**. The NPRM requests comment on the need for notice to QHPs in advance of the QHP certification process 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.

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.

**Separate Offer and Price**. The NPRM requests comment on the potential of any "administrative burden" on Exchanges and QHP issuers if the EHBP pediatric dental benefit is required to be offered and priced separately from the medical coverage, and whether it would preclude the offering of "bundled" medical and pediatric dental coverage by a QHP.

HHS recognizes that the separate offer and pricing of the pediatric dental benefits would promote comparison of the pediatric dental essential benefit offerings. This is consistent with the intent that competition is a key objective of the Exchange. Any concern that separate offer and pricing of dental would be administratively burdensome to Exchanges or qualified health plans could be

alleviated by simply requiring that QHPs must always price and offer a medical only version of each bundled medical-dental plan that it offers in the Exchanges.

Most health plan issuers today already routinely offer and price both medical and dental benefits separately. Currently 98% of all dental policies are offered and priced separately. In addition to requiring that health plan issuers to always offer medical-only options, health plan issuers should provide a full, separate description and summary of any dental coverage offered, whether in the bundled plan or separately. This will afford purchasers a fully informed choice and comparison.

This is also consistent with the Federal Employee Dental Benefit Program which provides for separate pricing and disclosure of stand-alone dental benefit plans.

Despite the fact that 98 percent of Americans with dental coverage today have a dental benefit policy that is separate from their medical policy, an infinitesimal number of health insurers provide the 2 percent of arrangements that "embed" dental and medical benefits together in one integrated policy. This small minority of health plans now ask HHS to resist the "separate offer and pricing" of pediatric essential dental benefits for consumers to compare.

Certainly any dental benefits that are "incidental" to medical benefits would not have to be separately offered and priced. Only those dental benefits that are intended to meet the pediatric essential benefit requirement would be separately offered and priced. The pediatric oral health services are themselves separately listed as a category of essential health benefits apart from the medical benefits in section 1302(b) of the ACA.

If a QHP "embeds" the pediatric essential benefit into its medical benefit plan it is still a benefit that actuaries have separately priced and that is integrated into the premium charged for the policy. It would not be "impractical" to disclose the price of that pediatric essential benefit since it is a known value to the QHP, and would not be "impractical" to separately disclose that value and a description of the benefit provided for that value.

The Senate Finance Committee's report to accompany S. 1796, "America's Health Future Act of 2009" (the initial version of the ACA) describes the purpose of the Exchange to make purchasing health insurance coverage easier and more understandable, to make companies compete on price and quality, and to make comparing and purchasing health coverage easier. See Senate Report No. 89, 111th Cong. at 4 (October 19, 2009).

A few health plans assert that separate offer and pricing of the pediatric essential benefit is "impractical." However, to allow "embedded" pediatric dental benefits to hide among the medical benefits would be inconsistent with, contrary to, and frustrate the very central purpose of the Exchange---to provide meaningful and standardized comparative information for the choices of benefit coverage options.

## Section-by-Section Comments

### PART 155 – EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

### Subpart A – General Provisions

155.10. Basis and scope. Subsection (b) "Scope". After "QHPs," add "requirements for stand-alone dental plans providing pediatric dental essential benefits,".

155.20. Definitions. Add definition for "stand-alone dental plan". Stand-alone dental plan means, a limited scope dental benefits plan that meets the requirements of section 9832(c)(2)(A) of the Internal Revenue Code and 2791(c)(2)(A) of the PHS Act. Amend the definition of Applicant in (1)(i) to add after "QHP" the phrase ", or stand-alone dental plan providing the pediatric essential benefit,".

### Subpart B – General Standards Related to the Establishment of an Exchange by a State

155.100. Establishment of a State Exchange. Subsection (a) General Requirements. Add after "QHPs" the phrase ", and stand-alone dental plans providing the pediatric essential benefit,".

155.105. Approval of a State Exchange. Subsection (a) Approval Requirement. Add after "QHPs" the phrase ", and stand-alone dental plans providing the pediatric essential benefit,".

155.130. Stakeholder consultation. Subsection (j) add after the phrase "health insurance issuers" the phrase ", stand-alone dental plan issuers".

155.160. Financial support for continued operations. "Assessments" or "User fees" should be based on a percent of premium. Comment. A flat-fee or per enrollee fee would disproportionately add to the administrative costs of stand-alone dental plans because premium amounts collected by stand-alone dental plans are only a small fraction of the premium amounts collected by full service medical plans. A percent of premium would provide a level playing field similar to the way states currently levy premium taxes.

**Subpart C – General Functions of an Exchange**

155.205. Required consumer assistance tools and programs of an Exchange. Subsection (c). Add after "QHPs" the phrase ", and stand-alone dental plans providing the pediatric essential benefit,". Comment. See new proposed Subpart L (below), section 155.1101 (Offer and Pricing of Pediatric Dental Benefit). The Exchange must be required to tailor the consumer assistance tools and programs for dental benefit coverage; the summary of benefits and coverage for pediatric dental benefits must be specific to dental.

155.210. Navigator program standards. Subsection (d)(3). Add after "QHPs" the phrase ", and stand-alone dental plans providing the pediatric essential benefit,".

155.220. Ability of States to permit agents and brokers to assist qualified individuals, qualified employers or qualified employees enrolling in QHPs. Heading and Subsection (a). After each reference to "QHP" or "QHPs" add the phrase ", and stand-alone dental plans providing the pediatric essential benefit,".

155.240. Payment of premiums. After each reference to "QHP" add the phrase ", and stand-alone dental plans providing the pediatric essential benefit,". Comment. The Exchange must take into consideration the HIPAA transaction and code set requirements for payment, differences in paying premiums by check or credit card, and coordination of the timing of payment with the provision and allocation of financial subsidies between qualified health plans and stand-alone dental plans.

**Subpart E – Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans**

155.400. Enrollment of qualified individuals into QHPs. Add after each reference to "QHPs" the phrase ", and stand-alone dental plans providing the pediatric essential benefit,"; and after each reference to "QHP issuer" the phrase "or issuer of a stand-alone dental plan providing the pediatric essential benefit." Comment. The proposal at (b)(1) would require sending information on a "timely" basis and should clarify this with a specific frequency standard and enrollment reconciliation. We conclude that "real-time" is not feasible for data exchange, but that the enrollment reconciliation should be required on a monthly basis at a minimum.

155.405. Single streamlined application. Add after each reference to "QHPs" the phrase ", and stand-alone dental plans providing the pediatric essential benefit,". Comment. The Exchange must develop appropriate pediatric dental benefit elements as part of the same single, streamlined application to account for the pediatric dental coverage in addition to the elements for medical coverage under a QHP.

155.410. Initial and annual open enrollment periods. Add after each reference to "QHPs" the phrase ", and stand-alone dental plans providing the pediatric essential benefit,". Comment. The initial and annual open enrollment periods should reflect the current enrollment practices for the individual and small employer markets and should not follow a Medicare or OPM model.

155.420. Special enrollment periods. Add after each reference to "QHPs" the phrase ", and stand-alone dental plans providing the pediatric essential benefit,".

155.430. Termination of coverage. Add after each reference to "QHPs" the phrase ", and stand-alone dental plans providing the pediatric essential benefit,".

**Subpart H – Exchange Functions: Small Business Health Options Program (SHOP)**

155.705. Functions of a SHOP. Add in (b) (4) after each reference to "QHP issuer" the phrase ", and stand-alone dental plans providing the pediatric essential benefit,". Add in (b) (8) and (9)

after each reference to "QHP" the phrase ", and stand-alone dental plans providing the pediatric essential benefit."

155.715. Eligibility determination process for SHOP. Add after each reference to "QHPs" the phrase ", and stand-alone dental plans providing the pediatric essential benefit,".

155.720. Enrollment of employees into QHPs under SHOP. Add after each reference to "QHPs" the phrase ", and stand-alone dental plans providing the pediatric essential benefit,".

155.725. Enrollment periods under SHOP. Add after each reference to "QHPs" the phrase ", and stand-alone dental plans providing the pediatric essential benefit,".

155.730. Application standards for SHOP. Add after each reference to "QHPs" the phrase ", and stand-alone dental plans providing the pediatric essential benefit,".

**Subpart K – Exchange Functions: Certification of Qualified Health Plans**

155.1065. Stand-alone dental plans. Amend head note to read as "Provision of pediatric oral health care services." Comment. This section is really a special rule permitting the waiver of the requirement to include the pediatric essential benefit for qualified health plans where a stand-alone dental benefit plan provides such coverage. Accordingly, the head note we suggest would more clearly designate the subsection's purpose.

## New Proposed Subpart L

**Subpart L – Exchange Functions: Benefits for Pediatric Oral Care Services.**

**Sec. 155.1100. Qualified Health Plan Waiver for Pediatric Dental Benefit**

(a) *General Requirement*. If a stand-alone dental benefits plan is offered through an Exchange, then a qualified health plan shall not fail to be treated as a qualified health plan solely because it does not offer the required essential health benefits for pediatric oral care services that are offered by the stand-alone dental benefits plan.

(b) *Qualified Health Plan Offer*. A qualified health plan may offer pediatric oral care services as part of the essential health benefits package so long as the plan meets the requirements of section 155.1101.

(c) *Request for Information*. An Exchange shall issue a request for information at a time that is sufficiently prior to the date of the QHP certification process (established in Part 156, Subpart C) to determine the extent of participation by stand-alone dental benefits plans offering the specified pediatric essential benefit for purposes of subparagraph (a).

(d) *Rule If No Stand-Alone Dental Benefits Plan Offered*. Where no stand-alone dental benefits plan is offered in an Exchange then a qualified health plan must include the specified pediatric oral care services as part of the essential health benefits package and meeting the requirements of section 155.1101.

**Sec. 155.1101. Offer and Pricing of Pediatric Dental Benefit**

(a) *Meaning of Pediatric for Specified Oral Care Services*. For purposes of the pediatric oral care services that are specified at section 1302(b)(1)(J) of the Affordable Care Act as part of the essential health benefits package, the term "pediatric" shall mean dental care services for children under 19 years of age.

(b) *Separate Offer and Pricing Required*. Pediatric oral care services under section 1302(b)(1)(J) of the Affordable Care Act must be offered and priced separately from the other categories of essential health benefits required under sections 1302(b)(1)(A) through (I), of the Affordable Care Act and from any other dental benefits that may be offered.

(c) *Pediatric Oral Care Services Benefits Comparison*. An Exchange shall facilitate the comparison of the pediatric oral care benefits, terms of the offer, and prices of the services, for stand-alone dental benefit plans and any qualified health plans that offer benefits for pediatric oral care services.

(d) *Combined Purchase Required*. An eligible individual with children who purchases qualified health plan coverage without pediatric oral care services from a qualified health plan described in 155.1100(a) must also purchase a separate stand-alone dental benefits plan for pediatric oral care services to meet the essential health benefits requirements. Comment. The statute does not explicitly provide exception from the pediatric essential benefits for eligible

persons without children; however, it would be reasonable to limit the requirement to apply only to coverage for those with children.

(e) *Relation to Existing Dental Coverage.* An eligible individual who purchases qualified health plan coverage without pediatric oral health care services from a qualified health plan described in 155.1100(a) may satisfy the requirement in (d) by certifying to the Exchange that the individual has an existing family dental policy that includes coverage equal to or exceeding the pediatric oral care services required in (a).

(e) *Adult and Family Oral Care Services Benefits*. An Exchange shall permit stand-alone dental plans and qualified health plans to offer benefits for oral care services that are in addition to the pediatric oral care services specified in section 1302(b)(1)(J) of the Affordable Care Act, including coverage for adult and family oral care services, provided that such additional benefits are separately priced and compared consistent with the requirements of this subsection.

**Sec. 155.1102. <u>Requirements Relating to Stand-Alone Dental Benefit Plans</u>**

(a) *General Requirement*. An Exchange shall allow a stand-alone dental benefits plan to offer dental coverage (either separately or in conjunction with a qualified health plan) if the stand-alone dental benefits plan provides pediatric oral care services that meet the standards for pediatric oral care services that are specified as essential health benefits under section 1302(b)(1)(J) of the Affordable Care Act

(b) *Required Pediatric Oral Care Services*. A stand-alone dental benefits plan is required to include dental benefits for pediatric oral care services to satisfy required essential health benefits under section 1302(b)(1)(J) of the Affordable Care Act.

(c) *Excepted Benefit Requirement*. A stand-alone dental benefits plan must meet the excepted benefit standards for a limited scope dental plan under section 9832(c)(2)(A) of the Internal Revenue Code of 1986 (must be separate contract) and shall not be treated as a qualified health plan.

(d) C*ertification, Recertification and Decertification*. The Exchange must establish a process for the certification, recertification and decertification of a stand-alone dental benefits plan that is appropriate and similar to the process for a qualified health plan.

**Sec. 155.1103. <u>Annual Limitation on Cost-Sharing for Pediatric Oral Care Services</u>**

(a) *General Requirement*. The cost-sharing incurred under a qualified health plan, or a stand-alone dental benefits plan, that is offered in an Exchange with respect to the covered benefits for pediatric oral care services specified under section 1302(b)(1)(J) of the Affordable Care Act for a plan year shall not exceed the amount determined under (b) as the annual limitation on cost-sharing for such services.

(b) *Annual Limitation*. The annual cost-sharing limitation for pediatric oral care services shall be an amount that is a portion of the annual limitation established under section 1302(c)(1)

of the Affordable Care Act, and that is based upon the ratio of the average stand-alone dental plan premium for pediatric oral care services in the Exchange to the average premium for a qualified health plan in the Exchange that does not offer the required essential health benefits for pediatric oral care.

(c) *Cost-Sharing Defined*. The term cost-sharing includes deductibles, coinsurance, copayments, or similar charges, and any other expenditure which is a qualified medical expense (within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986) with respect to benefits covered under the plan. The term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

**Sec. 155.1104. <u>Tax Credit Premium Assistance for Pediatric Dental Benefits</u>**

(a) *General Requirement*. For purposes of determining and administering the amount of the refundable premium assistance tax credit, if a person enrolls in a qualified health plan, and also in a stand-alone dental benefits plan, the monthly premium for the portion of the stand-alone dental benefit plan for required pediatric oral care services is treated as if it is a portion of the premium of a qualified health plan.

(b) *Limitation on Tax Credit Treatment*. In administering the tax credit premium assistance, an Exchange shall treat the portion of the premium for pediatric oral care services as the premium of a qualified health plan only for purposes of determining the tax credit.

(c) *Treatment of Stand-Alone Dental Plan.* An Exchange shall not treat a stand-alone dental benefits plan as a qualified health plan for any other purpose regarding requirements that are imposed on any qualified health plan except as provided in subsection (b) (relating to tax credit premium assistance).

(d) *Determination of the Credit Amount.* The tax credit allocable for coverage under a stand-alone dental benefit plan for the pediatric dental services shall be an amount that is based upon the ratio of the average stand-alone dental plan premium for pediatric oral care services in the Exchange to the average premium for a qualified health plan in the Exchange that does not offer the required essential health benefits for pediatric oral care.

**Sec. 155.1105. Technical Correction to Certain Cross-References**

The agency interprets certain incorrect statutory references as follows: (a) Affordable Care Act section 1302(b)(4)(F), reference to 1311(b)(2)(B)(ii) should read as 1311(d)(2)(B)(ii); and (b) Affordable Care Act section 1402(c)(5), reference to 1311(d)(2)(B)(ii)(I) should read as 1311(d)(2)(B)(ii).

DELTA DENTAL®

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January 31, 2012

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Via email: EssentialHealthBenefits@cms.hhs.gov

**Re: Comments on the Essential Health Benefits Bulletin**

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 16, 2011, Essential Health Benefits Bulletin. We are pleased to offer some general comments regarding the meaning of "pediatric" dental essential health benefits, the role of stand-alone dental benefits plans in providing the "pediatric" dental essential health benefit both inside and outside of an Exchange and comments specific to the Essential Health Benefits Bulletin.

In addition, our comments include proposed draft regulatory language for your consideration in defining and addressing certain critical issues relating to the "pediatric" dental essential health benefit. Our recommendations include: the "minimum" essential services that must be included in the "pediatric" dental essential health benefit; benchmark "pediatric" dental benefit plans; provision of an evidence-based "pediatric" dental benefit plan; application of the qualified health plan waiver both inside and outside the Exchange; and standards to maintain affordability.

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 135,000 dentists, serves more than 56 million Americans in over 95,000 group plans across the nation. We very much appreciate the opportunity to submit comments on this important guidance. Please let my staff or me know if you have any questions.

Sincerely,

Kim E. Volk
President and CEO

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**DELTA DENTAL PLANS ASSOCIATION ("DDPA") COMMENTS ON THE ESSENTIAL HEALTH BENEFITS BULLETIN ISSUED DECEMBER 16, 2011 BY THE CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT**

## In General

The Delta Dental Plans Association ("DDPA") welcomes the opportunity to comment on the December 16, 2011 "Essential Health Benefits Bulletin" ("EHB Bulletin") issued by the Department of Health and Human Services – Center for Consumer Information and Insurance Oversight. Underlying our comments is the significant difference in both the nature and structure of dental benefits from medical benefits and the corresponding difference in the legal treatment of stand-alone dental benefits and dental benefit plans.

Dental benefits provided by stand-alone dental benefit plans are treated as "excepted benefits" under federal law and as a result are not regulated in the same manner as comprehensive, major medical coverage. This was established in the 1996 HIPAA amendments to the PHSA, ERISA and the IRC, and the Accountable Care Act ("ACA") builds upon those provisions and continues the exception for "excepted benefits". *See also* footnote 14 of the EHB Bulletin.

As an "excepted benefits" plan, a stand-alone "limited scope" dental benefit plan is not subject to the ACA's prohibition on lifetime and annual limits on the dollar value of benefits. In fact, such limits are a critical standard feature of typical employer-provided dental benefit coverage currently offered in the market. In addition, typical employer-provided dental benefit plans establish frequency limits for certain dental services, restrictions on the amount of the fee for which a benefit will be computed, and limitations on the nature of the dental conditions for which a benefit will be payable.

Because of the unique nature of excepted benefit plans, we urge the agency to establish a separate subpart and set of dental-specific benchmarks in the EHB proposed rule for defining the pediatric oral health essential health benefits and the separate pricing and offering of those benefits by qualified health plans and stand-alone dental benefit plans. We offer suggested language for addition to the proposed rule, set forth below, following our specific comments on the EHB Bulletin.

## 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 should provide that individuals may satisfy the essential health benefit package requirements when purchasing health insurance either inside or outside the Exchange by demonstrating that existing family dental coverage includes benefits that meet the required pediatric essential health benefit.

## Comments Specific to the EHB Bulletin

**Benchmark Plan Approach Encouraged.** In general, we support the intended regulatory approach in the forthcoming EHB proposed rule that utilizes a "benchmark" reference plan to set the "covered services" required in the EHB. In fact, prior to the issuance of the EHB Bulletin, DDPA proposed a draft regulation for the pediatric dental essential benefit that employed this general approach of listing several benchmark plans that would satisfy the requirement. However, we recommend that the benefit for essential pediatric oral services required under Section 1302(b)(1)(J) should be determined by reference to a set of benchmark *dental* plans, rather than to any of the benchmark medical plans used by a State to define the EHB generally.

The EHB Bulletin recognizes that the initial four benchmarks set for determining the EHB may not contain dental benefits sufficient to set a pediatric dental essential benefit. Also, the ASPE research brief on essential health benefits notes that "routine" pediatric dental services are not frequently covered in the small group *health* market. *See* ASPE Research Brief (December 2011) at page 3. Moreover, 97 percent of dental coverage is provided through separate (stand-alone) dental plans or policies. Thus, we have a concern that the initial four benchmark options, while offering a range of benefit options for the EHB generally, do not accurately portray the average *dental* benefits being offered by employers.

We propose that HHS create a set of dental-specific benchmarks to accommodate the unique nature of excepted benefit plans instead of imposing the same four benchmarks being used for comprehensive medical plans. This modified benchmark approach is reflected in the regulatory language proposed below.

**The Recommended Benchmarks for Pediatric Dental Benefits.** In general, we support the EHB Bulletin inclusion of State employee plans, CHIP, and the Federal Employees Dental and Vision Insurance Program ("FEDVIP") as "benchmark" plans and would include these options in our proposed dental specific benchmarks. We request, however, that the agency clarify, with respect to the State employee and FEDVIP dental coverage, that the "benchmark" relates only to the dental benefits of those programs that are typically provided to children rather than to adults.

We also support including as a benchmark option any of the three largest small employer plans by enrollment, provided that the benchmark should be *dental* plans purchased by small group business employers. We also request that the agency include an explicit authorization for an alternative pediatric oral health essential benefit plan that employs an "evidence-based" approach to covered benefits. This approach is consistent with the EHB recommendations of the Institute of Medicine and is spelled out in the proposed regulatory language below (see Section 000.005).

If HHS declines to direct States to substitute these dental-specific benchmarks in place of the initial four EHB benchmarks when determining the essential pediatric dental benefit, as proposed in the section above, we recommend that HHS nevertheless allow States to consider all of these options when "supplementing" any of the initial four benchmarks chosen that do include dental benefits. Allowing States to choose only between FEDVIP and CHIP is too narrow a choice and, in particular, would not reflect the typical small group employer plan.

**Choice of Benchmark Must Be Guided by Affordability**. We also request that the term "essential benefits" be further defined to emphasize that their scope should be balanced by a consideration of affordability for individuals and small group employers.

While many benefits may be considered desirable by consumers, only a selection of them should be considered "essential" in order to attain the goal of affordability. It seems clear that Congress did not intend to include all of the same pediatric oral health care benefits that are included in the FEDVIP and CHIP programs because these programs can provide comprehensive benefits.

The phrase "essential" is not superfluous and has been interpreted by Congressional staff as meaning a "minimum" set of benefits. The plain meaning of the term essential is "basic", and as a result, the pediatric oral health care essential benefit must be benchmarked as a basic benefit and not as comprehensive dental benefits. See IOM, *Essential Health Benefits: Balancing Coverage and Costs* (2011) at page 60.

We therefore recommend that States be directed by HHS to ensure that affordability guides their choice of benchmark for the pediatric dental benefit. A suggestion for that approach is shown in the regulatory language proposed below (Section 000.001).

**Orthodontics Coverage Is Not Essential**. We support the EHB Bulletin notation that non-medically necessary orthodontia is not being considered for inclusion as pediatric EHB dental coverage. Non-medically necessary orthodontia is most often performed for cosmetic reasons and as a result would not be considered basic care for purposes of the pediatric oral health care essential benefit.

Medically necessary orthodontia is normally provided as a covered benefit only in medical plans, Medicaid, and some CHIP programs. In those cases the definition of "medical necessity" is typically defined narrowly.

The pediatric oral health care essential benefit is not a "medical" benefit and therefore must not include orthodontia that is cosmetic in nature nor incidental to or an integral part of treatment that is primarily "medical" care (most often the result of a genetic condition, an accident, injury, or other trauma).

## Outside the Exchange

DDPA member plans continue to have a significant concern with the ability of stand-alone dental plans to effectively provide coverage of the pediatric oral health services as part of the EHB in the individual and small group markets outside the Exchange.

Section 155.1065 (c) of the proposed Exchanges and Qualified Health Plans rule provides that a qualified health plan offered through an Exchange will not fail to be certified by an Exchange as a qualified health plan if a stand-alone dental plan in the Exchange offers the required pediatric dental benefit. (*See also* footnote 27 of the EHB Bulletin at page 10). This constitutes a limited "waiver" of the requirement that qualified health plans must provide all the health benefits listed in Section 1302(b)(1).

However, the ACA is silent with respect to whether this waiver is available to a health plan offering the EHB outside an Exchange because an Exchange does not certify plans in that market.

The existing market already relies upon freely available stand-alone dental plans in all States, and those stand-alone plans are expected to be the usual suppliers of the required pediatric dental benefit for purposes of meeting the EHB package in the individual and small group insurance market outside an Exchange. Accordingly, State regulators should not have to require a health plan to offer the essential pediatric dental benefit in those markets or be faulted for failing to enforce such a requirement.

Also, individuals and families utilizing stand-alone dental plans to satisfy their dental treatment needs should not have to switch plans or purchase duplicative coverage from a health insurance plan due to a drafting error in the ACA.

The legislative history of the Senate-passed provision clearly evidences an intent to authorize stand-alone dental benefit plans to offer the pediatric essential dental benefit outside the Exchange. The narrative explanation of the Senate Finance Committee's amendment states as its purpose: "to allow stand-alone dental plans to offer the required pediatric dental services and to be offered in the individual and small group markets <u>including</u> within the insurance exchanges." [Emphasis added].

HHS should therefore clarify that it is not necessary for State regulators to require health plans to cover the essential pediatric dental benefit portion of the EHB unless the benefit is not available from a stand-alone dental benefit plan.

This would apply the qualified health plan "waiver" consistently for the pediatric dental benefit portion of the EHB in the market outside the Exchange in the same manner that the qualified health plan "waiver" operates inside the Exchange, as intended by the Stabenow Amendment.

## <u>Proposed Pediatric Essential Health Benefits Regulation</u>

We are also submitting as part of these comments on the EHB Bulletin a draft proposed regulation for the agency's consideration in defining the scope of the pediatric essential health benefit and other clarifying rules that should be provided in order to establish some uniformity and consistency across the states with respect to certain aspects of the pediatric dental EHB requirement.

The proposed clarifications include: (1) definition of the minimum essential services (including affordability); (2) definition of pediatric; (3) establishment of benchmark pediatric dental plans; (4) benchmark plans specific to essential pediatric dental services; (5) explicit provision of an evidence-based benchmark; (6) application of the qualified health plan waiver inside and outside an Exchange; (7) allowance for existing family coverage to meet the pediatric dental EHB requirement; (8) exception from the "levels" of coverage applicable to "medical" plans; (9) clarification that families with children must purchase both the QHP medical plan and stand-alone dental plan to meet the EHB requirement; (10) a requirement for the separate offer and pricing of the pediatric dental benefit to facilitate the comparison and choice of the essential pediatric dental plans for consumers; and (11) the explicit use of uniform limits on benefits and services by excepted benefit plans to ensure affordability.

## Draft Regulatory Language

### SUBPART ABC. ESSENTIAL PEDIATRIC ORAL HEALTH SERVICES.

Sec. 000.001. In General. The essential pediatric oral health services required by Section 1302(b)(1)(J) of the ACA shall include typical dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions, provided that the scope of such services are guided by consideration of their affordability to individuals and small group employers.

Sec. 000.002. Definition of Pediatric. For purposes of this regulation, the term "pediatric" means an individual who is an infant, child, or adolescent that is under 19 years of age.

Sec. 000.003. Pediatric Dental Plans. A qualified health plan or a stand-alone dental benefit plan may offer coverage of the essential pediatric oral health services described in subsection 000.001 through a dental benefit package that is substantially equivalent to one of the benchmark dental benefit packages selected by the State from among those packages described in subsection 000.004.

Sec. 000.004. Pediatric Oral Health Services Benchmark Package. The benchmark dental benefit packages referenced in subsection 000.003 are pediatric oral health services covered under: (a) FEHBP; (b) CHIP; (c) any of the largest three commercial dental plans by enrollment that are purchased by small employers; (d) any of the largest three dental plans by enrollment offered to State employee; or (e) coverage under a plan described in 000.005.

Sec. 000.005. Evidence-Based Benchmark Package. The benchmark pediatric benefit package may include a plan that provides coverage of benefits based upon:

(a) appropriate individual risk and age factors (including limits on scope and frequency) determined on the best scientific-evidence; and

(b) an aggregate actuarial value that is equivalent to pediatric dental benefits provided under a plan for CHIP.

Sec. 000.006. Qualified Health Plan Waiver. A health plan shall not fail to be treated as a qualified health plan, nor shall a health plan be deemed not to offer the Essential Health Benefit Package required by section 1302(b)(1) of the ACA, solely because the plan does not cover the essential pediatric oral care services described in subsection 000.001, provided that coverage of such pediatric oral care services are available to prospective enrollees of the plan from at least one stand-alone dental benefits plan.

Sec. 000.007. Relation to Existing Dental Coverage. An eligible individual who purchases qualified health plan coverage without pediatric oral health care services from a qualified health plan may satisfy the requirement in 000.001 by certifying that the individual has an existing family dental policy that includes coverage equal to or exceeding the pediatric oral care services required in section 1302(b)(1)(J) of the ACA.

Sec. 000.008. Exception for Levels of Coverage. A qualified health plan or a stand-alone dental benefit plan that offers coverage of essential pediatric oral health services that meets the requirements of 000.003 *is not* required to provide the levels of coverage for pediatric oral health services described as bronze, silver, gold, and platinum as specified in section 1302(d) of the ACA.

Sec. 000.009. Combined Purchase Required. An eligible individual with children who purchases qualified health plan coverage without pediatric oral care services from a qualified health plan described in 000.006 must also purchase a separate stand-alone dental benefits plan for pediatric oral care services to meet the essential health benefits requirements.

Sec. 000.010. Separate Offer and Pricing Required. Pediatric oral care services under section 1302(b)(1)(J) of the Affordable Care Act must be offered and priced separately from the other categories of essential health benefits required under sections 1302(b)(1)(A) through (I), of the ACA and from any other dental benefits that may be offered.

Sec. 000.011. Scope and Affordability. Nothing shall be construed to prevent a stand-alone dental benefits plan, with respect to similarly situated individuals enrolled in the plan, from establishing: limitations or restrictions on the frequency of benefits for certain covered services; restrictions on the amount of the fee for which benefits are computed; and limitations on the level, extent, or nature of conditions for any covered benefits; and, provided further with respect to excepted benefit limited scope dental benefit plans, lifetime and annual limits on the dollar value of benefits.

DELTA DENTAL®

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May 29, 2012

Department of Health and Human Services

Via Email: ActuarialValue@cms.hhs.gov
CostSharingReductions@cms.hhs.gov

**Re: Comments on the Actuarial Value and Cost-Sharing Reductions Bulletin**

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 February 24, 2012 Actuarial Value and Cost-Sharing Reductions Bulletin. We are pleased to offer some general comments regarding the application of the "actuarial value" calculation to the role of stand-alone dental benefits plans in providing the "pediatric" dental essential health benefit in a federal or state administered health insurance exchange, as well as other comments specific to the bulletin and the unworkability of constructing a range of benefit levels for the pediatric essential dental benefit.

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 benefits programs and services. Our nationwide network of 39 companies and 142,000 dentists, serves more than 59.5 million Americans in over 97,000 group plans across the nation.

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

Sincerely,

Kim E. Volk

Kim E. Volk
President and CEO

Enclosure

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May 29, 2012

**DELTA DENTAL PLANS ASSOCIATION ("DDPA") COMMENTS ON THE ACTUARIAL VALUE AND COST-SHARING REDUCTIONS BULLETIN ISSUED FEBRUARY 24, 2012 BY THE CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT**

The Delta Dental Plans Association ("DDPA") welcomes the opportunity to comment on the February 24, 2012 "Actuarial Value and Cost-Sharing Reductions Bulletin" ("AV Bulletin") issued by the Department of Health and Human Services – Center for Consumer Information and Insurance Oversight. Underlying our comments is the significant difference in both the nature and structure of dental benefits from medical benefits and the corresponding difference in the legal treatment of stand-alone dental benefits and dental benefits plans.

## In General

Dental benefits provided by stand-alone dental benefit plans are treated as "excepted benefits" under federal law and as a result are not regulated in the same manner as comprehensive, major medical coverage. This was established in the 1996 HIPAA amendments to the PHSA, ERISA and the IRC, and the Patient Protection and Accountable Care Act ("ACA") builds upon those provisions and continues the exception for "excepted benefits." This is because stand-alone dental benefit plans do not provide comprehensive coverage for major medical benefits.

As an "excepted benefits" plan, a stand-alone "limited scope" dental benefit plan is not subject to the ACA's requirement imposed on Qualified Health Plans ("QHPs") to offer specified "metal" levels of coverage. A QHP expressly must provide the essential health benefits "package," which includes: (1) the essential health benefits; (2) limits on cost-sharing; and (3) either the bronze, silver, gold, or platinum levels of coverage.

These requirements do not apply to stand-alone dental benefit plans or the singular pediatric dental essential benefit. The "levels" of coverage apply to the "package" that a QHP is required to offer (including child only plans). A waiver is provided for a QHP with respect to the required pediatric essential dental benefit where a stand-alone dental benefit plan offers the pediatric essential dental benefit. There is no requirement that the "levels" of coverage apply to the pediatric essential dental benefit or to each other specific benefit.

## Actuarial Value for Pediatric Dental Benefits

Due to the construct of dental benefits in general and pediatric essential dental benefits specifically, achieving a wide range of actuarial value ("AV") for the pediatric essential oral health services would be difficult at best. For example, a policy covering in full a limited number of specified dental procedures without any consumer cost-share would have an AV of 100 percent. A benefit that mirrors national average employer-based coverage, with 100/80/50

percent coinsurance for diagnostic and preventive, basic and major dental services respectively would have an AV of roughly 86 percent.

To reduce the AV to the silver (70%) or bronze (60%) level would require significant cost-sharing on the consumer, putting the benefit plan out of line with the typical small group dental program, and even render the benefit "illusory" and not constituting true coverage as defined in several states under current regulation. In short, even if states were to try to apply the ACA's actuarial scheme to stand-alone dental in the exchange, the result would be an unworkable approach without any benefit to consumers.

## Differences Between Medical and Pediatric Dental Benefits

**Dental benefits include a higher concentration of preventive services compared to medical plan benefits.** In many dental benefit policies a substantial proportion of the cost comes from preventive services. Compare that to medical plans, in which preventive care costs are dwarfed by other categories of care such as hospital stays and surgeries. Because a large proportion of dental care costs are preventive in nature and typically covered at 100 percent as the ACA now requires for preventive care under medical plans, it is difficult to adjust the cost-sharing of a pediatric essential dental benefit to meet lower AV levels.

**Dental benefits have less prevalent use of deductibles compared to medical plan benefits.** While some employer-based dental policies have small annual deductibles, usually $50 or less, they are less prevalent than on medical benefits and are usually only applied to certain non-preventive types of procedures. Deductibles provide another avenue for medical plans to adjust member cost-sharing and hence the AV of a plan. While deductibles are allowed on EHBPs, a dental deductible separate from medical may not be incorporated into some designs for the pediatric essential oral services benefit. As noted, this is because much of the cost of dental care is preventive in nature and therefore required to be covered in full.

**Dental benefits have lower in-network utilization compared to medical plan benefits.** Most medical plans see high levels of in-network utilization due in part to broad provider networks. The dentist population is sparser and more heterogeneous across geographies and dental provider networks are often smaller than their medical counterparts. In addition, some dental preferred provider organizations ("DPPO") do not differentiate in the percentage reimbursement between in-network and out-of-network providers. As such, adjusting in-network cost-sharing has a smaller impact on a dental policy AV than on a medical policy.

**Pediatric dental benefits should not be based upon actuarial factors for adult medical plan benefits.** The uniform factors proposed for determining the "actuarial value" of the metal levels of the essential health benefits package are based upon "adult" medical claim measures that should not be applied to "pediatric" essential dental benefits.

## Conclusion

We respectfully request that the agency issue specific guidance that the "metal" levels and the AV requirements do not apply to the pediatric essential dental benefit for the reasons outlined above.

We are pleased to offer these comments regarding the application of the "actuarial value" calculation to the role of stand-alone dental benefits plans in providing the "pediatric" dental essential health benefit in a federal or state administered health insurance exchange, and the unworkability of constructing a range of benefit levels for the pediatric essential dental benefit.