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January 31, 2012

Center for Consumer Information and Insurance Oversight
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

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

Enclosure

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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.