DELTA DENTAL

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October 31, 2011

Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention CMS-9989-P
P.O. Box 8010
Mail Stop C4-26-05
7500 Security Boulevard
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

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President and CEO

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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).