

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

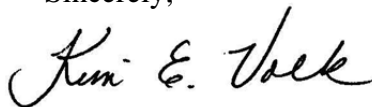
To Whom It May Concern:

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.

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

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 PHS Act, ERISA and the IRC, and the Patient Protection and Affordable 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.