



October 6, 2010

Co-Chair Director Michael McRaith
Co-Chair Commissioner Sandy Praeger
NAIC (B) Committee Exchange Subgroup
NAIC Central Office
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662

Dear Director McRaith and Commissioner Praeger:

NADP greatly appreciates the amount of work and the expediency in which NAIC has been working towards PPACA implementation. NADP's comments are in response to NAIC's recent release of the "American Health Benefit Exchange Model Act" (Exchange Model).

NADP is the largest non-profit trade association focused exclusively on the dental benefits industry, i.e. dental PPOs, dental HMOs, discount dental plans and dental indemnity products. NADP's members provide dental benefits to over 82% of the 176 million Americans with dental benefits. Our members include major commercial carriers, regional and single state companies, as well as companies organized as non-profit plans.

As has been reflected in previous NAIC presentations regarding Exchanges, limited scope dental plans are specifically allowed by PPACA to provide coverage for the required pediatric dental services of the Essential Health Benefits Package. NADP is concerned that as drafted, the Exchange Model, allows only medical carriers to provide the dental portion of the EHPB separately inside the Exchange. The definition of "health carrier" that is incorporated into Section 5(B)(2) may not be inclusive of the limited scope dental plans that have different licensing statutes in various states than those cited in the definition. NADP recommends that either the definition of health carrier be made fully inclusive or a separate definition be added for dental carriers. As well, this single section (5-B-2) does not provide a clear framework for the states in allowing the separate offer of dental coverage in Exchanges.

To provide a clearer framework for the states, we have attached a preliminary mark-up of the Exchange Model indicating areas where language may need to be added. Due to the tight timeframe for comments, some of the areas are marked with a comment rather than with suggested language. Where language is provided it has not had a full legal review and should be regarded as draft. However, we did want to take this opportunity to demonstrate the changes the dental benefits industry sees as necessary in the underlying structure of the model for state Exchanges to fully implement Congressional intent for the separate offer of dental benefits.

National Association of Dental Plans

12700 Park Central Drive • Suite 400 • Dallas, Texas 75251

972.458.6998 • 972.458.2258 [fax]

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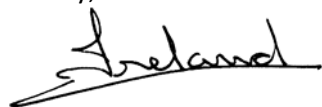
EVELYN F. IRELAND, CAE
National Association
of Dental Plans
Dallas, TX

To provide more in-depth background on Congressional intent, NADP has included the comments our association provided to the Office of Consumer Information and Insurance Oversight (OCIO) of the Department of Health and Human Services (HHS) regarding Exchanges. These comments reflect several additional concerns that NADP has with regard to Exchanges and their impact on American families with dental coverage in the current small group and individual market. These concerns are heightened by the imminent release of our annual survey of dental enrollment which will show a decline for the first time in the last 18 years. That decline, while spurred largely by the economy and employment layoffs, will be exacerbated if dental coverage is not made fully available not only to children but to adults through the Exchanges. And, as cited in our comments to HHS, the Surgeon General's Oral Health Report and other studies clearly show the lack of dental coverage will result in the decline of overall oral health which will negatively impact overall health.

NADP respectfully requests the NAIC to review and incorporate the suggested modifications into the Exchange Model so that dental coverage for millions of Americans will not be interrupted nor their oral health negatively impacted.

We are available to answer any of your questions with regard to the dental benefits industry; please feel free to contact Kris Hathaway, NADP's Director of Government Relations (972.458.6998x111 or email - khathaway@nadp.org) or me for additional information.

Sincerely,



Evelyn Ireland, CAE
National Association of Dental Plans

cc: Jolie Matthews, NAIC Senior Health Policy Advisor and Counsel
Brian Webb, Manager, Health Policy and Legislation

Attachment A: Preliminary Mark-Up of NAIC American Health Benefit Exchange Model Act
Attachment B: NADP Comments to OCCIO on 10-4-10

National Association of Dental Plans

12700 Park Central Drive • Suite 400 • Dallas, Texas 75251

972.458.6998 • 972.458.2258 [fax]



Draft: 9/27/10
A new model

Comments are being requested on this draft on or before Oct. 6, 2010. Comments should be sent only by email to Jolie Matthews at jmatthew@naic.org.

AMERICAN HEALTH BENEFIT EXCHANGE MODEL ACT

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Section 1. Title

This Act shall be known and may be cited as the American Health Benefit Exchange Act.

Section 2. Purpose and Intent

The purpose of this Act is to provide for the establishment of an American Health Benefit Exchange to facilitate the purchase and sale of qualified health plans in the individual market in this State and to provide for the establishment of a Small Business Health Options Program (SHOP Exchange) to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans offered in the small group market.

Drafting Note: States expanding the definition of “qualified employer” to include large employers, as permitted beginning in 2017 under the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (Federal Act), should remove the reference to “small” employers.

Section 3. Definitions

For purposes of this Act:

A. “Commissioner” means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term “commissioner” appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

B. “Dental benefit plan” means a policy, contract, certificate or agreement offered by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of dental care services.

C. “Educated health care consumer” means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical and scientific matters.

~~C.D.~~ “Exchange” means the [insert name of State Exchange] established pursuant to section 4 of this Act.

DE. “Federal Act” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under, those Acts.

EE. “Group health plan” means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, as defined in subsection I, and including items and services paid for as medical care to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

FG. (1) “Health benefit plan” means a policy, contract, certificate or agreement offered by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

NOTE: The Statutory Language Team recognizes that the definition of “health benefit plan” needs to be revisited to ensure its consistency with definitions used in HIPAA and the Affordable Care Act.

- (2) “Health benefit plan” does not include:
- (a) Coverage only for accident, or disability income insurance, or any combination thereof;
 - (b) Coverage issued as a supplement to liability insurance;
 - (c) Liability insurance, including general liability insurance and automobile liability insurance;
 - (d) Workers’ compensation or similar insurance;
 - (e) Automobile medical payment insurance;
 - (f) Credit-only insurance;
 - (g) Coverage for on-site medical clinics; or
 - (h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.
- (3) “Health benefit plan” does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:
- (a) Limited scope dental or vision benefits;
 - (b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
 - (c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.
- (4) “Health benefit plan” does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
- (a) Coverage only for a specified disease or illness; or
 - (b) Hospital indemnity or other fixed indemnity insurance.

- (5) “Health benefit plan” does not include the following if offered as a separate policy, certificate or contract of insurance:
- (a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;
 - (b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
 - (c) Similar supplemental coverage provided to coverage under a group health plan.

GH. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

Comment [EF11]: Legally, this definition of “health carrier” may not include all forms of carriers that provide a dental plan, particularly one licensed as a single service HMO, a non-profit dental service plan, etc.

HI. “Individual market” means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

IJ. “Medical care” means amounts paid for:

- (1) The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;
- (2) Transportation primarily for and essential to medical care referred to in paragraph (1); and
- (3) Insurance covering medical care referred to in paragraphs (1) and (2).

JK. “Qualified employer” means a small employer that elects to make its full-time employees and, at the option of the employer, some or all of its part-time employees eligible for one or more qualified health plans (or one or more qualified dental plans and one or more qualified health plans without pediatric oral health services) offered in the small group market through the Exchange provided that the employer:

- (1) Has its principal place of business in this State and elects to provide coverage through the Exchange to all of its eligible employees, wherever employed; or
- (2) Elects to provide coverage through the Exchange to all of its eligible employees who are principally employed in this State.

Comment [EF12]: NADP is concerned that if small employers are required to interact with multiple exchanges to provide coverage, they may opt not to offer coverage and push employees into individual coverage. As group coverage and enrollment is more cost effective, this may negatively impact employees who purchase on an individual basis. (See OCIO comments)

Drafting Note: Beginning in 2017, the Federal Act permits States to expand eligibility for Exchange participation beyond small employers. States that do so should amend subsection J accordingly.

KL. “Qualified dental plan” means a dental benefit plan that has in effect a certification that the plan meets the criteria established by the Exchange to provide separate dental coverage under section 7D of this Act.

M. “Qualified health plan” means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and section 7 of this Act.

L. (1) “Qualified individual” means an individual who:

- (a) Is seeking to enroll in a qualified health plan or a qualified dental plan and a qualified health plan without pediatric oral health services in the individual market offered through the Exchange; and
- (b) Resides in this State.

(2) “Qualified individual” does not include an individual:

- (a) If, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges; or
- (b) If, the individual is not, or is not reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

M. “Secretary” means the Secretary of the federal Department of Health and Human Services.

N. “SHOP Exchange” means the Small Business Health Options Program established under section 6 of this Act.

O. (1) “Small employer” means an employer that employed an average of not more than 50-100 employees during the preceding calendar year.

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Drafting Note: The Federal Act permits States to define “small employers” as employers with one to 50 employees for plan years beginning before Jan. 1, 2016.

(2) For purposes of this subsection:

- (a) All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as a single employer;
- (b) An employer and any predecessor employer shall be treated as a single employer;
- (c) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that is reasonably expected that employer will employ on business days in the current calendar year; and
- (d) An employer that makes enrollment in qualified health plans offered in the small group market available to its employees through the Exchange, and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of this Act as long as it continuously makes enrollment in qualified health plans available to its employees.

P. “Small group market” means the health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health plan maintained by a small employer.

Section 4. Establishment of Exchange

A. The [insert official title of the Exchange] is hereby established as a [insert description and governance provisions here, either establishing the Exchange as a governmental agency or establishing the Exchange as a nonprofit entity].

Drafting Note: States have different options to consider when establishing the Exchange. This Act does not include any specific option for governance. Section 1311(d) of the Federal Act, requires that any Exchange established must be a governmental agency or nonprofit entity. As such, the Exchange could be located at a new or existing State agency. Some possible advantages to having the Exchange within a State agency include having a direct link to the State administration and a more direct ability to coordinate with other key State agencies, such as the State Medicaid agency and the State insurance department. Some possible disadvantages include the risk of the Exchange’s decision-making and operations being politicized and the possible difficulty for the Exchange to be nimble in hiring and contracting practices, given most States’ personnel and procurement rules. The Exchange could also be located at an independent public agency, or a quasi-governmental agency, with an appointed board or commission responsible for decision-making and day-to-day operations. Some possible advantages to establishing the Exchange as an independent public agency, or a quasi-governmental agency, include possible exemption from State personnel and procurement laws and more independence from existing State agencies, which could result in less of a possibility of the Exchange being politicized. The Exchange’s enabling legislation would

specify how the Board members would be appointed, including its size, composition and terms. The Board would also select the Exchange's Executive Director. Some possible disadvantages include the possible difficulty for the Exchange to coordinate health care purchasing strategies and initiatives with key State agencies, such as the State Medicaid agency and the State insurance department and their employees because the Exchange would not be located at a State agency (unless those decisions are subject to the approval of a State official, such as the State insurance commissioner or the Governor). The Exchange also could be established by creating a non-profit entity. This means that most likely it would not be directly accountable to State government or subject to State government oversight nor would it most likely be subject to State personnel and procurement laws. Some possible advantages of establishing the Exchange as a non-profit include flexibility in decision making and less of a chance for those decisions being politicized and some possible disadvantages include isolation from State policymakers and key State agency staff and the potential for decreased public accountability. In addition, States can establish an Exchange using a combination of the options described above. The NAIC, through the Exchanges (B) Subgroup, intends to review the options for governance above and others related to establishing Exchanges and develop an issues paper on the topic to assist States in this area.

Drafting Note: States should be aware that section 1311(f) of the Federal Act permits States, with the approval of the Secretary of the federal Department of Health and Human Services, to establish regional or interstate Exchanges. This Act does not specify how to establish these Exchanges or how they would operate. The NAIC, through the Exchanges (B) Subgroup, intends to review those issues and others related to establishing regional or interstate exchanges and develop an issues paper on the topic to assist those states that wish to establish such exchanges. States participating in interstate Exchanges or establishing regional Exchanges should modify the relevant portions of this Act accordingly.

Drafting Note: Depending on how a State establishes its Exchange, a State may need to consider whether the Exchange should be exempt from the State's insurance producer or consultant licensing requirements or whether the Exchange needs to obtain such a license.

B. The Exchange shall:

- (1) Facilitate the purchase and sale of qualified health plans;
- (2) Provide for the establishment of a SHOP Exchange that is designed to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans offered in the small group market in this State;
- ~~(3)~~ Facilitate the sale and purchase of separate dental coverage from qualified dental plans; and
- ~~(3)(4)~~ Meet the requirements of this Act and any regulations implemented under this Act.

C. The Exchange may contract with an eligible entity for any of its functions described in this Act. An eligible entity includes, but is not limited to, the [insert name of State Medicaid agency] or an entity that has experience in the individual and small group markets, but a health carrier is not an eligible entity.

Drafting Note: States should be aware that when establishing the Exchange they will have to include additional sections in this Act that set out the appointment process, powers, duties and other responsibilities of any board, committee or other entity that will have day-to-day responsibility for carrying out the duties and responsibilities of the Exchange, as provided in this Act.

D. The Exchange may enter into information-sharing agreements with federal and State agencies and other State Exchanges to carry out its responsibilities under this Act provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all State and federal laws and regulations.

Section 5. General Requirements

A. The Exchange shall make qualified health plans and qualified dental plans available to qualified individuals and qualified employers beginning on or before January 1, 2014.

B. (1) The Exchange shall not make available any health benefit plan that is not a qualified health plan except as provided in (2) below.

Comment [EF13]: If all an Exchange can facilitate purchase of is a "qualified health plan" then a separate dental plan for child-only coverage or additional adult/family coverage cannot be offered. Thus a new subsection facilitate the sale & purchase of a separate policy of dental coverage for children and/or adults.

Comment [EF14]: See comment above

- (2) The Exchange State shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the Exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Federal Act.

- C. The Exchange may make a qualified health plan available notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 1302(b) of the Federal Act.

Drafting Note: The Federal Act allows States to require additional benefits, but only if the State defrays the additional costs of premium and cost-sharing assistance to enrollees. States electing this option should modify subsection C accordingly, specifying the additional benefits required and the mechanism for payment to or on behalf of the enrollees.

Section 6. Duties of Exchange

Drafting Note: The provisions in this section are the minimum requirements of the Federal Act. States are encouraged to consider assigning additional duties, consistent with the Federal Act, to the extent appropriate to the State's market conditions and policy goals. Optional clauses are provided at the end of this section to facilitate uniformity among those States that elect to use their Exchanges to address certain widely shared concerns.

The Exchange shall:

- A. Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the Secretary under section 1311(c) of the Federal Act and section 7 of this Act, of health benefit plans as qualified health plans and qualified dental plans;
- B. Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;
- C. Provide for enrollment periods, as determined by the Secretary under section 1311(c)(6) of the Federal Act;
- D. Maintain an Internet website through which enrollees and prospective enrollees of qualified health plans and qualified dental plans may obtain standardized comparative information on such plans;
- E. Assign a rating to each qualified health plan and qualified dental plan offered through the Exchange in accordance with the criteria developed by the Secretary under section 1311(c)(3) of the Federal Act;
- F. Utilize a standardized format for presenting health and dental benefit options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the PHSA;
- G. In accordance with section 1413 of the Federal Act, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that any individual is eligible for any such program, enroll that individual in that program;
- H. Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the Federal Act;
- I. Establish a SHOP Exchange through which individuals employed by qualified employers may enroll in any qualified health plan or qualified dental plan and a qualified health plans without pediatric oral health services offered through the SHOP Exchange through the carriers specified and at the level of coverage specified by the employer;

Drafting Note: States may elect to operate a unified Exchange by merging the SHOP Exchange and the Exchange for the individual market, but only if the Exchange has adequate resources to assist these individuals and employers.

Comment [EF15]: Health carrier as defined is not a term that is all inclusive so that dental carriers not otherwise licensed as health plans could offer the coverage in which they specialize.

This section alone is not sufficient to implement the Stabenow-Lincoln Amendment.

Comment [EF16]: NADP recommends that that employer continue to specify the carriers and coverage options available to employees. Otherwise the employer group is not group but individual coverage with attendant increases in administrative costs.

- J. Subject to section 1411 of the Federal Act, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because:
- (1) There is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or
 - (2) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;
- K. Transfer to the federal Secretary of the Treasury the following:
- (1) A list of the individuals who are issued a certification under subsection I, including the name and taxpayer identification number of each individual;
 - (2) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because:
 - (a) The employer did not provide minimum essential health benefits coverage; or
 - (b) The employer provided the minimum essential health benefits coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and
 - (3) The name and taxpayer identification number of:
 - (a) Each individual who notifies the Exchange under section 1411(b)(4) of the Federal Act that he or she has changed employers; and
 - (b) Each individual who ceases coverage under a qualified health plan or qualified dental plan and a qualified health plans without pediatric oral health services during a plan year and the effective date of that cessation;
- L. Provide to each employer the name of each employee of the employer described in subsection K(3)(b) who ceases coverage under a qualified health plan or qualified dental plan and a qualified health plans without pediatric oral health services during a plan year and the effective date of the cessation;
- M. Perform duties required of, or delegated to, the Exchange by the Secretary or the Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing or individual responsibility requirement exemptions;
- N. Select entities qualified to serve as Navigators in accordance with section 1311(i) of the Federal Act and award grants to enable Navigators to:
- (1) Conduct public education activities to raise awareness of the availability of qualified health plans or qualified dental plan and a qualified health plans without pediatric oral health services;
 - (2) Distribute fair and impartial information concerning enrollment in qualified health plans or qualified dental plan and a qualified health plans without pediatric oral health services, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Federal Act;
 - (3) Facilitate enrollment in qualified health plans or qualified dental plan and a qualified health plan s without pediatric oral health services;
 - (4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the PHSA, or any other appropriate State

agency or agencies, for any enrollee with a grievance, complaint or question regarding their health benefit plan or dental benefit plan, coverage or a determination under that plan or coverage; and

- (5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange;
- O. Review the rate of premium growth within the Exchange and outside the Exchange, and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers; and
- P. Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the Federal Act, and collect the amount credited from the offering employer; and
- Q. Consult with stakeholders relevant to carrying out the activities required under this Act, including:
 - (1) Educated health care consumers who are enrollees in qualified health plans or qualified dental plan and a qualified health plans without pediatric oral health services;
 - (2) Individuals and entities with experience in facilitating enrollment in qualified health plans or qualified dental plan and a qualified health plans without pediatric oral health services;
 - (3) Representatives of small businesses and self-employed individuals;
 - (4) The [insert name of State Medicaid office]; and
 - (5) Advocates for enrolling hard to reach populations.

[R. et seq.: Optional clauses specifying additional duties of the Exchange. The Exchanges (B) Subgroup Statutory Language Team preparing this initial exposure draft recommends that these clauses be developed with input from regulators and interested parties, and welcomes your suggested language.]

Drafting Note: States should be aware of the interplay between the duties established for the Exchange under this Act and ERISA's fiduciary duties.

Section 7. Health Benefit Plan Certification

- A. The Exchange may certify a health benefit plan as a qualified health plan if:
 - (1) The plan provides the essential health benefits package described in section 1302(a) of the Federal Act;
 - (2) The plan provides at least a bronze level of coverage, unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;
 - (3) The health carrier offering the plan:
 - (a) Is licensed and in good standing to offer health insurance coverage in this State;
 - (b) Offers at least one qualified health plan in the silver level and at least one plan in the gold level in the Exchange;
 - (c) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the Exchange and without regard to whether the plan is offered directly from the carrier or through an insurance producer; and
 - (d) Complies with the regulations developed by the Secretary under section 1311(d) of the Federal Act and such other requirements as the Exchange may establish.

Comment [EF17]: A provision should be added that says a health benefit plan shall not fail to qualify if it does not provide the pediatric oral health services as reflected in PPACA. However, when such a plan is purchased by a consumer with children, the consumer must also purchase, at minimum a separate dental policy providing the required pediatric dental benefit.

- (4) The plan meets the requirements of certification as promulgated by regulation by the Secretary under section 1311(c)(1) of the Federal Act and by the Exchange pursuant to section 9 of this Act; and
- (5) The Exchange determines that making the plan available through the Exchange is in the interest of qualified individuals and qualified employers in this State.

Drafting Note: States should consider whether the Exchange should delegate this function to the commissioner.

- B. The Exchange shall not exclude a health benefit plan:
 - (1) On the basis that the plan is a fee-for-service plan;
 - (2) Through the imposition of premium price controls; or
 - (3) On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.
- C. The Exchange shall require each health carrier seeking certification of a plan as a qualified health plan to:
 - (1) Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its Internet website. The Exchange shall take this information, along with the information and the recommendations provided to the Exchange by the commissioner under section 2794(b) of the PHSA, into consideration when determining whether to allow the carrier to make plans available through the Exchange;

Drafting Note: States with additional rate filing requirements should review the language in paragraph (1) above to ensure that it does not conflict with other applicable State law.

- (2) (a) Make available to the public, in the format described in subparagraph (b) of this paragraph, and submit to the Exchange, the Secretary, and the commissioner, accurate and timely disclosure of the following:
 - (i) Claims payment policies and practices;
 - (ii) Periodic financial disclosures;
 - (iii) Data on enrollment;
 - (iv) Data on disenrollment;
 - (v) Data on the number of claims that are denied;
 - (vi) Data on rating practices;
 - (vii) Information on cost-sharing and payments with respect to any out-of-network coverage;
 - (viii) Information on enrollee and participant rights under title I of the Federal Act; and
 - (ix) Other information as determined appropriate by the Secretary; and
- (b) The information required in subparagraph (a) of this paragraph shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act; and
- (3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or

coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet website and through other means for individuals without access to the Internet.

D. The Exchange may certify a dental benefit plan as a qualified dental plan if:

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- (1) The plan provides the pediatric oral health services essential health benefits package described in section 1302(b)(1)(J) of the Federal Act;
- (2) The plan provides at least a bronze level of coverage and such other levels of coverage as may be specified by the state;
- (3) The health carrier offering the dental plan:
 - (a) Is licensed and in good standing to offer dental insurance coverage in this State;
 - (b) Charges the same premium rate for each qualified dental plan without regard to whether the plan is offered through the Exchange and without regard to whether the plan is offered directly from the carrier or through an insurance producer;
 - (d) Complies with such other requirements as the Exchange may establish specifically for the limited scope pediatric dental benefit within the terms of the Federal Act, and
- (4) The Exchange determines that making the plan available through the Exchange is in the interest of qualified individuals and qualified employers in this State.

Section 8. Funding; Publication of Costs

- A. The Exchange may charge assessments or user fees to health carriers or otherwise may generate funding necessary to support its operations provided under this Act.
- B. The Exchange shall publish the average costs of licensing, regulatory fees and any other payments required by the Exchange, and the administrative costs of the Exchange, on an Internet website to educate consumers on such costs. This information shall include information on monies lost to waste, fraud and abuse.

Section 9. Regulations

The Exchange may promulgate regulations to implement the provisions of this Act. Regulations promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary under title I, subtitle D of the Federal Act.

Drafting Note: States that do not establish the Exchange in a governmental agency with rulemaking authority should substitute the agency responsible for the administration or oversight of the Exchange. As appropriate, the commissioner should be granted rulemaking authority to promulgate regulations to implement the provisions of this Act within the scope of the commissioner's authority, as provided under State law or regulations.

Section 10. Effective Date

This Act shall be effective [insert date].

W:\Health Care Reform\Exchanges\Health Benefit Exchanges.doc



October 4, 2010

Mr. Jay Angoff, Director
Office of Consumer Information and Insurance Oversight (OCIO)
U.S. Department of Health and Human Services (HHS)
P.O. Box 8010
Baltimore, MD 21244-8010

Attention: File Code: OCIO-9989-NC (FR Vol. 75, No.148)

Dear Director Angoff:

The National Association of Dental Plans (NADP) is responding to questions posted by OCIO in the August 3, 2010 proposed rules of the Federal Register, "Request for comments regarding the Exchange related provisions of the Patient Protection and Affordable Care Act (PPACA)" OCIO-9989-NC.

NADP is the largest non-profit trade association focused exclusively on the dental benefits industry, i.e. dental PPOs, dental HMOs, discount dental plans and dental indemnity products. NADP's members provide dental benefits to over 82% of the 176 million Americans with dental benefits. Our members include major commercial carriers, regional and single state companies, as well as companies organized as non-profit plans.

NADP's comments focus on the Exchange, providing information as requested by the federal register, however as **97% of dental policies are sold separately from medical policies**, our comments will intertwine with other features of PPACA directly impacting dental plans.

It is important to note the structure of Exchanges will have a significant impact on millions of Americans currently enrolled in a wide variety of dental plans that cover children as part of family plans. Small group and individual consumers comprise 39% of the 176 million Americans with dental benefits, which includes an estimated 1.65 million small employers, 43.7 million employees and 22.9 million children whose coverage could be disrupted. In addition, over 44% of American households currently enrolled in dental plans have an annual household income of \$50,000 or less, which means if they qualify under PPACA to receive a subsidy, they are more likely to move into the Exchanges to obtain coverage. Thus, how Exchanges are implemented will directly affect the market for dental benefits—both the carriers that provide benefits and the employers and consumers who purchase them. This impact will be magnified if states elect to open their Exchange(s) to the large group market in 2017 as allowed by PPACA.

National Association of Dental Plans

12700 Park Central Drive • Suite 400 • Dallas, Texas 75251

972.458.6998 • 972.458.2258 [fax]

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National Association
of Dental Plans
Dallas, TX

BACKGROUND FOR NADP COMMENTS

PPACA requires all Americans (with some exceptions) to have health coverage, generally termed as minimum essential coverage (MEC) or qualifying health coverage, and does not prescribe specific benefits. But for the small group and individual market, PPACA goes further to require that all policies sold in these markets include, at minimum, ten specific categories of benefits to be defined by HHS as the “Essential Health Benefits Package (EHBP).” One of the ten mandated benefits in the EHBP for the small group/individual market is “Pediatric services (including oral and vision care.)” This inclusion, while beneficial for the oral health of children, separates the traditional purchase of adult dental benefits from children’s benefits.

PPACA also establishes state Exchanges, in which only qualified health plans whose offerings include the EHBP can provide coverage in the Exchange with one notable exception. Inside Exchanges the pediatric dental benefit can be provided through separate limited scope dental policies. This exception is not specifically carried over to the private marketplace outside of the Exchanges for small groups and individuals, despite specific Congressional intent to do so. Outside the Exchange, medical plans (qualified health plans) must include children’s dental coverage within their policies to meet the EHBP (See Sec. 2707(a)). Therefore a separate dental policy sold in the private small group/individual market covering a family would be duplicative of the pediatric oral services in EHBP required to be sold through medical carriers.

NADP’s recommendations for OCIO’s consideration in developing the federal framework for Exchanges are followed by specific answers to questions posted in the federal register. In addition NADP has attached additional documentation to highlight Congressional intent regarding dental plans within PPACA.

NADP’S RECOMMENDATIONS

1: Allow the offer of both family and adult dental coverage within Exchanges in addition to the required pediatric dental benefits of EHBP

As PPACA allows for stand-alone dental policies to provide dental coverage within the Exchange if they provide pediatric coverage to meet the EHBP, HHS should also confirm stand-alone dental policies may also include or separately offer adult and family dental wrap around coverage inside the Exchanges. Family dental wrap around coverage would include benefits that go beyond the required pediatric dental services to allow the family to receive a traditional family dental coverage. Currently, child-only dental policies are rare in the commercial market; dental coverage is offered as an individual or family policy. NADP survey data on cost sensitivity in the purchase of dental benefits suggests that parents may drop private family dental coverage when required to purchase child-only dental coverage (either through the medical plan or a separate dental plan) in the Exchanges as required by the EHBP. Without express authority to offer add-on or wrap around dental coverage, parents and single adults will not have the option to purchase adult coverage in the Exchange.

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If the Exchanges do not allow family coverage, with the child's portion meeting the required EHBP, or if they do not allow separate adult coverage, parents and adults would only be able to continue their dental coverage by conducting another transaction outside the Exchanges in the private market. This makes the purchase of family dental coverage more cumbersome and less likely. If adult dental coverage is reduced there will be an attendant reduction in adult oral health. The 2000 Surgeon General's Report and dentally related surveys clearly show that Americans without dental benefits are less likely to visit their dentist, and as a result have poorer oral health. Since oral health impacts overall health, especially for individuals with high risk medical conditions, any reduction in oral health will negatively impact medical cost reduction efforts. Even if adults maintain separate dental coverage, the family connection to their dentist could become fractured between different policies with different networks of dental providers.

2: Ensure equitable application of cost-sharing provisions to EHBP within Exchanges,

PPACA requires states to subsidize coverage only through their Exchanges. As dental is allowed as a separate policy inside the Exchange (purchased in conjunction with a medical plan to meet the EHBP), consumers should be treated fairly by the equitable and proportional distribution of distinct tax credits, subsidies and any additional cost-sharing provisions between the dental and medical policies they purchase.

3: Consumer-friendly dental choices

An Exchange should provide consumer-friendly Web interfaces to facilitate clear choices based on benefit design and costs among:

- a) a separate medical and dental policy from different carriers with independent pricing;
- b) a separate medical and dental policy from the same carrier with independent pricing; or
- c) an integrated medical and dental plan purchased from a multi-line (or full service) carrier that sells these products within a single policy with one price.

These choices reflect the variety of offerings that consumers and employers have in the market today, as "a" and "b" together comprise 97% of the dental market today. The Federal Employee Health Benefit Plan (FEHBP) and the Federal Employee Dental and Vision Plan (FEDVIP) are reflective of the private market. Some medical plans have integrated basic dental benefits, but more robust dental benefits are provided as a separate option under FEDVIP.

#4: Continue purchasing power of small business employers in the Exchanges

The practice of selecting health benefits available to employees by their small business employers should be maintained and encouraged in the Exchanges. PPACA specifically included the Small Business Health Options Program (SHOP) within the Exchange, as well as particular tax credits to promote the role of small business employers. To promote simplicity for employees and efficiency in the sale of coverage, the SHOP should follow today's small group market practice in which the employer elects the specific medical and dental carriers and policies that will be available to their employees. The enrollment of the employee with any dependents would then be based upon the selections made by their employer.

Further, all employees and their dependents, regardless of state of residence, would purchase through the Exchange based on the employer's domiciliary state, or state of principal place of business. Such

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purchases would thus be subject to the requirements of the state of domicile of the small employer. This protocol aligns to the way a small employer and their employees purchase benefits today and is the straightforward process for employees of a small business to purchase benefits. Small employer interaction with multiple carriers and multiple state exchanges to serve employees living in multiple states would be administratively burdensome as well as costly and confusing to the employer and their employees. From the carrier perspective, if small group employees were allowed to select any plans offered within an Exchange, the employees of all small businesses in the Exchanges would become individual purchasers. Administrative costs and thus premiums would increase with the loss of group purchasing economies of scale. In addition, small employers may elect not to offer health benefits if faced with administrative complexities of multiple state exchanges.

5: Allow separate dental coverage outside Exchanges to meet EHBP

Prior to the passage of PPACA, the Senate Finance Committee unanimously passed the Stabenow-Lincoln (S-L) amendment (attached). The S-L amendment recognized 97% of dental policies are sold separately from medical, and specifically allows separate dental policies (purchased with a qualified health plan that covers all other EHBP benefits) to meet the pediatric dental requirement of the EHBP inside and outside of Exchanges. However, the statutory language of PPACA only partially implemented the S-L amendment by allowing separate dental policies inside the Exchange to meet the EHBP. PPACA does not explicitly allow the combination outside in the private small business/individual market. In fact, Section 2707 specifically requires health insurance issuers to assure that coverage sold in the small group/individual market coverage includes the EHBP required under section 1302(a) by PPACA. While the S-L amendment has significant Congressional support (see attached letters), effecting the legislative intent of the amendment could be accomplished more quickly through regulation as suggested by Senators Stabenow and Lincoln in their letter of September 21, 2010 (attached). OCIO should provide in future regulations that separate pediatric dental coverage outside the Exchange can meet the EHBP as is specifically provided inside the Exchanges.

NADP'S RESPONSE TO QUESTIONS POSED IN THE FEDERAL REGISTER

OCIO Question: *C. State Exchange Operations - 5. What are the considerations for States as they develop web portals for the Exchanges?*

6 NADP Answer: NADP recommends reviewing the federal FEDVIP portal [<http://opm.gov/insure/dental/index.asp>], which has been used to enroll federal employees since 2007, and now includes approximately 2 million federal employees and their annuitants who have voluntarily purchased a dental and/or vision program. This portal was developed by a third party vendor with experience in benefit offerings through portals. Like FEDVIP, an Exchange web portal should:

- serve as a resource for enrollees;
- provide an objective comparison of plans to be offered;
- provide benefit information in formats which are easily understood;
- be capable of handling large volumes of transactions and provides timely/daily transactional data to the Qualified Health Plans (QHPs) and dental carriers;
- clarify a distinction that the pediatric dental services can be purchased by a non QHP;
- allow enrollment and maintenance of enrollment information through the portal; and
- Serve as the database of record for all enrollment information while carriers bill and collect premium from employers and individuals.

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OCIIO Question: *D. Qualified Health Plans (QHPs) – 1. What are some of the major considerations involved in certifying QHPs under the Exchanges...?*

7 NADP Answer: While dental plans cannot become QHPs as they do not offer medical coverage (among many reasons), PPACA Sec. 1311 (d)(ii) specifically allows for limited scope dental benefits (under IRS Code Sec. 9832(c)(2)(A) to offer a dental policy through the Exchanges. This can be done either separately or in connection with a QHP if the plan provides pediatric dental benefits meeting the requirements of PPACA. Some certification of these dental plans should be included in a scope that is appropriate to the limited benefit provided. The certification process should include at the minimum for a carrier to:

- have a valid operating license from the state where the exchange is housed;
- maintain adequate reserves consistent with the state's financial requirements; and
- be operating without any restrictions by the state's regulatory authority.

OCIIO Question: *D. Qualified Health Plans (QHPs) – 2. What factors should be considered in developing the Section 1311(c) certification criteria? To what extent do States currently have similar requirements or standards for plans in the individual and group markets?*

8 NADP Answer: NADP recommends dental certification at the state level, although NAIC guidelines may be useful if they allow enough flexibility among the states. States now have specific licensing statutes and standards that are applied to dental plans that should be relied upon for dental certification criteria. These standards, which differ by state and vary by type of dental product, are more appropriate than a single national standard for the limited pediatric dental benefit that is required in the Exchanges. A single national standard would create confusion in the market and potentially conflict with state standards. For dental any new standards should not be based on medical coverage but developed for and based on the limited scope of dental coverage.

The majority of dental plans remain small to medium sized companies that operate on a single state or regional basis, although some dental plans have grown into large companies or merged and affiliated with medical plans. Exchanges need to take this into consideration when deciding who may enter the market and the certification they must earn. Annual dental premiums are usually about the cost of a single month's medical premium and on average increase at the same rate as the overall inflation or below. Thus, costs for participating in Exchanges and the policies allowed to be offered into the Exchanges must be moderated proportionately to the size of carrier and scope of benefit provided.

NADP has the expertise and breadth of access to the dental market to provide feedback to both the NAIC and HHS in considering the formulation of standards that are specific to dental plans, if regulatory oversight of non QHPs is included in the model of Exchanges.

OCCIO Question: *D. Qualified Health Plans (QHPs) – 2a. What issues need to be considered in establishing appropriate standards for ensuring a sufficient choice of providers and providing information on the availability of providers?*

9 NADP Answer: Similar to #8, standards to ensure a sufficient choice of dental providers would need to be considered in light of the pediatric benefit that is required, and the geography of the states. Today states have processes in place to assure consumer access to care. State requirements for dental vary from those of medical due to the differences in the delivery of medical and dental care. Unlike medical care, 80% of dental care is provided by general dentists, rather than specialists, and both practice primarily in solo offices. Dentists are trained to perform all aspects of dentistry, and general dentists are likely to be capable of providing pediatric dentistry required by the EHBP.

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States have learned through working with their licensed dental plans and through their own public programs, that there is a maldistribution of general dentists in certain states and regions, such as the Northwest and rural areas. As well, there are more limited numbers of specialists like pediatric dentists. Currently there is only 1 pediatric dentist for every 27 general dentists (approximately 4800 pediatric dentists nationwide). Most states currently allow a dental plan to file provider network access and availability standards for state review and approval. The few states that have actual standards are typically limited to dental HMOs. NADP recommends that this process be maintained to provide state flexibility in addressing access to dental providers which is unique in each state.

OCCIO Question: *D. Qualified Health Plans (QHPs) – 5. What factors are important in establishing minimum requirements for the actuarial value/level of coverage?*

10 NADP Answer: Dental plans are unique in how they are included in PPACA, and states may need some flexibility in how the mandated “Pediatric services (including oral and vision care)” of the Essential Health Benefits Package is provided inside and outside the Exchange. Currently there are few child-only dental policies for comparison in the private market. Based on common employer-provided dental coverage, NADP has consulted dental actuaries and determined that various tiers of actuarial value could be achieved. However as the required pediatric dental benefit is, as yet, undefined, it is impossible to conclusively determine if all four tiers of actuarial value can be practically achieved.

OCCIO Question: *D. Qualified Health Plans (QHPs) – 6. ...To what extent should the Exchanges accept all plans that meet minimum standards or select and negotiate with plans?*

11 NADP Answer: Exchanges should accept all dental plans that qualify, so consumers have a similar selection of dental plans in the Exchanges to those which are available in the private market. Allowing small businesses and consumers an array of dental choices, broadens the number of plans for better consumer choice, increases competition, continues an open marketplace and keeps premiums low and affordable. These carriers should be admitted for a specified number of years with annual recertification or renewal.

OCCIO Question: *E. Quality – 1c. How much flexibility is desirable with respect to establishing State-specific thresholds or quality requirements above the minimum Federal thresholds or quality requirements?*

12 NADP Answer: Quality measurement is not as well developed in dental as it is in medical due in part to the lack of nationally recognized diagnostic codes. However, in the past two years a national Dental Quality Alliance has been in development at the request of CMS. The DQA organizational meeting is scheduled in October 2010. This effort was initiated under the auspices of the ADA but is intended to become an independent effort in the near future. NADP serves as the payer representative on the Executive Committee of the DQA. The work of DQA should be considered in creation of any standards. Quality requirements for dental should consider the pediatric benefit involved as well as lack of diagnostic codes in the dental industry. Standards should limit variation by geography, be evidence based and vetted through dental, not medical, professionals to maximize effectiveness and efficiency.

OCCIO Question: *G. Enrollment and Eligibility – 7. What considerations should be taken into account in establishing procedures for payment of the cost-sharing reductions to health plans?*

13 NADP Answer: As stated in # 2: PPACA requires states to subsidize coverage only through their Exchanges. As dental is allowed as a separate policy inside the Exchange (purchased in conjunction with a medical plan to meet the EHBP), consumers should be treated fairly by the equitable and proportional distribution of distinct tax credits, subsidies, cost sharing and any additional cost-sharing provisions between the dental and medical policies they purchase.

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OCCIO Question: *K. Employer Participation – What factors are important for consideration in determining the employer size limit (e.g., 50 versus 100) for participation in a given State’s Exchange?*

14 NADP Answer: States may wish to align the employer size initially with the employer size in their own Small Employer Group laws whether 50, or 100. This will mitigate confusion or disruption in their state marketplace as well as allow a phased in approach in some states to identify and correct any issues prior to expansion in 2016 to 100 and beyond after 2017.

The following employer groups by size offer dental plans to their employees; to encourage enrollment in state Exchanges, they should allow family and adult dental policies as those are benefits employers feel are important to offer their employees.

- 41% of employers sized 6-24 employees offer a dental plan
- 57% of employers sized 25-49 employees offer a dental plan
- 70% of employers sized 50-99 employees offer a dental plan
- 95% of employers sized 100+ employees offer a dental plan

OCCIO Question: *M. Comments Regarding Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act – 3. Are there unique benefits and costs affecting consumers? How will these consumer benefits be affected by States’ Exchange design?*

15 NADP Answer: NADP survey data suggests that adults with current dental family coverage may not go outside the Exchange to purchase their own dental coverage once they have their child/ren covered with a policy inside the Exchange. Thus, state Exchanges should allow for family wrap around and adult dental benefits to be sold as optional coverage in the Exchanges (in addition to the pediatric required coverage) to facilitate continuation of adult coverage in place today in the small group market. Even if adults do purchase separate dental coverage from their child/ren’s required dental policy inside the Exchanges, there is potential for disruption of the family’s relationship with their dentist due to the potential of different carriers and therefore different networks. Allowing for a variety of family dental policies to be offered inside as well as outside Exchanges will give families the choices they need to maintain their dental health.

The portal should facilitate family benefit decisions. Therefore, for the pediatric benefit, it will be important to show the plan design and pricing options, and provide a calculator, as required by PPACA, for understanding subsidies. This transparency in benefits and pricing should be available for family wrap around coverage purchased through the exchanges.

NADP applauds the importance placed on oral health as part of health care reform. NADP values oral health and the role of the dental benefits industry in improving access to affordable, quality dental care. We look forward to working with federal and state regulators in developing solutions for the dentally uninsured, which is one of the main goals of the Exchanges.

(cont.)

National Association of Dental Plans

12700 Park Central Drive • Suite 400 • Dallas, Texas 75251

972.458.6998 • 972.458.2258 [fax]



NADP greatly appreciates the opportunity to share our views and research on the dental benefits industry. As the representative and nationally recognized resource on dental benefits, we are available to answer any of your questions with regard to the dental benefits industry. Please feel free to contact Kris Hathaway, NADP's Director of Government Relations (972.458.6998x111 or email - khathaway@nadp.org) or me for additional information.

Sincerely,



Evelyn Ireland, CAE
Executive Director

Attachment A: 09.21.10 Letter from Senator Stabenow and Senator Lincoln to Secretary Sebelius
Attachment B: 12.24.09 Letter from 21 Senators to Senate Majority Leader Reid
Attachment C: 09.24.09 Stabenow-Lincoln amendment as passed by Senate Finance Committee

National Association of Dental Plans

12700 Park Central Drive • Suite 400 • Dallas, Texas 75251

972.458.6998 • 972.458.2258 [fax]



United States Senate

WASHINGTON, DC 20510

September 21, 2010

Secretary Kathleen Sebelius
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius:

As you work to implement insurance provisions included in the historic Affordable Care Act (ACA), we urge you to clarify rules allowing stand-alone pediatric dental coverage to operate outside the Exchanges in the individual and small group markets similar to its treatment inside the Exchanges. We also ask that you clarify certain aspects of the pediatric dental benefit inside the exchange to ensure its administration is consistent with the relevant provisions of ACA. These clarifications would be consistent with the intent of our amendment adopted by the Senate Finance Committee.

ACA will vastly improve children's oral health through a number of important provisions. Defining the "essential health benefits package (EHBP)" to include coverage of oral health services for children is particularly important in that regard. The law allows stand-alone dental benefits inside the Exchanges to qualify as meeting the dental component of the EHBP. However, outside the Exchanges, in the individual and small group markets, ACA is less clear. Although our amendment was clearly intended to allow stand-alone dental benefits both inside and outside the Exchanges, we are concerned that the language of the law could be interpreted to allow only medical plans to cover the dental component of the EHBP outside the Exchange.

Today, 97% of Americans with dental coverage receive that coverage through stand-alone oral health policies, with benefits separate from traditional medical coverage. Congress intended, through our amendment adopted by the Senate Finance Committee, to recognize this fact and allow for separate pediatric dental coverage, both inside and outside the Exchanges. Our amendment also required that plans offering the essential pediatric benefit comply with any relevant consumer protections for that benefit.

Disallowing the separate offer of dental benefits outside the Exchanges would result in the disruption of dental coverage provided today to 43.7 million employees and dependents through 1.65 million small businesses (with fewer than 100 employees). In 2014 some 22.9 million children would be removed from their parents' existing dental coverage to have their oral health services provided instead by a medical carrier.

Additionally, within the Exchanges, some provisions were enacted in a manner that, under some interpretations, could be inconsistent with the intent of our amendment, raising some questions that should be clarified about cost-sharing, premium subsidies, and the treatment of applicable consumer protections.

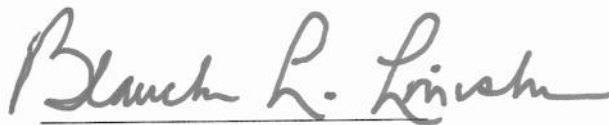
We urge you to 1) clarify that outside the Exchanges (in the individual and small group markets), a stand-alone dental plan offering required pediatric dental benefits that comply with essential benefits requirements and provisions of Title I that are relevant to the scope of stand-alone pediatric dental coverage, together with a health plan offering all other required benefits except pediatric dental, shall meet the essential benefits package and the individual mandate; 2) clarify that cost-sharing limits and cost-sharing assistance apply, relevant to the scope of stand-alone pediatric dental coverage, to stand-alone plans offering the essential pediatric dental benefit inside the Exchanges; 3) clarify that inside and outside the Exchanges, the presence of one dental plan does not obviate the requirement for all other health plans to offer the essential pediatric dental benefit. Our intent is to ensure robust competition that reflects a balance of options for consumers, including an option that a stand-alone dental plan offering required pediatric dental benefits together with a health plan offering all other required benefits except pediatric dental meets the essential benefits package inside the Exchange.

We ask for your help in closing the gap in these areas between the provisions adopted by the Senate Finance Committee and the possible interpretations of statutory language to ensure the continuity of coverage and care envisioned by ACA. We especially urge you to ensure that as in the Exchanges, stand-alone dental coverage outside the Exchanges in the individual and small group markets be allowed to count toward fulfillment of the EHBP, together with a qualifying medical plan covering all other medical benefits. ACA kept its promise to ensure no one would be forced to give up his or her doctor – this promise is equally important for patients and their dentists, too.

Sincerely,



Debbie Stabenow
United States Senator



Blanche L. Lincoln
United States Senator

United States Senate

WASHINGTON, DC 20510

December 24, 2009

The Honorable Harry Reid
Majority Leader
United States Senate
522 Hart Senate Office Building
Washington, DC 20510

Dear Senator Reid:


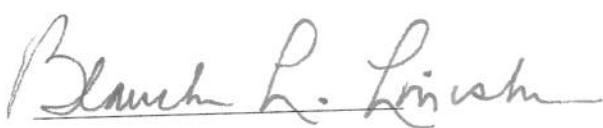



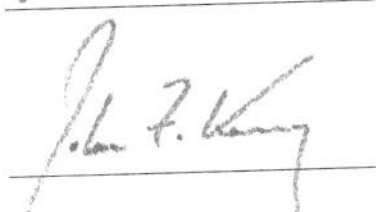
We strongly support the Stabenow-Lincoln dental amendment adopted by the Finance Committee and urge you to include technical changes in the conference report necessary to fulfill the promise of that amendment.

The Stabenow-Lincoln amendment provided assurances that stand-alone dental plans can directly offer the required pediatric dental benefits both inside *and* outside of the new health insurance exchanges as they do today.

Unfortunately, the current Senate language provides that assurance only for coverage offered inside of the insurance exchange. Technical changes are needed for coverage offered outside of the exchange so that existing family dental coverage in the individual and small group market is not disrupted as well as to ensure families can easily access the bill's affordability and consumer protections.

Our campaign for health insurance reform started with a simple premise: no one would be forced to give up his or her doctor. We are proud the bill being considered keeps that promise for doctors. Like you, we strongly support efforts to improve access to oral health benefits and urge you to include the full Stabenow-Lincoln amendment to ensure this promise is kept between patients and their dentists, too.

Sincerely,

Jeffrey A. Merkle

Ron Wyden

Wm J. Gans

Arline Jech
Dental

E. Benjamin Nelson

Janne Shaker

Ann Feingold

Herb Kohl

Barbara By

John Paul

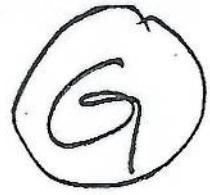
Sherrill Brown

Whitmore

Tom Odell

Muri Anderson

Wm F. B. A



Stabenow-Lincoln MODIFIED Amendment C-7 to the Chairman's Mark

Short title/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.

Description of Amendment: The Chairman's mark states that no policies could be issued in the individual or small group market (other than grandfathered plans) that did not meet the actuarial standards described and that all plans in the individual and small group markets, at a minimum, would be required to offer coverage in the silver and gold categories. Furthermore, all plans must offer pediatric services, including dental and vision. The current language precludes stand-alone dental plans, which currently provide 97 percent of the dental benefits in the United States, from competing with medical plans for pediatric dental coverage in the Exchange.

This amendment would ensure that people who like their dental plans would be able to keep them. To accomplish this, stand-alone dental plans must be allowed to offer the required pediatric dental benefits directly and to offer coverage through the Exchange and must comply with any relevant consumer protections required for participation in the Exchange.

Required pediatric dental benefits in the non-group and small group markets (in and outside an Exchange) may be separately offered and priced from other required health benefits. Coverage for these required pediatric dental benefits may be provided by any state-licensed stand-alone dental-only carrier that meets the requirements of section 2791(c)(2)(A) of the Public Health Service Act. Stand-alone dental-only together with a qualified health plan that provides all of the other required benefits satisfies the required benefits standards. Tax credits and cost-sharing assistance for the required pediatric dental health benefits would be designed to ensure they do not total more than they would have otherwise been under the Chairman's Mark.

Offset: this amendment would not score because there would be no additional funding provided for the purchase of the non-pediatric section of the dental-only plan