



January 31, 2012

The Honorable Kathleen Sebelius
U.S. Department of Health and Human Services
Director Steve Larsen
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington D.C. 20201
Submitted via: EssentialHealthBenefits@cms.hhs.gov

Dear Secretary Sebelius and Director Larsen:

The National Association of Dental Plans (NADP) appreciates the opportunity to provide comments on the “Essential Health Benefits Bulletin” (Bulletin) proposed by the Center for Consumer Information and Insurance Oversight (CCIIO) released on December 16, 2011. NADP members provide over 80 percent of all dental benefits for Americans today. NADP and our members appreciate the U.S. Department of Health and Human Services’ (HHS) recognition in the Bulletin that dental benefits constitute coverage separate from medical policies and that the benchmarks should be created with an understanding of the unique nature of dental plans.

The Patient Protection and Affordable Care Act’s (ACA) inclusion of “pediatric services, oral and vision care” (pediatric oral services) in the Essential Health Benefits Package¹ (EHB) required in policies sold by 2014 is an important achievement for the oral health of children. However, it also significantly impacts the dental benefits industry and more than 40 million consumers with dental coverage in the small group and individual market. NADP continues to stress that consumers with dental coverage today should be able to keep that coverage with access to their preferred family dentist – as implied when President Obama promised Americans who like their health plan will be able to keep it under the ACA. As expressed in your letter dated November 15, 2010 to Senator Stabenow, the implementation of the ACA should preserve the beneficial parts of the current market and ensure a balance between the law’s provisions and market flexibility. A thoughtful approach can allow for the continuation of current dental coverage while providing much needed oral health coverage for children.

¹¹ ACA Section 1302, “Essential Health Benefits Requirements” March 2010

National Association of Dental Plans

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

972.458.6998 • 972.458.2258 [fax]

OFFICERS & DIRECTORS

Chairman

KAREN M. GUSTIN, LLIF
Ameritas Life
Insurance Corp.
Lincoln, NE

Vice Chair

FORREST FLINT
HealthPartners
Minneapolis, MN

Secretary

DOYLE C. WILLIAMS, DDS
DentaQuest
Boston, MA

Treasurer

Kirk E. Andrews
United Healthcare Dental
Santa Anna, CA

JEFF ALBUM

Delta Dental of
CA, NY, PA & Affiliates
San Francisco, CA

JEANNE HENSEL

Humana Specialty Benefits
Insurance Co.
Green Bay, WI

FRED SHARPE, DDS

Avesis Third Party Admin.
Owings Mills, MD

CHRIS SWANKER

Guardian Life Insurance
Company of America
Bethlehem, PA

BRIAN WATTS

First Dental Health
San Diego, CA

Immediate Past Chair

BRUCE R. HENTSCHEL,
CLU, FLMI, HIA, ALHC
Principal Financial Group
Des Moines, IA

Executive Director

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



This comment letter will provide background information describing the current dental insurance landscape and sets forth NADP's recommendations concerning the Bulletin, including additional dental-specific benchmarks that can provide states the maximum flexibility to develop the pediatric oral services requirement that best balance the needs of the state and its' citizens. Taken together, these recommendations address the goals of minimizing disruption to existing family dental coverage, assuring continuity of dental care, preserving the affordability of that care, and expanding access to oral care while avoiding adults dropping their dental coverage. Included for your reference is a brief analysis of the extent to which dental services are included in the proposed benchmarks in Attachment 1.

BACKGROUND

Dental benefits vary significantly from traditional medical insurance in policy structure, cost, coverage and market penetration. These differences are critical to balancing coverage, affordability, and simplicity in developing the EHB.

While most large employers (more than 100 employees) include medical and dental coverage as part of the health benefits package offered to employees, only 48% of all small employers now offer dental coverage². Moreover, dental coverage in many cases is offered on an employee-pay-all (voluntary) basis, particularly in the small employer group market. Therefore, the inclusion of pediatric oral services will be an expansion of coverage in much of the small employer market, and potentially an extra cost to employers. Consequently, the breadth of the added pediatric dental coverage must be balanced against the need for affordability.

Dental benefits are usually sold and purchased as a separate product; distinct and apart from medical coverage. In the private market (not including public programs), roughly 98 percent of Americans with dental coverage today have a dental benefit policy separate from their medical policy³. Less than two percent of Americans get their medical and dental policies integrated (or embedded) into a single policy with medical coverage. These policies cover individuals or families. "Child-only" policies are rarely offered in the current dental market. Recognition of the separate nature of dental coverage is critical to affording consumers in all markets equitable access to affordable, quality dental coverage and allowing them to keep the coverage they have, as promised during the passage of the ACA.

According to the Department of Labor (DoL) Survey⁴, the most common commercial (private) dental policy type across all states is the dental preferred provider organization (DPPO.) These plans typically contain cost-sharing elements that include coinsurance percentages, annual benefit maximums, deductibles, and frequency limitations. They traditionally cover 100% of the cost of preventive services, 80% of basic dental services, and 50% of the cost of major dental services from network providers. Lower percentages may be covered for non-network providers. An annual limit applies to all these

² NADP 2011 Purchaser Behavior Survey, May 2011

³ NADP/DDPA Joint Dental Benefits Report: Enrollment, November 2011

⁴ Department of Labor, "Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services," April 15, 2011



coverage categories. If the policy also covers orthodontia, that coverage has a separate lifetime limit and medical necessity criteria is generally not applied—the benefit is available to everyone with this additional coverage. Benchmarking to plans that are distinctly different than the most common commercial dental policy type and do not include common maximums and other limitations would significantly impact the premium for dental coverage. Including orthodontic coverage without a medical necessity requirement in the EHB would increase costs significantly which is counter to providing coverage that is affordable and accessible for most Americans.

NADP applauds CCIIO for recognizing in the Bulletin that dental coverage policies typically differ from medical coverage. In addition to this recognition, there are several additional issues that are critical, and need to be addressed in future regulatory guidelines or regulations and are highlighted below:

RECOMMENDATIONS:

#1: Align inside and outside exchange rules to provide for equitable treatment for consumers in all markets.

Before benchmarks are set for coverage of pediatric oral services, HHS should address concerns about the consistent treatment of dental policies both inside and outside the Exchange. Families with current dental coverage should be assured that they can keep the dental policies they have and the dentists they see under their current policies. NADP, members of the US House and Senate, as well as the US Chamber of Commerce have asked HHS to address the dichotomy that will be created in the small group and individual markets inside and outside the Exchanges if all medical policies in the markets outside of the Exchanges must include pediatric oral services while inside the Exchanges, separate dental policies can provide the pediatric oral services of the EHB along with medical policies that cover the balance of the EHB (see keepourcoverage.com for additional background).

Without this clarification there are multiple negative impacts on consumers. Some 44 million enrollees, including 22.9 million children, with dental coverage through 1.65 million small employers today could have their dental coverage and access to their dentist disrupted. Two parent families where both parents are employed could be required to purchase duplicative coverage. As well, states may have to make significant changes to standards for Coordination of Benefits between medical and dental policies. These are unnecessary complications in the implementation of the ACA for consumers, regulators and markets that operate efficiently today.

The Bulletin states in Footnote 27 that Qualified Health Plans (QHP) do not have to include pediatric oral services inside Exchanges. NADP requests a similar clarification for policies offered by QHPs outside the Exchange in the small group and individual market.

#2: Consumers with dental coverage should not be required to purchase duplicative coverage.

NADP's 2011 Purchaser Behavior Survey found that about 80% of small employers plan to maintain their dental and other ancillary benefits outside of Exchanges. The ACA was built to expand access for those



not covered while allowing the continuity of coverage and care for those with coverage. When small employers bring their employees to Exchanges for medical coverage, the dental benefits they provide for their employees outside the Exchange should be accepted if they meet the state's benchmark established for pediatric oral services. In addition there will be instances when children with two parents or guardians will have coverage through the parent or guardian working for a large employer. In this instance, the parent or guardian working for a small employer should not be required to purchase duplicative coverage for the children.

HHS should make it clear that employers and families should not be required to purchase duplicative dental coverage inside the Exchange, or outside the Exchange in the small group and individual market, if they have a dental policy that meets their family's needs and the EHB requirement set by the state.

#3: Set the age range for “pediatric” at the federal level.

The age range covered by the term “pediatric” must be defined for benefits to be modeled and priced across the country for both dental and vision services. While the ACA addresses dependent coverage and CCIIO has clarified that “child-only” policies are issued for individuals up to age 19, there is no definition of “pediatric” as it relates to dental services. To provide equity for Americans across the country and consistency for multistate employers, the age range for “pediatric” should be defined by HHS not left to the individual states. The NADP/DDPA Exchange White Paper⁵ offers options for this clarification, including: the clinical age of development of permanent teeth identified by the American Dental Association beginning at age 12; the CHIP program age for coverage up to 19, or the Medicaid age for coverage of children to 21.

#4: Clarify when a state must supplement its medical benchmark with a dental specific benchmark to meet the “pediatric oral services” of the EHB.

The bulletin describes a process where states would use dental benchmarks to supplement medical benchmarks when “pediatric oral services” are “missing” from the medical benchmarks. As described in NADP's Attachment 1, all of the benchmarks listed have “pediatric oral services” provided by pediatricians, (such as oral screening and fluoride varnish) with only one of the medical benchmarks covering dental services that would typically be provided to children under a dental policy.

HHS should clarify what services are necessary and sufficient to include as “pediatric oral services” so a state can determine when to utilize other benchmarks to fill in these services. As “child-only” policies are extremely rare in the dental market, the clarification should specify that only those services typically provided to children of the defined pediatric age in the selected dental benchmark are required to be added to the EHB developed by the state.

⁵ NADP/DDPA White Paper: “Offering Dental Benefits in Health Exchanges, A Roadmap for Federal and State Policymakers”, September 2011.



#5: Provide flexibility to the states to fill in “missing pediatric oral services” by using the dental plan offered in any of the categories of medical plan benchmarks.

If “pediatric oral services” includes the services provided to children under a “typical separate dental plan,” states should be able to select from dental products that parallel the categories of medical benchmarks identified in the Bulletin. As reflected in Attachment 1, while most of the medical benchmarks include some “pediatric oral services” but do not include dental services covered under typical dental policies, there are ample corresponding dental plans offered by employers in each benchmark category. Attachment 1 also shows the dental specific FEDVIP and CHIP benchmarks are significantly different than the commercial dental plans in the other categories. Accordingly, a state should be able to look at the largest small employer dental plan, the largest state employee dental plan or the largest dental HMO (DHMO) in the state rather than moving to the less common or familiar federal benchmarks.

#6: Allow states to utilize plan benefits and cost sharing typical in dental plans.

Most of the benchmarks that cover dental services for children cover similar procedures or services although the benefits for those services may be in different categories of coverage or have different cost-sharing, frequency limits, etc. The key difference in the benchmarks comes from cost sharing (the consumer’s out of pocket expenses) and limitations on those procedures or services. Waiting periods, frequency limits, cost sharing and annual maximums are common in dental policies but vary by market segment (for example, small employer plans typically have greater cost sharing than large employer plans.) The premium costs for dental plans differ according to the plan’s benefits and cost sharing provisions.

NADP requested that Milliman (a recognized independent actuarial firm) examine the range of costs for pediatric oral services in dental plans similar to the benchmarks addressed in the EHB Bulletin. While the services covered are similar, the costs per child per month range from around \$5 for the BCBS FEHBP benchmark plans, to \$25 for a typical commercial DPPO, to about \$48 for a CHIP plan with orthodontia (see Attachment 2). The FEDVIP dental benchmark would fall on the high end of this range. This is a great range of costs which must be considered in assessing the balance between benefits and affordability in the 10 benefit categories of the EHB package. The range of costs demonstrates the use of benefit limitations, cost sharing, and maximums allows dental plans to be offered at affordable and variable price points.

Allowing the benefit structure (including limits and cost sharing) typical in dental plans today will keep pediatric oral services affordable, while enabling and encouraging access to oral care. Without application of the limitations currently used by dental plans, benefits will not be “typical” of those offered in the rest of the market and the costs may not be in balance with the rest of the EHB package.

National Association of Dental Plans

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

972.458.6998 • 972.458.2258 [fax]

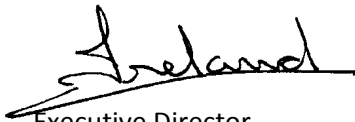


#7: HHS should affirmatively state if “medically necessary” orthodontia is part of the EHB and covered under a medical benchmark.

The Bulletin observes HHS is considering excluding from the EHB, non-medically necessary orthodontia. This implies that “medically necessary” orthodontia is to be included. In typical employer plans, “medically necessary” orthodontia is usually covered by the medical policy not the dental policy. Therefore, if included, it should be part of the medical benchmark. HHS should clearly indicate this in future guidance.

NADP is greatly appreciative of your time and attention to our concerns, and we look forward to future discussions on these critical issues to the dental benefits industry. Questions regarding our comments should be directed to Kris Hathaway, Director of Government Relations at khathaway@nadp.org or 972 458-6998 x111. Again, thank you for your consideration.

Sincerely,
Evelyn F. Ireland, CAE



Executive Director
National Association of Dental Plans

NADP DESCRIPTION

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 80% percent of the 176 million Americans with dental benefits. Our members include the entire spectrum of dental carriers: companies that provide both medical and dental coverage, companies that provide only dental coverage, major national carriers, regional and single state companies, as well as companies organized as non-profit plans.

National Association of Dental Plans

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

972.458.6998 • 972.458.2258 [fax]



NADP ATTACHMENT 1 OF 2

BENCHMARKS

The Bulletin outlines four distinct health benefit benchmarks for states to use in defining their EHB's. In short they include policies from: small employer, state employee, Federal Employees Health Benefits Program (FEHBP) and non-Medicaid HMOs. The Bulletin also adds two specific benchmarks for dental when "pediatric oral services" are "missing" from these health specific benchmarks; they include the Federal Employees Dental & Vision Program (FEDVIP), and the Children's Health Insurance Plan (CHIP).

Every medical plan must adhere to the recommendations of the American Academy of Pediatrics oral health guidelines. These guidelines are referenced in the July 2010 Interim Final Rules Relating to Coverage of Preventive Services. The oral health component referred to in these regulations consists of pediatrician-delivered oral services including:

- Oral health screenings at various ages, as recommended in "The Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care," consisting of discussing the child's oral hygiene with the parent and looking in the child's mouth to assess the risk of caries;
- Prescribing fluoride supplements for children in areas where water is not fluoridated;
- Three-year and six-year well-child visits to determine whether the patient has a dental home. If the patient does not, then a referral should be made to one.

These services are "pediatric oral services" that would be in every medical benchmark. As the Bulletin provides for several benchmarks, including two dental specific benchmarks, NADP has briefly examined each medical benchmark and commented on whether this benchmark category typically includes services provided in a dental office setting:

Small Employer: In general medical policies do not include dental services whether small group or large group. Only 48 percent of small employers (100 or fewer EE) offer separate dental policies while more than 90 percent of large employers offer dental policies. Many of the services covered are similar in both groups of policies, although smaller employers may not cover as many Major services or offer an additional orthodontia rider. A key difference identified in the data charts in the DoL Survey is the average annual maximum; the DoL Survey shows the average annual maximum is \$1000 for small employers versus \$1500 for all employers. In addition, small employers are less likely to pay for any of the premium for dental coverage, and may have coverage that imposes more cost containment features such as waiting periods or higher cost sharing provisions.

State Employee: Similar to policies provided in the large employer market, state employee health benefit packages usually include dental policies separate from medical policies. States vary in contributions to the premium cost ranging from fully paid by the state to a full

National Association of Dental Plans

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

972.458.6998 • 972.458.2258 [fax]



“employee pay all” or “voluntary” policy. While DPPO and indemnity dental policies commonly provide network benefits at 100/80/50 percent, there are variations in the cost sharing structure by state, and often states provide several benefit levels for an employee’s choice.

FEHBP: The most common FEHBP is the Blue Cross Blue Shield Standard Option. Uniquely, this policy includes a schedule of dental procedures as part of medical coverage with specific differences for plan payments based on member age. While the services included are those that are most commonly utilized, the reimbursement provided for each service results in greater cost sharing for the consumer than common commercial DPPOs.

Note: One interpretation of the Bulletin’s language suggests if “pediatric oral services” is “missing” from all the selected medical benchmarks, a state should utilize the additional dental benchmarks included in the Bulletin. However, as one of the medical benchmarks, i.e. the FEHBP most common policy, includes dental coverage, another interpretation is that states would always use FEHBP and be precluded from using the two specific dental benchmarks. NADP has addressed this issue in Recommendation #5.

Health Maintenance Organization (not related to Medicaid): Most HMOs do not embed dental procedures in the HMO. Dental again, is usually chosen in a separate benefit package whether DHMO, DPPO or dental indemnity.

DENTAL SPECIFIC BENCHMARKS

When one of the medical benchmarks is missing “pediatric oral services” as a category of coverage, the Bulletin offers two dental specific benchmarks:

FEDVIP: FEDVIP is the voluntary federal dental and vision program where benefits are 100 percent paid by the federal employee to supplement the dental benefit provided by FEDVIP. The dental plan in FEDVIP with the highest enrollment is MetLife High Option which has a \$10,000 annual maximum with a separate lifetime maximum of \$3500 for orthodontia with a 2 year waiting period. While the services covered in this plan are similar to many commercial dental plans, the annual maximums are significantly more robust than average commercial dental plans cited in the DoL Survey particularly compared to small employer dental plans.

CHIP: In 2009, CHIP was reauthorized (CHIPRA) and mandated that states must include dental coverage for children. (Previously most states were including dental coverage but were not required to do so.) CHIP specifically mandates “child health assistance provided to a targeted low-income child shall include coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.”⁶ The scope of coverage under CHIP is comprehensive. However to contain costs, service limitations may be set in line with accepted periodicity schedules and medical necessity criteria may be applied to determine the frequency of services or eligibility to receive certain

⁶ [Medicaid.gov/Medicaid & CHIP Program Information/Dental Care for Medicaid and CHIP Enrollees](https://www.Medicaid.gov/Medicaid & CHIP Program Information/Dental Care for Medicaid and CHIP Enrollees)



services.⁷ These service limitations are not common in commercial dental policies. While orthodontia is a category of covered service under CHIP, states apply a range of standards to orthodontia from allowing it only in cases of cleft palate to applying special indices of need, such as the Salzmann index, currently not used in commercial dental coverage. Additionally, CHIP benefits are usually available only through a closed panel of contracted dentists, unlike the PPO plans most commonly sold in the commercial market that provide a benefit regardless of whether the dentist is in or out of network.

⁷ Kaiser Family Foundation “CHIP Tips. Children’s Oral Health Benefits,” March 2010

National Association of Dental Plans

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

972.458.6998 • 972.458.2258 [fax]



NADP ATTACHMENT 2 OF 2

2014 Illustrative Costs per Child, in Addition to Medical⁸

OPTION	Per Month	Per Year
Screenings by Pediatricians	\$0	\$0
BCBS FEHBP Standard Option Medical with Dental Schedule - Cost sharing on a per procedure basis (without Ortho)	\$4.50	\$54
Diagnosis/Prevention/Emergency Treatment	\$18.50	\$222
Common Employer-sponsored DPPO without Ortho - \$1,500 annual maximum - In Network: 100/80/50 with \$50 deductible - Out-of-network: 80/60/40 with \$50 deductible	\$21.25	\$255
Common Employer-sponsored DPPO with Ortho - \$1,500 annual maximum with separate ortho maximum of \$1,500 for non-medically necessary ortho - In Network: 100/80/50 with \$50 deductible - Out-of-network: 80/60/40 with \$50 deductible	\$25.40	\$305
CHIP Equivalent without Ortho - No annual maximums or cost-sharing	\$29.25	\$351
CHIP Equivalent with Ortho - With no medical necessity criteria applied - No annual maximums or cost-sharing	\$48.25	\$579

NOTES:

- Premium estimates developed by Milliman, Inc based on national industry averages; state costs may vary.
- Age of 21 used and costs calculated per child.

⁸ Milliman, "Considerations in Offering Dental Insurance on Exchanges," August 31, 2011

