December 26, 2012

The Honorable Kathleen Sebelius
U.S. Department of Health and Human Services
Marilyn Tavenner
Centers for Medicare & Medicaid Services
Attention: CMS-9980-P
P.O. Box 8010
Baltimore, MD 21244-8010
Sent electronically via www.regulations.gov

Dear Secretary Sebelius and Acting Administrator Tavenner:

The National Association of Dental Plans (NADP) appreciates the opportunity to provide comments on the proposed rule CMS-9980-P regarding "Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation" (Proposed Rule) published by HHS in the Federal Register on November 26, 2012. NADP is greatly appreciative of the detailed attention HHS has provided to dental benefits and the obvious time they have spent in considering best options for consumers while understanding the cost and administrative restrictions placed on dental benefit offerings.

In these comments, NADP will address a number of areas covered by the Proposed Rule:

A. Ensuring equitable consumer access to dental coverage on and off the Exchanges;
B. Setting a reasonable cost sharing limit for separate[1] dental policies;
C. Modifying the actuarial value (AV) high/low dental option;
D. Clarifying" cosmetic orthodontia" related to pediatric oral services; and
E. Limiting variability in the age definition for pediatric dental services.

[1] In our comments, "separate dental policy" is used for a separate policy of coverage whether from a carrier that is affiliated with a medical plan or "stand-alone." "Stand-alone dental plan" is a policy of coverage that is issued by a "stand-alone" carrier that is not affiliated with a medical plan. The ACA and the proposed rules use the term "stand-alone dental plan" to mean a "separate dental policy."

A. Consumer Access to Dental in the Small Group and Individual Market

The Affordable Care Act (ACA) Section 1302(b)(1)(J) includes coverage for pediatric oral health services as part of the Essential Health Benefits (EHB) package. As the Proposed Rule reiterates on page 54, ACA Section 1311(d)(2)(B)(ii) specifically allows for separate dental policies to provide coverage for the required pediatric oral health services in the Exchange. Congress intended both to expand pediatric dental coverage and to allow pediatric dental coverage to be provided under a separate dental policy both inside and outside the Exchanges. HHS has broad legal authority to interpret the ACA and should use this authority to implement Congressional intent as it has with other issues since ACA's enactment.

Without clarification from HHS, medical plans being offered in the small group and individual (SGI) market outside the Exchange will have to embed the pediatric dental benefit and render dental policies in place today duplicative to what a medical plan will include in its coverage. With 99% of dental policies sold separately from medical today, this issue can cause significant disruption to consumers. If HHS does not act:

- 1.65 million Small businesses' dental coverage (fewer than 100 employees) will be impacted;
- 43.7 million Employees and dependents could see their dental benefits disrupted;
- 22.9 million Children, who now have coverage under their parents' existing dental policies through small employers, will have their existing dental coverage duplicated or issued by a medical carrier[2] that may or may not provide access to the family's current dentist; and
- 11 million Americans may drop their own adult dental coverage when their children are removed from their dental policies.

HHS must clarify through the Proposed Rule that health plans can provide the EHB Package without pediatric oral services outside Exchanges as they can inside of Exchanges to

- Provide consistent competitive markets for consumers;
- Assure that dental coverage and dentist-patient relationships can be maintained in the SGI market; and
- Avoid potential adverse selection between markets.

At the same time HHS should also assure that consumers up to age 19 (the federally proposed pediatric dental age) obtain coverage for pediatric oral services either under a separate dental policy or a health plan. While HHS has appropriately provided for affordable medical options in Exchanges by the allowance to purchase coverage without pediatric dental services[3], this interpretation should not obviate the goal of expanding dental coverage for consumers up to age 19.

Following is a summary which highlights the intention of the ACA, the policy background of why the off Exchange interpretation is vital in maintaining a competitive dental market for consumers and HHS's legal authority to clarify any ambiguities that result.

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[2] Where separate dental policies are provided under a dental plan that is an affiliate or subsidiary of a medical carrier, disruption can be minimized.

[3] CMS 9989-F: PPACA; "Establishment of the Exchanges, and Qualified Health Plans; Exchange Standards for Employers"; 45 CFR Parts 155, 156, and 157.

Congressional Intent was for Dental to be Offered in the Same Ways Inside & Outside an Exchange

The inclusion of Section 1311 (d)2(B)(ii) in the Affordable Care Act (ACA), which allows separate pediatric dental policies to be purchased inside an Exchange, was specifically due to 99% of dental coverage being provided under separate dental policies today. One of the main goals of the ACA was to allow for consumers to maintain their health coverage if they like what they currently have, and by allowing separate dental policies, this goal is extended to dental coverage. To emphasize that importance, the Stabenow amendment was adopted unanimously by the Finance Committee and **clearly intended** separate dental policies to be allowed to provide the required pediatric dental benefit as part of the EHB on and off the Exchange and that those benefits meet the ACA's requirements for coverage. As the Stabenow amendment states, "Stand-alone dental, only together with a qualified health plan that provides all of the other required benefits, satisfies the required benefits standards."

The process of the ACA passage did not allow specific statutory clarifications to fully implement the Stabenow amendment. To reiterate Congressional intent and demonstrate the breadth of support for equitable treatment of pediatric dental coverage, a bi-partisan Congress forwarded multiple letters to HHS in 2011, including a Senate letter with 24 signatures, a letter from the House of Representatives with 33 signatures, and additional letters from various individual Congressional members. Similar letters were sent to the White House when a clarification was not included in the 2012 Exchange regulations[4] as the "request is outside the scope of this final rule…" With the release of these rules without the clarification, US Senate members—both Democrat and Republican—again have urged HHS to follow Congressional intent on this issue. Additional support from a variety of stakeholders including the U.S. Chamber of Commerce and the American Dental Association has also been forwarded. To allow separate pediatric dental policies inside AND outside Exchanges was and continues to be a priority by many of those interested in maintaining oral health for children.

Consumers & States Need Equitable Treatment of Dental Plans Inside & Outside the Exchange

Along with Congressional intent, there are consumer, market, and cost implications that need to be considered in providing equitable treatment. In addition to preserving a pediatric consumer's coverage and a relationship with their dentist, HHS's interpretation is critical to maintaining robust competition in the dental market.

States have continually requested clarification on this issue as many have identified this as an adverse selection issue between their Exchanges and the private SGI market. States are waiting on HHS clarification as some state Exchange rules require policies sold on their state Exchange to be offered in the private market (i.e. California and Maryland). QHPs offered without dental on the Exchanges could not be offered off the Exchange under HHS proposed rules. An example is Oregon's recent update within their SERFF filings, "WHEN FILING PEDIATRIC DENTAL IN 2014 FORM FILINGS: When filing the forms you may bracket the pediatric dental benefits in the event

[4] CMS 9989-F: PPACA; "Establishment of the Exchanges, and Qualified Health Plans; Exchange Standards for Employers"; 45 CFR Parts 155, 156, and 157.

that qualified health plans (QHPs) are not required to include pediatric dental benefits. This will allow for the provision to be deleted or added based on future guidance." This issue is made even more complicated when a state has decided to require separate offer and pricing of dental (i.e. Washington), or QHPs to offer plans without dental (i.e. under consideration by Maryland.)

About two-thirds of the separate dental policies in the market today are provided by stand-alone dental plans. Many of these dental plans market primarily to the small group and individual market. Without equitable treatment, these dental plans may not be able to continue to offer competitive products in this market, thereby reducing competition and choice.

Legal Authority to Ensure Consumer Access to Dental Coverage

NADP has met with and provided a legal memo for HHS to make the recommended interpretation. The ACA key provisions providing HHS authority are summarized in a shorter legal analysis on clarifying an off Exchange interpretation.

As the most recent legal analysis elucidates, ACA Sec. 2707(a) on its own terms states a health plan offering health coverage in the "…small group and individual market shall ensure that such coverage includes the essential health benefits package," and HHS's interpretive authority is sufficient to support an interpretation that the EHB package be offered with or without pediatric dental coverage. This would reflect typical employer coverage as required by the statute (Sec. 1302(b)(2)(A)) and is within the Secretary's authority to determine. This interpretation provides the path for medical and separate dental policies to be purchased together to meet EHB in the SGI market. It also provides the path for QHPs to meet any state specific Exchange requirements mandating QHPs to offer the policies they have on the Exchange, off the Exchange at the same price. Without the interpretation this provision would be an unresolved anomaly in the ACA.

To assure that employers and consumers understand what is required as minimum essential coverage (MEC) when the full EHB package is not included in a single policy, HHS should clarify that when consumers under age 19 are covered by a health plan without pediatric dental coverage, a separate dental plan covering the pediatric consumer must also be purchased. In these instances, EHB should be defined as either 1) a health plan offering full EHB or 2) a health plan offering EHB (except the state's benchmark pediatric dental coverage) and a separate dental policy that covers the pediatric dental coverage of the state's EHB pediatric dental benchmark.[5] IRS would then have a clear path to enforce the penalties for not maintaining MEC under Sec. 5000A.

B. Defining A Reasonable Dental Out Of Pocket Dental Maximum

In the Proposed Rule's section 156.150(a), HHS proposes "stand-alone" (meaning separate) dental plans to have a "reasonable" annual limitation on cost sharing, separate from QHPs covering the remaining

[5] Separate dental policies could be co-offered by a medical carrier or provided by a "stand-alone" carrier. (see page 47 of NADP/DDPA White Paper on Offering Dental Benefits in Health Exchanges)

EHB package. HHS also proposes that the plan would demonstrate the annual limitation on cost sharing is "reasonable" for coverage of the pediatric dental EHB.

NADP supports HHS' proposed approach in setting a separate annual cost-sharing limit for separate dental plans. Coordination between carriers is administratively complex and cost-prohibitive and should be avoided to keep premiums low and to create an easier claims experience for members that are consistent with what they experience today. Furthermore, many consumers will benefit from a separate limit on dental, since under a coordinated OOP cost sharing limit their pediatric dental benefits will be contingent on their meeting the higher cost sharing limits set for QHPS which requires significant medical expense[6]. Based on the analysis provided by Milliman for NADP, consumers will have greater protection for catastrophic OOP costs for pediatric dental services under a separate limit.

NADP provided a memo on this issue to HHS based on work done by Milliman. That memo outlines the needed balance between limiting catastrophic dental costs and keeping premium increases affordable. However, a wide variance in determining "reasonable" would make coverage difficult for consumers to compare. Therefore, NADP recommends that a federal standard should be set for a separate dental OOP just as there is a single standard for the OOP requirement for a medical plan. After reviewing various scenarios, NADP recommends a $1000 OOP maximum per child be established for pediatric dental of the EHB. This OOP maximum reflects the 98th percentile of claims distribution. Setting the OOP amount any lower will make reaching a 70 or 75% AV level extremely difficult. This maximum should be indexed in a manner similar to that for the medical OOP maximum to assure adjustment for future inflation.

A $1,000 OOP maximum increases dental premiums per child from 10% to 25% over the estimated cost of pediatric dental benchmarks without any OOP depending on the coverage levels and assumptions related to medically necessary orthodontic procedures. This threshold does, in most instances, give consumers with catastrophic dental costs earlier and greater payment of those costs than coordination with a medical OOP maximum[7]. Routine dental care may result in a few hundred dollars in OOP costs, but medically necessary costs of orthodontia average just over $6000 nationally. At a common coinsurance rate, medically necessary orthodontia could result in more than $3000 in OOP cost without hitting a medical OOP limit. The $1000 amount will be simple for consumers to understand while keeping pediatric dental costs relatively affordable.

C. Differentiation in Dental AV Limits

NADP analyzed the impact of actuarial values (AV) on dental coverage in both the Exchange White Paper and an issue brief. In that Issue Brief we recommended two levels for separate dental plans at the

[6] Medical plan design will affect the number of consumers who hit the medical cost sharing limits for out-of-pocket expense, but is generally estimated to be less than 10%. The most recent Medical Expenditure Panel survey (1996-2004) shows that 18% to 19% of children have orthodontic procedures. Milliman estimates that 30% of these would meet a medical necessity standard and hit the separate dental cost sharing limit for out-of-pocket expense. The small percentage of children with dental claims hitting the cost sharing limit is not likely to overlap with the 10% or less of consumers that hit medical cost sharing limits.

[7] For 2013 this is $12,500 annually for a family and $6250 annually for an individual.

approximate value of silver and gold. We also indicated that the structure of common DPPO coverage today exceeds the gold level and will be impacted by the inclusion of medically necessary orthodontia.

The Proposed Rule includes a separate high/low AV option specific to the pediatric dental benefit and lists the low level at 75+/-2% and the high level as 85+/-2%. NADP agrees with the solution of a high/low AV approach for pediatric dental coverage. NADP commissioned Milliman to examine the coinsurance and deductible levels using the $1000 OOP maximum and including medically necessary orthodontia. That analysis confirms that the 85% high level reflects the coinsurance structure of the current FEDVIP benchmark[8] used as the default plan for pediatric dental coverage with a $50 deductible on all but preventive services. However, it should be noted that this plan will have higher premium costs from the benchmark coverage because of the inclusion of medically necessary orthodontia and the application of the $1000 OOP limit. Since the 75% low AV level does not offer much price variation for consumers relative to the 85% level, NADP proposes that the lower level be set at 70+/-2% to provide a more affordable option for consumers and parallel to the silver level within an Exchange..

It should be clarified that carriers offering separate dental policies on Exchanges can offer coverage at either or both pediatric dental AV levels and that a plan at either level can be used for calculation of the consumer subsidies.

D. Defining "Cosmetic" Orthodontia

In Section 156.115(d), the Proposed Rule excludes "cosmetic" orthodontia from EHB. NADP requests HHS to clarify the intention of this phrasing. While insurance policies generally exclude coverage for all cosmetic procedures, earlier use of the term "medically necessary orthodontia" in benchmark guidance suggests that this language may be intended to require coverage of medically necessary orthodontia when orthodontia is part of a state's designated benchmark plan for EHB. Cosmetic orthodontia is not a term normally utilized by the dental industry. However, there are clinical standards and tools to measure "medically necessary" orthodontia. These standards are currently used in some state CHIP programs. If HHS intends that some portion of orthodontic procedures be covered, NADP recommends changing the verbiage to parallel HHS's initial guidance and standard industry language. Thus, the Proposed Rule should limit orthodontia coverage in a state's designated EHB dental benchmark to medically necessary orthodontia.

E. Set a single age standard for "pediatric services"

In response to state requests for consistency, the proposed rule interprets pediatric services under the ACA to be "under 19 years." The interpretation is based on the age stated in the Affordable Care Act's prohibition on preexisting conditions for children and the age limit for eligibility to enroll in a state CHIP. The Proposed Rule goes onto say that a state may "extend pediatric coverage beyond the proposed 19

[8] FEDVIP in-network cost-sharing is 100% for preventive care, 70% for basic services and 50% for major services, Orthodontia is also covered at 50% for children up to age 19 after a 24 month waiting period. These cost-sharing percentages are reduced by 10% in each category of coverage when services are obtained out-of-network (90%/60%/40%).

year age limit." Adding the flexibility to increase pediatric age reintroduces inconsistency in the standard. For carriers, pricing and product development is complicated by the uncertainty of a flexible standard. Costs and premiums would increase for products covering different older age groups. NADP accepts the reasoning used by HHS for setting the limit and recommends it be a single age across all states.

RECOMMENDATIONS:

1. Clarify through HHS regulations that Qualified Health Plans can offer the Essential Health Benefit Package without pediatric oral services outside Exchanges as long as separate dental policies covering those benefits cover consumers up to the defined pediatric dental age;
2. Set a federal out of pocket pediatric dental annual maximum per child of $1000 for separate dental policies, and index for future inflation;
3. Decrease the lower pediatric dental AV option from 75% to 70% for separate dental policies;
4. Change the exclusion of cosmetic orthodontia to inclusion of medically necessary orthodontia when orthodontia is included in a state's EHB benchmark; and
5. Set a single standard for pediatric age at "under 19 years".

OTHER COMMENTS:

While NADP supports the proposed separate OOP maximum (and the proposed high/low AV levels) for separate dental plans offering pediatric dental services, it's important that HHS consider the benefit differences the Proposed Rule could create between the pediatric oral services offered by stand-alone dental plans (or dental plans offered in conjunction with a QHP), versus those pediatric oral services embedded within a QHP. Different application of OOP maximums, the potential for different deductibles (especially with an HSA plan), the explicit actuarial value for separate dental benefits, and the constraints placed on medical plan rating means consumers who are shopping for pediatric dental services defined by the EHB benchmarks will be comparing and evaluating very different benefit options.

Again, NADP is extremely appreciative for the consideration of dental in the Proposed Rule by HHS staff. They have met with the dental industry to better understand best practices and to implement appropriate pediatric oral services within the ACA for consumers. NADP looks forward to future discussions on the critical issues we addressed above, as well as implementation of the ACA overall 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.

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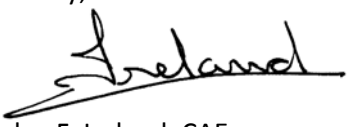
Sincerely,



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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 92 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.