



September 26, 2012

Commissioner William P. White
Chair, HRIC Insurance Subcommittee
810 First Street, NE, Suite 701
Washington, DC 20002
Sent via email: Brendan.rose@dc.gov

Re: The District of Columbia's Selection of an EHB Benchmark Plan

Dear Commissioner White:

The National Association of Dental Plans (NADP) appreciates the opportunity to provide comments on the DC Essential Health Benefit (EHB) benchmark selection. The content of our comments focuses on how the required "pediatric oral services" should be offered as part of the District of Columbia (DC) EHB package.

The DC HRIC Insurance Subcommittee's [Essential Health Benefits Bulletin](#) presents the various state benchmark options. Within the Bulletin, Compass Solutions' report is cited with estimating the cost of the pediatric dental benchmark as being 1% or \$4 PMPM of the cost of the average plan. NADP has also reviewed the benchmarks as presented by HHS, in an effort to clarify the variety of premiums, benefits and cost sharing related to the pediatric dental benchmark. NADP commissioned an independent analysis by Milliman (attached) which illustrates:

- FEHBP is \$4.50 PMPM with an Actuarial Value (AV) of 21% without medically necessary (MN) orthodontia, and \$7.30 PMPM with MN orthodontia
- FEDVIP is \$27.30 PMPM with an AV of 73% with MN orthodontia
- CHIP is nationally averaged to \$32.05 with an AV of 93% with MN orthodontia

Washington D.C. needs to be aware premiums will vary significantly from current dental employer coverage as annual and lifetime limits will not apply to the pediatric dental benefit. As well, HHS has instructed that medically necessary orthodontia should be included in the benchmark; however, we have heard from some states they will not be including this benefit and HHS has not corrected them at this juncture. NADP has also learned in

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conversations with states that if the dental benchmark includes adults (FEHBP and FEDVIP), then the adult coverage may become part of the required benefit. NADP encourages conversing with HHS to have this issue clarified as it would significantly impact the cost of the overall EHB benchmark.

NADP has continued to advocate for the allowance of a pediatric dental benefit which parallels a “typical employer plan” as cited in the ACA as the basis for the EHB. Unfortunately, the proposed dental specific benchmarks of the FEDVIP and CHIP are not comparable to an employer plan. States should have the flexibility to choose a more affordable dental benchmark rather than moving to the less common public program dental benchmarks of FEDVIP and CHIP. Benchmarking to dental policies that are distinctly different than common commercial policies, while not allowing common cost sharing mechanisms will significantly impact the premium for dental coverage.

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 EHBs for DC. While most large employers (more than 100 employees) include medical and dental coverage¹ as part of the health benefits package offered to employees, only 48% of all small employers now offer dental coverage². The inclusion of “pediatric oral services” in the EHB will be an expansion of coverage in much of the small employer market, and potentially an extra cost to employers. The breadth of the added pediatric dental coverage must be balanced between the beneficial new dental coverage for the consumer and the need for affordability.

According to the Department of Labor (DoL) Survey³, 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.

In NADP’s attached Issue Brief “EHB Dental Benchmarks,” the costs, actuarial value, and benefit structure of dental benchmarks are presented. We encourage your department to review the Issue Brief for additional background information when choosing a dental benchmark. In addition, a dental state fact sheet with relevant provider and marketplace information specific to DC is attached.

NADP appreciates your time and attention to our comments, and look forward to future discussions on these critical issues to the residents of DC. Several of our member companies in DC will also be submitting comments for your consideration. Please contact me at 972.458.6998x111 or khathaway@nadp.org for questions and additional information. Again, thank you for your consideration.

¹ An estimated 99% of Americans with dental coverage today have a dental benefit policy separate from their medical policy. NADP/DDPA Joint Dental Benefits Report: Enrollment 2012.

² NADP 2011 Purchaser Behavior Survey, May 2011.

³ Department of Labor, “Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services,” April 15, 2011.

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Sincerely,



Kris Hathaway
Director of Government Relations
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cc: Mr. Brendan Rose, DISB

NADP DESCRIPTION

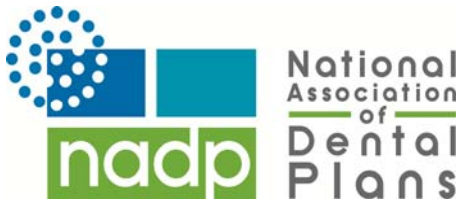
NADP is the largest non-profit trade association focused exclusively on the dental benefits industry, i.e. dental PPOs, dental HMOs, discount dental plans and dental indemnity products. NADP's members provide dental benefits to over 90 percent of the 176 million Americans with dental benefits. Our members 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.

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ISSUE BRIEF: EHB DENTAL BENCHMARKS

Premiums & AVs for Pediatric Dental within State Benchmarks

PURPOSE: NADP's *Issue Brief: EHB Dental Benchmark* is to provide background and cost information for state and federal policymakers developing the pediatric dental portion of the EHB benchmarks. This Issue Brief includes a brief summary of how pediatric dental is included within current HHS EHB guidance, the costs and actuarial value levels of those dental benchmarks, and recommendations from the dental benefits industry.

ACA BACKGROUND: The Patient Protection and Affordable Care Act's (ACA) inclusion of "pediatric services, oral and vision care" (pediatric dental) in the Essential Health Benefits Package¹ (EHB) is an important achievement for the oral health of children. These services will be a required component in policies sold in the small group and individual market beginning in 2014. The Pew Center on the States estimates that 5.3 million children will be added to dental coverage by the ACA primarily in public programs².

DENTAL IN BENCHMARKS: On December 16, 2011 HHS released the *Essential Health Benefits Bulletin* followed on February 17, 2012 by the *Frequently Asked Questions Essential Health Benefits Bulletin*. These documents provided guidance to states on what the EHB should parallel in the current marketplace. HHS outlines four distinct health benefit benchmarks for states to use in defining their EHB's. In short they include policies from small employers, state employees, the Federal Employees Health Benefits Program (FEHBP) and non-Medicaid HMOs. HHS also adds two specific benchmarks for dental when pediatric dental is "missing" from these health specific benchmarks; they include the Federal Employees Dental & Vision Program (FEDVIP), and the state's Children's Health Insurance Plan (CHIP). In addition, HHS notes that it is considering adding "medically necessary" orthodontia as part of the EHB package.

Of the four health options above, the FEHBP is the only benchmark which consistently includes pediatric dental coverage. The FEHBP two largest health plans have a schedule of preventive and restorative dental procedures with greater cost sharing (higher out of pocket costs) on the consumer than typical employer dental coverage³. The two additional dental specific benchmarks, FEDVIP and

¹ ACA Section 1302, "Essential Health Benefits Requirements" March 2010.

² The Pew Center on the States: "The State of Children's Dental Health: Making Coverage Matter," Gehshan, Shelly, et al. May 2011.

³ 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.

CHIP cover similar services; however, FEDVIP has high annual maximums while CHIP has no⁴ consumer cost sharing so neither benchmark parallels typical private market dental plans. HHS has not specifically included a benchmark that reflects pediatric dental in a typical employer policy per ACA Sec. 1302(b)(2)(A).

With the inclusion of the dental specific benchmarks, HHS implies that “pediatric oral services” are tied to typical dental plans. However, since the benchmarks that are used are atypical, NADP has requested that HHS allow states to utilize small employer dental coverage as a benchmark for pediatric dental just as the default for health coverage is small employer medical coverage. For full descriptions on dental in HHS benchmarks, please review [Attachment 1](#) of NADP Comments to HHS on the *Essential Health Benefits Bulletin*. [Please see NADP Recommendation #1].

PREMIUMS: NADP commissioned Milliman (an independent actuarial firm) to develop monthly premium costs for the pediatric dental benchmarks outlined in HHS guidance. The core parameters for these premium cost estimates included no annual or lifetime limits, coverage of child related services for ages up to 21, and no deductible applied to Class I (preventive services). The estimated premiums reflect national average costs from Milliman’s dental database. Costs are displayed on a per child basis since policies will have to be offered as ‘child-only’ per HHS guidance, and the benefit is only required for ‘pediatric’ age children within ACA.

To be able to compare the current EHB benchmarks to a typical employer plan as it exists today, Milliman also estimated premiums for a small employer dental plan. And while that plan includes procedures and services similar to the dental specific benchmarks, the deductibles, cost sharing and annual limits differ significantly.

Premiums were also calculated on three levels of orthodontia services since no guidance is given for “medical necessity” and states vary widely in their parameters for orthodontia in public programs. The most restrictive level calculated provides coverage only for treatment of cleft palate, the mid-range level provides coverage for treatment of “severe or handicapping malocclusion,” and the high range level allows treatment whenever indicated by a dentist. The definition used for medically necessary orthodontia results in a substantial range of costs. The cost illustrated in the chart represents the mid-range “medically necessary” orthodontia coverage with 50% coinsurance. Without coinsurance the cost would double.

ACTUARIAL VALUE (AV): The HHS February Bulletin proposing a methodology for standard calculation of actuarial value of health plans did not include a factor for dental coverage. As such the AV level of the dental portion of the Essential Health Benefit package **will not affect** the AV level of a health plan. In the NADP/DDPA White Paper on Exchanges, we proposed that AV levels not be applied to dental as it is only a small portion of the overall EHB. However, some state and federal regulators have raised questions about the actuarial values of dental plans which suggest that they may require dental policies on Exchanges to meet AV levels separately or in combination with a medical plan.

To determine the AV levels of today’s typical dental plans and how the proposed dental benchmarks fall within the ACA required AV benchmarks for Exchanges, NADP again commissioned Milliman.

⁴ While our calculation of the state CHIP benchmark does not include cost sharing, most states utilize a variety of limits to contain costs within this public program.

Milliman developed AV for the benchmarks as they exist today with annual and lifetime limits as well as without annual and lifetime limits for comparison purposes. Milliman's calculations reflect the HHS proposed methodology of using in network claim values only and the waiver of the typical \$50 deduction on Class I (preventive services) as is often done in today's dental benefit market. The AV levels illustrated below would be slightly lower if in network claims are blended with out of network claims (see footnote 7).

The chart shows that typical dental plans and the proposed benchmarks will approximate the gold or platinum level of coverage outlined in the ACA. Milliman also calculated AV levels with the common \$50 deductible applied to all dental services which brought the AV levels of the typical small employer plan and the benchmarks down to the silver range. While dental benefits do not explicitly impact the AV level of the EHB, whether offered embedded or stand-alone, with appropriate cost sharing dental benefits can be developed within the range required for Exchange participation. Please see NADP Recommendation #4.

States must weigh the limited dental benchmarks carefully to find the right balance for their state and to allow pediatric dental coverage to be consistent with the required silver and gold actuarial values for Exchange participation. While medically necessary orthodontia raises the overall premium cost of dental coverage, it **could lower** the actuarial value. A state must decide what the parameters are for medical necessity if HHS includes it as part of the pediatric dental benefit. Please see NADP Recommendation #3.

CONSUMERS & COSTS: In considering benchmark options for pediatric dental, states should consider the impact of the cost of these services on families purchasing coverage. Through 2008, 57% of the U.S. population had dental coverage—a percentage that had been relatively stable for several years. In 2009, enrollment in dental plans dropped to 54% with 10 million fewer Americans having dental coverage, a decrease for the first time since the industry has been tracking enrollment. The lower enrollment reflected both decreased employment and employees choosing not to purchase coverage for which they pay all or a substantial portion of the cost due to other economic pressures as during this period both new and in-force premiums rose only by 1% to 4% depending on the type of product. NADP consumer survey data confirms there is high price sensitivity to increases in the premiums for dental coverage among consumers.

Requiring coverage for children's dental within the EHB changes the dynamic of coverage. Currently, employers offer dental benefits to their employees with the election to have their families covered. Now, the policy is issued on the child with the adults as additional coverage. Therefore if the cost of the children's coverage is excessive, parents may not continue dental coverage for themselves. Based on consumer surveys, NADP has projected half of adults with employer-provided dental coverage in the small group market today, i.e. 11 million, would drop coverage if their dental coverage is separated from their children's coverage and the cost of the children's coverage is substantial. With Pew Institutes estimate that 5.3 million children will be added to programs providing dental coverage -- most in public not commercial dental plans--the net loss in coverage and reduction in access to dental care could be significant.

With the Surgeon General's finding that dental coverage results in more dental visits by both adults and children and the more recent linkages of oral and overall health, any degradation of dental coverage will have an overall negative impact on oral health, overall health and ultimately the costs of

medical conditions like diabetes, cardiovascular disease and low birth weight babies. Therefore, allowing families to stay together while providing high quality dental policy options with affordable costs is critical for consumers.

RECOMMENDATIONS:

1. To best approximate current small group coverage, states should be given an option to use a small employer dental policy as a benchmark for “pediatric oral services” with the typical cost sharing and other limits of that plan (keeping in place the exclusion of annual and lifetime maximums). Employer plans are able to balance appropriate services needed for children while staying affordable by utilizing cost containment structures such as frequency limits and Least Expensive Alternative Treatment (LEAT) provision.
2. Allow dental coverage, both stand-alone and embedded, to apply the common \$50⁵ deductible to pediatric oral services and reduce the deductible of any medical policy without dental by \$50⁶. This eliminates both the potential that any consumer will have to meet the full ACA deductible before accessing dental benefits and the complexity of coordinating between the medical and dental deductibles. Anyone using dental benefits during the year will easily satisfy the \$50 deductible.
3. If “medically necessary orthodontia” is included in the final EHB rules as part of “pediatric dental services,” HHS or the states should provide guidance for medical necessity as the application of “medical necessity criteria” for orthodontic coverage is not common in commercial dental plans today and public programs vary widely in their coverage of orthodontia for children.
4. Pediatric dental coverage offered separately or included in a medical plan should provide benefits consistent with the silver and gold actuarial value levels required for Exchange participation. This recommendation is contingent on the adoption of the \$50 deductible for dental outlined above as without this deductible dental coverage would exceed the gold AV level⁷. Since HHS does not include pediatric dental services in the standard calculation of AV levels for health plans, a separate standard calculator for dental should be developed.
5. When a consumer selects a medical plan without pediatric dental services and a separate dental plan covering these services, the subsidy, which is set on the 2nd lowest silver health plan with dental included, can either be distributed in one of 3 ways:
 - a. paid entirely to the medical plan;
 - b. distributed proportionately to the medical and the dental plan based on the ratio of the two premiums to the total premium; or
 - c. paying the full dental premium with the balance to the medical plan.

Given geographic differences in premiums, NADP recommends that the subsidy be calculated on a state-by-state basis and proportionately distributed (see b above) when consumers select separate dental coverage⁸. If HHS or the state determines that the full subsidy should be paid to the medical plan, processes should be adopted to reduce the disproportionate risk that dental plans would assume in the collection of all dental premium from the consumer. These processes could be the provision of EFT or credit card payment or payment of the annual premium or some portion of premium in advance.

⁵ Any amount that is set as the initial standard for a dental deductible may need to be indexed for inflation over time.

⁶ The split deductible should not be applied to a High Deductible Health Plan offered in the Exchanges.

⁷ Milliman June 11th memo on AV of dental coverage.

⁸ Based on currently available information NADP estimated the portion of the subsidy to be distributed to dental will average approximately 3.6% nationally. The calculation is available on request.

2014 Dental Benchmark Premium & AV Levels per Child up to Age 21ⁱ

Benchmark Dental Plan Description	Without Orthodontia					With Mid-Level Medically Necessary Ortho @ 50% Coinsurance				
	Per Child Per Month As Exists Today	AV as Plan Exists Today	Per Child Per Month without Limits	AV No Limits ⁱⁱ & \$50 Deductible on Class II & III Only	AV No Limits w/\$50 Deductible on All Services	Per Child Per Month	AV as Plan Exists Today with Ortho	Per Child Per Month without Limits with Ortho	AV No Limits & \$50 Deductible on Class II & III Only	AV No Limits w/\$50 Deductible on All Services
Typical Small Employer DPPO Dental Plan without Ortho <i>(currently not allowed as a dental benchmark)</i> \$1,000 Annual Maximumⁱⁱⁱ ; In Network: 100/80/50, Out-of-network: 80/60/40, \$50 deductible applied only to Class II & III services ^{iv} .	\$21.00	76%	\$24.50	81%	73%	\$23.80	72%	\$27.30	77%	74%
FEHBP Plan with Largest Enrollment --BCBS Standard <i>(BCBS Standard and BCBS Basic are the only EHB health benchmarks that include dental)</i> Schedule of covered dental procedures includes diagnosis, prevention, emergency, restorative & extractions with scheduled payment based on age. Any services not listed are not covered.	\$4.50	21%	no change	no change	no change	\$7.30	26%	no change	no change	no change
FEDVIP Dental with Largest Enrollment--MetLife DPPO^v <i>(dental specific benchmark)</i> \$10,000 annual maximum ^{vi} ; In network 100/70/50, Out-of-network 90/60/40 with \$50 deductible on Class II & III services.	\$24.50	77%	\$24.50	77%	73%	\$27.30	73%	\$27.30	73%	70%
State CHIP Program Without^{vii} Ortho <i>(dental specific benchmark)</i> No annual maximums or cost-sharing	\$29.25	100%	same	n/a	n/a	\$32.05	93%	same	n/a	n/a

Cost for Addition of Orthodontic Coverage <i>Cost depends on definition of "medical necessity"^{viii}.</i>	Cleft Palate Only	Severe or Handicapping Malocclusion	As Administered Today
Medically Necessary (MN) Ortho* with 50% coinsurance ^{ix}	\$ 0.40	\$2.80	\$9.40
Medically Necessary (MN) Ortho with no coinsurance ^x	\$0.80	\$5.60	\$18.75

NOTE: Premiums are estimated based on currently available information. They do not include the impact of the ACA's insurer assessment or fees that will be levied for Exchange operation.

Chart Footnotes

ⁱ Costs were developed by Milliman for NADP as a national average with in-network utilization as proposed in HHS's AV calculation. Costs will vary by geographic area. Assumptions included that the age of pediatric services to be 21. NOTE: If utilization is blended between in and out of network, AV levels drop by 7% to 10% in the typical small employer plan, by 4% in the FEDVIP plan, and 1% in the CHIP plan with MN orthodontia.

ⁱⁱ No lifetime or annual limits are applied.

ⁱⁱⁱ The data presented to HHS by the Secretary of Labor indicates small employer plans have a \$1000 annual maximum while overall employer plans currently have a \$1500 annual maximum.

^{iv} The deductible is waived for Class I preventive services. If the standard dental deductible is not utilized and the \$2000 ACA annual deductible is coordinated with a medical plan, the cost of coverage could be decreased by as much as half. However, a consumer would incur significant expense before receiving any dental services other than prevention which usually consists of periodic office visits, cleanings, sealants and topical fluoride.

^v The MetLife plan also includes 50% coinsurance on orthodontia (ortho) up to age 19 with a 24 month waiting period and \$3500 lifetime limit. This provision was not priced since HHS indicated that what was being considered is *medically necessary* ortho.

^{vi} Actual annual limit of the MetLife DPPO for 2012 is \$10,000. For purposes of the analysis of children's benefits, a \$10,000 maximum is essentially equal to no annual maximum.

^{vii} The MEPS Chartbook 17 shows the average annual expense for children from birth to 20 with a dental visit in 2004 was \$635 for children with private dental coverage and \$272 for children with public dental coverage. Public programs have put in place limits for receiving care that are substantial even without the annual limits commonly used by private coverage. The cost of a CHIP equivalent program is substantial because private insurers will not be able to impose the limits that states do now in CHIP programs—like lower provider reimbursement.

^{viii} The range of costs for orthodontia was based on the following alternatives derived from state CHIP programs. Lowest estimate is based on coverage for ortho for cases of cleft palate only. The middle estimate is based approximates the application of a mid-range Salzman index to reflect a National Center for Health Statistics study that found 29% of pediatric population had a handicapping to severe malocclusion. The high range is the provision of an ortho benefit as it is administered today without regard to medical necessity.

^{ix} As administered today ortho claims are subject to 50% coinsurance and a separate annual limit. Although the full lifetime limit is usually paid on each claim, there is significant cost sharing for the procedure. Since it is unclear whether cost sharing will be allowed for "medically necessary" ortho treatment, Milliman developed estimated premium for no coinsurance as well.

^x Ibid

RELEASED: June 2012, v1.0

NADP DESCRIPTION:

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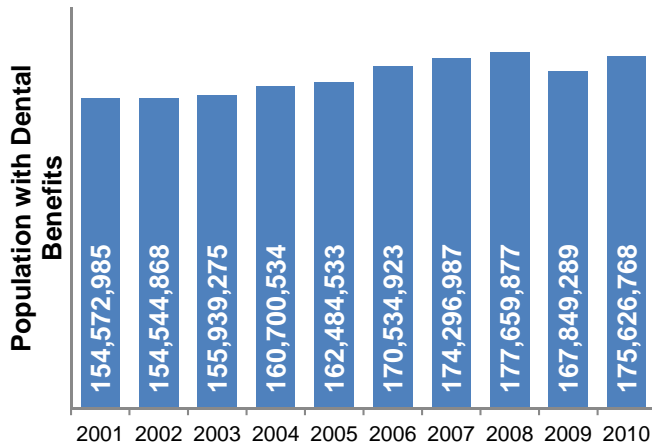
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Washington, D.C.

Dental Benefits Fact Sheet

National Enrollment Trends



Source: 2011 NADP/DDPA Joint Dental Benefits Report on Enrollment

State Enrollment

An estimated 434,080 people are enrolled in a private dental plan from Dist. Of Col.

Private Plan Enrollment

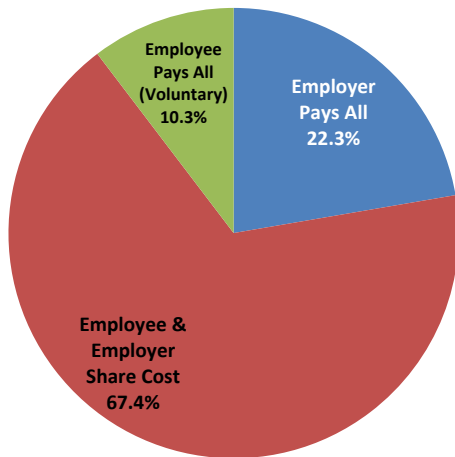
Plan Type	Enrollment
DHMO	34,856
DPPO	213,388
Indemnity	173,513
Other Private	12,323

Public Plan Enrollment

Medicaid/CHIP ¹	218,942
Other Public	38,437

Source: 2011 NADP/DDPA Joint Dental Benefits Report on Enrollment

Group Policy Funding

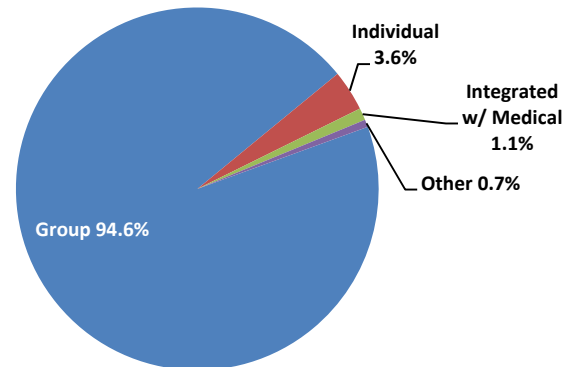


Source: 2011 NADP/DDPA Joint Dental Benefits Report on Enrollment

Distribution of Commercial Benefits: State v. National

	DHMO	DPPO	Indemnity	Other
Dist. Of Col.	8.0%	49.2%	40.0%	2.8%
National	8.3%	73.7%	10.8%	7.3%

Sources of Private Dental Coverage



Source: 2011 NADP/DDPA Joint Dental Benefits Report on Enrollment

Additional Facts

- According to the Surgeon General, dental insurance matters as uninsured children are 2.5 times less likely than insured children to receive dental care.²
- Premium increases for existing group coverage ranged from 3.0% for DPPO products to 3.8% for Dental Indemnity products.³

¹ Data from the Center for Medicare and Medicaid Services. If 0, then CMS data is not available.

² Surgeon General's Report on Oral Health, May 2000

³ NADP 2011 Premium and Benefit Utilization Trends

Washington, D.C. Dental Benefits Fact Sheet

Workforce

The federal standard for an adequate supply of dentists is 3.33 practicing dentists per 10,000 population.⁴

According to the American Dental Association, 403 dentists are actively practicing in Washington, D.C. or 6.70 dentists per 10,000 population.⁵

Network Type	Total Dentists	General Dentists	Pediatric Dentists	Specialists
DHMO	28	20	0	8
DPPO	154	97	12	45
Discount	69	45	2	22

Source: 2011 NADP/DDPA Joint Dental Benefits Report on Network Statistics

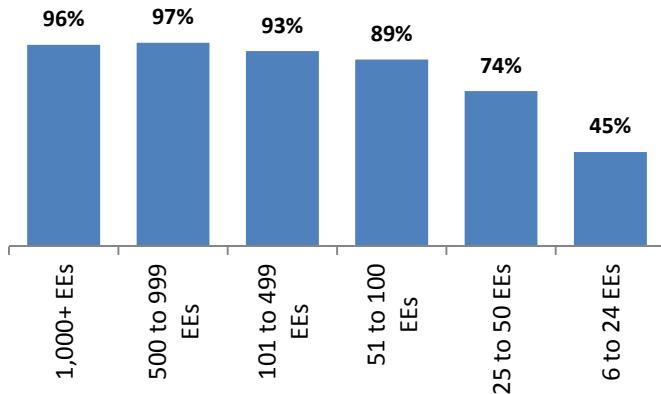
NADP Members

Plan Type	NADP Members Offering Dental Plans
DHMO	6
DPPO	24
Indemnity	14
Discount	14

Source: 2011 NADP Membership Directory

Where do Consumers Get Dental Benefits

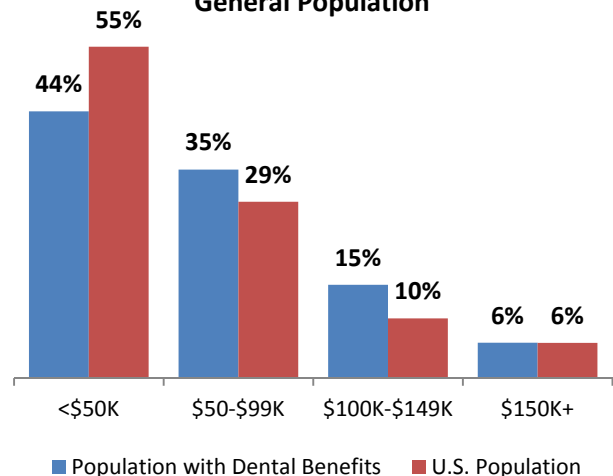
Employers Offering Dental Benefits by Employer Size



Source: 2011 NADP Purchaser Behavior Survey

Who Has Dental Benefits?

Consumers with Dental Benefits by Household Income compared to General Population



Source: 2009 NADP Survey of Consumers

About NADP

The National Association of Dental Plans (NADP), a nonprofit corporation with headquarters in Dallas, Texas, is the “representative and recognized resource of the dental benefits industry.” NADP is the only national trade organization that includes the full spectrum of dental benefits companies operating in the United States. NADP’s members provide Dental HMO, Dental PPO, Dental Indemnity and Discount Dental products to 141 million Americans, more than 80% of all the dental benefits in the U.S.

⁴ U.S. Department of Health and Human Services

⁵ American Dental Association