



September 4, 2012

Ms. Molly Voris  
Director of Policy, Health Benefit Exchange  
521 Capitol Way South  
Olympia, WA 98507  
Sent via email

**Re: “Pediatric Oral Services” in Washington Exchange**

Dear Ms. Voris,

The National Association of Dental Plans (NADP) is writing to provide information on the dental benefits industry and how dental benefits are included in the Affordable Care Act (ACA) and Exchanges. We feel it is imperative for your agency to consider how “pediatric oral services” as part of the Essential Health Benefits (EHB) package should be incorporated into Washington’s Exchange.

**DENTAL IN THE ACA**

Children’s oral health coverage was expanded in the Affordable Care Act (ACA) through the inclusion of pediatric oral health services in the EHB package. The EHB package is required in all health policies offered in the small group and individual market. However, ACA specifically states “Each Exchange within a State shall allow an issuer of a plan that only provides limited scope dental benefits meeting the requirements... to offer the plan through the Exchange (whether separately or in conjunction with a qualified health plan) if the plan provides pediatric dental benefits meeting the requirements...”<sup>1</sup>

In addition, a Qualified Health Plan (QHP) does not need to include the pediatric dental benefit if the coverage is offered through a stand-alone dental plan *inside* an Exchange<sup>2</sup>. There has been discussion with the Center for Consumer Information and Insurance Oversight (CCIIO) of the U.S. Department of Health and Human Services regarding clarification to also allow medical carriers to not include the pediatric dental

<sup>1</sup> Affordable Care Act Section 1311(d)(2)(B)(ii)

<sup>2</sup> Affordable Care Act Section 1302 (b)(4)(F)

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benefit in their policies *outside* of Exchanges if a stand-alone dental policy that includes the required pediatric dental benefits is already being offered within the market.

The reason behind the ACA language, and the potential clarification in the private market, is dental benefits are typically purchased as a separate product by consumers. In the private market (not including public programs), an estimated 99 percent of Americans with dental coverage today have a dental benefit policy separate from their medical policy<sup>3</sup>. Thus, the ACA allows Exchange customers to purchase dental policies separately from their medical plan just as it is commonly done in the commercial market today. Attached is a [fact sheet](#) which outlines the Washington dental market to provide additional insight.

#### **WASHINGTON HEALTH BENEFIT EXCHANGE**

NADP applauds Washington State for taking a leading role in establishing a health insurance Exchange and being well on the way to becoming one of the first state-based Exchanges as required under the ACA. Most recently the Exchange Board viewed a presentation on “Dental Plans in the Exchanges”, and per the timeline outlined by Washington’s consultants, the Exchange’s Advisory Committee will be working with the Dental Plan Technical Advisory Committee on dental related recommendations.

NADP would like to offer some background from the ACA, the recent CCIIO regulations, and industry insight on key issues Washington should consider related to incorporating dental; as well as some policy options to review. As states initiate conversations related to dental, it may at first seem overwhelming, but NADP has been discussing these issues since ACA’s passage and is ready to assist and educate states as they traverse through various pathways to a successful Exchange in which the consumer shopping experience is simple, and the options are flexible, varied, and affordable.

#### **OFFER AND PRICING OF DENTAL POLICIES**

**Background:** The ACA as cited above requires the allowance for stand-alone dental plans to offer the pediatric dental portion of the EHB on the Exchange. This creates a marketplace imbalance for stand-alone dental plans if all the medical plans embed dental in the policies they offer on the Exchanges, leaving consumers with only an embedded medical/dental policy to purchase. On the other hand, medical plans are currently allowed to embed dental coverage, and a change in policy may disrupt consumers with current embedded coverage. CCIIO requested comments during their initial Exchange regulations, and in their final regulations they addressed the issue:

*Comment:* A set of commenters addressed the request for comment in the proposed rule on whether the final rule should establish that QHPs must separately offer and price coverage for the pediatric dental essential health benefit so that consumers have the potential to enroll in dental coverage that is different from the dental benefits offered by the QHP they selected. Some suggested a standard for QHPs to separately price and offer pediatric dental coverage so consumers could make direct comparisons based on premium, cost-sharing, and benefits. Other commenters stated that it would be easier for consumers if the benefits were bundled. A

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<sup>3</sup> 2011 NADP/DDPA Joint Dental Benefits Report: Enrollment 2012.



number of commenters also recommended that HHS direct QHPs to offer medical-only options without pediatric dental coverage.

*CCIIO Response:* If an Exchange determines that having QHPs separately offer and price pediatric dental coverage is in the interest of the consumer, as described in § 155.1000(c), then the Exchange may establish such standard as a condition of QHP certification. Otherwise, QHPs are not uniformly directed to separately price and offer pediatric dental coverage under this final rule.<sup>4</sup>

On March 8, 2012, Washington passed HB 2319 which included “Consistent with section 1311 of P.L. 111-148 of 2010, as amended, the board shall allow stand-alone dental plans to offer coverage in the exchange beginning January 1, 2014. Dental benefits offered in the exchange must be offered and priced separately to assure transparency for consumers.”<sup>5</sup> Due to the legislation the Washington Exchange will be requiring dental benefits within the Exchange to be offered and priced separately.

Washington has made their choice on dental policy offerings within the legislation. In states that have not set their policy on dental in Exchanges, NADP has proposed a solution in which there is transparency for consumers while allowing current marketplace options. Within the Exchange, if a medical carrier decides to include a dental policy within their medical policy, then they should also be required to offer a medical policy without dental so that consumers can choose medical with their dental policy included, or purchase a medical policy and dental policy from separate carriers.

In recent meetings, officials from CCIIO’s Federally-facilitated Exchange staff confirm that they will require benefit comparisons of a medical plan’s pediatric dental coverage to stand-alone dental options. By emulating today’s marketplace, Exchanges can promote the conditions under which medical-only, dental-only and full service plans can compete and thrive in Exchanges while consumers elect what is best for them.

#### ACA REQUIREMENTS TO CONSIDER

**Actuarial Value (AV):** If Washington will be utilizing the CCIIO AV calculator, dental will not be included, and thus not part of the overall EHB calculation. CCIIO has not discussed how they intend for the pediatric dental policy to be included within the four metal levels; however, NADP has an [Issue Brief](#) on the issue with background costs of the various dental benchmarks and AV levels which is attached for your review. Otherwise, if Washington incorporates their own AV calculator, the pediatric dental is so minimal to the AV calculations that the impact to the overall EHB AV level is equal to or smaller than one percentage point.

**Out of Pocket Costs:** The ACA limits out-of-pocket health expenditures by the consumer. When a consumer selects both a health plan and a separate dental plan, NADP has recommended, and CCIIO

<sup>4</sup> Federal Register, Vol. 77, No. 59 “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers”, pg. 18411, March 27, 2012.

<sup>5</sup> HB 2319 “Affordable Care Act Implementation,” Part IV Qualified Health Plans, Section 8 (2).



and most states are looking to proportionately separate the out-of-pocket costs between the medical and separate dental policies. By allowing a proportionate division, it simplifies a consumers understanding of their two policies, streamlines claims processing and eliminates costly coordination among a variety of carriers.

**Cost Sharing Reductions:** Low income individuals who enroll in the Exchange between the 100-400% of FPL are eligible for cost sharing reductions.<sup>6</sup> However, if an individual enrolls in both a qualified health plan and a standalone dental plan that provides pediatric dental benefits, the portion of any cost-sharing reduction allocable does not apply.<sup>7</sup>

**Information Technology (IT):** In today's markets, private exchanges and insurance shopping websites already offer medical and dental policies to be purchased together or separately. In NADP's discussions with CCIIO, it seems they agree and are likely to allow a similar purchasing path to parallel the private market today. The programming does not need to be reinvented; many IT vendors have already incorporated these consumer shopping experiences into their planning process and should be required by Washington's IT staff and vendors.

**QHP Dental Requirement:** The ACA does require QHPs to include the pediatric dental benefit as part of the EHB unless there are stand-alone dental plans offering the required pediatric dental benefit.<sup>8</sup> CCIIO will be requesting a "Conditional Intent Form" from dental plans to confirm there will be separate dental policies available, and then announcing to QHPs whether they will need to include dental in their policies. California is taking a similar approach by requiring a "Notice of Intent" from dental carriers.

**Sufficient Choice & Capacity:** Washington should allow for the flexibility of a variety of dental plans to offer coverage on their exchange, similar to medical plans. Both CCIIO and Maryland Exchanges will be open to all plans which qualify and then that structure will be reevaluated as the Exchanges progress. To require subcontracting, riders or coordination between separate medical and dental carriers will add burdensome administrative costs, resulting in higher premiums while confusing the consumer. By paralleling today's typical employer coverage, which is the goal of the ACA, a consumer should have the option to purchase their medical and dental from the same or different carriers in a simple and transparent manner. This summer, NADP surveyed our members and found in Washington **17** dental carriers looking to participate in the AHBE Exchange, and **7** dental carriers planning to participate in the SHOP Exchange. By narrowing down choices Washington limits a consumer's options and minimizes competition.

CCIIO and most state Exchanges recognize a fundamental goal is to allow a variety of benefit choices for consumers with affordability playing a key component. Both the Federally-facilitated Exchange and the Maryland Exchange (Oregon and California are currently reviewing their options) are allowing all stand-alone dental plans that qualify to offer the pediatric dental benefit on their Exchanges; per the ACA

<sup>6</sup> Affordable Care Act Section 1402 (b)

<sup>7</sup> Affordable Care Act Section 1402 (c)(5)

<sup>8</sup> Affordable Care Act Section 1302 (b)(4)(F)



these Exchanges are looking to parallel typical employer coverage. Washington should consider and encourage multiple dental policies from a variety of medical and dental carriers to ensure ample choices to meet their resident's needs on the Washington Health Benefit Exchange.

#### **SUPPLEMENTAL DENTAL COVERAGE**

It is important to allow consumers to purchase dental coverage that go beyond the pediatric dental benefit benchmark, both for adults as well as additional coverage for children - so they can enjoy the same options as other Washingtonians. As the U.S. Surgeon General's report *Oral Health in America* emphasized, dental insurance plays an important role in promoting oral health. As enrollee's are more than 40% likely to visit a dental provider when they have dental coverage<sup>9</sup>, adults should be able to purchase coverage for themselves. In addition, a parent may want additional coverage to assist in expensive procedures for their children, such as cosmetic orthodontia. In NADP's discussions with CCIIO they have confirmed they intend to allow optional adult and non-pediatric dependent coverage on both their AHBE and SHOP Federally-facilitated Exchanges.

#### **CERTIFICATION OF DENTAL PLANS**

The final CCIIO Exchange rules<sup>10</sup> require relevant stand-alone QHP certification standards to be applied to the stand-alone dental plan offering pediatric dental benefits in the Exchange. Per CCIIO's request, NADP reviewed each of the QHP certification standards and offered recommendations in an [Issue Brief](#) on the application of those standards on dental plans. It is unclear whether CCIIO will provide direct regulations on QHP standards applying to dental plans, or whether the responsibility and decision will be made individually by each state.

It is critical that the Washington Health Benefit Exchange ensure a variety of affordable dental options not only for their residents' health, but to keep the Exchange a vibrant health marketplace for years to come. We encourage you to utilize the two attachments, "Issue Brief: EHB Dental Benchmarks" and "Issue Brief: Certification of Dental Plans Offering Pediatric Dental through an Exchange" in the hopes they will assist in your future recommendations related to dental plans. In addition, the [NADP/DDPA Exchange White Paper](#) is an in-depth analysis on offering dental benefits in Exchanges. If you need any further information, statistics or background, please contact me at your convenience at [khathaway@nadp.org](mailto:khathaway@nadp.org) or 972-458-6998x111.

NADP appreciates your time and attention to our comments, and we look forward to future discussions on these critical issues to the dental benefits industry. Again, thank you for your consideration.

Sincerely,



<sup>9</sup> The Have and the Have-nots: Consumers With and Without Dental Benefits, NADP Consumer Survey 2009.

<sup>10</sup> Federal Register, Vol 77, No. 59 "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers", pg. 18412, March 27, 2012.

National Association of Dental Plans

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cc:

Ms. Beth Berendt, Office of Insurance Commissioner  
Mr. Brad Finnegan, Health Benefit Exchange  
Ms. Meg L. Jones, Office of the Insurance Commissioner  
Members of the Washington Exchange Board (sent via mail)

**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.

National Association of Dental Plans

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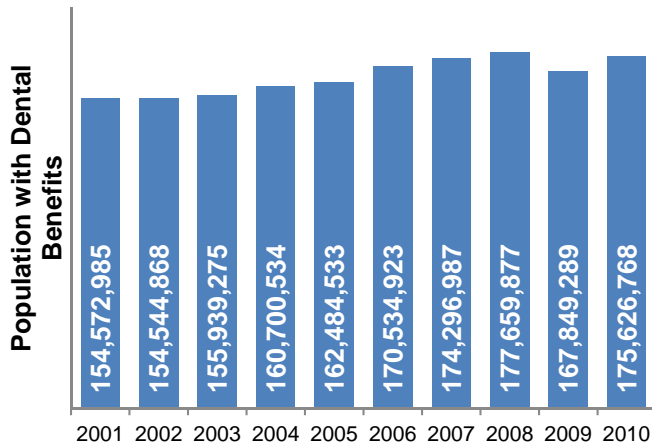
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# Washington

## Dental Benefits Fact Sheet

### National Enrollment Trends



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

### State Enrollment

An estimated 2,864,959 people are enrolled in a private dental plan from Washington

#### Private Plan Enrollment

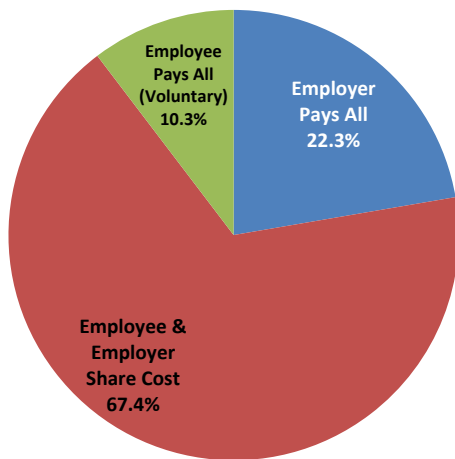
Plan Type	Enrollment
DHMO	123,652
DPPO	2,382,142
Indemnity	247,090
Other Private	112,074

#### Public Plan Enrollment

Medicaid/CHIP <sup>1</sup>	33,139
Other Public	342,920

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

### Group Policy Funding

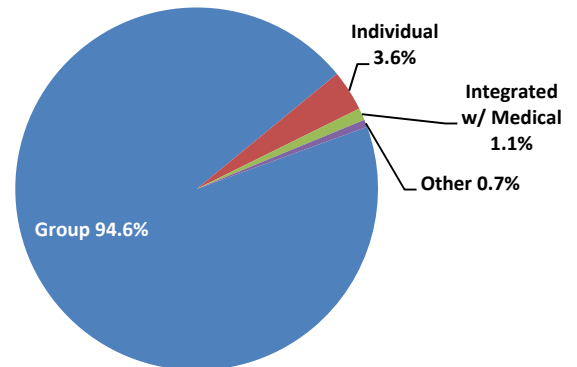


Source: 2011 NADP/DDPA Joint Dental Benefits Report on Enrollment

### Distribution of Commercial Benefits: State v. National

	DHMO	DPPO	Indemnity	Other
Washington	4.3%	83.1%	8.6%	3.9%
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.<sup>2</sup>
- Premium increases for existing group coverage ranged from 3.0% for DPPO products to 3.8% for Dental Indemnity products.<sup>3</sup>

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

<sup>2</sup> Surgeon General's Report on Oral Health, May 2000

<sup>3</sup> NADP 2011 Premium and Benefit Utilization Trends



# Washington Dental Benefits Fact Sheet

## Workforce

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

According to the American Dental Association, 4,579 dentists are actively practicing in Washington or 6.81 dentists per 10,000 population.<sup>5</sup>

Network Type	Total Dentists	General Dentists	Pediatric Dentists	Specialists
DHMO	255	170	3	82
DPPO	3,443	2,804	136	503
Discount	2,250	1,845	95	245

## NADP Members

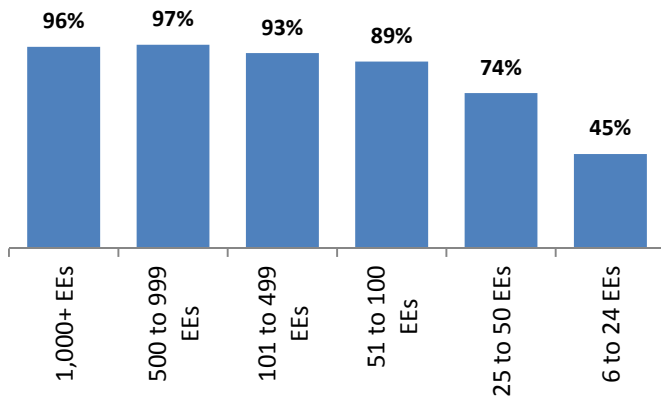
Plan Type	NADP Members Offering Dental Plans
DHMO	9
DPPO	24
Indemnity	19
Discount	15

Source: 2011 NADP Membership Directory

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

## Where do Consumers Get Dental Benefits

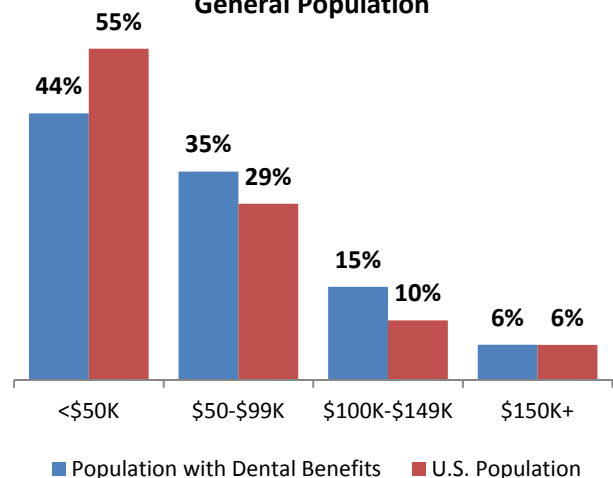
**Employers Offering Dental Benefits by Employer Size**



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

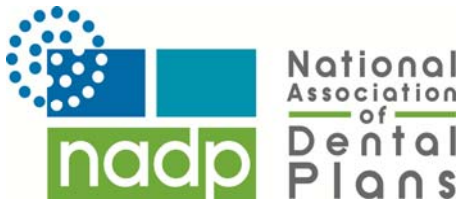
## About NADP

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.

<sup>4</sup> U.S. Department of Health and Human Services

<sup>5</sup> American Dental Association





# ***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 Package<sup>1</sup> (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 programs<sup>2</sup>.

**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 coverage<sup>3</sup>. The two additional dental specific benchmarks, FEDVIP and

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<sup>1</sup> ACA Section 1302, "Essential Health Benefits Requirements" March 2010.

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

<sup>3</sup> 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 no<sup>4</sup> 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.

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<sup>4</sup> 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 \$50<sup>5</sup> deductible to pediatric oral services and reduce the deductible of any medical policy without dental by \$50<sup>6</sup>. 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 level<sup>7</sup>. 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 2<sup>nd</sup> 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 coverage<sup>8</sup>. 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.

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

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

<sup>7</sup> Milliman June 11th memo on AV of dental coverage.

<sup>8</sup> 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 21<sup>i</sup>

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 <sup>ii</sup> & \$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
<b>Typical Small Employer DPPO Dental Plan without Ortho</b> <i>(currently not allowed as a dental benchmark)</i> <b>\$1,000 Annual Maximum<sup>iii</sup></b> ; In Network: 100/80/50, Out-of-network: 80/60/40, \$50 deductible applied only to Class II & III services <sup>iv</sup> .	\$21.00	76%	\$24.50	81%	73%	\$23.80	72%	\$27.30	77%	74%
<b>FEHBP Plan with Largest Enrollment --BCBS Standard</b> <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
<b>FEDVIP Dental with Largest Enrollment--MetLife DPPO<sup>v</sup></b> <i>(dental specific benchmark)</i> \$10,000 annual maximum <sup>vi</sup> ; 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%
<b>State CHIP Program Without<sup>vii</sup> Ortho</b> <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"<sup>viii</sup>.</i>	Cleft Palate Only	Severe or Handicapping Malocclusion	As Administered Today
Medically Necessary (MN) Ortho* with 50% coinsurance <sup>ix</sup>	\$ 0.40	\$2.80	\$9.40
Medically Necessary (MN) Ortho with no coinsurance <sup>x</sup>	\$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

<sup>i</sup> 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.

<sup>ii</sup> No lifetime or annual limits are applied.

<sup>iii</sup> 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.

<sup>iv</sup> 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.

<sup>v</sup> 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.

<sup>vi</sup> 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.

<sup>vii</sup> 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.

<sup>viii</sup> 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.

<sup>ix</sup> 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.

<sup>x</sup> Ibid

**RELEASED: June 2012, v1.0**

### **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: Certification of Dental Plans Offering Pediatric Dental Through an Exchange

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## BACKGROUND

On March 13, 2012, the Department of Health and Human Services (HHS) released its final rule regarding the establishment of Exchanges and Qualified Health Plans (hereinafter the “Final Rule”).<sup>i</sup> The purpose of this rule is to implement the requirements regarding the key functions of Exchanges with respect to eligibility, enrollment, as well as plan participation and management. This rule addresses only those health insurance plans offered through Exchanges and not the entire individual and small group market.<sup>ii</sup>

In order to be offered through an Exchange, a plan must have in effect a certification issued or recognized by the Exchange as a Qualified Health Plan (QHP).<sup>iii</sup> § 155.1000. To be certified as a QHP, the Final Rule requires that a plan provide evidence that it complies with the minimum certification requirements. § 155.1000(c)(1). As noted below, a limited scope dental plan is not a QHP; but because the pediatric dental benefit is an essential benefit, dental plans must comply with relevant QHP certification requirements. The certification requirements set forth under the Final Rule require that an issuer of QHPs must, with respect to each of the QHPs it offers through the Exchange, also be certified by the Exchange.

According to the Final Rule, a “limited scope dental benefits plan” may be offered through an Exchange if, among other things, the plan and issuer of such plan meets qualified health plan (QHP) certification standards, with the exception of any certification requirement that cannot be met because the plan covers only the pediatric dental essential health benefit. 45 C.F.R. § 155.1065.

As representatives of the dental benefits industry, the National Association of Dental Plans (NADP) and Delta Dental Plans Association have reviewed the QHP certification requirements to provide guidance to state and federal Exchange officials in applying the requirements to separate dental policies and dental plans, i.e. issuers of dental policies.

## SUMMARY & GUIDE

As the essential health benefits (EHB) package includes “pediatric services, including oral and vision services” (pediatric dental), the QHP requirements are applied to the pediatric dental portion of the EHB and on the issuer, when appropriate, not on the non-essential dental benefits that may be offered in a separate dental policy.<sup>iv</sup> Therefore certification requirements are restricted to pediatric dental, unless the requirement is structured so that the full plan or issuer must comply.

For easier review, the comments are color coded:

- **Green:** Dental plans meet this requirement today and thus, can be compliant in an Exchange;
- **Blue:** Dental plans can meet all or part of the requirements if the requirement is customized for dental;
- **Red:** Dental plans cannot meet the QHP certification requirement.

The quick summary below is organized in the three groups of certification requirements. However, the overall comments are structured to follow in order of the Affordable Care Act and Final Rule with a restatement of the requirement followed by an explanation by NADP and DDPA. In brief, the overall comments conclude that the QHP certification requirements fall into these groups:

**Dental Plans Can Meet the Requirements:** Licensing, Payments & Fees, Child-Only Plans, Non-Discrimination, Plan Rates, Provider Costs, Marketing, Community Providers, Geographic Coverage, Broker & Plan Offerings, Enrollment Periods, Payment Processes, Enrollee Termination, SHOP Requirements, Enrollee Non-Recertification, and QHP Decertification.

**Dental Plans Will Need the Requirements Customized:** Benefit Design, Quality Improvements, Rate Information & Justification, Policy & Enrollee Information, Network Adequacy, Provider Information, Enrollee Notifications, and Enrollee Information.

**Dental Plans Can Not Meet the Requirements:** Benefit Design, Quality Improvements, Risk Adjustment, Actuarial Value, Premium Rates, Accreditation, Abortion Coverage, and Prescription Coverage.

## Certification Requirements:

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### **Benefit Design**

1) *Comply with benefit design standards requiring:*

*(1.1) coverage of the essential health benefits described in section 1302(b) of the Patient Protection and Affordable Care Act (the “ACA”);*

*(1.2) cost-sharing limits described in section 1302(c) of the ACA; and*

*(1.3) a bronze, silver, gold, or platinum level of coverage described in section 1302(d) of the ACA (or catastrophic coverage described in section 1302(e) of the ACA). § 156.200(b); see also § 156.20 (definition of “benefit design standards”).*

**NADP:** Benefit design standards are also incorporated through the QHP certifications, but we will address these specific requirements separately:

**1.1 NADP & DDPA:** No, this requirement is not applicable to dental plans. The requirement to cover all essential health benefits clearly does not apply to a limited scope dental plan because, by definition, it covers only dental benefits. ACA Sec 1311 (d)(2)(B)(ii) specifically allows for dental plans not to meet the full EHB, or QHPs not to include dental if one stand-alone dental plan is present in the Exchanges.

**1.2 NADP & DDPA:** Yes, dental plans can comply with the various elements of cost sharing limits (deductibles, out-of-pocket costs and elimination of annual/lifetime limits) for the pediatric dental portion of EHB with guidance on appropriate methods of meeting this provisions under a separate policy. The NADP/DDPA Exchange White Paper includes several recommendations for the addressing cost-sharing limits that are applicable to subsidized consumers when purchasing EHB through both medical and dental policies through Exchanges. These include

1. Designing “pediatric oral services” in a way that requires no cost-sharing;
2. Apportioning the total OOP maximum between medical and dental;
3. Developing individual carrier systems to administer a shared OOP maximum;
4. Setting up the Exchange to serve the function of claims aggregator

Under the current regulations, Option 2 is the simplest for consumers and Exchanges and the most cost effective alternative for issuers of Exchange policies. Dependent on benchmarks chosen by states, Option 1 could be too costly if the dental policy reflects the dental benchmark options of the FEDVIP or CHIP benefit. Option 3 would include extensive administrative costs, increasing premiums without increasing benefits or



lowering costs for the consumer. Additional advantages and disadvantages of the above options are laid out in the NADP/DDPA Exchange White Paper Issue Brief 5 with regard to out-of-pocket costs.

How the deductible limit is administered must also be considered. The deductible can have a significant impact on claims utilization and costs. For dental benefit plans, the overall ACA deductible amount would be inappropriate. Typical dental benefit deductibles are \$50 per person which is most often waived for preventive care. If the pediatric dental benefits and traditional medical plan benefits each are set with a proportionate deductible which together does not exceed the maximum, then this issue is fully addressed in a manner consistent with how medical and dental coverage works in today's marketplace, as well as being the most expedient and consumer friendly option.

**1.3 NADP & DDPA:** No, this requirement should not be applied to dental plans (for details see #6.)

### **Licensing**

2) *Be licensed and in good standing to offer insurance coverage in the state (i.e., have no outstanding sanctions by the department of insurance).*<sup>v</sup> § 156.200(b)(4).

**NADP & DDPA:** Yes, dental plans comply with proper DOI licensing in their state(s).

### **Quality Improvements**

3) *Implement and report on a quality improvement strategy (or strategies), disclose and report information on health care quality and outcomes, and implement appropriate enrollee satisfaction surveys in accordance with the applicable provisions of the ACA.* § 156.200(b)(5).

**NADP & DDPA:** No, dental plans cannot currently meet this requirement with regard to quality and outcome measures. Currently, the lack of use of diagnostic codes in the dental profession impedes the types of quality improvement strategies or health care quality outcomes envisioned under ACA. In the future, measurements on pediatric dental may be available as the Dental Quality Alliance, initiated by HHS through the ACA and CHIP Reauthorization, is currently reviewing potential quality measures for the dental industry.

**NADP & DDPA:** However, reporting requirements could be introduced that assist in demonstrating the care provided by dental plans (to parallel QHP<sup>vi</sup> policies) for Exchange consumers. Utilization reporting could be submitted by dental plans. For example, in HEDIS there are measures on dental office visits and sealant applications for children which would be reflected in utilization data. In addition, enrollee satisfaction surveys can be incorporated if they are dental specific. Both NADP & DDPA can work with stakeholders to develop these surveys.

### **Payments & Fees**

4) *Remit user fee payments, or any other payments, charges or fees assessed by the Exchange.* § 156.200(b)(6); see also § 156.50(b).

**NADP & DDPA:** Yes, dental plans can pay appropriate Exchange fees. Exchange fees applied to dental plans should be structured to recognize the wide variances among medical and dental premiums<sup>vii</sup>. We recommend they be assessed proportionately.

### **Risk Adjustment**

5) *Comply with standards related to the risk-adjustment program under 45 C.F.R. Part 153.* § 156.200(b)(7).

**NADP & DDPA:** No, risk adjustment and its' related components are not applicable to dental plans as acknowledged in the preamble of HHS regulations on these topics<sup>viii</sup>.

### **Actuarial Value**

- 6) *Offer at least one QHP in the silver coverage level of actuarial equivalence and at least one QHP in the gold coverage level of actuarial equivalence described in section 1302(d)(1) of the ACA. § 156.200(c)(1). All QHPs must provide at least the bronze level of actuarial equivalence.*<sup>ix</sup>

**NADP & DDPA:** No, an Exchange should not require pediatric dental to be offered at the silver and gold actuarial value (AV). Pediatric dental is only part of one category of the ten overall benefit categories included as part of the EHB package. As outlined by Milliman for the NADP/DDPA White Paper on Exchanges, the metal level applies to the EHB as a whole; not to each service within the EHB Package. They found the typical DPPO in today's market has an 86% AV level and that significant cost sharing would need to be applied to meet lower AV levels. While this could be done, it would not reflect current dental benefit design. As well, the AV calculators that have been developed for medical are not able to separate the pediatric dental from the remaining medical categories.

NADP has contracted with Milliman, to provide information on the actuarial values (AV) of the EHB benchmark plans for dental. The information will include their value as structured today; as they will be structured in 2014 (without annual or lifetime limits); and with the addition of a "medically necessary" orthodontic benefit. NADP will forward the information when completed as further background material on this issue.

### **Child-Only Plans**

- 7) *Offer a child-only plan at the same level of coverage as any QHP offered through the Exchange to individuals who have not obtained age 21 by the beginning of the plan year. § 156.200(c)(2).*

**NADP & DDPA:** Yes, dental plans are developing child-only policies to offer on the Exchange. NADP and DDPA have compiled information on the number of dental issuers that is provided in a separate report.

Dental issuers still need a clarification if child-only policies for pediatric dental will cover children up to age 21. Currently, the dental profession identifies age 13 (the clinical age of getting permanent teeth) as the age applicable to pediatric care. Age 13 is also the age utilized in the embedded dental portion of the FEHBP BCBS medical plan – one of the four EHB benchmarks as outlined by HHS. However, since state CHIP programs use age 19 for their policies, and Medicaid utilizes age 21, it is unclear which age should be applied to these policies.

### **Discrimination**

- 8) *Not discriminate, with respect to its QHP, on the basis of race, color, national origin, disability, sex, gender identity or sexual orientation. § 156.200(e).*

**NADP & DDPA:** Yes, dental plans do not utilize these criteria today and can comply with non-discrimination.

### **Plan Rates**

- 9) *Set plan rates for an entire benefit year. § 156.210(a).*

**NADP & DDPA:** Yes, dental plans can adhere to Exchange rules related to plan rates within specific calendar timelines.

### **Rate Information & Justification**

- 10) *Submit rate and benefit information to the Exchange, § 156.210(b), and provide a justification for rate increases prior to the implementation thereof (and post such justifications prominently on its website). § 156.210(c); see also § 155.1020(a) & (c).*

**NADP & DDPA:** Yes, all issuers, including dental plans, will need to submit rate and benefit information to the Exchanges. However, as issuers of HIPAA excepted benefits<sup>x</sup> dental policies would not be subject to the justification of rate increases based on current HHS regulations<sup>xi</sup>. Dental plans comply with states that include rate review as part of their product filing requirements.

### **Policy & Enrollee Information**

11) *Submit the following information to the Exchange, HHS, and the state insurance commissioner: (1) claims payment policies and practices; (2) periodic financial disclosures; (3) data on enrollment; (4) data on disenrollment; (5) data on the number of claims that are denied; (6) data on rating practices; (7) information on cost-sharing and payments with respect to any out-of-network coverage; and (8) information on enrollee rights under Title I of the ACA. This information must be submitted in plain language and must also be made available to the public. § 156.220(a)-(c).*

**NADP & DDPA:** Yes, dental plans can comply with financial and data disclosures in sections 1-7 above for the pediatric dental benefit, and provide information on enrollee rights. However, in section (8) there is a reference to Title 1 that is unclear. Title 1 contains no section on enrollee rights but does include market reforms that are not applicable to HIPAA excepted benefits including dental plans sold as separate policies of insurance. More specificity is needed to respond as to appropriateness for dental plans. For instance, if "enrollee rights" includes the Patient Protections named in Section 2719A for emergency treatment, it must be recognized that although dental plans provide emergency benefits at the network level, dental plans do not cover hospitalization or treatment rendered in hospital emergency rooms. Additionally, typical dental PPO plans do not require a designation of a primary care provider, whereas dental HMO plans may require such selection. Applying this requirement to issuers of dental plans overall is not practical given the small number of pediatric dentists nationally<sup>xii</sup>, and the ability of general dentists to deliver pediatric dental care.

### **Provider Costs**

12) *Make available, upon request by an individual, the amount of enrollee cost-sharing under the individual's plan or coverage with respect to the furnishing of a specific item or service by a participating provider. § 156.220(d).*

**NADP & DDPA:** Yes, dental plans can provide cost-sharing information to consumers regarding services provided by an in-network dentist on the predetermination process for the pediatric dental benefit.

### **Marketing**

13) *Comply with applicable state laws and regulations regarding marketing by insurance issuers and refrain from using marketing practices that have the effect of discouraging enrollment by individuals with significant health needs. § 156.225.*

**NADP & DDPA:** Yes, dental plans already meet marketing regulations per their state's insurance requirements.

### **Network Adequacy**

14) *Comply with the applicable network adequacy requirements, which require QHPs to maintain a network of a sufficient type and number of providers to assure that all covered services will be available without undue delay. § 156.230(a)(2); see also § 155.1050(a).*

**NADP & DDPA:** Yes, dental plans comply with "dental specific" network adequacy requirements, in the few states that have these standards specific to dental. These requirements are not specific to a children's benefit, and they are most often applied to dental HMOs where consumers must use an in-network provider.

Dental HMOs networks are also smaller than dental PPOs which are the predominant dental product. Nationwide, dental HMOS have one fifth the number of participating dentists as dental PPOs.

HHS recognized the need for dental specific requirements in the preamble of the Final Rule, noting adequacy requirements may need to be specific to the unique nature of limited scope dental plans. In general, states that have network adequacy requirements allow dental plans to set their own targets based on communities to be served (urban, suburban, rural) and monitor compliance with established targets. This is the approach that should be considered if network adequacy standards are added by Exchanges. Additionally, choice of a pediatric dentist as a primary care provider is not practical given the small number of pediatric dentists available and the ability of general dentists to provide needed care<sup>xiii</sup>.

### **Community Providers**

15) *Include in its network a sufficient number and geographic distribution of essential community providers who provide care to predominately low-income and medically-underserved populations in order to ensure reasonable and timely access to a broad range of such providers for the medically underserved in the QHP's service area. § 156.230(a)(1); see also §§ 155.1050 & 156.235.*

**NADP & DDPA:** Yes, dental plans can comply if requirements are dental specific. Employers, who hire minimum wage employees, sometimes request their dental carrier contract with providers who work in community health centers, or provide similar services for a low income population. Carriers will contract with these providers and centers if they meet a carrier's credentialing standards. However, due to the severe maldistribution of dentists and extremely low number of dentists who work within public programs, targets for dental community providers need to be flexible and likely set by the state when appropriate.

### **Geographic Coverage**

16) *Consistent with section 2702(c) of the Public Health Service Act ("PHSA"), not deny coverage to employers or individuals within a service area based on a lack of capacity unless it does so uniformly and without regard to claims experience. § 156.230(a)(3).*

**NADP & DDPA:** Yes, dental plans can comply with this prohibition.

### **Provider Information**

17) *Make its provider directory for a QHP available to the Exchange electronically and to potential enrollees in hard copy upon request. § 156.230(b); see also § 155.206(b)(1)(viii). This information should identify those providers who are no longer accepting new patients, § 156.230(b), as well as information on provider credentials, specialty, and contact information, which could include institutional affiliation.<sup>xiv</sup>*

**NADP & DDPA:** Yes, dental plans can comply with most of this requirement. However, the information on institutional affiliation should not be applied to dental plans as very little dental care is provided outside the dental office environment. In general dental plans do not request nor do dental providers indicate their institutional affiliation on applications. Deleting this portion of the certification would recognize the difference between medical and dental delivery without harm to the consumer. In addition, information on provider credentials should take into account the variation between state requirements as well as product types, i.e. dental HMO provider credentialing includes additional information not collected for providers within dental PPO networks.

### **Enrollee Notifications**

18) *Provide all applications and notices to enrollees in accordance with standards established by the Exchange. § 156.250; see also § 155.230(b).*

**NADP & DDPA:** Yes, dental plans can provide applications and notices to Exchange enrollees as required by Exchanges; however, NADP & DDPA urge creation of different formats or content as appropriate for pediatric dental.

### **Premium Rates**

19) *Charge the same premium rate with respect to a plan that is offered through an Exchange as the issuer would charge with respect to a plan offered directly by issuer or through an agent or broker. § 156.255(b). A QHP issuer is permitted, however, to vary premiums by the rating areas established under section 2701(a)(2) of the PHSA. § 156.255(a).*

**NADP & DDPA:** Dental plans can offer similar plans at the same premiums as described above. However, this is a complex issue as medical carriers may be required to include pediatric dental in the medical policies offered outside the Exchange. Inside the Exchange, medical carriers can exclude pediatric dental if at least one dental plan has been certified to offer a separate pediatric dental policy which meets the EHB. The policy costs therefore would be different for both medical and dental plans inside and outside Exchanges as plan offerings can differ inside and outside Exchanges. For example, dental plans may not issue child-only policies outside the Exchange because currently the coverage must be included in all medical policies offered in the small group and individual market, making dental plan child-only policies a duplicative purchase by consumers.

NADP & DDPA have continuously requested that HHS clarify this issue through regulations. Such regulations should clearly reflect the intent of the Stabenow-Lincoln dental amendment that was unanimously approved by the Senate Finance Committee.

### **Broker & Plan Offerings**

20) *In order to be eligible for premium tax credits and cost-sharing assistance, individuals must enroll through Exchanges. Thus, a QHP issuer may not enroll an individual directly. Similarly, the issuer may not enroll individuals through an agent or broker, as this would not be “enrollment through the exchange.” Instead, the issuer may only enroll an individual if the Exchange notifies the issuer that the individual is eligible to enroll in the plan. § 156.265(b)(1). If the individual seeks to enroll directly with a QHP, the QHP issuer must either direct the individual to file an application with the Exchange, or ensure the applicant received an eligibility determination for coverage through the Exchange. § 156.265(b)(2). Eligibility determinations must then be made by the Exchange and transmitted to the QHP issuer. § 156.265(c). The issuer must acknowledge receipt of enrollment information transmitted from the Exchange. § 156.265(g). The QHP issuer must reconcile enrollment files with the Exchange at least once a month. § 156.265(f).*

**NADP & DDPA:** Yes, dental plans can comply for pediatric dental. Individual adults will be able to go directly to a dental plan or through an agent/broker to purchase adult dental coverage or wrap-around family dental coverage as those benefits are not EHB requirements.

NADP & DDPA recommend the development of dental specific application templates and enrollment forms for ease of use and transparency for both consumers and Exchanges.

### **Enrollment Periods**

21) *Enroll individuals during the initial and annual open enrollment periods established by the Final Rule, make available special enrollment periods for individuals who have experienced a “triggering event,” and abide by the effective dates of coverage established by the Exchange. § 156.260(a).*

**NADP & DDPA:** Yes, dental plans will comply with initial and annual enrollment periods.

### **Enrollee Information**

22) *Notify the individual of the effective date of his or her coverage, § 156.260(b), and provide new enrollees with an information package, including a summary of benefits and a coverage document. § 156.265(e).*

**NADP & DDPA:** Yes, dental plans will be in compliance; however, the summary of benefits and coverage documents should be modified to be dental specific. NADP & DDPA are willing to work with HHS to develop templates (parallel to the medical templates already designed by the NAIC) and suggest the utilization of the outlines of coverage typically used in the individual dental market today (which may vary by state).

### **Payment Processes**

23) *Adhere to the premium payment process established by the Exchange. § 156.265(d); see also § 155.240.*

**NADP & DDPA:** Yes, dental plans can comply.

### **Enrollee Termination**

24) *Only terminate coverage under certain, specified circumstances, including: (1) the enrollee is no longer eligible for coverage in a QHP through the Exchange; (2) non-payment of premiums by the enrollee; (3) the enrollee's coverage is rescinded; (4) the QHP terminates or is decertified; (5) the enrollee changes from one QHP to another during an annual open enrollment period or special enrollment period. § 156.270(a); see also § 155.430(b). The plan must establish a standard policy for the coverage of enrollees due to non-payment of premiums that allows for a three-month "grace period" for non-payment of premiums with respect to individuals who are receiving premium subsidies. §§ 156.270(c)-(g).*

**NADP & DDPA:** Yes, dental plans can comply. When individuals are not receiving subsidies, however, state regulations related to non-payment premiums (typically 30 days) should be applied.

### **Enrollee Termination**

25) *Provide enrollees with notice at least 30 days prior to terminating coverage if their coverage in a QHP is terminated for any reason. § 156.270(b)(1). The QHP issuer must also notify the Exchange together with the reason for the termination, § 156.270(b)(2), and keep a record of termination of coverage in accordance with standards established by the Exchange under § 155.430(c), 156.270(h). (Section 155.430(c)(3) also requires a QHP issuer to make reasonable accommodations for all individuals with disabilities before terminating their coverage, although this particular requirement is not cross-referenced in § 156.270(h).)*

**NADP & DDPA:** Yes, dental plans can comply.

### **Accreditation**

26) *Be accredited within the timeframe established by the Exchange and maintain such accreditation for as long as the issuer offers QHPs. § 156.275(b); see also § 155.1045.*

**NADP & DDPA:** No, dental plans cannot comply as accreditation programs specific to dental plans do not exist. HHS recognized this fact in the Final Rule.

### **Abortion Coverage**

27) *Comply with certain requirements relating to abortion coverage. § 156.280.*

**NADP & DDPA:** No, dental plans cannot comply as this procedure is never covered by a dental plan.

### **SHOP Requirements**

28) Comply with certain additional provisions if the QHP is offered to small employers through a Small Business Health Options Program or “SHOP” Exchange. § 156.285. These provisions require that an issuer of QHPs must, with respect to each of the QHPs it offers through the SHOP Exchange:

1. Accept premium payments from the SHOP Exchange rather than directly from the employer. § 156.285(a)(1).
2. Change rates at a uniform time that is either quarterly, monthly, or annually, and not change rates for an employer during the employer’s plan year. § 156.285(a)(2) & (3).
3. Enroll eligible employees and dependents during the employer’s annual open enrollment period (established pursuant to the SHOP Exchange’s rules) consistent with the plan year of the employer, and as of the date an employee first becomes eligible for the employer’s plan if that occurs outside the employer’s annual open enrollment period. § 156.285(b)(1), (b)(3) & (c)(6).
4. Make available special enrollment periods similar to those otherwise available on the Exchange, except that they do not have to include changes in immigration status or changes in eligibility for advance payments of the premium tax credit or for cost-sharing reductions. § 156.285(b)(2).
5. Abide by the effective dates of coverage specific to the SHOP Exchange, which require, among other things, first determining whether the employer is qualified to participate in the SHOP Exchange. § 156.285(b)(4) & (c)(1).
6. Safeguard the privacy of enrollment information received in an electronic format in accordance with §§ 155.260 and 155.270. § 156.285(c)(2).
7. Follow the same rules regarding termination of coverage that otherwise apply on the Exchange, except that if an employer withdraws from the SHOP Exchange the QHP issuer must terminate coverage for all employees and other enrollees of the employer. § 156.285(d).
8. Impose group participation rules only if and to the extent authorized by the SHOP Exchange. A SHOP Exchange may authorize only uniform group participation rules and, if it authorizes a minimum employee participation rate, the rate must be based on the rate of employee participation in the SHOP Exchange, not on the rate of employee participation in a particular QHP or the QHPs of a particular QHP issuer. § 156.285(e).

**NADP & DDPA:** Yes, dental plans can comply.

### **Enrollee Non-Recertification**

29) If a QHP issuer elects not to seek recertification with the Exchange, the QHP issuer must notify the Exchange of its decision prior to the beginning of the recertification process, cover benefits for each enrollee through the end of the current plan or benefit year of the certification, fulfill data reporting obligations from the last plan or benefit year of the certification, provide a written notice to each enrollee, and comply with the applicable requirements regarding the termination of enrollees (described above). § 156.290(a). The issuer must also provide a written notice to each enrollee. § 156.290(b).

**NADP & DDPA:** Yes, dental plans can comply.

### **QHP Decertification**

30) If a QHP is decertified by the Exchange, the QHP issuer may terminate coverage for enrollees only after the Exchange has provided a notice of decertification to the QHP and enrollees have had an opportunity to enroll in other coverage. § 156.290(c).

**NADP & DDPA:** Yes, dental plans can comply.

### **Prescription Coverage**

31) *If the plan covers prescription drugs, provide to HHS the information regarding prescription drug distribution and cost reporting required under section 6005 of the ACA.<sup>xv</sup> § 156.295.*

**NADP & DDPA:** No, dental plans cannot comply as they do not typically cover prescription drugs.

## Other Requirements

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### **Geographic Coverage**

32) *The Final Rule also requires that the service area of the QHP cover a minimum geographical area that is at least the entire geographic area of a county (unless the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers). § 155.1055(a). The Final Rule further requires that the service area must have been established without regard to racial, ethnic, language, health-status-related factors, or other factors that exclude specific high utilizing, high cost or medically-underserved populations. § 155.1055(b).*

**NADP & DDPA:** Yes, dental plans can comply.

The **National Association of Dental Plans (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% 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.

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Based in Oak Brook, IL, **Delta Dental Plans Association (DDPA)** is a national network of 39 independently operated not-for-profit dental service corporations specializing in providing dental benefits in all 50 states, the District of Columbia and Puerto Rico. Collectively, Delta Dental is the largest provider of dental benefits in the country, covering more than 56 million people in over 95,700 groups across the country.

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<sup>i</sup> 77 Fed. Reg. 18,310; CMS-9989-F "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers", March 27, 2012

<sup>ii</sup> 77 Fed. Reg. 18,312; CMS-9989-F "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers", March 27, 2012

<sup>iii</sup> Once certified, the plan will be subject to ongoing monitoring to ensure compliance with the certification standards by the Exchange, § 155.1010(a)(2), and will be required to undergo recertification at intervals to be established by the Exchange, § 155.1075.



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<sup>iv</sup> In the Final Rule's Summary of Regulatory Changes for Stand Alone Dental Plans, HHS notes in the response related to cost-sharing that, "...for any benefit offered by a stand-alone dental plan beyond those established under section 1302(b)(1)(J) of the Affordable Care Act, standards specific to the essential health benefits would not apply."

<sup>v</sup> 77 Fed. Reg. 18,415; CMS-9989-F "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers", March 27, 2012

<sup>vi</sup> ACA Sec 1311(g)(1) requires QHPs to implement health care quality improvement strategies which include activities such as prevention of hospital readmissions, reduction of medical errors, etc. These are examples of specific activities dental plans cannot meet.

<sup>vii</sup> Dental premiums today are about 1/12<sup>th</sup> that of medical premiums. Pediatric premiums would be an even smaller portion of medical premium.

<sup>viii</sup> 77 Fed. Reg. 17220; CMS-9938-AR07 "Standards Related to Reinsurance, Risk Corridors and Risk Adjustment; Final Rule", March 23, 2012

<sup>ix</sup> 77 Fed. Reg. 18,415; CMS-9989-F "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers", March 27, 2012

<sup>x</sup> 2794 PHSA

<sup>xi</sup> 77 Fed Reg. 18,411, Section h. Stand-alone Dental Plans; CMS-9989-F "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers", March 27, 2012

<sup>xii</sup> There are 5,800 Pediatric Dentists practicing in the U.S. according to the American Dental Association's Distribution of Dentists in the United States by Region and State, 2008, August 2010.

<sup>xiii</sup> Ibid

<sup>xiv</sup> 77 Fed. Reg. 18,420; CMS-9989-F "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers", March 27, 2012

<sup>xv</sup> This information includes data regarding: (1) the percentage of all prescriptions that were provided under the QHP through retail pharmacies compared to mail order pharmacies, and the percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type, that is paid by the QHP issuer or the QHP issuer's contracted PBM; (2) the aggregate amount, the type of rebates, discounts, or price concessions (excluding bona fide service fees) that the QHP issuer or its contracted PBM negotiates that are attributable to patient utilization under the QHP, and the aggregate amount of rebates, discounts, or price concessions that are passed through to the QHP issuer, and the total number of prescriptions that were dispensed; and (3) the aggregate amount of difference between the amount the QHP issuer pays its contracted PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies, and the total number of prescriptions that were dispensed.