



October 31, 2011

Dr. Donald Berwick, Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention CMS-9989-P  
P.O. Box 8010  
Baltimore, MD 21224-8010

RE: CMS-9989-P: Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans

Dear Dr. Berwick:

The National Association of Dental Plans (NADP) is writing in response to the "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans" proposed rules as published in the Federal Register, Vol. 76/No. 136 on Friday, July 15, 2011.

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 almost 90 percent of the 166 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.

Specifically, our comments that follow respond to topics raised by the Centers for Medicare and Medicaid Services (CMS), as well as focus on issues that should be addressed in the proposed rule to assure equitable consumer access to limited scope, standalone dental policies inside *and outside* the Exchanges.

Much of the content of our comments is taken from our recently released joint White Paper with the Delta Dental Plans Association, "Offering Dental in Health Exchanges: A Roadmap for State and Federal Policymakers" which is available at [nadp.org](http://nadp.org). Questions regarding our comments should be directed to Kris Hathaway, Director of Government Relations at [khathaway@nadp.org](mailto:khathaway@nadp.org) or 972 458-6998 x111.

Sincerely,

Evelyn F. Ireland, CAE  
Executive Director  
National Association of Dental Plans

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**NATIONAL ASSOCIATION OF DENTAL PLANS  
COMMENTS ON PROPOSED RULE CMS-9989-P:  
ESTABLISHMENT OF EXCHANGES AND QUALIFIED HEALTH PLANS**

**In General**

Dental benefits vary significantly from traditional medical insurance in policy structure, cost, and coverage. Typical employer health benefits (large and small) include not just medical coverage but dental coverage as well. Dental policies are usually sold and purchased as a separate product; distinct and apart from medical coverage and in many cases are offered on an employee-pay-all basis. In the private market (not including public programs), roughly 98 percent of Americans with dental coverage today have a dental benefit policy separate from their medical policy. Only about two percent of Americans get their medical and dental policies integrated (or embedded) into a single policy from the same carrier. Recognition of the separate nature of dental coverage is critical to affording consumers in all markets equitable access to affordable, quality dental coverage and allowing them to keep the coverage they have

**Exchange Recognition of Existing Dental Coverage Held Outside of Exchanges**

Recognizing existing dental coverage is the key to meeting the promise that Americans can keep the health policies they already have and like. Approximately 141 million consumers, 43 million of whom are children, have dental coverage in the private market outside of Exchanges. Of these almost 44 million, half of whom are children, get coverage through some 1.65 million small employers that are initially eligible to use Exchanges in 2014. Even when one parent is employed by a small employer that does not offer dental coverage and that employer brings its employees to the Exchange, the other parent may be employed in a large employer and have dental coverage for their children through that employer. In these instances, requiring the parent obtaining health coverage through the Exchange to also purchase coverage for pediatric oral services would be duplicative.

A recent NADP survey of employers found that almost 70% of employers with 100 or fewer employees that currently offer dental intend to maintain dental coverage outside of Exchanges.<sup>1</sup> If “pediatric oral services” are defined to reflect a “typical employer plan,” as referenced in the Patient Protection and Affordable Care Act (ACA), the dental coverage most employees have today will likely satisfy, and potentially far exceed, the HHS threshold for essential “pediatric oral services.” Thus, a consumer with employer sponsored dental coverage coming into the Exchange to purchase medical coverage is more likely than not to have dental coverage that meets the “pediatric oral services” required as part of the Essential Health Benefits Package (EHBP) for their children. Unless their existing dental coverage is recognized at the time they apply for medical coverage from the Exchange, the coverage offered through the Exchange will duplicate the dental benefits for the children of these consumers.<sup>2</sup>

Recognizing separate dental policies purchased outside the Exchanges is the first step needed in regulations. In addition, Qualified Health Plans (QHPs)<sup>3</sup> inside Exchanges should be required to offer medical coverage options without “pediatric oral services” to assure that consumers have an option to purchase coverage that is not

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<sup>1</sup> NADP 2011 Purchaser Behavior Survey, September 2011

<sup>2</sup> NADP/DDPA Exchange White paper, September 2011

<sup>3</sup> ACA Section 1301

duplicative. Accepting family dental coverage purchased outside the Exchange that includes essential “pediatric oral services” would allow the full premium tax subsidy to be applied to medical coverage purchased in the American Health Benefit Exchange (AHBE). Additionally, acceptance of this coverage eliminates the need to coordinate limits on out-of-pocket costs between medical and the “pediatric oral services” portion of dental policies as only those pediatric oral service benefits purchased inside the AHBE are subject to limits on out-of-pocket costs.

***Recommendation:*** HHS should provide that separate dental policies purchased outside Exchanges can be accepted by Exchanges to meet the “pediatric oral services” required in the EHBP.

### **Equitable Access for Consumers to Stand-Alone Coverage Outside the Exchanges**

NADP remains seriously concerned that there is no clear guidance on whether, like inside the Exchanges, limited-scope standalone dental policies can fulfill the requirements of the EHBP together with a QHP covering all other benefits other than “pediatric oral services.” If consumers are afforded the opportunity to purchase separate medical and dental policies both inside the Exchange as well as outside the Exchange in the large group market, it is a disservice to consumers in the small group market outside of the Exchanges not to have the same choices.

This issue can be easily addressed by providing comment in the preamble to this rule that the same waiver to the operation of qualified health plans inside the Exchange (per Section 155.1065 (c) of the Exchanges and Qualified Health Plans proposed rule) is afforded to Qualified Health Plans in the small group and individual market outside the Exchange. This should include (as outlined in the section on “Adults without Children” pg.4), the ability for individuals without children, or with children covered from another source, to purchase the EHBP without “pediatric oral services.” The employer offering coverage or agent/broker selling coverage can assure that the consumer maintains the coverage that is appropriate to fulfill the requirements of the EHBP.

There are significant consequences of failure to provide clarification on this point on a timely basis:

- Failure to address this matter will broadly disrupt the market as it currently stands, and go against President Obama’s promise that “if you like the coverage you have, you can keep it.”
- Americans will have “pediatric oral services” included in family dental policies they enjoy today duplicated by medical coverage creating additional cost, confusion in claims payment and potential disruption of their current dentist relationship. While two parent families with one parent employed in a large group and the other in a small group can be impacted, specifically and immediately impacted will be:
  - 1.65 million small businesses covering,
  - 43.7 million small business employees and their dependents, including
  - 22.9 million children.
- It breaks a system that is currently working, and unnecessarily disrupts the existing small group market outside the Exchanges.
- American adults covered by dental insurance would likely decrease, as surveys suggest that about half of parents will drop their own coverage if their children are separated from their coverage resulting in:
  - Reductions in dental visits as Americans with dental insurance go to the dentist about 2.5 times more frequently than those without coverage,
  - Decreased overall oral health due to lack of preventive care and early detection by dentists of potential medical conditions, and

- Potential increases in the cost of treatment of chronic medical conditions that are impacted by poor periodontal health.
- Competition may be reduced as the 40% of the total private dental market represented by small employer groups may be consolidated into fewer carriers as:
  - Medical carriers are required to include essential pediatric dental coverage in all their small group and individual market policies which would leave only adult coverage and children’s coverage that is not required as part of the EHBP to be marketed by standalone dental plans.
  - In many states, a single medical carrier holds dominant market shares as high as 60, 70, 80 percent or higher which limits opportunities to partner as these carriers most often have their own dental affiliate or subsidiary, and
  - Competition inside the Exchanges may be diminished due to the above factors.

This proposed rule deals with the establishment of Exchanges and Qualified Health Plans. As noted in recent letters to Secretary Sebelius from 24 members of the US Senate and 33 members of the US House<sup>4</sup>, the goal of providing equitable access to all consumers, inside and outside Exchanges, as well as ensuring continued robust competition, makes this matter germane for HHS to clarify in this rule.

***Recommendations:***

1. *The final rule should deem that outside the Exchanges, in the individual and small group market, standalone dental policies fulfill the requirements of the EHBP together with a qualified health plan covering all other benefits other than “pediatric oral services”; and*
2. *A waiver similar to the language proposed in Section 155.1065(c) of the proposed rule is provided for Qualified Health Plans if the consumer purchases a dental plan meeting the requirements of Section 9832(c)(2)(A) of the Code and 2791(c)(2)(A) of the PHS Act that provides at least the pediatric dental essential health benefit as described in Section 1302(b)(1)(J) of the Affordable Care Act.*

**Adults without Children**

Typically, medical and dental coverage in the private market is sold as employee only, employee and dependent (could be a spouse or a child) and as employee and family—each with a different premium. So in “typical employer plans,” employees are not required to select and purchase coverage for anyone other than themselves. Additionally, with many spouses both working, only one spouse covers the children, to avoid duplicate expenses and coverage.

HHS should provide guidance in the final rules allowing Exchange customers without children to “opt-out” of the “pediatric oral services” by purchasing a medical plan without these services. The required offer of medical plans that do not include “pediatric oral services” or—perhaps the offer of an “adult-only” or “adult plus adult dependent” plan would facilitate the “opt-out.” Exchanges should already be designing operational processes to determine whether the individual applying for coverage wants to cover others, including children, which would support the administration of coverage differences between consumers with children and those without—both young and old.

NADP believes that HHS has the authority to provide such guidance under the structure of the ACA’s coverage provisions and provided a legal memo from Hogan Lovells to HHS in this regard (attached). Since the

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<sup>4</sup> Senate and House letters attached.

requirement of ACA is that 1) Minimum Essential Coverage (MEC) be maintained by all Americans but MEC is not defined as a specific set of benefits, and 2) EHBP is required to be offered in the small group and individual market but consumers are not specifically required to purchase EHBP, consumers in Exchanges could be allowed to purchase the coverage which fits their circumstances as is done in the private market today. Allowing adults without children (or children covered by their spouse) to “opt out” of coverage for “pediatric oral services” which they will not use would also reduce the federal cost of subsidies for coverage which cannot be utilized.

***Recommendation:*** *Given the requirement in ACA for states to allow separate offer of dental coverage, HHS should specify in the final rule that Exchanges can allow adults without children to purchase a medical plan without “pediatric oral services.”*

## **Response to Specific CMS Questions**

### **In General**

The National Association of Dental Plans supports the rule’s proposed codification of the requirements in §155.1065(a) of section 1311(d)(2)(B)(ii), 1302(b)(1)(J), and 1302(b)(4)(F) of the Affordable Care Act (ACA) related to limited scope, standalone dental plans. These provisions require that states allow the offer of limited scope standalone dental plans in Exchanges provided that the plan furnishes at least the pediatric essential dental benefit and incorporates statutory references to the definition of a limited scope, standalone dental plan. This language allows QDPs to offer consumers in Exchanges coverage options with expanded children’s dental benefits as well as adult dental benefits. NADP further supports the codification of the option that a dental plan can be offered in conjunction with a QHP which reflects the co-offered benefit option, one of three dental policy configurations available in today’s market (see “Separate Pricing of All Dental Benefits” pg. 11.)

To implement the Stabenow-Lincoln amendment which was adopted unanimously by the Senate Finance Committee in the passage of the ACA (attached) and served as the genesis for the ACA’s language on stand-alone dental, it is important to assure the offer of limited scope, standalone dental plans provides a real choice for consumers. Thus, in the final rule HHS should consider that when a standalone dental plan is offered in the Exchange, states ensure that collectively QHPs offer a sufficient number of medical-only policy options to allow for a robust and vibrant Exchange marketplace where consumers can compare and choose between both QDP and QHP-offered dental benefits. Further to assure consumers have the option to purchase only what is included in the EHBP definition of “pediatric oral services,” HHS should provide any carrier, either QHP or a Qualified Dental Plan (QDP, as defined in the NAIC Exchange Model Act), that offers separate dental coverage, offer a “child-only” policy in addition to any other limited scope, dental coverage options.

***Recommendation:*** *HHS should provide when a QDP is offered in an Exchange, QHPs must offer at least one plan option without “pediatric oral services.” (see “Separate Pricing of All Dental Benefits,” pg. 9.)*

*HHS should also provide that each QHP or QDP that offers separate dental coverage must offer a child-only policy covering only the required “pediatric oral services” in addition to any other limited scope, dental coverage options.*

## Requirements to Certify Dental Plans

In the development of its American Health Benefit Exchange Model Act (Model), the National Association of Insurance Commissioners (NAIC) recognized plans providing “dental only” policies would also need to be qualified and included a definition and requirements for a “qualified dental plan” (QDP) for state consideration in establishing Exchanges. The Model provides a QDP should be licensed to provide dental benefits but need not be licensed to offer medical benefits and shall comply with the provisions applicable to a QHP “to the extent relevant.”

Dental plans which meet state licensure requirements including solvency, market conduct, as well as contract and rate requirements applicable in the relevant state, should be eligible to offer dental policies in Exchanges. States should utilize existing state standards to qualify dental carriers for Exchange participation wherever possible, rather than creating new, duplicative or conflicting standards. Use of current state standards will ensure efficiency and continuity in the marketplace and minimize disruptions and unnecessary administrative costs which increase consumers’ dental premiums.

In reviewing the application of any additional QHP criteria, the differences in medical and dental coverage must be considered. As well, policymakers should weigh the value of the criteria and cost of implementation given the limited scope of the “pediatric oral services” required as part of EHBP. It will also be useful for each state to compare the criteria to existing state requirements for licensure, but in general terms NADP has compared the criteria cited by HHS in the proposed rule and offers these broad observations and recommendations:

- **Network Adequacy:** The local nature of networks and uneven geographic distribution of dentists make a single national network adequacy standard inappropriate for dental plans. Network adequacy should be applied by those states which have such standards in place now for dental HMOs and dental PPOs by virtue of licensure.
- **Quality & Accreditation:** Dental plans are rarely judged according to specific quality metrics. This is because dentistry does not have diagnostic codes and therefore has no means of tracking outcomes or establishing specific quality benchmarks. While there are systems of diagnosis codes under development; no system has been fully tested or widely adopted. Employers and plan sponsors often receive reports primarily focused on utilization, such as number of visits or use of specific benefits. The lack of current accreditation programs for dental plans would make their use in certifying QDPs to provide “pediatric oral services” unworkable in the near term.
- **Consumer Protections:** Dental plans are primarily licensed and regulated at the state level where many consumer protections exist today including requirements for summary of benefits, plain language, as well as standard claims and appeals processes. In general, as Health Insurance Portability and Accountability Act (HIPAA) “excepted” benefits, limited scope, standalone dental benefits are not subject to major medical market reform provisions of ACA. Other ACA consumer protections should only be applied to the “pediatric oral services” portion of a dental policy that is required as part of the EHBP to the extent that they are relevant to those services and do not undermine the affordability of those benefits thereby increasing taxpayer supported federal subsidies. With dental premiums that are in general 1/12<sup>th</sup> of medical premium and the premium of the pediatric portion of dental coverage even smaller, the implementation cost of some ACA market reforms, such as external review, could be greater than the annual premium of a dental plan.
- **Transparency and Other Consumer Service Measures:**

- **Dental Plan Performance:** Utilization and performance measures are typically captured for all enrollees. Measures such as claims processing time frames and speed of answer for consumer calls would be difficult to isolate solely for children receiving the required “pediatric oral services.” Regulators should weigh the cost of collection and relevance of these measures to specific performance in covering children, and if determined to be applicable, should accept these metrics from dental plans for their entire population regardless of age.
- **Marketing:** States have existing regulations related to marketing standards which are applied to dental policies.
- **Summary of Coverage & Disclosure:** While the NAIC has developed coverage summaries and standard disclosures for medical coverage, these forms are not applicable to limited scope, standalone dental coverage. If required to qualify dental plans, a separate form or requirements appropriate to the limited scope dental product offering should be developed.

**Recommendation:** HHS should provide states with the flexibility to determine which criteria are appropriate as QDP qualifying criteria in their state.

HHS additionally asked for comment on whether some of the requirements on QHP issuers should also apply to standalone dental plans as a Federal minimum. Transparency requirements for cost-sharing disclosures, plan performance, and summary of benefits could be established at the federal level taking into account the differences appropriate for separate dental policies covering a limited scope benefit for “pediatric oral services.” If this approach is taken, the NAIC’s expertise should be utilized in developing templates and standards appropriate to separate, non-integral dental policies.

**Recommendation:** HHS could establish, with the advice of the NAIC, federal standards for cost-sharing disclosures and summary of benefits that are applicable to the “pediatric oral services” offered under limited scope, standalone dental policies through Exchanges. (For additional commentary, please see NADP’s comments responding to CMS-9982-P.)

## Operational Standards Related to Dental Plans

HHS requested comment on whether specific operational minimum standards should be set with regard to dental plans with regard to allocation of advance payments of the premium tax credits, actuarial values, and appropriate notice for QHPs that their Exchange offerings need not include pediatric dental coverage. NADP offers the following recommendations in these three areas and makes an additional observation on centralized collection of premiums.

### Actuarial Value

HHS should provide that limited scope, standalone dental coverage, as only one category of coverage in the EHBP, need not separately meet every actuarial level of coverage (AV), i.e. “metal levels” in Exchanges. The scope of dental services covered in typical dental policies and the historic prevalence of diagnostic and preventive dental services being covered at 100 percent, results in even the most basic of dental plan designs having a silver or 70% actuarial value. A benefit that mirrors national average employer-based coverage, with 100/80/50 percent coinsurance for diagnostic and preventive, basic and major dental services respectively would have an AV of roughly 86 percent—between the gold and platinum AV levels. A policy covering in full a limited number of specified dental procedures would have an AV of 100 percent as there would be no member

cost-sharing. To reduce the AV to a Silver or Bronze level, significant costs would have to be shifted to the consumer, making the benefit plan disproportionate with industry norms.

Requiring dental plans to meet several different actuarial value targets separate from medical plans would be confusing for consumers and produce variation in benefit levels that are not meaningful. Instead, states should be authorized to accept high and low dental options which will usually both exceed the actuarial value of the silver level. Additional background on the reasons standalone dental plans should not be required at each actuarial level in Exchanges is provided by Milliman, Inc as part of the *NADP/DDPA Exchange White Paper*

**Recommendation:** *HHS should specify in the final regulations that separate dental plans offered in the Exchanges are not required to be offered at all the actuarial levels of coverage but can be offered on a high and low option as long as neither has an actuarial value lower than the bronze level.*

### **Allocation of Advance Payments of Premium Tax Credit**

ACA indicates tax credit payments are made to the insurer. NADP looked at several options to fulfill this provision (all of which are detailed in the *NADP/DDPA Exchange White Paper*.) When consumers select both a medical plan and a dental plan to meet the coverage required by EHBP and are eligible for a subsidy, they will expect some portion of the premium for each policy to be subsidized. Given the medical plan and dental plan selected may be from two different carriers, it is not reasonable to direct the full amount of the subsidy to one or the other and require the carrier receiving the subsidy to pass through a portion to other carrier. Thus, NADP recommends the subsidy be proportionately allocated on the basis of the premium. A federal allocation by state eliminates the need to develop infrastructures on the medical and dental plan levels which could increase premium costs.

**Recommendation:** *When a consumer selects a separate dental plan covering “pediatric oral services,” the federal government should split the value of the tax credit on a basis proportionate to the premium for the “pediatric oral services” in the dental policy and a medical policy without such services. As required by ACA, the subsidy should be paid directly to the dental plan and medical plan on behalf of the consumer. Where an aggregator is used by the state Exchange, the subsidy should be paid to the aggregator for distribution on the same basis as required for subsidies paid directly to the dental plan and medical plan.*

### **Premium Collection**

While the cost of dental benefits vary geographically by product and benefit plan design, in general dental policies cost about eight percent (less than 1/12) of the cost of medical insurance annually. A dental PPO covering an individual, costs on average about \$28.50 a month, i.e. \$340 a year, while a family dental PPO coverage costs about \$1,140 a year or \$95 a month.

Thus, dental plans collect relatively small premium amounts when compared to medical plans. In some circumstances, an individual’s premium contribution toward their dental plan in the AHBE could be as little as a few dollars a month. The cost to the dental plan of collecting this small premium relative to the value of the premium may make it cost prohibitive for dental plans to collect AHBE premiums on an individual basis. This scenario will likely be exacerbated by the expected low-dollar value of the required “pediatric oral services” as part of the EHBP unless the full cost of these services is funded by the federal subsidy.



In the private market the collection of small individual premiums is often done on an annual basis or through an automatic deduction from a designated account or credit card. Allowing the Exchange to centralize collection and aggregation with subsidies will reduce administrative costs for plans, particularly standalone dental plans collecting small premium amounts and keep premiums low for consumers. It also allows Exchanges to answer consumers' questions on payment status on a real-time basis.

***Recommendation:*** HHS should allow states to centralize premium collection in addition to ACA required consumer option for direct payment to the QHP.

### **Advance Notice of QDPs for QHPs**

There are no fewer than 15, and often more than 30, dental plans offered in each of the contiguous 48 states and at least five in Hawaii and Alaska. So the dental benefits market is highly competitive in most states. Thus, it is extremely unlikely there will not be at least one dental plan applying for and qualifying to offer "pediatric oral services" in each Exchange.

If HHS accepts NADP's recommendation to recognize dental coverage held outside the Exchange as meeting the "pediatric oral services" provision of the EHBP, all QHPs will need to provide for a medical plan without pediatric oral services so that the services covered by the dental plan are not duplicated.

While QHP's should assume there will be competitive standalone dental plans in the Exchange market, outlining a process that provides notice to QHPs applying to offer coverage in the Exchanges is preferable. Several options for such a process include:

- Providing an explanation in the RFPs for QHPs that they will not fail to be recognized as QHPs if their EHBP offering does not include "pediatric oral services,"
- Announcing the certification or availability of QDPs prior to QHPs application deadline, or
- Selecting a Multi-State Dental Plan at the federal level for inclusion in each state Exchange.

***Recommendation:*** HHS should provide in the final regulations that states should adopt a procedure to notify QHPs that a standalone dental plan will be part of the Exchange's offerings.

### **Separate Pricing of All Dental Benefits**

Federal Register Vol. 76/No. 136 states: "...some commenter's to the RFC requested that we require all dental benefits to be offered and priced separately from medical coverage, even when offered by the same issuer. Such a requirement would preclude QHP issuers from offering a "bundled" QHP that covers all essential health benefits, including the pediatric dental benefit, under one premium. While we recognize that requiring a QHP to price and offer dental benefits separately could promote comparison of dental coverage offerings, we have significant concerns about the administrative burden this could impose on Exchanges and QHP issuers."

HHS requested comment on the statement quoted above which indicates that a requirement for separate offering and pricing of dental benefits necessarily "would preclude QHP Issuers from offering a 'bundled' QHP that covers all essential health benefits, including the pediatric dental benefit, under one premium." NADP

believes that one approach does not preclude the other; there is a middle ground that should be examined by HHS. (see Configuration 2, “Co-Offered Dental and Medical Policies,” pg. 11.)

As observed in our general comments above, the Stabenow-Lincoln amendment was unanimously adopted by Senate Finance in the passage of the ACA to provide consumers and employers the same options inside and outside the Exchanges that are available today in the private market. There are three basic configurations of providing dental benefits in the private market today which establish a blueprint for how Exchanges should offer the “pediatric oral services” required by the EHBP, as well as the supplemental dental coverage for adults and children that exceeds the essential benefit threshold. HHS’s proposed codification of section 1311(d)(2)(B)(ii) of the ACA and QHP certification requirements encompasses all three options which include:

- Separate carriers, i.e. dental and medical policies from different carriers;
- Co-offered, i.e. separate dental and medical policies from the same carrier or with the dental policy from its affiliate, subsidiary or partner; and
- Integrated dental services (including “pediatric oral services”) within a medical policy.

To meet the ACA’s objectives of full transparency and choice among policy options for consumers, Exchanges should allow all three dental policy configurations with clear descriptions of the “pediatric oral services” included in each. These options can be managed by an Exchange to easily mirror the options now available in the employer market which provide pricing clarity, and allow each of those options to work smoothly for the consumer.

The discussion below (based largely on the “*NADP/DDPA White Paper: Offering Dental in Health Exchanges*”) explains these options as well as the implications and merits of ensuring each are successfully managed so as to optimize the consumer shopping experience. Exchanges will need to develop robust search engine capabilities such as those used by many large employers and on commercial websites to enable customers to browse and search for specific plan characteristics, including the number of participating dental providers. The federal dental and vision program – FEDVIP <http://www.opm.gov/insure/dental/index.asp> – provides one example of how these functions can be performed successfully.

#### *Configuration 1: Dental and Medical Policies from Separate Carriers*

While states are specifically required by ACA to allow the offer of separate dental policies, this configuration is only viable if medical policies with no coverage for “pediatric oral services” are also offered on Exchanges. Most of the larger QHPs offer dental policies through an affiliate, subsidiary or partner they will want to use in Exchanges. And in almost all states, the top two QHPs today cover at least half of all state residents with health insurance. In some states, the top two QHPs cover as many as 95% of all residents with health insurance.

Therefore, the offer of standalone dental by dental carriers will be viable only if QHPs are always required to make available medical policy options without “pediatric oral services,” i.e. “medical-only” that can be purchased alongside a standalone dental product. While it could be administratively burdensome to require every QHP to offer medical-only options for every plan design, HHS should consider ensuring that states provide sufficient “medical-only” EHBP options collectively from all QHPs in each AV level so that consumers have the option to purchase medical and dental policies from separate carriers at various price points. Failure to require the separate offer of a medical-only option by all QHPs would prevent consumers from choosing the dental option they may want, or which possibly includes their current family dentist. The proposed structure therefore mirrors dental benefit coverage

in today's employer market, while conforming to the often stated goals of ensuring transparency, competition and choice within Exchanges.

*Configuration 2: Co-Offered Dental and Medical Policies*

Another configuration available in the employer market today is a dental policy co-offered by the carrier offering the medical policy or by its affiliate, subsidiary or partner. Such arrangements are allowed under ACA in Exchanges through HHS's codification of the 155.085(b)(2). This configuration may provide a simplified process to purchase both medical and pediatric dental coverage required by the EHBP. To support the intent of ACA's mandate to allow standalone dental carriers to compete for the required "pediatric oral services" (as well as other supplemental dental benefits), carriers co-offering medical and dental policies should make their policies available separately. Such separate offer and pricing does not preclude the packaging of medical and dental policies from a single carrier, affiliated carriers or strategic partners.

Additionally, it is important to note co-offering medical and dental policies does not dictate post-sale administrative practices. This means the consumer could deal with one or two companies for the administration of their coverage, depending on the agreement between those companies for the co-offering.

It is critical when Exchanges make co-offered medical and dental coverage available, they do so under a set of guidelines or rules – and with a robust web interface – which provides consumers with the tools they need to weigh and compare the dental-only element of the co-offered EHBP with the separate standalone dental options. Cost transparency and ability to access one's existing dentist should be readily visible to all who shop for coverage in the exchange in all configurations.

*Configuration 3: "Pediatric oral services" integrated within a medical policy*

The third configuration in today's market is medical plans that integrate or embed dental services within their medical policy. ACA specifically requires QHPs to include all of the benefits defined as the EHBP. However, where a separate dental plan is available in the Exchange, the QHP can be qualified without the inclusion of "pediatric oral services." This configuration would not undermine transparency or choice so long as QHPs with embedded "pediatric oral services" are also required to offer a medical-only policy, i.e. a medical policy without "pediatric oral services," and sufficient "medical-only" EHBP options are available in each AV level from all QHPs collectively.

Consumers opting for embedded or integrated dental will have simplified purchase and administrative processes, because their EHBP is delivered under a single policy from the same carrier. Additionally, as embedded dental services are "integral" to the medical policy under the Public Health Service Act, they would no longer be "excepted benefits" and subject to the market reforms applicable to medical plans under ACA.

As with co-offered medical and dental, integrated medical and dental services should be offered with the online shopping and comparison tools which allows the consumer to compare the dental portion of the offer with the other dental coverage options available in the exchange.

Providing all of the three above configurations of medical and dental, with information about the dental-only element within each, allows Exchanges to maximize transparency and choice for consumers. 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 choose what's best for them.

***Recommendation:*** Dental policies should be offered in Exchanges under all three of the configurations found in today's private marketplace. When a separate dental policy is offered on the Exchange, HHS should require that QHPs in the Exchanges offer a medical policy without integrated "pediatric oral services" to allow consumers who purchase dental coverage outside of Exchanges a medical policy that does not duplicate their dental coverage, and to ensure the standalone dental offering within the Exchange is a viable option. Exchanges should consider whether there are sufficient medical-only policies collectively available from all QHPs participating in Exchanges for consumers to purchase alongside a stand-alone dental policy at any AV coverage level.

*If "pediatric oral services" is defined to include services normally covered by separate dental policies, a child-only dental policy covering the "pediatric oral services" required in EHBP should be a separate option offered by all carriers offering dental policies.*

# United States Senate

WASHINGTON, DC 20510

June 23, 2011

The Honorable Kathleen Sebelius, Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Secretary Sebelius:

As you work to implement insurance provisions included in the Affordable Care Act (ACA), we urge you to clarify the rules allowing stand-alone pediatric dental coverage to operate outside of the Exchanges in the individual and small group markets similar to its treatment inside the Exchanges. We also recommend that dental and medical policies may need to be offered and priced separately to ensure competition, transparency and access. Without these clarifications, the dental coverage of 43.7 million employees and dependents could be disrupted.

Children's dental health coverage was greatly expanded in the ACA which includes oral health services for children in the "essential health benefits package (EHBP)." The law allows stand-alone dental benefits inside the Exchanges to qualify as meeting the dental component of the EHBP. The Stabenow-Lincoln dental amendment adopted by the Finance Committee during consideration of the ACA clearly intended that stand-alone dental plans also meet this requirement outside of the Exchanges. The amendment stated that "pediatric dental benefits in the non-group and small group markets (in and outside an exchange) may be separately offered and priced from other required health benefits." This intent was reiterated in a letter from more than 20 Senators to the Majority Leader in December, 2009. However, we are concerned that the language of the law could be interpreted to allow only medical plans to cover the dental component of the EHBP outside the Exchange.

Today 97% of Americans with dental coverage receive that coverage through stand-alone dental policies. Disallowing the separate offer of dental benefits outside the Exchanges could result in 22.9 million children being removed from their parents' existing dental coverage to have their dental health services provided instead by a medical carrier. The issue of stand-alone dental coverage outside of exchanges must be clarified soon for insurers to obtain state approval of policies in time for the 2014 effective date.

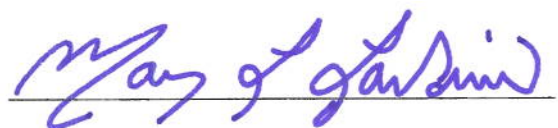
To ensure the law's intended access to pediatric dental coverage, we also support robust competition in the Exchanges so that consumers may choose from a wide range of affordable dental and medical policies and compare their options on the basis of price, benefits, services and quality. This may require that dental and medical policies be offered and priced separately to ensure the transparency they will need to make adequate comparisons.

We urge you to use your authority to ensure that outside of Exchanges in the individual and small group market, stand-alone dental policies are deemed to fulfill the requirements of EHBP together with a qualified health plan covering all benefits other than pediatric oral health services and that inside Exchanges dental benefits be offered and priced to ensure transparency for consumers.

Sincerely,



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John J. Kenney

Carl Levin

Mark R. Warner

Kirsten E. Gillibrand

Ron Wyden

to Benjamin Nelson

Shirley

Shirley Brown

Richard Blumenthal

Paula Paul

Will F. Blumenthal

Kay R. Hagan

Jim Johnson

Bara Bot

Jeffrey A. Merkle

Daniel K. Spaka

Mark Udall

Dianne Feinstein

Care McCasill

Herb Kohl

Jeanne Shaheen

Bob Casey, Jr.

**Congress of the United States**  
**Washington, DC 20515**

July 29, 2011

The Honorable Kathleen Sebelius, Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Secretary Sebelius:

As you work to implement insurance provisions included in the Affordable Care Act (ACA), we urge you to clarify the rules allowing stand-alone pediatric dental coverage to operate outside of the Exchanges in the individual and small group markets similar to its treatment inside the Exchanges. We also recommend that dental and medical policies may need to be offered and priced separately to ensure competition, transparency and access. Without these clarifications, the dental coverage of 43.7 million employees and dependents could be disrupted.

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We urge you to use your authority to ensure that outside of Exchanges in the individual and small group market, stand-alone dental policies are deemed to fulfill the requirements of EHBP together



with a qualified health plan covering all benefits other than pediatric oral health services and that inside Exchanges dental benefits be offered and priced to ensure transparency for consumers.

Sincerely,

Adam

Leonard I. Boswell

Al

Bill Johnson

John

Brett Guthrie

Steve Curtis

Jim Langwer

Rich Lusser

OT-16

Pat Tibben

Jul H. Clark

Bob Gibbs

Brent Elder

Marcia L. Dodge

Bob Jones

Robert Jones

Aaron A. Davis

Dave Lambert

Ben Chandler

By C. Peters

J. Young

Todd L. Little

John Long

John Bally

E. C. Lewis

Allen C. Pelt

Ben N. Lynn

Mike

Hanson Clarke

Bruce Bailey

Madison

John Russell

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