November 8, 2010

Mr. Joseph G. Murphy
Commissioner of Insurance
1000 Washington Street
Boston, MA 02118--6200
Attn. Docket Clerk, Hearings and Appeals, Division of Insurance
Re: Docket No. G2010-13

Dear Commissioner Murphy,

The National Association of Dental Plans (NADP) is responding with written comments to Docket No. G2010-13, notice of proposed new regulation 211 CMR 147.00 – methodology for calculating and reporting medical loss ratios (MLRs) of health benefit 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 82% 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.

Proposed regulations, 211 CMR 147.00 will start requiring dental plans to report their MLR by means of utilizing the NAIC MLR methodology. The NAIC methodology was developed pursuant to Section 2718(b) of the Public Health Service Act. Stand-alone dental benefit plans are exempt from the requirements of 2781(b) and thus, the methodology developed by the NAIC was not designed to accommodate stand-alone dental plans. In fact, the Blanks form offered by NAIC to calculate MLR, specifically exempts dental from reporting. (See the attached letter by Secretary Sebelius confirming market reforms required in the Patient Protection and Affordable Care Act (PPACA), such as the requirements of 2718(b) of the Public Health Service Act, was neither designed nor applicable to HIPAA excepted benefits). We would also note that the methodology contains many specific references to terminology that is applicable only to medical and not to dental plans. Accordingly, we believe that at best, stand-alone dental plans would find it very difficult to utilize this methodology to report on MLRs and would be inherently disadvantaged by the methodology as the methodology was designed specifically for medical plans.

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NADP recommends postponing MLR reporting for dental plans until further discussion and implications can be properly evaluated and until a methodology appropriate for dental plans can be developed. As stated, dental was not considered in the NAIC MLR methodology and therefore how dental plans interpret the medical Blanks form would be unknown, and the data gathered may be incorrect, inconsistently applied plan by plan, and statistically not viable. It is worth noting that in its October 27, 2010 transmission letter to Secretary Sebelius, the NAIC noted "concerns about the potential for unintended consequences arising from the medical loss ratio." We believe that the potential for unintended consequences is even greater by any attempt to fit stand alone dental benefit plans into a reporting methodology designed for medical plans - - and we strongly urge the Division and the Commissioner not to do so.

NADP greatly appreciates the opportunity to share our views and research on the dental benefits industry. As the representative and nationally recognized resource on dental benefits, we are available to answer any of your questions with regard to the dental benefits industry. Please feel free to contact NADP for any additional information.

Sincerely,

Kris Hathaway
Director of Government Relations
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THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

September 8, 2010

Kurt L.P. Lawson, Partner
Hogan Lovells US LLP
Columbia Square
555 Thirteenth St, NW
Washington, DC 20004

Dear Mr. Lawson:

Thank you for your letter expressing concern over whether limited scope dental and vision benefits provided under a separate health plan or policy will continue to be exempt from the substantive requirements of the Public Health Service Act (PHSA).

Limited scope dental and vision coverage are considered to be "excepted benefits" provided they are (1) offered as separate benefit policy, certificate, or contract of insurance; or (2) not an integral part of the plan. To be considered not an integral part of the plan, in general, participants must have the right to elect not to receive coverage; and if a participant elects to receive coverage, the participant must pay an additional premium or contribution for that coverage. See section 2722 of the PHSA, section 732 of the Employee Retirement Income Security Act (ERISA), and section 9831 of the Internal Revenue Code (Code) and their implementing regulations at 45 CFR 146.145(c)(3), 29 CFR 2590.732(c)(3), and 26 CFR 54.9831-1(c)(3).

As outlined in the preamble to the interim final regulations relating to status as a grandfathered health plan, the exceptions for excepted benefits in ERISA and the Code remain in effect. Moreover, the Department of Health and Human Services (HHS) also stated in the preamble that it does not intend to use its resources to enforce the PHSA requirements with respect to nonfederal governmental plans that offer dental and vision benefits that meet the definition of excepted benefits. States have the primary enforcement authority for insurance companies that sell coverage meeting the definition of an excepted benefit. HHS encourages states to exercise the same discretion and will not consider the state to be failing to enforce the PHSA with respect to dental and vision plans that meet the definition of excepted benefits. See 75 FR 34538, 34539-34540 (published June 17, 2010).

Again, thank you for your letter and for your continued advocacy and leadership on this important issue.

Sincerely,

Kathleen Sebelius

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