

**DATE:** DECEMBER 6, 2010

**RE:** IOM & ESSENTIAL BENEFITS

**CONTACT:** KRIS HATHAWAY, NADP DIRECTOR OF GOVT. RELATIONS  
[khathaway@nadp.org](mailto:khathaway@nadp.org), 972.458.6998x111



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## BACKGROUND

At the request of the Secretary of HHS, the IOM is undertaking a study that will make recommendations on the criteria and methods for determining and updating the essential health benefits package. They included 10 questions on their website in which interested stakeholders could cut and paste their responses. Included in this memo:

- NADP's answers to questions #1, #5, and #6 (we did not respond to the other posted questions).
- Description of the IOM survey - from their main web page 'Determination of Essential Health Benefits'.
- Additional IOM information from their web page 'Project Information' on the IOM website.
- The full 10 questions posted by IOM.

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## NADP Answers to IOM EHBP Questions 12-6-10

### Q 1: What is your interpretation of the word "essential" in the context of an essential benefit package?

*Intro:* 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 80% of the 167 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.

*Answer:* All components of the essential health benefit package (EHBP) listed in question 6 are extremely important to the required recipients - individuals and employees working for small group businesses. The dental benefits industry is connected to the essential benefits package by the inclusion of "pediatric services, including oral and vision care."

Over 97% of oral health benefits provided in the United States today are covered by separate dental policies. The Patient Protection and Affordable Care Act (ACA) maintains Americans access to dental benefits offered by these specialty providers of coverage under Section 1311(d)(2). This section requires states to allow stand-alone dental plans to provide the pediatric oral benefit independently from medical plans. When identifying 'essential' for oral services in EHBP, IOM should be aware of the differences between medical and dental.

The organization and delivery of dental care differs from the medical care model. Dental disease is largely preventable, and primarily limited to well established conditions—tooth decay and gum disease—that rarely require hospitalization. As a result, 85% of dental care is provided in a primary care setting by general dentists, which is markedly different from medical care. The provider systems are dissimilar, as almost 80% of dentists are in solo practice, compared to less than 10% of physicians. There is no nationally accepted system of dental diagnosis codes for dental care. The coding systems for procedures are also separate, the Current Dental Terminology (CDT) is used in dental rather than the Current Procedural Terminology (CPT) which is used for medical. The 50 most frequently used CDT codes account for 95% of all dental procedures delivered annually.

The distinct nature of dental care and delivery, and the effective organizing of dental networks requires an expertise that differs from medical plan management. Given that the IOM Advisory Committee includes no dental experts, NADP offers access to the experts in dental coverage as IOM further develops guidelines for coverage of pediatric oral health services.

Dental benefit plans' understanding of the dental marketplace has allowed plans to develop prevention-oriented programs such as creating financial incentives to encourage regular office visits, fluoride treatments, cleanings and dental sealants for children. Dental plans build comprehensive networks of dentists, negotiate fee discounts, develop educational information and offer administrative efficiency by managing claims and networks in a cost-effective manner. As a consequence, dental premiums remain affordable and are growing more slowly than medical premiums.

The Centers for Medicare and Medicaid Services have indicated oral diseases are progressive and cumulative, and if left untreated, become more complex and difficult to manage over time. Additionally, there are growing indications in the scientific literature of a more widespread systemic impact of oral disease. Dental caries and its sequelae have been implicated in nutritional deficiencies in children, failure to thrive, difficulties in speech and poorer academic performance. Dental insurance is a major determinant of whether Americans receive the preventive care necessary to address their oral health needs to obviate progression of the disease and avoid escalating costly treatments. Dental caries (tooth decay) is the single most common chronic childhood disease – 5 times more common than asthma. While evidence based dentistry (EBD) is in its infancy, evidence should be a clear guide to what is included in essential coverage. For instance, fluoride varnish and sealants, two benefits that are almost universally covered for children, when used together have proven to reduce cavities by 93 percent. The ADA's clinical guidelines on sealants and fluoride suggest their use on "at risk" patients which suggests that risk should be a factor in coverage so that resources are directed to where they are most needed. NADP has conducted "Industry Snapshots," (essentially short surveys) on both sealants and fluoride that are available on request.

As there is no system of diagnostic codes nor nationally accepted quality measures, parameters that may be applicable to medical may not be appropriate guidelines for dental coverage. The Dental Quality Alliance, in which NADP is a participant, is in the early stages of developing performance measures for dentistry which may, in the future, be relevant references in determining appropriate pediatric oral health services. NADP is available as a resource on typical commercial coverage and related issues for the IOM's development of appropriate parameters for pediatric oral health services.

**Q 5: What type of limits on specific or total benefits, if any, could be allowable in packages given statutory restrictions on lifetime and annual benefit limits? What principles and criteria could/should be applied to assess the advantages and disadvantages of proposed limits?**

*Answer:* As typical commercial dental plans and state CHIPRA benefits cover diagnosis and prevention at 100%, preventive care is critical to identifying and controlling dental disease. Dental disease is predominantly limited to tooth decay and gum disease which are both preventable and treatable. However, given that evidence based dentistry is in its infancy, there could be significant risk of overtreatment without any limits on coverage.

Almost 70% of the dental policies sold in the United States are dental PPOs according to the most recent data in the [2010 NADP/DDPA Dental Benefits Report: Enrollment](#). Most dental PPO plans have a median deductible of \$50 and a maximum annual benefit of \$1,000 to \$1200 although higher maximum policies are available in the market. Some dental plans now offer policies that roll some portion of an unused annual maximum over until the next year. However, only 3% of Americans ([NADP Premium Trends Report, 2009](#)) with dental benefits reach their annual maximums. There is limited experience in the dental benefits industry with no annual maximum

policies. In the few employer settings where they have been implemented, additional utilization controls were put in place and virtually all groups returned to annual maximums after short periods of time due to utilization and resulting premium increases. Thus, there is no reliable estimate of the near or long-term premium cost for no annual limits. The cost of each dental benefit added must be carefully tested for the cost impact versus the value of the coverage to the consumer.

Absent performance measures or evidence-based standards, dental carriers have used Advisory Committees of dentists to set other types of limits in coverage to balance the value versus cost equation. These include frequency and age limits for some coverage and even limits on the teeth covered by the benefit. Alternate benefit or LEAT (Least Expensive Alternative Treatment) provisions are another component in maintaining dental coverage affordability. As there are varying clinical solutions for certain dental conditions, an alternate benefit provision allows the benefit to be based on an alternative procedure that is generally less expensive. One of the most common examples of an alternate benefit that would impact children is the use of amalgam rather than composite restorations on posterior teeth. Employer groups use consultants to develop RFPs that often include similar limits in defining the procedures that are to be covered under the employer's policy.

According to [NADP's 2008 Snapshot on Coverage of Sealants and Topical Fluoride](#), a variety of limits now apply to benefits focusing on children. Only half of the reporting carriers cover sealants on primary teeth while virtually all cover sealants on permanent teeth. The median age range for application of sealants is from 0-16. Other coverage limits allow the application of sealants only to posterior teeth or to molars. Frequency limits vary such as application of sealants only once in 24 months and no more than 2 times to any tooth. Similar age limits apply to fluoride varnish but frequency varies with up to two applications per year. Although less common on children, frequency limits are also common on other procedures such as crowns and root canals.

[NADP's 2007 Consumer Survey](#) found that individuals without dental coverage are 2.5 times less likely to visit a dentist than those with insurance—similar to federal findings cited in [Oral Health in America: A Report of the Surgeon General, 2000](#). Visiting the dentist is the first step to improving oral health. Additional data on the changes in oral health behaviors and results can be found in the [NADP 2007 Consumer Survey](#) which shows people with dental coverage are far more likely to obtain needed services than those who lack coverage and to maintain their permanent tooth structures—a key indicator of improved oral health. The combination of limits—annual, frequency, age, and tooth structure—have provided low cost coverage for Americans and resulted in improved oral health with less than 3% of Americans reaching their annual dental limits as indicated in the previous response. Maintaining other limits on coverage will become more critical to cost containment with the removal of annual limits.

Affordability is a parameter the IOM should include in its analysis. Both employers and consumers are cost conscious when selecting dental coverage which has an annual cost averaging the equivalent of one month's medical premium. Employers have not greatly increased their annual maximums for two decades as utilization suggests that virtually all their employees' dental care is adequately covered under the current limits. And, in a survey of consumers related to the impacts of health benefit taxes discussed in health care reform, 56 percent of Americans would drop "family" dental benefits if annual taxes of \$300 were imposed and 38 percent of Americans would drop their "employee-only" dental benefits if \$100 was added to their annual tax bill. These dollar figures are approximately a 30% increase in premium which could easily be reached by the removal of annual maximums. Without internal limits mitigating overutilization, the cost impact of providing pediatric oral health services which are now included in family policies could lead to adults dropping their coverage to provide the required pediatric oral health services only for their children.

**Q 6: How could an "appropriate balance" among the ten categories of essential care be determined so that benefit packages are not unduly weighted to certain categories? The ten categories are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use**

**disorders services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.**

*Answer:* While most of the essential benefits are typically covered under medical policies, except for the rudimentary oral health screening required of pediatricians under the “The Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care,” pediatric dental benefits are covered by separate dental policies within commercial coverage. Various states also utilize stand-alone dental plans to cover dental services in public programs, such as Medicaid and CHIPRA. As such, the benefit covering the children’s dental care needs to be addressed separately, by allowing independent subsidies of premiums as provided in Section 1311(d)(2) of the ACA. Separate pricing of the children’s dental benefit allows for transparency of this extremely important benefit which will keep cost increases to a minimum and enhance policy choices for all consumers.

Separate choices between medical and dental plans mirrors the commercial market today in which employers and individuals can choose their own medical, dental, vision, short/long term disability, and other supplemental benefits with a variety of choices. Defining the EHBP should include a careful review and deliberate guidance regarding the offer of dental benefits, whether provided by a separate stand-alone dental carrier, or by a full service medical carrier, to ensure that an appropriate, proportionate share of premium subsidies and cost sharing is dedicated to the children’s dental benefit of the EHBP.

To determine an appropriate balance for pediatric oral health services, only procedure codes for which there is utilization data should be considered for coverage. Utilization data for the most commonly utilized CDT procedure codes can be obtained from FAIR Health, the New York successor public organization to Ingenix. As indicated in an earlier response, the 50 most utilized CDT codes account for 95% of the dental care delivered annually. FAIR Health’s first iteration of dental data will be published in January of 2011.

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### **Determination of Essential Health Benefits**

<http://iom.edu/Activities/HealthServices/EssentialHealthBenefits.aspx>

#### **Activity Description:**

The Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010, will allow individuals and businesses to purchase health insurance directly through exchanges—competitive marketplaces where buyers can compare coverage. These exchanges will offer a choice of qualified health plans (QHPs) that vary in coverage levels but meet certain standards in categories of care and limits on patient cost sharing. The PPACA stipulates that these QHPs will cover the general categories of: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services including oral and vision care. Further details of an “essential health benefit” package are to be defined by the Secretary of Health and Human Services (HHS) based on the scope of benefits offered by a typical employer plan.

At the request of the Secretary of HHS, the IOM is undertaking a study that will make recommendations on the criteria and methods for determining and updating the essential health benefits package. The IOM will not define specific service elements of the benefit package. Instead, the IOM will review how insurers determine covered benefits and medical necessity and will provide guidance on the policy principles and criteria for the

Secretary to take into account when examining QHPs for appropriate balance among categories of care; the health care needs of diverse segments of the population; and nondiscrimination based on age, disability, or expected length of life.

Additionally, the IOM will offer advice on criteria and a process for periodically reviewing and updating the benefits package.

#### **Committee Members:**

- John R. Ball, MD, JD, MASCP, MACP (Chair), Retired as Executive Vice President, American Society for Clinical Pathology (ASCP)
- Michael S. Abroe, FSA, MAAA, Principal, Consulting Actuary, Milliman, Inc.
- Michael Chernew, PhD, Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School
- Paul Fronstin, PhD, Senior Research Associate, Employee Benefits Research Institute
- Robert S. Galvin, MD, MBA, FACP, Chief Executive Officer, The Blackstone Group
- Marjorie Ginsburg, BSN, MPH, Founder and Executive Director, Center for Healthcare Decisions
- David Guzick, MD, PhD, Senior Vice President for Health Affairs and President, University of Florida and Shands Health System
- Samuel Ho, MD, Chief Medical Officer, UnitedHealthcare
- Christopher F. Koller, MPPM, MAR, Health Insurance Commissioner, State of Rhode Island
- Elizabeth A. McGlynn, PhD, Associate Director, RAND Health and RAND Distinguished Chair in Health Care Quality, The RAND Corp.
- Amy B. Monahan, JD, Professor of Law, University of Minnesota Law School
- Nancy H. Nielsen, MD, PhD, Senior Associate Dean for Medical Education and Clinical Professor, Medicine, School of Medicine and Biomedical Sciences, State University of New York at Buffalo
- Linda Randolph, MD, MPH, President and CEO, Developing Families Center, Inc.
- James Sabin, MD, Clinical Professor of Ambulatory Care/Prevention and Psychiatry, Harvard Medical School; Director, Harvard Pilgrim Health Care Ethics Program
- John Santa, MD, MPH, Director, Consumer Reports Health Ratings Center, Consumers Union
- Leonard D. Schaeffer, Judge Robert Maclay Widney Chair and Professor, University of Southern California
- Joe V. Selby, MD, MPH, Director, Division of Research, Kaiser Permanente Medical Care Program
- Sandeep Wadhwa, MD, MBA, Vice President, Coding and Reimbursement, 3M Health Information Systems

#### **Project Information**

<http://www8.nationalacademies.org/cp/projectview.aspx?key=IOM-HCS-10-04>

Project Title: Defining and Revising an Essential Health Benefits Package for Qualified Health Plans  
 PIN: IOM-HCS-10-04  
 Major Unit: [Institute of Medicine](#)

#### **Project Scope**

The Patient Protection and Affordable Care Act (Affordable Care Act) established criteria for qualified health plans (QHPs) to participate in exchanges as defined in section 1301 of the statute. An ad hoc IOM committee will make recommendations on the methods for determining and updating essential health benefits for QHPs based on examination of the subject matter below.

In so doing, the committee will identify the criteria and policy foundations for determination of the essential

health benefits offered by QHPs taking into account benefits as described in sections 1302(b)(1) and 1302(b)(2)(A), and the committee will assess the methods used by insurers currently to determine medical necessity and will provide guidance on the "required elements for consideration" taking into account those outlined in section 1302(b)(4)(A-G), including ensuring appropriate balance among the categories of care covered by the essential health benefits, accounting for the health care needs of diverse segments of the population, and preventing discrimination against age, disability, or expected length of life. The committee will also take into account language in 1302 on periodic review of essential health benefits, other sections of the Affordable Care Act, for example, coverage of preventive health services (section 2713), utilization of uniform explanation of coverage documents and standardized definitions (section 2715), and other relevant tasks found in the Affordable Care Act for the Secretary HHS. The committee will provide an opportunity for public comment on the tasks of defining and revising the essential health benefits.

The project is sponsored by the U.S. Department of Health and Human Services  
 The approximate start date for the project is September 29, 2010.  
 A report is expected to be issued by the end of September, 2011.

**Project Duration:** 16 months

***For More Information Contact***

Ashley McWilliams  
 Phone: 202-334-1910  
 Fax: 202-334-2647  
 E-mail: [essentialbenefits@nas.edu](mailto:essentialbenefits@nas.edu)

**QUESTIONS by IOM re Essential Health Benefits Package**

[Limit of 1,000 words per answer]

1. What is your interpretation of the word "essential" in the context of an essential benefit package?
2. How is medical necessity defined and then applied by insurers in coverage determinations? What are the advantages/disadvantages of current definitions and approaches?
3. What criteria and methods, besides medical necessity, are currently used by insurers to determine which benefits will be covered? What are the advantages/disadvantages of these current criteria and methods?
4. What principles, criteria, and process(es) might the Secretary of HHS use to determine whether the details of each benefit package offered will meet the requirements specified in the Affordable Care Act?
5. What type of limits on specific or total benefits, if any, could be allowable in packages given statutory restrictions on lifetime and annual benefit limits? What principles and criteria could/should be applied to assess the advantages and disadvantages of proposed limits?
6. How could an "appropriate balance" among the ten categories of essential care be determined so that benefit packages are not unduly weighted to certain categories? The ten categories are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.
7. How could it be determined that essential benefits are "not subject to denial to individuals against their wishes" on the basis of age, expected length of life, present or predicted disability, degree of medical dependency or quality of life? Are there other factors that should be determined?

8. How could it be determined that the essential health benefits take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups?
9. By what criteria and method(s) should the Secretary evaluate state mandates for inclusion in a national essential benefit package? What are the cost and coverage implications of including current state mandates in requirements for a national essential benefit package?
10. What criteria and method(s) should HHS use in updating the essential package? How should these criteria be applied? How might these criteria and method(s) be tailored to assess whether: (1) enrollees are facing difficulty in accessing needed services for reasons of cost or coverage, (2) advances in medical evidence or scientific advancement are being covered, (3) changes in public priorities identified through public input and/or policy changes at the state or national level?