The Children’s Dental Health Project (CDHP) appreciates the opportunity to comment on the proposed rule “Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation.” As the national organization with the vision of achieving oral health for all children, we see access to affordable dental coverage as essential to addressing the national epidemic of childhood tooth decay and we view the Affordable Care Act (ACA) as an enormous opportunity for expanding coverage to millions of children. Congress recognized the importance of oral health by including dental benefits as part of a comprehensive set of required pediatric services in the Essential Health Benefits (EHB).

We believe the intent of the law was not to maintain a separation between oral health services and other child health benefits but rather to move towards a more integrated approach to coverage as a means of achieving better health through higher quality care at lower costs. Unfortunately, the treatment of stand-alone dental plans by the law itself and in this proposed rule positions dental care as secondary to medical care and runs the risk of undermining the law’s intent by creating additional barriers to coverage, especially with regard to consumer affordability.

**Congressional Intent**

In a September 2011 colloquy, Senators Bingaman, Stabenow, and Baucus clarified that the intent of allowing stand-alone dental plans to provide a portion of the EHB was not to create separate standards but to create competition in the insurance exchanges and allow consumers choice in the marketplace. The Senators left no question in their colloquy that all relevant consumer protections and cost-sharing provisions should apply equally to health and dental plans. In addition, 11 Senators and 27 members of Congress, many of whom sat on the committees that drafted the Affordable Care Act, sent a letter to HHS making clear that children who receive pediatric services from a stand alone dental plan should have the same level of consumer protections as those children who get coverage through a qualified health plan. Simultaneously, CDHP and numerous other child health organizations similarly urged HHS draft rules to ensure that consumers receive equitable treatment regardless of how they purchase their pediatric essential health benefits.

Therefore we are deeply concerned that the proposed rule sidesteps and, in some cases, ignores Congressional intent and dismisses the concerns of some of the foremost provider and consumer organizations in this country. Therefore we seek clarification on and your reconsideration of the following issues outlined below.

**Age limit for pediatric services**

The proposed rule establishes the age limit for pediatric services as 19; however, because many families may be transitioning between exchange coverage and public insurance, we strongly encourage efforts to ensure consistency in coverage options, especially for low-income families. Therefore, we urge HHS to increase the age limit to 21 in order to align with the existing Medicaid standards for pediatric benefits.
Supplementing pediatric oral services
CDHP appreciates HHS’ emphasis on pediatric oral health services as a critical piece of the EHB package by requiring that states supplement benchmark plans that lack coverage of these services. CDHP supports the clarification that benchmark plans lacking pediatric oral services must supplement with either FEDVIP or CHIP. Both of these supplemental benchmarks typically cover a comprehensive set of pediatric dental services although CHIP dental benefits do vary from state to state. In the December 2011 Essential Health Benefits Bulletin, the Center for Consumer Information and Insurance Oversight proposed a third option which would allow states lacking a separate CHIP program to establish a pediatric dental benchmark that is “consistent with the applicable CHIP standards.” We seek clarification as to whether this will remain an option for states that do not have a separate CHIP program.

Actuarial value standards and premium tax credits
The rule proposes to establish separate actuarial value targets for stand-alone dental plans of 75% and 85% for “low” and “high” options but does not specify how this may impact the consumer from an affordability standpoint. Unfortunately, because the law exempts stand-alone dental plans from the cost-sharing reduction requirements of section 1402, families at or below 250% of the Federal Poverty Level (FPL) who choose or are forced to purchase pediatric dental coverage through a stand-alone dental plan will pay more than if they were to purchase the same coverage through a health plan. Furthermore, there is no guarantee that families will have the option to buy anything but stand-alone dental coverage in the exchanges. Consumer advocates are concerned that these actuarial targets may not be beneficial to the consumer and recommend much greater transparency and clarity about the methods and assumptions by which pediatric dental spending was included in the actuarial value calculator. Placing the bulk of pediatric dental costs in the highest spending brackets does not reflect actual pediatric dental spending distribution. We urge HHS not to finalize this aspect of the rule until additional information has been publicly released and additional opportunity to comment provided.

With regard to the plans providing coverage in the exchanges, we are concerned that the proposed rule’s treatment of stand alone dental plans, in combination with other federal rules, will inappropriately exclude premiums paid for pediatric dental benefits from the tax credits for which they should be eligible. The Affordable Care Act is clear that premiums paid for the pediatric dental benefits in stand alone dental plans are eligible for premium tax credits. ACA section 1401(a) added IRC section 36B(b)(3)(E), which reads:

“(E) SPECIAL RULE FOR PEDIATRIC DENTAL COVERAGE.—For purposes of determining the amount of any monthly premium, if an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii)(I) of the Patient Protection and Affordable Care Act for any plan year, the portion of the premium for the plan described in such section that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J) of such Act shall be treated as a premium payable for a qualified health plan.”

Premium tax credits are determined by the amount of a family's income and the cost of the second lowest cost silver plan available to them, limited by the amount the family pays in premiums. IRS regulations at 26 CFR 1.36B-3(k) appropriately include payments for pediatric dental benefits in the amount families pay in premiums, so their maximum tax credit reflects costs for all EHBs. However, to assure that families get the full tax credit to which they are entitled, the cost of pediatric dental benefits should also be included in computing the cost of the second lowest cost silver plan. If the second lowest cost silver QHP does not include pediatric dental benefits, its cost must be adjusted to include the cost of stand alone pediatric dental benefits. This is consistent with the statutory language cited above, which references “determining the amount of any monthly premium.” “Any monthly premium” should be interpreted to include the “adjusted monthly premium for an applicable second lowest cost silver plan” referenced in 36B(b)(3)(C).

This interpretation should be expressed in section 156.150, in the definition of silver plan at 156.140(b), and in IRS regulations at 26 CFR Part 1. Codifying this interpretation will allow families’ premium tax credits to reflect the true cost to families of purchasing coverage for the essential health benefits.
Cost-sharing limits
The March 27, 2012 Final Rule on Establishment of Exchanges and Qualified Health Plans states that: “We accept the recommendation of commenters that cost-sharing limits and the restrictions on annual and lifetime limits should apply to stand-alone dental plans for coverage of the pediatric dental essential health benefit.” However, the proposed rule on Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation proposes a separate cost-sharing limit for stand-alone dental plans in addition to the out-of-pocket maximums that will already apply to a family’s EHB-associated costs. The rule further states that the additional cost-sharing limit be “reasonable” but fails to propose a specific test for reasonableness. This proposed change effectively increases a family’s out-of-pocket maximum and therefore fails to hold families harmless when purchasing separate dental coverage. No family should be subject to out-of-pocket expenses in excess of the law’s clearly established affordability provisions. This proposed rule would make pediatric dental coverage less affordable for families purchasing it separately from the rest of their EHBs, effectively creating a disincentive to purchase a critical piece of a child’s benefit package.

If a state exchange allows pediatric dental benefits to be priced and offered separately, many families may forgo the purchase of dental coverage for their children for two reasons: they will be forced to consider purchase of a separate insurance product and their out-of-pocket expenses may be higher.

For those same families that are enrolled in a stand-alone dental plan, the burden of tracking out-of-pocket expenses for both medical and dental should not fall on them. Insurance companies are well-positioned to coordinate with one another in order to determine when families have reached their out-of-pocket maximums, notify families, and adjust cost sharing accordingly. We strongly urge you to require that the out-of-pocket maximums established by the statute be applied to costs related to all essential health benefits – including those services covered by stand-alone dental plans – and to require that costs be tracked and coordinated among all insurance carriers for a family.

Millions of families across the country live in areas with few or no dental providers and while exchanges are now required to ensure that health and dental plans have adequate networks, no network adequacy standards have been established for the purpose of dental coverage in the exchanges. Additionally, qualified health plans are exempt from providing pediatric dental coverage in the exchanges if a single stand-alone dental plan participates. These factors increase the likelihood that many families may not be able to access an in-network dental provider for their children. Therefore, we further urge HHS to allow out-of-network expenses to count towards the out-of-pocket maximum.

We appreciate the opportunity to comment on these proposed rules and look forward to working with HHS on clarifying the concerns we have outlined and implementation in the coming year. Please do not hesitate to contact us for additional information by calling or emailing Colin Reusch at (202) 417-3595 or creusch@cdhp.org.

Sincerely,

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