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**Attention: [CMS-9989-P] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans**

To Whom It May Concern:

The Children's Dental Health Project (CDHP) is pleased to provide public comments regarding the proposed rule for the Establishment of Exchanges and Qualified Health Plans consistent with title I of the Affordable Care Act (ACA) as requested in the July 15, 2011 *Federal Register*. CDHP is a national organization with the vision of achieving oral health for all children to ensure that they reach their full potential. As a consumer organization, we view this rule as critical to ensuring that children have access to high-quality, comprehensive, affordable oral health coverage including standardization of all applicable consumer protections, regardless of the type of issuer that provides that coverage.

A child's health includes their oral health. Tooth decay is a contagious bacterial infection and cavities are an outcome of that disease. Established by preschool, the disease that leads to cavities (dental caries), remains the most common chronic condition in childhood, even though it is preventable. Unfortunately, nearly half of all children entering kindergarten have at least one cavity which left untreated, leads to the spread of infection and pain as well as problems eating, speaking and learning. Later in life, poor oral health is linked to increasing complications with heart disease, diabetes, stroke and preterm birth. While more than twice as many children lack dental insurance as health insurance, access to dental care is often overlooked until there is a problem. ACA requires the essential benefits package to include dental coverage for our youth in order to address preventable oral health problems early and in a cost-effective manner.

**Therefore, the following comments will focus on the pediatric oral health care benefit provided in the ACA.**

ACA Section Sec. 1302(b)(1)(J) requires the inclusion of pediatric oral health care as part of the essential benefits package. The statute goes further to provide significant flexibility to states by allowing dental coverage to be provided through a Qualified Health Plan (QHP) or a stand-alone dental benefit plan either separately or in conjunction with a QHP [Sec. 1311(d)(2)B(ii)]. This added complexity to the delivery of the essential health benefits is representative of the longstanding precedent that medical and dental care maintains separate financing and delivery structures in the private insurance market. Considerable attention is needed by Exchanges and Federal regulators to ensure access to comprehensive pediatric dental benefits, high quality care, adequate provider networks, consumer protections and affordable coverage in the changing insurance market. It is imperative that the final rule explicitly clarifies that insurance reforms and consumer protections should be applied equally to stand-alone dental plans and QHPs to assure families parity in benefits, cost, and access to dental care within an Exchange. Therefore, we urge you to ensure that any final rules relevant to the establishment Exchanges and the certification of QHPs take the following comments into consideration to address the ACA mandate for pediatric dental coverage.





## Stand-alone dental plans (§155.1065)

### **Stand-alone Dental Plans Compliance with QHP Certification Requirements and Consumer Protections**

The proposed rule states: “*We are considering interpreting this provision such that an Exchange may require issuers of stand-alone dental plans to comply with any QHP certification requirements and consumer protections that the Exchange determines to be relevant and necessary.*” CDHP agrees that there should be parity between stand-alone dental plans and dental benefits provided through QHPs. CDHP urges that the final rule ensures that certification and recertification standards are equivalent and consistent for QHPs and stand-alone dental plans. At a minimum, they must have the same participation standards, benefit design standards, quality standards, requirements for child-only plans, rates and benefit information, transparency in coverage, and network adequacy standards, which we discuss in detail below. The inclusion of section 1311(d)(2)B(ii), which allows for stand-alone dental plans to participate in an Exchange, was devised to provide meaningful consumer choice. However, the provision, in our interpretation, was never intended to provide a competitive advantage to stand-alone dental plans or QHPs in providing or omitting the pediatric dental benefit. **Consumers would be best served by consistency in the benefits offered, transparency in operational functions of issuers and associated costs to obtain those benefit by companies that desire to participate in an Exchange.**

**Participation Standards:** Stand-alone dental plans should be required to comply with the processes, procedures and standards outlined by the Exchange for certification and recertification of QHPs. Although stand-alone dental plans are not required to provide the full-range of benefits outlined in section 1302(b) they should be subject to the same process for certification. The stand-alone issuer, like the QHP, should be required to meet the standards which indicate their ability to prove that they are in good standing with the State and able to provide high-quality, affordable, and accessible dental coverage to children. Such requirements would serve to assure consumers that the plan they choose to purchase for their children has met the standards established by the Exchange.

**Benefit Design Standards:** Certification of stand-alone dental plans to participate in the Exchange should include adherence to section 1302(a) as will be defined in future rulemaking. We understand that more details will be provided regarding requirements for meeting the essential benefits [1302(b)(1)(J)]. Until that rule is released, this rule should stipulate the necessity to meet section 1302(a)(b) and (c), particularly with regard to cost-sharing protections. To maintain a competitive marketplace within the Exchange, neither a QHP or stand-alone should be exempt from cost-sharing protections. **We view these cost-sharing standards as an effort to create equity in affordability and transparency with regard to what benefits an individual/family can expect to receive for a given payment.** The ability of an Exchange to offer a single stand-alone dental plan (therefore exempting a QHP from offering pediatric dental coverage) makes the cost-sharing protections that much more critical to maintaining the affordability for pediatric dental coverage if there is a lack of competition. Cost-sharing standards with corresponding benefit information and transparency are necessary to maintain affordability, particularly given the current structure of dental insurance which requires significant out-of-pocket expenses for routine restorative services that could easily exceed an individual’s cost-sharing maximums.

**Quality Standards:** Stand-alone dental plans should not be exempt from meeting quality standards outlined in section 1311(c) or benefitting from incentives detailed in section 1311(g) by virtue of offering a dental benefit outside of a QHP. Recognizing that quality standards will be addressed in future rulemaking, we support the inclusion of stand-alone dental issuers as an applicable entity for those rules.



**Child-only Plans:** Due to the requirement in section 1302(b)(1)(J) for pediatric oral care with no explicit requirement for a comparable adult benefit, it seems pertinent to codify that section 1302(f) also applies to dental benefits provided through a QHP or a stand-alone dental plan. Since premium tax subsidies are only applicable to the child portion of a dental benefit, we seek explicit clarification that QHPs or stand-alone dental plans must provide and price separately a child-only dental benefit as a certification requirement to participate in an Exchange.

**Rate & Benefit Information:** CDHP believes that the best method to foster direct competition on the basis of price and quality is to create uniformity among issuers of dental coverage. Therefore, just as QHPs must provide an annual rate justification, so too should stand-alone dental plans. Maintenance of annual rates for a benefit year, justification for significant rate increases, and public display of this information for consumers are the current basic standards to inform choice and competition.

**Transparency in Coverage:** In addition to providing comparable and justified pricing, certification of both QHPs and stand-alone dental plans should include transparency of coverage relevant to an issuer's quality and cost. Stand-alone dental plans, like QHPs, should be required to meet the statutorily-required disclosures outlined in §156.220. Notably, the ability of a consumer to obtain information on their cost-sharing responsibilities for specific services (in-network and out-of-network) and their rights as an enrollee are necessary to make decisions about their choices within the Exchange. Such standards are necessary to allow consumers to make informed decisions when purchasing health insurance.

**Network Adequacy:** Recognizing that dental coverage is the first, but not the last step in obtaining dental care, the ability to find an in-network dentist within a reasonable distance of an enrollee is an issue the Exchange must address. Research has consistently reported the insufficient supply and distribution of dentists, particularly in rural areas and in low-income communities. Exchanges should require the demonstration of adequate dental provider networks by a QHP or stand-alone dental plan as part of the certification process.

### **Federal Minimum Consumer Protection Standards for Stand-Alone Dental Plans**

The proposed rule states: *"We request comment on whether some of the requirements on QHP issuers should also apply to stand-alone dental plans as a Federal minimum and what limits Exchanges may face on placing requirements on dental plans given they are excepted benefits."* CDHP recognizes the distinct difference between the model and structure of stand-alone dental plans in comparison to traditional health insurers, however the ACA allows both to participate in order to foster competition and advance quality of care. The pediatric oral care portion of the essential benefits should be no exception. In order to provide equitable benefits, consumer protections, and intended insurance reforms, HHS must provide Federal minimum standards for the participation of stand-alone dental plans in an Exchange. While the HIPAA "excepted benefits" definition was used throughout ACA for purposes of referring to stand-alone plans, it was not intended to evade insurance reforms and consumer protections. The ability of an Exchange to assure families equivalent benefits, cost, protections and transparency depends on minimum Federal standards.

### **Operational Minimum Standards for Stand-Alone Dental Plans**

The proposed rule states: *"We also request comment on whether we should set specific operational minimum standards."* As previously stated, there are substantial differences between the current model and structure of a stand-alone dental plan compared to a traditional health insurer. However, those differences do not prevent the calculation of actuarial value or determination of equitable premium subsidies. The distinctions between the



differing models provide an opportunity for HHS to take a leadership role in developing guidance on providing information and data that is comparable. Clarity is needed from HHS on allowable data to be used in determining actuarial values and subsidies for these plans. Without minimum standards that detail the allowable portioning of the premium tax credit in conjunction with the potential for limited choice (if only one stand-alone participates in a state and no QHP offers pediatric dental coverage), drastic differences in out-of-pocket costs could occur across the country. CDHP recommends an independent entity assist HHS in identifying Federal premium subsidy standards based on existing historic and industry data. This formula consequently could be provided to state Exchanges for certification standards and actuarial standards.

### **Offering and Pricing Medical and Dental Coverage Separately**

The proposed rule states: “...commenters 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... We request comment on whether either option should be required.” **Providing consumers with information that is clear and accurate regarding benefits and out-of-pocket expenses among the plans provided in an Exchange is vitally important to promoting competition based on price and quality.** However, providing separate pricing for dental benefits by issuer (either a QHP and/or a stand-alone dental plan) is only valuable if the data is comparable. Clarifying issues addressed in this draft rule regarding applicability of certification processes, consumer protections, cost-sharing and other areas not covered in this rule (regarding transparency of appeals and loss ratios), is necessary for determining instructions for what would be included in the “cost” of a benefit. Failing to provide clear guidance to issuers on what “costs” are allowable, may create incomparable data that would be confusing at best and provide a competitive advantage for a company, at worst. Therefore, we support separate pricing if detailed guidance is provided to Exchanges on how that pricing must be determined.

We appreciate the opportunity to comments on this draft rule. If you have any questions or would like additional information, please contact Meg Booth at [mbooth@cdhp.org](mailto:mbooth@cdhp.org) or at 202.833.8288 x206.

Sincerely,

Catherine Dunham, Ed.D.  
Executive Director