



**ADA** American  
Dental  
Association

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Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Room 445-G, Hubert H. Humphrey Building  
200 Independence Avenue, NW  
Washington, DC 20201

Attention: CMS-9980-P

On behalf of the American Dental Association (ADA) and the American Academy of Pediatric Dentistry (AAPD), we are pleased to offer comments regarding the Department of Health and Human Services' proposed rule titled "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation." This proposed rule, affecting implementation of the Patient Protection and Affordable Care Act (ACA), serves as an important guide to states grappling with the numerous challenges of establishing a health benefit exchange or considering whether to engage in such an endeavor.

The proposed rule is important not only for what it addresses but also for what it fails to address. It is extremely important that the pediatric dental "essential health benefit" (EHB) be a required purchase for all families with children who buy their coverage in the individual or small group market after January 1, 2014 if they do not already have such coverage. Children up to age 21 should be covered by a dental benefit that is "necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions" and there should be adult dental coverage for emergencies as part of the EHB package. Finally, stand-alone dental plans and medical plans with an embedded dental benefit must be able to compete on an equal footing both inside and outside the exchange to ensure consumers have a robust selection of dental products.

### **Comments**

The agency must provide clear and comprehensive information as it sets standards for exchanges and health insurance issuers to facilitate the expansion of private sector coverage. The ADA and AAPD, in general, believe that state exchanges must maximize competition among plans to ensure that the marketplace is competitive on January 1, 2014 and beyond. Products offered through state exchanges meeting the EHB requirements must be affordable and provide consumers with an adequate network of providers. Individuals and small businesses seeking coverage through a state exchange (perhaps for the first time) must be able to fully understand the value of each product. At a minimum, this will require transparency on price, benefits, consumer protections and network adequacy.

It is estimated that 3 million children will gain dental benefits through the health insurance exchanges by 2018, or roughly a 5 percent increase over the current number of children with

private dental benefits.<sup>1</sup> It is important to note that a significant portion of children will also gain dental benefits outside of health insurance exchanges through, for example, employer-sponsored dental benefits with dependent coverage. The effects on dentistry could be significant if, for example, the ACA-required essential pediatric oral benefit is inadequate or too expensive or if plans with inadequate dental networks dominate the exchange marketplace.

Also, as detailed below, the expansion of children's dental coverage in the exchange could be undermined by an interpretation of the ACA that requires the pediatric oral benefit to be offered as one of the EHBs but does not necessarily require it to be purchased. This must be addressed by the agency in its final rule. Finally, there is a concern that stand-alone dental benefit plans will not be able to effectively compete in the individual and small group markets outside the exchange after January 1, 2014, because the proposed rule is silent on the plans' role as an issuer of the EHB pediatric oral benefit in this marketplace. This issue must also be resolved.

### **Mandated Offer vs. Mandated Purchase of the Pediatric Oral Essential Health Benefit in the Health Care Exchange**

The ADA and AAPD believe the ACA clearly *mandates the purchase* of the entire EHB package including the pediatric oral benefit for families with children in the health care exchange if the children do not otherwise have dental coverage. This can be accomplished by purchasing the dental benefit as an embedded product in a medical plan or by pairing a medical plan without a dental benefit with a stand-alone dental plan.

There is some confusion concerning the mandate to purchase the pediatric oral EHB benefit because the requirement on the individual to purchase coverage sufficient to avoid a penalty or tax (the "individual mandate") does not require the purchase of stand-alone dental benefits. Therefore, the reasoning goes, individuals need not purchase the EHB dental coverage when they buy coverage on the exchange. This line of reasoning ignores the mandates placed on state and federal officials (discussed in detail below) to ensure that plans in the exchange are offered in a manner that requires families with children to purchase the pediatric EHB dental coverage as part of the total EHB package. This can be addressed by designing the exchange web portal so that any consumer that purchases dependent coverage cannot finalize that purchase unless the plan(s) include the pediatric oral benefit.

Pediatric oral health services are included among the list of EHBs outlined in the ACA<sup>2</sup> and the law specifically allows stand-alone dental plans to compete in the exchange.<sup>3</sup> This is consistent with the Administration's intent of minimizing disruptions of the current market by letting individuals and families maintain their current coverage. Currently about 98 percent of dental benefit plans are sold separately from medical coverage.<sup>4</sup> Unfortunately, there have been inconsistent messages from the agency on the potential effects of these two provisions.

The language allowing stand-alone plans to compete is being interpreted by some as creating an unintended loophole that negates the clear mandate for families with children to purchase

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<sup>1</sup> Milliman, Inc., Health Insurance Exchanges and the Individual Mandate Under the Affordable Care Act: Impact on the Dental Market, July 23, 2012

<sup>2</sup> PL 111-148, § 1302(b)(1)(J)

<sup>3</sup> Id., § 1302(d)(2)(B)(ii)

<sup>4</sup> National Association of Dental Plans and the Delta Dental Plans Association, Offering Dental Benefits in Health Exchanges, A Roadmap for Federal and State Policymakers, September 2011, pg. 20.

the EHB pediatric oral benefit. This conclusion has been reached by some because of a disconnection between the “minimum essential coverage” requirement placed on individuals (known as the “individual mandate”) and the requirement placed on individual and small group plans (both inside and outside the exchange) to meet the “qualified health plan” (QHP) standard. To meet the individual mandate requirement, the individual need only purchase minimum essential coverage, which does not include coverage by stand-alone dental plans.<sup>5</sup> On the other hand, the QHP standard requires all individual and small group plans (both inside and outside the exchange) to offer the total EHB package, including the pediatric oral benefit. The one exception is that medical plans in the exchange do not have to offer the EHB pediatric oral benefit if a separate dental benefit plan option is available, and the medical plan will still be deemed a QHP. This creates an opportunity for an individual to purchase a medical plan without the pediatric oral benefit in the exchange and not be penalized for failing to meet the individual mandate.

In individual and small group markets inside (and outside) of the exchanges, obtaining minimum essential coverage means obtaining a qualified health plan which contains all of the essential health benefits. An individual’s mandate to purchase coverage may be different, but that does not affect the ACA-established separate rules for the operation of exchanges. *If the individual comes to the exchange to purchase coverage, the individual must play by the exchange’s rules.*

Allowing some medical plans to opt out of the EHB pediatric oral benefit is merely an administrative accommodation so that dental benefit plans can truly compete in the exchange. The intent of the administrative accommodation is to avoid redundancy, not to undermine the EHB package. This interpretation is supported in a Senate colloquy in which one of the amendment’s sponsors, Senator Debbie Stabenow (D-MI), stated “The amendment ensured that stand-alone dental policies may fulfill the requirements of the Essential Health Benefits Package when **paired** with a qualified health plan covering all benefits other than pediatric oral health services within the exchange.”<sup>6</sup>

Several states that have taken the lead on ACA implementation agree that EHB pediatric oral benefits must be purchased. For example, in Washington, the Office of the Insurance Commissioner (OIC) told the exchange that, beginning in 2014, the OIC could not certify an insurance plan unless it contained all 10 EHBs. If the exchange had decided to only make pediatric dental a mandated offer, OIC would not have been able to certify any of the medical insurance plans that did not include all 10 EHBs. With this in mind, the Exchange Board of Directors decided to make pediatric dental a mandated purchase.

In California, exchange officials are requiring bidders to propose products and rates that include and exclude the EHB pediatric dental benefit. In communications with their state officials, the California Dental Association asserts the EHB pediatric dental benefit must be purchased by families with children, but also suggests the state provide flexibility for childless adults. This allows such adults to purchase products that meet their needs in a cost-effective manner. This is important because they will make up a great number of the “young invincibles” whose engagement in the exchange will be critical to its success.

Clearly, there is ample precedent that state officials establishing exchanges are interpreting the ACA to require the purchase of the pediatric dental EHB benefit. This is a wise public policy decision, as well. An analysis conducted by the ADA’s Health Policy Resources Center

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<sup>5</sup> PL 111-148, § 1501(b)

<sup>6</sup> 157 Cong. Rec. S5974 (daily ed. Sept. 26, 2011) (emphasis added)

indicates that children with private dental insurance are about 25 percentage points more likely to have at least one dental visit than children without coverage.<sup>7</sup> Also, private dental insurance coverage among children has declined from 57.3 percent in 2001 to 48.8 percent in 2010.<sup>8</sup> Regular dental visits are an important component of ensuring good oral health and ultimately controlling health care costs through the application of preventive measures.<sup>9</sup>

We strongly urge the agency to direct officials (federal and state) setting up an exchange to require families with children to verify that they have the children's EHB dental coverage before they can finalize the QHP purchase in the exchange. At a practical level, this could be designed through the exchange web portal so that any consumer that purchases dependent coverage cannot finalize that purchase unless the plan(s) include the pediatric oral benefit. The ADA and AAPD believe this would be consistent with the intent of the ACA.

## **EHB Benchmark Plan Standards**

### Definition of pediatric services

The proposed rule seeks to codify a "child-only" medical coverage standard in §147.150(c) for individuals seeking child-only coverage to individuals who "have not attained the age of 21." The proposed definition of "pediatric services" for the purposes of the oral health and vision benefit is up to 19 years of age, though states have the ability to increase it to 21.

We believe that pediatric oral health services should be available to individuals up to age 21. Based on an analysis of the Medical Expenditure Panel Survey (MEPS) data, utilization among children declines steadily from age 8 through 21, and there is particularly a sharp decline between the ages of 18 and 21. Extending coverage through age 21 may mitigate some of this decline in dental utilization.

This age limitation would be consistent with services covered under a "child-only" medical plan and aligns with the age range currently being used to develop dental quality measures by the Dental Quality Alliance.<sup>10</sup> The different age limitations may create confusion for consumers and dental providers if there is inconsistency within the same benefit plan, such as a medical plan with an embedded pediatric oral benefit. The inconsistency may also create an unlevel playing field depending on the way the pediatric oral benefit is purchased. Adoption of a uniform age limit up to age 21 in lieu of leaving the decision to the states will avoid disruptions and disparities in the marketplace.

### Benchmark plan options and supplementation

The proposed rule and December 16, 2011 bulletin issued by the agency recognize that many benchmark plans may not contain all 10 EHB categories and specifically have addressed the need for supplemental coverage for pediatric oral and vision services. The proposed rule

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<sup>7</sup> 2000-2009 Medical Expenditure Panel Survey (MEPS)

<sup>8</sup> 2001 and 2010 MEPS

<sup>9</sup> Cigna. Improved health and lower medical costs: why good dental care is important, a white paper [Internet] 2010 [cited 2012 Dec 12]. Available from: [http://www.cigna.com/assets/docs/life-wall-library/Whygooddentalcareisimportant\\_whitepaper.pdf](http://www.cigna.com/assets/docs/life-wall-library/Whygooddentalcareisimportant_whitepaper.pdf).

<sup>10</sup> The Dental Quality Alliance (DQA) is an Alliance of professional organizations, the dental benefits and health plan industry, federal agencies, non-dental stakeholders, and a public member. The mission of the DQA is to advance performance measurement as a means to improve oral health, patient care and safety through a consensus-building process.

provides further clarification that the options states may choose to supplement pediatric oral coverage are: 1) the Federal Employee Dental and Vision Insurance Program (FEDVIP) plan with the largest enrollment (MetLife High option) or 2) a state's separate CHIP program. Both options provide a range of services, including preventive services, appropriate for the pediatric population.

What remains unclear is the trigger mechanism that requires states to add the supplemental coverage. The rule states "...that to the extent that the default base-benchmark plan option does not cover any items and services within an EHB category, the category must be added by supplementing the base-benchmark plan." We believe it is possible for a state to select a benefit package that is so minimalist that it is inconsistent with the intent of the ACA. For example, Utah has chosen a benchmark medical plan option with an extremely limited pediatric oral benefit. According to the benchmark plan information available on the agency's website, Utah has chosen the Public Employee's Health Program, Utah Basic Plus plan. The pediatric oral benefit provides for only a "dental check-up" that includes coverage for periodic oral exam fees, twice per year. At this time, Utah has not identified additional plans to supplement the EHB categories.

We request that states be allowed to supplement the pediatric oral health benefit if the benchmark plan does not contain an array of dental services appropriate for the pediatric population. Dental disease is highly prevalent among children and is preventable. The need for access to dental services was recognized when a requirement was included in the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA). CHIPRA requires CHIP programs to provide dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency condition. This definition encompasses services that are recommended by evidence-based guidelines developed by the ADA and AAPD.

### **Covered Services**

The proposed rule expressly states an issuer may not include routine adult dental services and cosmetic orthodontia in the EHB package. The ADA and AAPD believe basic adult dental coverage is an important benefit. While we recognize that the EHB categories were established in the law, we suggest that the agency clarify that coverage for emergency adult dental services are permitted under this definition. Providing such services will help defray unnecessary costs associated with emergency room visits and hospitalizations. This is increasingly important as a recent analysis<sup>11</sup> covering years 1997-98 and 2007-08 showed that dental emergency department (ED) visits increased from 1.15 percent to 1.87 percent of total ED visits, with the largest increase among young adults aged 20 to 34.

Coverage for orthodontic services was referenced in the agency's December 16, 2011 bulletin in medically necessary situations. However, we believe the way this language is written in the proposed rule is confusing and should be clarified so that it is clear that the EHB pediatric oral dental benefit includes *medically necessary* orthodontic coverage. Thousands of children are born each year with craniofacial anomalies from birth defects that may impair their ability to eat and speak and children involved in accidents or other traumatic events may require orthodontic treatment to repair injuries. We request clarification that the EHB pediatric oral benefit includes

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<sup>11</sup> Wall T. Recent trends in dental emergency department visits in the United States: 1997/1998 to 2007/2008. [J Public Health Dent.](#) 2012; 72(3):216-220.

medically necessary orthodontic coverage. Covering medically necessary orthodontia would also ensure children who move between public and private coverage would have access to continuity of care since Medicaid and many CHIP programs do provide this type of coverage.

State coverage mandates in place before December 31, 2011 may be included in a state's EHB benchmark plan without additional financial impact on the state. States are responsible for defraying 100 percent of the cost of additional mandates enacted after such date for plan years 2014 and 2015. The ADA and AAPD support this proposal as a common sense means of honoring a number of important state mandates in a manner that does not penalize state budgets or individuals and families that benefit from such mandates. For example, at least 35 states have adopted laws or regulations that address dentally-related (adjunctive) medical costs, emphasizing the importance and necessity of addressing this issue. Associated medical costs refers to the requirement that medical plans pay for hospitalization and related medical expenses, such as the administration of general anesthesia, when dental treatment is best performed in the hospital or an outpatient surgical facility. Children with special health care needs, including cognitive and physical disabilities, as well as children with extensive dental treatment needs may require treatment in such settings more frequently than other children. Allowing states to retain these mandates for the interim plan years will provide additional time for a consensus to be reached on a comprehensive set of benefits that appropriately serves all populations.

### **Dental Benefit Plans Competing Outside the Exchange**

As long as the benefits, costs, standards, and provisions of stand-alone and embedded plans are clearly stated, the ADA and AAPD believe that consumers will be able to make informed decisions that best meet their needs. However, we are concerned that stand-alone dental benefit plans will not be able to effectively compete in the individual and small group markets *outside* the exchange after January 1, 2014. The proposed rule is silent on the stand-alone plans' role as an issuer of the EHB pediatric oral benefit in this marketplace. Within the exchange, the ACA expressly allows stand-alone dental benefit plans to pair-up with medical plans that do not contain a dental benefit but are still deemed to be a QHP. Outside the exchange, all individual and small group plans will need to contain all ten EHB categories to meet the QHP designation, including the pediatric oral benefit.

Without further clarification from the agency, the EHB pediatric oral benefit in stand-alone plans would be superfluous in *all* cases. The insurance industry projects that absent regulatory clarification over 43 million people that now have separate dental policies through 1.65 million small businesses will have their current dental coverage disrupted.<sup>12</sup> As a result, many families may be forced to give up the doctor of their choice, which is inconsistent with one of the Administration's underlying tenets of the ACA of allowing Americans to keep the coverage they currently enjoy.

To address this, our organizations recommend that the agency require any medical plan with the EHB pediatric oral benefit participating as a QHP outside the exchange also offer a companion plan without the EHB dental package. The companion plan would be identical in every respect except for the dental benefit. The agency should also make clear that if the plan being purchased is for a family with children then the medical QHP without dental benefits must be paired with a stand-alone dental benefit plan to ensure all 10 EHB categories are met. This approach has the added advantage of allowing individuals without children to purchase a plan in

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<sup>12</sup> NADP Issue Brief, April 2012

the individual or small group market after January 1, 2014 and not be subject to additional costs for coverage that will never be used.

### Cost Sharing

The proposed rule states that cost-sharing requirements will not apply towards benefits provided by out-of-network providers for non-emergency services. The ADA and AAPD believe consumers should have the ability to seek services from the dental provider of their choosing and that out-of-pocket costs paid by, or on behalf of, a beneficiary should count toward the annual limitation on cost sharing in all instances. At a minimum, beneficiaries living in limited access areas should be permitted to receive covered services from out-of-network providers and have those costs count toward the out-of-pocket maximums. This would allow children with special health care needs to better access oral health services and facilitate the provision of services for children who may require referrals to specialists.

The proposed rule suggests that a separate out-of-pocket maximum be applied to stand-alone dental plans. The language states that plans will be required to demonstrate a “reasonable” limitation for this type of coverage. The ADA and AAPD remain concerned over what “reasonable” will mean for families and how it will impact overall out-of-pocket costs. We request that HHS provide a definition of what is reasonable with respect to stand-alone dental plans with the goal of ensuring that families are not penalized for choosing one plan type over another and the cost-sharing is equitable. We also request HHS to clarify in its final rule that this standard is to be uniformly established across all exchanges. To limit any additional financial burden that families may incur, we request that HHS consider subtracting the separate out-of-pocket maximum for stand-alone dental plans from the overall out-of-pocket maximum. This would ensure that families who choose to purchase a dental benefit from a stand-alone plan are not required to meet an additional out-of-pocket maximum and will allow them to choose a dental benefit plan that meets their needs.

We request clarification from HHS on how the proposed actuarial values, 75 percent (low) and 85 percent (high), will impact affordability for families. We also seek clarification on how the premium tax credit will be applied when the pediatric dental benefit is purchased through a stand-alone dental plan. Families with children should have the ability to choose a dental benefit that works for their individual family, regardless of how the benefit is purchased.

Thank you for the opportunity to comment on this proposed rule. Please feel free to contact Mr. Thomas Spangler with the ADA’s Washington DC office at 202-789-5179 or [spanglert@ada.org](mailto:spanglert@ada.org) with any questions.

Sincerely,



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