

January 31, 2012

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Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

RE: Essential Health Benefits Bulletin, December 16, 2011

Dear Mr. Larsen:

On behalf of the Organized Dentistry Coalition, we are pleased to offer comments regarding the Center for Consumer Information and Insurance Oversight's (CCIIO) December 16, 2011 bulletin on the implementation of Essential Health Benefits (EHB) as outlined in the Patient Protection and Affordable Care Act (PPACA).

We appreciate CCIIO's efforts to seek a balance between keeping the EHB affordable and making benefits comprehensive. However, we believe more needs to be done to ensure that a pediatric oral health benefit in the EHB package more accurately reflects the current market and provides a meaningful and comprehensive level of benefits for children. It is essential that CCIIO recognize the limitations of coverage for oral health services, particularly pediatric oral health services within the medical benchmark plans being proposed for state selection to administer the EHB package. In the absence of regulations that implement the CHIP dental benefit required by CHIPRA, it is also unclear what pediatric oral health benefits a state should make available to consumers if a state opts to supplement their selected medical benchmark plan with the state's separate CHIP program.

Background

Pursuant to PPACA, the EHB package includes a pediatric oral health benefit and the scope of benefits in the package must be equal to the scope of benefits provided under a typical employer plan. Recommendations from the Institute of Medicine (IOM) to the agency suggested that the EHB reflect plans in the small group market guided by a national premium target and that states be given flexibility in determining the services within the EHB package.

The guidance offered by CCIIO in the bulletin provides states flexibility in meeting the essential benefit requirements for 2014 and 2015¹, including what would be considered acceptable pediatric oral health services, by recommending that states select a benchmark health insurance plan to cover all essential health benefit categories. Specifically, CCIIO states it proposes that the "EHB be defined by a benchmark plan selected by each State."

The benchmark plans are:

- The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market;
- Any of the largest three state employee health benefit plans by enrollment;
- Any of the largest three national Federal Employee Health Benefit Plan (FEHBP) options by enrollment; or

¹ The benchmark process will be reassessed in 2016.

- The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state.

If the pediatric oral health benefit is missing from the chosen benchmark plan a state must supplement the benchmark to cover the EHB category with one of the following options:

- The Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment; or
- The state's separate Children's Health Insurance Program (CHIP).

Health insurance issuers offering the EHB could adopt the scope of services and limits of the state benchmark or vary it. But the issuer must offer a plan with benefits that are "substantially equal" to the benefits of the benchmark plan selected by the state (and modified as necessary by the state to reflect the 10 coverage categories). The insurer will have some flexibility to adjust benefits, including specific services and any quantitative limits, provided they offer coverage for all 10 statutorily-required EHB categories. CCIIO states that providing this flexibility will provide greater choices for consumers. The agency is considering allowing substitution across benefit categories, which might be subject to a higher level of scrutiny.

CCIIO states it intends to propose the EHB definition not include orthodontic benefits that are not medically necessary.

During the transitional years of 2014-2015, if a state chooses a benchmark plan that is subject to existing state benefit mandates, those mandates would be included in the EHB package, obviating the requirement that the state defray the cost of the mandates. If the state selects a benchmark that does not include some or all of the mandates, the state would have to pay for those mandates not covered by the benchmark. For 2016 and beyond, the agency will develop an approach that might exclude some state benefit mandates from the EHB package.

CCIIO states that the bulletin is applicable to only covered services. Cost sharing such as deductibles, copayments and coinsurance will be addressed in subsequent guidance.

Comments

Surveys of Dental Benefit Plans

An analysis of the dental benefit market developed by the National Association of Dental Plans (NADP) and the Delta Dental Plans of America (DDPA)² cites a 2005 Bureau of Labor and Statistics (BLS) survey that details dental coverage levels for private industry workers (approximately 170 million people). The BLS survey found that certain preventive and diagnostic services (exams and x-rays) were covered 100 percent of the time, basic and major restorative services (fillings, surgery, periodontal and endodontic care, and prosthetics) were covered from 98 to 100 percent of the time, and orthodontia was covered 73 percent of the time.³ The BLS found that dental benefit levels are generally consistent across industry, occupational group, firm size and union and non-union subgroups. According to the analysis, the April 2011 Department of Labor (DOL) survey that was intended to aid in the development of the EHB, concerning dental benefit levels of employer-sponsored services found very similar results.

² 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.

³ Ibid, p.75.

Benchmark Plans

According to data included in a December 2011 research brief published by the Office of the Assistant Secretary for Planning and Evaluation within the Department of Health and Human Services (ASPE), coverage for “preventive and basic dental care” varies across and within markets.

The ASPE analysis cited data from HealthCare.gov, which surveyed ten state employee plans, the largest three small group products in each state by enrollment, and the three FEHBPs. The results indicate that dental services vary across and within markets and that routine dental services are not frequently covered in medical plans within the small group markets. This reflects data collected by NADP and DDPA which indicates that approximately 98 percent of dental benefits are provided through separate, stand-alone dental plans.⁴ ASPE’s analysis of the three largest small group products offered in each state and the District of Columbia show 40 percent of plans do not cover a dental check-up for children and 55 percent of those plans provide such coverage as an optional benefit. Only five percent of the medical plans provide coverage; however, the analysis identifies dental services within the benchmark plans as a “dental check-up for children”. Without a definition as to what specific services or categories of services are covered, it is impossible to determine if the dental services covered are comprehensive to meet the oral health needs of all children. Our own analysis of the state employee plans is consistent with ASPE’s findings.

Our organizations believe that, at best, it is unclear whether the proposed benchmark plans would provide a comprehensive pediatric oral health benefit that meets the needs of all children, including children with special health care needs. Furthermore, we strongly support the inclusion of comprehensive oral health benefits that ensure a range of services are available and reflect current offerings in the broader commercial dental benefit market.

Supplemental Options

The bulletin states that in the event a benchmark plan does not provide pediatric oral health services, HHS is considering allowing a state to select supplemental benefits from either the FEDVIP dental plan with the largest national enrollment or the state’s separate CHIP program. .

FEDVIP

Further analysis of the FEDVIP through information provided by the Office of Personnel Management includes the following dental/oral health offerings for the 2012 benefit year:

- Class A (Basic) services which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays;
- Class B (Intermediate) services which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments;
- Class C (Major) services which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures; and
- Class D (Orthodontic) services with up to a 24-month waiting period.

A plan providing the Class A definition of services within the FEDVIP is limited to preventive care without providing treatment that may be necessary after a child receives a dental examination. This limited scope of services would not provide a comprehensive pediatric oral health benefit. The benefits vary depending on the class level chosen.

⁴ Ibid., p. 20

Separate CHIP Programs

CHIP programs are required by law to provide coverage that is necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions for all children up to age 19. This definition was included in the *Children's Health Insurance Programs Reauthorization Act of 2009* to create a federal standard for dental benefits in CHIP programs. Our organizations believe this definition is broad and provides states with the flexibility to design an appropriate dental benefit for children while ensuring a wide range of services will be available. However, regulations to define this benefit and its implementation have yet to be released by CMS. A recent analysis conducted by the National Maternal and Child Oral Health Policy Center showed that most states have not yet submitted state plan amendments to CMS to propose dental benefit changes to their current CHIP programs to address the CHIPRA oral health requirement. Without further guidance or instruction from CMS, it is impossible to understand what pediatric oral health benefits will be made available through separate CHIP programs and whether those benefits are comprehensive to provide appropriate oral health services to children.

Crossover in Dental and Medical Coverage

As the pediatric oral health benefit is being designed, it is important to ensure that every child will have coverage for needed services to address a health condition where medical and dental care are both clinically required. There are health care situations that exist where an underlying medical condition may necessitate a dental intervention. For example, a patient may have both cancer and an oral infection. When chemotherapy or therapeutic intervention (such as a bone marrow transplant) compromise the immune system, it is necessary to first eradicate the dental infection before cancer treatment can be initiated. In some cases, general anesthesia may be required to perform necessary dental procedures due to the patient's age, complexity of the procedure, or limiting conditions such as developmental disability. This situation is problematic without clear direction as to the coverage responsibilities of the medical and the dental plan in this respect.

Since 1995, at least 32 states have adopted laws that address medically necessary adjunctive healthcare costs when dental services are performed. Specifically, these statutes require that general anesthesia and related hospitalization benefits available under a medical reimbursement plan may not be denied when dental treatment is provided to patients meeting certain age, disability, or other specified requirements. Children with special needs, including cognitive or physical disabilities, children with complex medical conditions, very young children and children with extensive dental treatment needs may require care in a hospital or outpatient surgical facility.

Conversely, a pediatric oral health benefit should ensure coverage for dental services necessitated by special needs for which medical coverage may be provided. Twenty-nine states require coverage for applied behavior analysis (ABA) therapy for autism. Despite the failure of the FEHBP Blue Cross Blue Shield Standard Option plan, for example, to cover ABA therapy for autism, a pediatric oral health benefit should cover dental services necessitated by autism.

Additionally, children with congenital craniofacial anomalies may require services that interweave medicine and dentistry. According to the Centers for Disease Control and Prevention, it is estimated that 2,651 babies are born annually in the U.S. with a cleft palate and 4,437 are born with a cleft lip, with or without a cleft palate, requiring coordinated medical and dental intervention. In fact, for most of these children, oral orthopedic procedures provided by a dentist are pre-surgical elements essential for the success of plastic surgical reconstruction of the birth defect. Often coverage for the pre-surgical oral orthopedics is not a benefit of the patient's medical plan because it is considered to be a "dental procedure" not within the scope of the medical plan. In addition, many dental benefit plans specifically exclude "orthodontics." In these situations, necessitating coordinated dental and medical services, the key issue is ensuring proper synchronization between the medical and dental plans, and clarity about which services are covered by the respective plans to avoid coverage denials by both entities.

In summary, it is important to understand that there may be situations where a child's underlying medical condition may necessitate a dental intervention. HHS should directly address this issue in future guidance or regulation to ensure that it is not overlooked at the state level.

Evaluation

The bulletin addresses updating the EHB on a regular basis to ensure that consumer needs are being met. As part of any EHB evaluation, HHS should address the ability of consumers to utilize covered services in a timely manner. In addition, the agency should ensure data is collected on experience with cost-sharing, network adequacy and plan transparency. In order to facilitate early intervention, plans offering dental benefits should not contain deductibles or copayments for preventive, diagnostic and emergency services.

In addition to updated recommendations from the US Preventive Health Services Task Force, CCIO should consult with professional organizations to receive information on updated evidence-based recommendations for services. Recommendations will change as scientific evidence changes and any EHB package should allow for updates to reflect the most current evidence-based guidelines for all categories of services.

Recommendations

Our organizations believe that the benchmark plans identified by HHS fall short of finding the proper balance between affordability and ensuring a comprehensive set of pediatric oral health benefits for the EHB package. The potential for the selection of an inadequate dental benefit embedded in a benchmark plan is simply too great. We believe this problem needs to be remedied and urge HHS to address the pediatric oral health benefit in a separate guidance. We suggest the following general table be used as a guide for determining if the benchmark plan chosen by the state is in line with the typical employer-sponsored plan currently offered in the dental benefits market.

Typical Employer-Sponsored Dental/Oral health Plan Coverage

- *Preventive and Diagnostic Services* – 100% coverage
- *Basic Restorative Services* – 80% coverage
- *Major Restorative Services* – 50% coverage
- *Orthodontics* – 100% coverage for medically necessary treatment, including cleft palate and other similar craniofacial anomalies

Additional information on what is considered truly essential for a child's oral health is provided in the American Academy of Pediatric Dentistry's Model Dental Benefits Policy. This policy delineates the diagnostic, preventive and restorative services that are essential for the pediatric population.⁵

Lastly, we recommend that a final guidance or proposed regulations address the need to ensure proper coordination between the coverage provided by medical and dental plans to avoid coverage denials by both plans that result in children with congenital craniofacial anomalies and other medical conditions "falling through the cracks." This includes a requirement that benchmark plans include state requirements for general anesthesia for dental services in 2016 and beyond.

Thank you for your consideration of our comments. The inclusion of pediatric oral health services as part of the EHB is a victory for children and oral health providers who care about improved coverage for oral health care services and good oral health outcomes for all children. Dental disease is largely preventable and far too common for children in this country today. Early interventions and ongoing treatment can help children achieve optimum oral health and therefore good overall health.

⁵ American Academy of Pediatric Dentistry Model Dental Benefits Policy, available at: http://www.aapd.org/media/Policies_Guidelines/P_ModelDentalBenefits.pdf.

Please feel free to contact Janice Kupiec at the ADA, kupiec@ada.org or 202-789-5177, or C. Scott Litch at the AAPD, slitch@aapd.org or 312-337-2169.

Academy of General Dentistry

American Academy of Oral and Maxillofacial Pathology

American Association of Oral and Maxillofacial Surgeons

American Academy of Pediatric Dentistry

American Academy of Periodontology

American Association of Orthodontists

American Dental Association

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