DELTA DENTAL

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Via Email
January 25, 2012

To: California Health Benefits Exchange Board

Re: Comments to the California Exchange Board Response to the Essential Health Benefits Bulletin Issued by CCIIO

Dear Exchange Board Members:

Enclosed, please find an excerpt of formal comments we helped develop for the Delta Dental Plans Association, responding to the Center for Consumer Information and Insurance Oversight (CCIIO) regarding the Essential Health Benefits Bulletin issued on December 16, 2011, and for which final comments are due January 31, 2012. We have included and highlighted comments that we believe would be of particular interest to the California Exchange Board. A full copy of our comments is available upon request.

We suggest the Exchange Board take these comments into consideration when developing its own response on the topic of Essential Health Benefits, specifically on the issue of the pediatric oral health benefit addressed in the Bulletin at pages 6 and 11. The enclosure provides a more full explanation of our position, which might be summarized as follows:

- States should be directed to look towards a *"dental-specific"* benchmark that is based on any of the top three largest by enrollment commercial small group dental programs. This provides greater state flexibility than would "filling in" the missing dental component from either the FEDVIP or CHIP benchmarks referred to in the Bulletin.

- Because of the many respects in which dental is different from medical, the scope of services defined in the benchmark plan approach is actually less significant than the cost sharing provisions that will be addressed in forthcoming HHS regulations, and possibly to be adopted by each state.For dental in particular, the cost sharing parameters are what will determine affordability. For this reason, it is critical that HHS continue to acknowledge the excepted benefit status of dental benefits when offered separately, so that routine limitations and exclusions that are standard in most commercial dental

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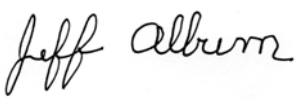
policies today can be employed in the exchange. Preserving this structure will help ensure affordable dental options for all consumers, both inside exchanges and out.

We appreciate the opportunity to provide comments to your proposed response. If you have any questions, please do not hesitate to call me at (415) 972-8418, or our legislative advocate, Maureen O'Haren at (916) 498-1900.

Sincerely,



Jeff Album
Vice-President, Public & Government Affairs

Cc: Peter V. Lee, Executive Director

Attachment A

In General

The Delta Dental Plans Association ("DDPA") welcomes the opportunity to comment on the December 16, 2011 "Essential Health Benefits Bulletin" ("EHB Bulletin") issued by the Department of Health and Human Services – Center for Consumer Information and Insurance Oversight. Underlying our comments is the significant difference in both the nature and structure of dental benefits from medical benefits and the corresponding difference in the legal treatment of stand-alone dental benefits and dental benefit plans.

Dental benefits provided by stand-alone dental benefit plans are treated as "excepted benefits" under federal law and as a result are not regulated in the same manner as comprehensive, major medical coverage. This was established in the 1996 HIPAA amendments to the PHSA, ERISA, and the IRC, and the Accountable Care Act ("ACA") builds upon those provisions and continues the exception for "excepted benefits". *See also* footnote 14 of the EHB Bulletin.

As an "excepted benefits" plan, a stand-alone "limited scope" dental benefit plan is not subject to the ACA's prohibition on lifetime and annual limits on the dollar value of benefits. In fact, such limits are a critical standard feature of typical employer-provided dental benefit coverage currently offered in the market. In addition, typical employer-provided dental benefit plans establish frequency limits for certain dental services, restrictions on the amount of the fee for which a benefit will be computed, and limitations on the nature of the dental conditions for which a benefit will be payable.

Because of the unique nature of excepted benefit plans, we urge the agency to establish a separate subpart and set of dental-specific benchmarks in the EHB proposed rule for defining the pediatric oral health essential health benefits and the separate pricing and offering of those benefits by qualified health plans and stand-alone dental benefit plans.

Existing Dental Plan Coverage

Millions of Americans currently have family dental plan coverage. Included in these plans are benefits for children. A major concern is that as the essential health benefits package only includes a requirement for a pediatric dental benefit, families may be encouraged to drop their coverage because of this segmentation. Alternatively, families may be forced to split up coverage between adults and children with different carriers, lose access to their child's dentist due to switching networks, or purchase duplicative coverage to preserve the coverage that they already have and enjoy. This appears to be an unintended consequence of a provision meant to extend and improve coverage.

To avoid these complications for families, HHS should provide that individuals may satisfy the essential health benefit package requirements when purchasing health insurance either inside or

outside the Exchange by demonstrating that existing family dental coverage includes benefits that meet the required pediatric essential health benefit.

Comments Specific to the EHB Bulletin

Benchmark Plan Approach Encouraged. In general, we support the intended regulatory approach in the forthcoming EHB proposed rule that utilizes a "benchmark" reference plan to set the "covered services" required in the EHB. In fact, prior to the issuance of the EHB Bulletin, DDPA proposed a draft regulation for the pediatric dental essential benefit that employed this general approach of listing several benchmark plans that would satisfy the requirement. However, we recommend that the benefit for essential pediatric oral services required under Section 1302(b)(1)(J) should be determined by reference to a set of benchmark *dental* plans, rather than to any of the benchmark medical plans used by a State to define the EHB generally.

The EHB Bulletin recognizes that the initial four benchmarks set for determining the EHB may not contain dental benefits sufficient to set a pediatric dental essential benefit. Also, the ASPE research brief on essential health benefits notes that "routine" pediatric dental services are not frequently covered in the small group *health* market. *See* ASPE Research Brief (December 2011) at page 3. Moreover, 97 percent of dental coverage is provided through separate (stand-alone) dental plans or policies. Thus, we have a concern that the initial four benchmark options, while offering a range of benefit options for the EHB generally, do not accurately portray the average *dental* benefits being offered by employers.

We propose that HHS create a set of dental-specific benchmarks to accommodate the unique nature of excepted benefit plans instead of imposing the same four benchmarks as being used for comprehensive medical plans.

The Recommended Benchmarks for Pediatric Dental Benefits. In general, we support the EHB Bulletin inclusion of State employee plans, CHIP, and the Federal Employees Dental and Vision Insurance Program ("FEDVIP") as "benchmark" plans and would include these options in our proposed dental specific benchmarks. We request, however, that the agency clarify, with respect to the State employee and FEDVIP dental coverage, that the "benchmark" relates only to the dental benefits of those programs that are typically provided to children rather than to adults.

We also support including as a benchmark option any of the three largest small employer plans by enrollment, provided that the benchmark should be *dental* plans purchased by small group business employers. We also request that the agency include an explicit authorization for an alternative pediatric oral health essential benefit plan that employs an "evidence-based" approach to covered benefits. This approach is consistent with the EHB recommendations of the Institute of Medicine).

If HHS declines to direct States to substitute these dental-specific benchmarks in place of the initial four EHB benchmarks when determining the essential pediatric dental benefit, as proposed in the section above, we recommend that HHS nevertheless allow States to consider all of these options when "supplementing" any of the initial four benchmarks chosen that do include dental

benefits. Allowing States to choose only between FEDVIP and CHIP is too narrow a choice and, in particular, would not reflect the typical small group employer plan.

Choice of Benchmark Must Be Guided by Affordability. We also request that the term "essential benefits" be further defined to emphasize that their scope should be balanced by a consideration of affordability for individuals and small group employers.

While many benefits may be considered desirable by consumers, only a selection of them should be considered "essential" in order to attain the goal of affordability. It seems clear that Congress did not intend to include all of the same pediatric oral health care benefits that are included in the FEDVIP and CHIP programs because these programs can provide comprehensive benefits.

The phrase "essential" is not superfluous and has been interpreted by Congressional staff as meaning a "minimum" set of benefits. The plain meaning of the term essential is "basic", and as a result, the pediatric oral health care essential benefit must be benchmarked as a basic benefit and not as comprehensive dental benefits.

We therefore recommend that States be directed by HHS to ensure that affordability guides their choice of benchmark for the pediatric dental benefit.

Orthodontics Coverage Is Not Essential. We support the EHB Bulletin notation that non-medically necessary orthodontia is not being considered for inclusion as pediatric EHB dental coverage. Non-medically necessary orthodontia is most often performed for esthetic and cosmetic reasons and as a result would not be considered basic care for purposes of the pediatric oral health care essential benefit.

Medically necessary orthodontia is normally provided as a benefit only in Medicaid and some CHIP programs as well as in some medical plans. In those cases the definition of "medical necessity" is typically defined narrowly. The pediatric oral health care essential benefit is not a "medical" benefit and therefore must not include orthodontia that is not incidental to or an integral part of treatment that is primarily medical care (most often the result of a genetic condition, an accident, injury, or other trauma).