DELTA DENTAL

FACT vs. FICTION:

DENTAL BENEFIT PLANS AND HEALTH INSURANCE EXCHANGES

Fiction	Fact
Separate offer and pricing of the essential pediatric dental benefit cannot be required	**U.S. Department of Health and Human Services ("HHS") specifically allows state Exchanges to offer separate offer and pricing of dental benefits.** In the final rule establishing standards and guidance for Exchanges and Qualified Health Plans ("QHPs"), HHS stated that the essential pediatric dental benefit can be required to be offered and priced separately from the medical coverage where an Exchange determines that it "is in the interest of the consumer." 77 *Fed. Reg.* 18309 at 18411 (March 27, 2012).
HHS has weighed the consequences and expressed concerns about administrative burdens of separate offer and pricing	**HHS has not offered an opinion on this issue**. The agency merely posed the question in its proposed rule on the establishment of Exchanges in response to a small minority of major medical health insurance issuers who had expressed concerns. HHS asked for comments and after the comment period, responded in the final rule by explicitly saying it was permissible for an Exchange to require separate offer and pricing when it determines that separate offer and pricing "is in the interest of the consumer." The agency's silence on this being an "administrative burden" seems a telling conclusion that HHS found no evidence to support this. 77 *Fed. Reg*. 18309 at 18411 (March 27, 2012).
Only QHPs have the ability to participate on Exchanges and offer the pediatric benefit	**The Affordable Care Act ("ACA") specifically allows standalone dental plans to provide the pediatric benefit.** The statute and the final Exchange rule also provide that an Exchange must allow standalone dental plans to offer the essential pediatric dental benefit either independently from a QHP or as a subcontractor of a QHP issuer, and cannot limit the participation of standalone dental products to only one of these options. This is a required statutory provision of the ACA that results in the pediatric dental benefit being offered to consumers separate from a QHP. ACA section 1311(d)((2)(B)(ii); and 45 CFR 155.1065(a)-(b).
Separate offer and pricing of the pediatric dental benefit is not in the consumer's interest	**Separate offer and pricing of dental benefits empowers consumers and facilitates transparency, which is why the majority of medical and dental benefits are sold this way today.** "Embedded" pediatric dental benefits can hide within the much larger medical package, which would be inconsistent with, contrary to, and frustrate the very central purpose of the Exchange---to provide meaningful and standardized comparative information in order to assist consumers in making the best choice from the available benefit coverage options. ACA section 1311(d)(4)(E); and Sen. Rpt. 111-89 at 4 (October 19, 2009).

Fiction	Fact
Separate offer and pricing of the pediatric dental benefit is not in the consumer's interest (cont'd)	Embedding or integrating the payment of dental benefits into major medical insurance coverage will not improve coverage or delivery of dental care. No peer-reviewed studies even suggest that embedding or integrating dental benefits into medical benefit payment systems will result in more coverage or improve the quality of dental care. Embedding the payment of dental benefits into medical benefit policies will only overwhelm and subsume dental issues to more costly and complex medical benefit issues. The reality is that the delivery of dental care is separate, and medical and dental professionals are separately trained and practice separately. The technology, systems and human resource infrastructure required to administer medical and dental benefits are likewise entirely separate and non-redundant.
The ACA envisioned that consumers would only be making one plan selection of an embedded pediatric benefit	**The ACA specifically calls for standalone dental plans to be offered as a separate selection.** The offer of the pediatric dental benefit by a standalone dental plan in the Exchange is a required statutory element in defining the essential health benefits. QHPs are provided a "waiver" from providing the pediatric dental benefit if a standalone dental plan offers the pediatric dental benefit. ACA section 1302(b)(4)(F) ("Required Elements").
Separate offer and pricing will create an administrative burden for QHP issuers	**Most full-service health plans already separately offer and price their dental.** The. Currently 98 percent of all dental policies are offered and priced separately, largely in response to the demand of the marketplace. Health plan issuers can and do provide a full, separate description and summary of the dental coverage they offer, and can easily be required to do so whether that coverage is bundled with medical benefits or offered separately. This will afford purchasers a fully informed choice and comparison. NADP-DDPA *Exchanges Roadmap* (September 2011) at 20.
Exchange websites will stress transparency and consumers will not need separate offer and pricing to compare	**Separate offer and pricing creates the needed transparency called for in the ACA and by HHS in countless subsequent announcements**. Exchange consumers will be mostly first-time individual purchasers, many of them selecting insurance without the help of an experienced broker, which means they will need comparative information. Those health plans now resisting the "separate offer and pricing" of pediatric essential dental benefits are in fact arguing to make it more difficult for consumers to understand, compare, and choose pediatric dental benefits. Without separate offer and pricing, a QHP could offer the pediatric dental benefit on a "take all or leave all" basis, which would eliminate choice. That is not "in the interest of the consumer."

Fiction	Fact
Outside an Exchange the pediatric dental benefit must be embedded to meet the Essential Health Benefit ("EHB") requirement	**Clarification of this issue by HHS in the final Essential Health Benefit Rule is expected, and will likely uphold the alignment of rules concerning the importance of standalone dental both inside and outside exchanges.** The Senate explanation of the pediatric dental benefit amendment as considered and adopted describes as its purpose "to allow standalone dental plans to offer the required pediatric dental services and to be offered in the individual and small group markets including within the insurance exchanges." Stabenow-Lincoln Amendment #C-7 to S.1796 Chairman's Mark. Clearly, Congress intended for standalone dental plans to be made available to meet the essential health benefit requirement for pediatric oral services both inside and outside the Exchange marketplace.
Full integration of medical and dental is an inevitable market trend that the Exchanges should accelerate and promote	**No trend toward integration has been documented or ever established, except in various marketing materials and bylined articles in which full-service health plan executives are pitching their embedded products to an unconvinced marketplace**. Nor would integration benefit consumers. Currently, only two percent of the private dental benefits market is integrated. Even most large state and federal government programs (TRDP, FEDVIP, California, Colorado and Texas Medicaid, among many others) use a standalone dental benefit program. After a twelve year old boy in Maryland named Deamonte Driver died of a brain infection in 2007 (caused by untreated tooth decay) the State of Maryland, after a statewide assessment of how its dental program could be improved, carved dental services out from the medical services package of benefits of its Medicaid program to administer dental benefits through a dental-only "home." Other states have followed in order to devote full resources to dental benefits in recognition of the importance of dental health to overall medical health. House Hrg. 110-90 (September 23, 2008). In 2009, Congress amended the State Children's Health Insurance Program to add specific and separate dental benefits. A dental benchmark package was established that is separate and apart from medical benefits for targeted low-income children. CHIPRA section 501. This is also consistent with the Federal Employee Dental Benefit Program which provides for separate pricing and disclosure of standalone dental benefit plans. 5 U.S. Code Chap. 89A. **The market is evolving towards the separation of medical and dental policies in order to improve access to coverage and care.**

Fiction	Fact
Some QHPs cannot develop a second price as a subset of a benefit for the larger medical plan	**If a QHP "embeds" the pediatric essential benefit into its medical benefit plan, the dental benefit remains a distinct set of benefits that the plan's actuaries must be able to separately price in order to calculate the total premium charged for the policy.** It would not be "impractical" to disclose the price of that pediatric essential benefit since it is a known value to the QHP, nor is it "impractical" to separately disclose that value and a description of the benefit provided for that value. NADP-DDPA *Exchanges Roadmap* (September 2011) at 36.
It is inappropriate to separately price embedded pediatric dental benefits because of the out-of-pocket limit	**The out-of-pocket limit must necessarily account for pediatric dental benefits separately as a portion of the total out-of-pocket limit.** This is because Congress expressly provides that an Exchange "shall" allow a standalone dental benefit plan to offer the pediatric dental benefit on the Exchange. Accordingly, the allowable cost sharing limitations for the dental plan, including the out-of-pocket limit, must be calculated in proportion to the total premium of the entire benefit package. Practically, most of the pediatric dental benefit is likely "preventive" care; therefore there would be no out-of-pocket costs for much of the benefit. ACA sections 1001, 1302(c)(1), and 1311(d)(2)(B)(ii).
Consumers would never really be comparing the pediatric dental benefit apples-to-apples because of variability	In its EHB Bulletin, HHS empowers each state to select a pediatric dental plan benchmark. This benchmark will set a floor for the children's dental benefit and, **as plans standardize to meet this benchmark, permit consumers to make real comparisons among similarly designed dental plans.** In fact, the vast majority of pediatric dental benefit coverage would be "preventive" items and services. As a result there will be very little variation in the "essential" pediatric dental benefit and it will likely be a standardized benefit within each Exchange. CCIIO, Essential Health Benefits Bulletin (December 16, 2011).
Because separate offer and pricing of dental is not required in the market today, it is inappropriate to require it on the Exchanges	The Exchanges are distinct from the outside market because consumers, many of them purchasing insurance for the first time, will be without the benefit of brokers' expertise when making their decisions. These purchasers must be given all appropriate tools, including pricing transparency, to make the choices that work best for them. **They should not be forced to purchase a dental plan they don't want because of the medical plan they have selected.**