October 3, 2011

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

Re: File code CMS-9989-P

Dear Director Larsen,

The members of the Organized Dentistry Coalition (ODC) listed below appreciate the opportunity to offer comments in response to the July 15 Federal Register publication of the proposed rule, Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans.

We note that the proposed rule states that exchanges are intended to provide “… competitive marketplaces for individuals and small employers to directly compare available private health insurance options on the basis of price, quality and other factors.” It is in that spirit that we recommend that the final rule include the following suggestions that apply to exchanges affecting both the individual and small business markets:

- Stand-alone dental plans that participate in exchanges should provide consumers with the same consumer protections and other safeguards and benefits (such as plan transparency) that are available to consumers who purchase their dental coverage through medical plans operating as “qualified health plans” (QHPs) in the exchanges. In addition, we request that the Secretary recommend that the exchanges consider additional consumer protections suggested by state dental societies.

- Stand-alone dental plans should be subject to the same certification requirements as medical plans operating as QHPs in the exchanges except in instances where a criterion is clearly not applicable to stand-alone dental plans, such as accreditation requirements and perhaps actuarial values of coverage requirements.

- State or federal officials who develop the exchange or exchanges in each state should strive to maximize the dental plan choices available to consumers in the exchanges.

- Dental benefits offered by QHPs and stand-alone dental plans in the exchanges should allow for an “apples-to-apples” comparison so that consumers can easily understand their choices based on price, quality and other factors.

- State or federal officials who develop the exchange or exchanges in each state must seek input from state dental societies, which includes representatives of the National Dental Association and Hispanic Dental Association, in the early development of the exchanges to help assure consumer-friendly web sites for dental patients.

- Access to dental health care for special needs individuals with disabilities should be specifically addressed in the exchange design and implementation.
• Individuals serving as consumer navigators in the exchanges should have a full understanding of the dental coverage options because the dental delivery system is very different from the medical system.

§155.1065: Stand-alone dental plans

Consumer Protections Requirements

Stand-alone dental plans that participate in exchanges should provide consumers with the same consumer protections and other safeguards and benefits (such as plan transparency) that are available to consumers who purchase their dental coverage through medical plans operating as “qualified health plans” (QHPs) in the exchanges. We are pleased that the agency suggested in the proposed rule that it is considering interpreting the ACA provisions in a manner that requires 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. However, we do not believe that goes far enough to ensure fair and uniform consumer protections.

We believe that quality reporting, transparency measures, summary of coverage information, the provider network standard, and standards regarding the consumer’s experience in comparing and purchasing dental plans are necessary and should be required as a federal minimum for all stand-alone dental plans participating in an exchange, as well as medical plans offering dental coverage and dental plans offering coverage in conjunction with a medical plan. While we appreciate the agency’s desire to give the exchange flexibility in this matter, we believe all consumers deserve equal access to these needed safeguards irrespective of the plan (medical or dental or some combination) used to purchased the dental coverage or the state in which the exchange is located.

In addition, we request that the Secretary recommend that the exchanges consider additional consumer protections suggested by state dental societies. For example, at the request of state dental societies, 26 states have passed laws prohibiting a dental plan from dictating fees for procedures that the plan does not cover. It is important to have this consumer protection in place for all plans offering dental benefits in the exchange because it brings a sense of stability to the practitioner-insurer relationship by eliminating a provision that could drive many dentists out of networks that dictate fees for non-covered services.

Finally, an area of frequent misunderstandings regularly occurs around the issue of how much the plan will pay for a given service, especially when it is based on a percentage of the practitioner’s fee. The exchange should insist on an easily understood and transparent means of explaining this aspect of the dental benefit package to consumers and providers, including the availability of claims data.

Plan Certification Requirements

Stand-alone dental plans should be subject to the same certification requirements as medical plans operating as QHPs in the exchanges except in instances where a criterion is clearly not applicable to stand-alone dental plans, such as accreditation requirements and perhaps actuarial values of coverage requirements. We also support the inclusion of a requirement that all QHPs offering the pediatric oral health benefit be required to demonstrate network adequacy as part of the certification process and that state exchanges regularly monitor network adequacy to ensure all consumers are able to access necessary care. This includes demonstrating that the participating providers are accepting new patients.

Maximize Dental Plan Choices

State or federal officials who develop the exchange or exchanges in each state should strive to maximize the dental plan choices available to consumers in the exchanges. Something that is not addressed in the proposed rule but is extremely important is for the exchange to do what it can to attract multiple plans that offer dental coverage to participate in the exchange. This is especially important in the states that have historically been dominated by a single dental carrier. The prospect of a single dental carrier in a state exchange is not unlikely, especially if the agency codifies (as it proposes to do) section 1302(b)(4)(F) of
the ACA that allows medical plans to participate in an exchange as a QHP without having to offer the pediatric essential benefit, provided that a single stand-alone dental plan is offered. With this dental "opt-out" provision in place, many medical plans will be less likely to go to the expense of developing a dental network in a market where currently over 90 percent of Americans with dental coverage have that coverage through stand-alone plans. If the agency has the authority, we recommend that the agency not codify section 1302(b)(4)(F). In the alternative, we request that the agency encourage states to design their plan certification process in a manner that attracts multiple carriers that offer dental benefits. Specifically, we request that the agency recommend that exchanges ensure there are a variety of dental benefit models available to consumers by requiring plans offering dental benefits in an exchange to offer at least one fee-for-service dental network.

In addition, consumers would greatly benefit if they had the option of purchasing dental coverage without annual benefit levels and purchasing plans with enhanced annual limits. Universally and for many decades, dental benefit plans have had relatively paltry annual benefit limits of $1,000 to $2,000, which are quickly exceeded with one major restorative service. We request that the agency recommend the exchanges seek to have dental plans without annual limits and plans with annual limits that exceed the status quo as options for consumers.

**Facilitate "Apples-to-Apples" Comparison of Plans**

**Dental benefits offered by QHPs and stand-alone dental plans in the exchanges should allow for an "apples-to-apples" comparison so that consumers can easily understand their choices based on price, quality and other factors.** The agency notes that it has been asked to require all dental benefits to be offered and priced separately from medical coverage, even when offered by the same issuer, to facilitate comparisons of dental benefits among plans. The agency is not inclined to do so because it would preclude issuers from offering a "bundled" QHP that covers all essential health benefits under one premium and it would impose a potentially unacceptable administrative burden.

We suggest an alternative way -- that allows the consumer to understand how much of the premium cost is attributable to the dental component of the medical plan without actually separately pricing and offering the dental coverage in all cases. Certainly all medical carriers know the cost of their dental component and could make that figure available to consumers with the understanding that it was for informational purposes only as part of a "bundled" package. In that case, the dental benefits would remain an integral part of the medical plan. The consumer cannot opt out of the dental coverage because it is part of a "bundled" package with one premium.

To help ensure consumers who want to purchase the stand-alone dental plan policy have more choices of medical plans without the dental component, we suggest that the agency require all carriers offering a "bundled" package to also offer a similar medical policy without dental services. In addition, any carrier participating in the exchange that chooses to offer dental services should be required to offer a separately priced pediatric dental benefit as provided for under the essential benefit package. Finally, all plans that choose to compete in the dental market within the exchange should be encouraged to offer a family dental coverage option, as studies have shown that parents with dental coverage are more likely to ensure that their covered children access care.

These plan choices should allow the consumer to identify how much the dental component “cost” thereby facilitating the "apples-to-apples" comparison necessary for the consumer to “directly compare available private health insurance options on the basis of price, quality and other factors”, as called for in the proposed rule. This suggested approach should also be more compatible with the agency’s desire to avoid operational problems associated with allocating advance payments of the premium tax credit and calculating a plan’s actuarial value.
Seek Input from State Dental Societies

State or federal officials who develop the exchange or exchanges in each state must seek input from state dental societies, which includes representatives of the National Dental Association and Hispanic Dental Association, in the early development of the exchanges to help assure consumer-friendly web sites for dental patients. The agency thoughtfully included a reference to “health care providers” in the “Stakeholder Consultation” provision (section 155.130), where exchanges are encouraged to reach out to experts in the community. The ODC has members in every state. In addition, each state has a dental society and there are dental societies in many large cities in the United States, in all representing over 68 percent of the dental profession nationwide. Our members have a long history of addressing issues with carriers that affect their patients and are a knowledgeable and willing resource for policy makers who are involved in designing the exchanges. We have asked our members to reach out to relevant state officials. We ask that the agency modify section 155.130 to require relevant authorities to include representatives of organized dentistry among the stakeholders they consult in developing an exchange.

Patients with Special Needs

Access to dental health care for special needs individuals with disabilities should be specifically addressed in the exchange design and implementation. We are pleased that the agency is encouraging the exchanges to reach out to advocates for individuals with disabilities (section 155.130) to ensure they have appropriate services. This is another area where the state dental society could be helpful. In addition, we urge that the network standards include a requirement for dentists who have experience treating children with special health care needs and who can accommodate them into their practice.

Consumer Navigators

Individuals serving as consumer navigators in the exchanges should have a full understanding of the dental coverage option because the dental delivery system is very different from the medical system. As the agency knows, the dental delivery and financing system has historically developed separately from the medical system. Dental consumers would benefit from navigators who truly understand the nuances that are peculiar to dental plans. Also, understanding the requirements of the law, benefits available through an exchange, eligibility for advance tax credits or premium subsidies and all other applicable options will be challenging for consumers. We believe navigators should be in place on the first day of the initial open enrollment period for states that intend to meet the January 1, 2014 target date and that these navigators understand the unique nature of the dental delivery and financing system.

Other provisions

§155.106 Election to Operate an Exchange after 2014: We agree that states should be afforded additional time to establish an exchange if a state is unable to do so prior to January 1, 2014. States may need additional time to ensure that the exchange reflects the needs of its population and offers a competitive marketplace for consumers.

§155.105(e) Establishment of a State Exchange: We agree with the requirement that states must notify HHS before significant changes are made to the exchange plan and receive approval prior to the effective date of such changes. The proposed rule suggests using the state plan amendment process for such changes. Regardless of what model is used, it is imperative to ensure that coverage is not disrupted.

§155.205 Required Consumer Assistance Tools and Programs of an Exchange: We agree with the outlined consumer assistance standards in the proposed rule. Additionally, we support a requirement that state exchanges operate a call center outside of traditional business hours, provide a mechanism for consumers with limited English proficiency to receive the assistance necessary to purchase coverage and that an adequate number of call center staff be trained to address the range of issues with which consumers may need assistance. We recommend including a requirement for exchanges to implement a
quality assurance program for call centers to ensure all consumers are being adequately served, including consumers with physical and intellectual disabilities.

§155.230 General Standards for Exchange Notices: We agree with the proposed standards for exchange notices. All notices, applications, forms and other official documents should be written in plain language and available to meet the needs of diverse populations. This includes individuals with limited English proficiency, low literacy and those with disabilities that may require additional mechanisms of communication. We support the proposed requirement that exchanges evaluate the appropriateness and usability of forms, notices and applications on an annual basis. We suggest requiring exchanges to solicit input from consumers as part of the evaluation process.

§155.420 Special Enrollment Periods: We support the inclusion, as identified in subsection (d) (9), of a special enrollment period for exceptional circumstances such as natural disasters or a circumstance that would prohibit an individual from enrolling in a QHP on a timely basis. Consumers should not be penalized for events that abruptly disrupt their lives and are out of their control. Exchanges should be required to have a plan in place in the unfortunate event a natural disaster occurs to ensure that consumers can access coverage. Additionally, in such instances an exchange should be required to make accommodations for premium payments without loss of coverage.

§156.230 Network Adequacy Standards: In addition to our previous comments regarding network adequacy standards, we agree that as a condition of certification, a QHP must make its provider directory available electronically to the exchange. We recommend adding a requirement that all QHP maintain updated provider directories and at a minimum, the electronic directories be updated biannually.

We appreciate the opportunity to provide comments on the proposed rule. Please contact Janice E. Kupiec of the American Dental Association at 202-789-5177/kupiecj@ada.org with any additional questions or request for additional information.

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American Academy of Pediatric Dentistry
American Academy of Periodontology
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