January 4, 2013

National Healthcare Operations
Healthcare and Insurance
U.S. Office of Personnel Management
1900 E St., NW
Room 2347
Washington, DC  20415

Attention: RIN: 3206-AM47

On behalf of the American Dental Association (ADA) and the American Academy of Pediatric Dentistry (AAPD), we are pleased to offer comments regarding the U.S. Office of Personnel Management’s (OPM) proposed rule titled “Patient Protection and Affordable Care Act; Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges.”

This proposed rule affects implementation of the Patient Protection and Affordable Care Act’s (ACA) section 1334, which creates the Multi-State Plan Program (MSPP). According to the proposed rule, the MSPP is intended to facilitate the establishment of at least two multi-state plans (MSP) on each of the exchanges in the 50 states and the District of Columbia. In the first year an MSP is offered it must be capable of offering its plan in at least 31 states, and in 36 states in the second year, in 44 states in the third year, and in all states and the District of Columbia in all subsequent years.

OPM will administer the MSPP in a manner similar to the Federal Employees Health Benefit Program, although the programs will remain separate. This means, for example, OPM has the authority to negotiate with each MSP over the medical loss ratio, the plan’s profit margin, the premiums to be charged, and “such other terms and conditions of coverage as are in the interests of enrollees in such plans.” In the proposed rule, OPM states the agency’s oversight and contract negotiation experience will “ensure consumers get the greatest value for their premium dollars.”

OPM will certify the MSPs, so they will not have to apply separately to each state for certification, although the MSPP issuer must be licensed in every state. Issuers applying for an MSPP contract may include a group of issuers affiliated by either common ownership and control or by the common use of a nationally licensed service mark (such as a word, name, or symbol that an issuer uses consistently nationwide to identify itself). MSPs will meet the same standards imposed on qualified health plans (pursuant to state and federal laws) in the exchanges, “except to the extent any such laws are inconsistent with these regulations, OPM guidance, or OPM’s contracts with MSPP issuers.” The agency could not identify at this time the laws that might be inconsistent with its regulations, guidance or contracts.
The ACA requires the MSP to offer a benefit plan that is uniform in each state and consists of the essential health benefits (EHB) package. OPM is proposing that the benefits for each MSP must be uniform within a state but not necessarily uniform among states. Consistent with this approach, OPM is proposing that MSPP issuers offer a benefit package in all states that is substantially equal to either (1) the EHB-benchmark plan in each state in which the issuer operates, or (2) any EHB-benchmark plan selected by OPM. The MSPP issuer must make a selection and apply it uniformly. For example, the issuer would not be permitted to use state-benchmark plans in some states in which it is operating and an OPM-chosen benchmark in other states. OPM is proposing to use the three largest FEHBP plans (BCBS Standard Option, BCBS Basic Option and Government Employees Health Association Standard Option) as its benchmark plans. If these plans lack pediatric dental coverage, they must be supplemented by the addition of the entire category of benefits from the largest Federal Employee Dental and Vision Insurance Program (FEDVIP) (MetLife Federal Dental Plan, High Option). Also, at least for years 2014 and 2015, OPM is proposing that its benchmark plans include any state mandated benefits enacted by December 31, 2011 that are include in the state’s benchmark plan or specific to the market in which the MSP offers coverage.

OPM is expressly requesting comments regarding the provision of pediatric dental services by MSPs in order to meet the requirement pursuant to section 1302 (b)(1)(J) of the ACA that states pediatric oral health services are part of the EHB package. The agency is soliciting comments on the advantages, disadvantages and possible approaches (e.g. the role of stand-alone dental plans and medical plans with embedded dental benefits) of meeting this requirement.

Comments Summary

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 plan. At a minimum, this will require transparency on price, benefits, consumer protections, and network adequacy.

In summary, the ADA and AAPD believe:

- Exchanges must maximize competition among plans to ensure that the exchange marketplace is competitive on January 1, 2014 and beyond. The addition of MSPs could help exchanges meet this goal if those plans offer real value and provide consumers with an adequate network of providers.
  - Each MSPP issuer should be required to establish an advisory panel of covered patients and participating dentists to provide meaningful input to the MSPP issuer on its plans’ policies.
  - To help ensure an adequate network, OPM should make it clear that MSPs’ fee schedules will not apply to non-covered services and that the plans will be required to make prompt payment of claims. MSPP issuers must be required to offer dentists a separate participating agreement for MSPs offered within the exchange to enable a full and fair review by the practitioners.
  - Individuals who purchase oral health benefits through a MSP deserve equal access to consumer protections irrespective of the plan (medical or dental) used to purchase the dental coverage.
  - Patients covered by more than one plan should be guaranteed the full value of their purchased coverage, up to 100% of the cost of the procedure by requiring a
secondary insurer to pay the remainder of a claim up to, but not exceeding, 100 percent of the amount of the claim.

- A plan beneficiary should be able to designate payment for covered services to a provider who is not participating in the network, so that the patient does not have to pay for such services out-of-pocket and wait to be reimbursed by the plan.
- ADA and AAPD agree with OPM’s requirement that an MSPP issuer make its provider directory available to the exchange for online publication and to potential enrollees in hard copy upon request.

- The pediatric dental **EHB must 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 the children do not already have such coverage. **Stand-alone dental plans and medical plans with an embedded dental benefit must be able to compete on an equal footing** inside the exchange to ensure consumers have a robust selection of dental products.
  
  - OPM can address this issue by requiring all MSPs to offer both a medical plan with an embedded dental EHB package and an identical medical plan without the dental benefit in all exchanges where stand-alone dental plans are available.

- **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 necessary to address a health condition where both medical and dental care is clinically required. There should be **adult dental coverage for emergencies as part of the EHB package**.
  
  - We recommend that OPM direct all MSPs to ensure the pediatric oral health services are available to individuals up to age 21.
  - We request that OPM recognize that the dental coverage in the three OPM-chosen benchmark plans (BCBS Standard Option, BCBS Basic Option and Government Employees Health Association Standard Option) are fundamentally inadequate to meet the needs of the pediatric population and that OPM deem the FEDVIP’s MetLife Federal Dental Plan (High Option) as the required pediatric dental EHB coverage.
  - Every child must be able to access needed services to address a health condition where both medical and dental care is clinically required.
  - We also recommend that OPM use its authority under the ACA to ensure that all MSPP issuers include adult dental coverage for emergencies as part of the EHB package.

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. 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.

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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. At least with regard to MSPs, this must be addressed by OPM in its final rule.

**Comments**

**Maximize Competition**

It is important that all dental plans offer an adequate provider network to make the exchange an attractive alternative for consumers. MSPs should be required to make information about their networks readily available to providers and the viability of the network should be regularly tested. Networks should allow all dentists willing to accept the terms of the contract to participate in the network. Also, carriers must be required to offer dentists a separate participating agreement for plans offered within the exchange to enable a full and fair review by the practitioners.

Individuals who purchase oral health benefits through a MSP deserve equal access to consumer protections irrespective of the plan (medical or dental) used to purchase the dental coverage. Reporting standards, use of plain language in the coverage explanation, cost-sharing information disclosure and past performance of the plan have been identified as important transparency measures. An appeals process that permits an external review is also very important that applies to all plans offering dental benefits.

A plan should be prohibited from dictating fees for procedures that the plan does not cover. All patients would benefit from this provision as 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. Prompt and fair payment is necessary to ensure the continued viability of dental networks that work well for providers and their patients, as well as insurance carriers that want to attract an adequate number of participating dentists.

Patients covered by more than one plan should be guaranteed the full value of their purchased coverage, up to 100% of the cost of the procedure by requiring a secondary insurer to pay the remainder of a claim up to, but not exceeding, 100 percent of the amount of the claim. A plan beneficiary should be able to designate payment for covered services to a provider who is not participating in the network, so that the patient does not have to pay for such services out-of-pocket and wait to be reimbursed by the plan.

**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.

Pediatric oral health services are included among the list of EHBs outlined in the ACA\(^2\) and the law specifically allows stand-alone dental plans to compete in the exchange.\(^3\) 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.\(^4\) Unfortunately, there have been inconsistent messages from some federal authorities 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 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.\(^5\) 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

\(^2\) PL 111-148, § 1302(b)(1)(J)
\(^3\) Id., § 1302(d)(2)(B)(ii)
\(^5\) PL 111-148, § 1501(b)
Package when paired with a qualified health plan covering all benefits other than pediatric oral health services within the exchange.\textsuperscript{6}

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 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.\textsuperscript{7} Also, private dental insurance coverage among children has declined from 57.3 percent in 2001 to 48.8 percent in 2010.\textsuperscript{8} Regular dental visits are an important component of ensuring good oral health and ultimately controlling health care costs through the application of preventive measures.\textsuperscript{9}

In earlier comments submitted to the Centers for Medicare and Medicaid Services, we strongly urged 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.

\textit{OPM can address this issue by requiring all MSPs to offer both a medical plan with an embedded dental EHB package and an identical medical plan without the dental benefit in all exchanges where stand-alone dental plans are available.}

\textsuperscript{7} 2000-2009 Medical Expenditure Panel Survey (MEPS)
\textsuperscript{8} 2001 and 2010 MEPS
\textsuperscript{9} Cigna. Improved health and lower medical costs: why good dental care is important, a white paper [Internet] 2010 [cited 2012 Dec 12]. Available from: \url{http://www.cigna.com/assets/docs/life-wall-library/Whygooddentalcareisimportant_whitepaper.pdf}. 
EHB Benchmark Plan Standards and Covered Services

The ACA gives OPM the authority to determine if MSPs meet the EHB package requirements and other “qualified health plan” requirements.

Definition of pediatric services

The CMS 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. 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. We recommend that OPM direct all MSPs to ensure the pediatric oral health services are available to individuals up to age 21.

Covered Services

The proposed rule recognizes 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 provides further clarification that the option the MSPP issuer must choose to supplement pediatric oral coverage is the FEDVIP plan with the largest enrollment (MetLife High option), which provides a range of services, including preventive services, appropriate for the pediatric population. Unfortunately, the three OPM-chosen benchmark plans (BCBS Standard Option, BCBS Basic Option and Government Employees Health Association Standard Option) are fundamentally inadequate to meet the needs of the pediatric population.

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10 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.

11 All of the plans fail to cover some important pediatric dental services, such as endodontic treatments (e.g. root canals, pulpal therapy), oral surgery other than “simple extractions” and medically necessary orthodontics.
What remains unclear is the trigger mechanism that requires the MSPP issuer to add the supplemental coverage. If the MSPP issuer selects one of the three OPM-chosen benchmark plans, we believe it would result in a benefit package that is so minimalist that it is inconsistent with the intent of the ACA. We believe the Children’s Health Insurance Reauthorization Act of 2009 (CHIPRA) offers a better standard, covering services that are “necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.” This definition encompasses services that are recommended by evidence-based guidelines developed by the ADA and AAPD.

We request that OPM recognize that the dental coverage in the three OPM-chosen benchmark plans are fundamentally inadequate to meet the needs of the pediatric population and that OPM deem the FEDVIP’s MetLife Federal Dental Plan (High Option) as the required pediatric dental EHB coverage.

Adult Dental Coverage, Medically Necessary Orthodontic Services, and State Mandates

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 OPM state that coverage for emergency adult dental services is 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 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.

OPM should clarify that coverage for medically necessary orthodontic services is part of the EHB pediatric oral dental benefit. 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. 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.

According to the proposed rule, state coverage mandates in place before December 31, 2011 may be included in a MSP’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

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plan years will provide additional time for a consensus to be reached on a comprehensive set of benefits that appropriately serves all populations.

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 with any questions.

Sincerely,

American Dental Association              American Academy of Pediatric Dentistry
President                            President

RAF: JHB: tjs