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April 18, 2014

SUBMITTED VIA EMAIL
Dr. Leighton Ku, Chair
Ms. Katherine Stocks, Vice-Chair
D.C. Health Benefit Exchange
Dental Plan Advisory Working Group II

RE: D.C. Health Benefit Exchange - Dental Workgroup II Minority Report

Dear Dr. Ku and Ms. Stocks:

This letter is in regards to the report and recommendations on the issues addressed by the Dental Plan Advisory Working Group II for the District's Health Benefit Exchange ("Exchange"). Over the course of the three meetings which took place on March 7th , 14th and 28th, this workgroup considered, among other issues, the following threshold issue:

1. *The Exchange (HBX) should require some major medical plans to be offered without dental benefits embedded.*

We appreciate the opportunity to provide these closing comments, and it is the undersigned standalone dental companies' combined position that we cannot join in the final recommendation of the Working Group regarding the proposed 2015 structure of dental offerings in the Exchange, which is stated in the report as follows:

> *Major medical carriers have the choice to embed, or not embed, the pediatric essential health benefits in their qualified health plans. (It is our understanding that the recommendation does not distinguish between the Individual and the Small Business Health Option Program ("SHOP") market).*

Structure of 2014 Dental Offerings

By way of background, for the 2014 benefit year, the Exchange solicited standalone dental plans for inclusion in the Exchange. While several standalone dental plans expended time and resources toward successfully bidding their products for the Exchange, their collective child-only products were deemed unnecessary by the Department of Insurance, Securities and Banking ("DISB"). The reason for this was because all 300+ products filed for the Exchange by QHPs included embedded pediatric dental benefits, thereby making the standalone child-only products completely duplicative. As a result, the only standalone dental product currently available on the Exchange is the supplemental adult/family dental product.

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Structure of 2015 Dental Offerings

The Chair's report correctly points out that the workgroup failed to reach a consensus recommendation on the threshold question of whether or not the Exchange should ensure a QHP offers a product that omits the essential pediatric dental benefits, either voluntarily, or as a requirement by the Exchange for the 2015 benefit year. Despite the lack of consensus however, we note that without board action to adopt such a policy, the board is in fact, by virtue of inaction, creating once again an all-embedded dental environment in the Exchange. Such an environment renders standalone dental plans non-viable, with the following consequences for DC Exchange enrollees:

1. Reduced competition between carriers for dental benefits specifically;
2. Reduced access to care due to the smaller dental networks of health carriers, which puts consumers at risk for not being able to see their family dentist when forced to accept the dental benefits embedded with the selected medical plan;
3. Increased consumer costs for dental due to the much higher maximum out of pocket limit (MOOP) for children in embedded dental plans ($6,350, individual/$12,700, family), compared with $350/$700 for standalone dental plans; this threatens every child with medically necessary orthodontic needs to incur prohibitively high out of pocket costs;
4. Zero guarantee of a high actuarial value dental plan, because AV requirements only follow standalone dental, and never an embedded dental plan.

For all these reasons, we recommend that the D.C. Health Link board override the workgroup's inability to arrive at a consensus position, and to instead require a minimally sufficient number of QHP offerings without pediatric dental benefits, which in turn eliminates all four of the significant consumer disadvantages referenced above.

Based on a review of the distinct advantages of standalone dental, this coalition of carriers recommends an approach that provides choice and competition for the District consumer as follows:

a. QHP with embedded pediatric dental benefits (10.0)
b. QHPs without pediatric dental benefits, voluntarily or required (9.5)
c. Stand-alone pediatric dental plan (.5)

This structure – by far the most common structure in exchanges throughout the country in 2014 – puts all choice options in the hands of the consumer where it belongs. The consumer can choose to pair up any QHP with any pediatric dental offering, regardless of whether that offering is from the same QHP, or a different QHP or a standalone QDP. As was brought up during our working group sessions, there are numerous advantages to ensuring the inclusion and viability of standalone dental plans:

- District consumers regain the ability to choose their children's dental plan rather than be forced to accept the more limited dental plans embedded in their selected QHP; only residents able to use pediatric dental coverage would be required to buy them, thereby lowering the cost of coverage for childless adults and those with dependents who are 19 and over;
- The dental market regains the important element of healthy competition, which keeps prices in check and ensures better quality and choice; and

- District consumers benefit from the availability of separate, far lower cost-sharing elements found in the standalone product, which promotes the acceptance of needed care, versus the deferral of care, as so often occurs with dentistry.

Regarding the Authority of the Board to Structure How Dental is Offered

We offer the following citations from the Exchange bill (B19-2) that was enacted by the District in 2011, which empowers the Exchange to use its authority's to create the structure of the DC Health Link in the manner that it feels is in the best interests of the consumer or small employer. Taken together, we urge that the Authority exercise these powers to create an environment where QHPs bid a mix of 10.0 and 9.5 plans, and standalone is therefore allowed to be a viable purchase in combination with those 9.5 plans.

> Sec. 7 Powers and duties of executive board. (g) The executive board may limit the number of plans offered in the exchanges using selective criteria or contracting; *provided, that individuals and employers have an adequate number and selection of choices.*
>
> Sec. 10(a) To be certified as a qualified health plan, a health benefit plan shall, at a minimum: (7) *Be determined by the Authority that making the plan available through the exchanges is in the interest of qualified individuals and qualified employers.*
>
> Sec. 17(a) The executive board shall: (1) Study, in consultation with the advisory boards established under this act and with other stakeholders: (B) *The rules under which health benefit plans should be offered inside and outside the exchanges in order to mitigate adverse selection and encourage enrollment in the Exchanges.*

These conditions are also permissible under the Affordable Care Act (ACA) and subsequent federal regulations. The ACA clearly establishes the legal standing for the inclusion of standalone dental plans under Sec. 1311(d)(2)(B)(ii):

> (d) REQUIREMENTS.—
> (1) IN GENERAL.—An Exchange shall be a governmental agency or nonprofit entity that is established by a State.
> (2) OFFERING OF COVERAGE.—
> (A) IN GENERAL.—An Exchange shall make available qualified health plans to qualified individuals and qualified employers.
> (B) LIMITATION.—
> (i) IN GENERAL.—An Exchange may not make available any health plan that is not a qualified health plan.
> (ii) OFFERING OF STAND-ALONE DENTAL BENEFITS.—Each Exchange within a State shall allow an issuer of a plan that only provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J)).

In the preamble to the Exchange final and interim final rule published in the Federal Register on March 27, 2012, it states:

> *[T]he Exchange must allow stand-alone dental plans to be offered either independently from a QHP or as a subcontractor of a QHP issuer, but cannot limit participation of stand-alone dental products in the Exchange to only one of these options.* (p. 18411)
>
> and
>
> *If an Exchange determines that having QHPs separately offer and price pediatric dental coverage is in the interest of the consumer,…then the Exchange may establish such standard as a condition of QHP certification.* (p. 18411)

We conclude that the Exchange Board therefore has the authority to structure the plan offerings in a manner that provides full transparency of the pediatric dental benefit and the cost of that benefit, with the widest range of choice and competition that are in the best interests of District consumers, and we therefore recommend that the Board consider this alternative approach than that which has been offered by the Chair of the dental workgroup.

Supplemental Adult/Family Dental in 2015

As mentioned, standalone dental plans will be allowed to continue offering supplemental adult/family dental benefits through the Exchange, and we appreciate the opportunity to do so. Indeed, Delta Dental's adult dental product in the DC exchange and many other state exchanges is proving to be quite popular, enjoying healthy enrollment. However, for the Exchange to continue to offer supplemental dental coverage, the product today and in 2015 must continue to include the essential pediatric coverage within the policy. This creates an environment where consumers may inadvertently purchase the pediatric coverage twice, because they could unintentionally sign up their children to receive duplicate coverage since all children have embedded pediatric dental benefits through their QHP.

We therefore strongly urge the Exchange to utilize all of the tools at their disposal, including web technology, popup dialog boxes, narrative text, and training materials to emphasize to the consumer – and to the navigators who often advise them – that because the pediatric dental is embedded, there is no need to pay for the same coverage twice. This will have the advantage of emphasizing the supplemental dental offerings for their true purpose, which is to cover adults and other family members over the age of 19 with quality and comprehensive dental benefits.

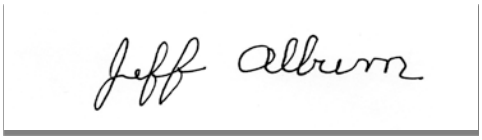
Structure of SHOP Exchange for 2016 Plan Year

Should the board not heed this approach as we recommend, and QHPs are allowed to continue to embed the pediatric dental offering in all their products, we alternately recommend that Qualified Dental Plans (QDPs) at least be offered an opportunity to compete on an equal footing with QHPs in the SHOP for the 2016 benefit year, when the small group market will be consolidated in the District Exchange. Purchasers of small group coverage have an even greater vested interest in choice for their employees, and current marketplace dynamics reinforce that small groups want to compare plan offerings and make the best choice possible for their employees and their dependents. Remember that there are no subsidies available in the SHOP, hence mandated purchase of pediatric dental makes less sense in the employer/employee market. In fact, Congressional staff currently receive their medical benefits via the Exchange, but their dental benefits are still maintained through the FEDVIP Program, so it makes little sense to make this important subset of DC Health Link enrollees pay for benefits they aren't qualified to receive, and for which they are already purchasing through FEDVIP.

Under this alternate scenario, a minimally sufficient number of QHP products would be offered without pediatric dental. This would allow standalone QDPs to compete effectively against purely embedded products and afford employers and employees the kind of choice they have come to expect in purchasing healthcare benefits. Therefore, we petition that this dental workgroup reconvene before the end of 2014 to initiate a review and recommendation on the structure of offerings in the SHOP for the 2016 benefit year.

If you have any questions, please do not hesitate to contact any one of the undersigned parties at the associated email address listed. Thank you for affording us the opportunity to participate in the dental workgroup, and for your consideration of this joint letter.

Sincerely,



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