February 4, 2015

Mr. J.P. Wieske
Chair, Network Adequacy Model Review (B) Subgroup
National Association of Insurance Commissioners
444 North Capitol Street NW, Suite 701 Washington, DC 20001
Attention: Jolie Matthews, J.D., Senior Health and Life Policy Counsel

Re: Comments on the Proposed Revisions to the NAIC’s Managed Care Plan Network Adequacy Model Act (Model #74)

Dear Mr. Wieske:

I am writing on behalf of Delta Dental Plans Association (DDPA) in response to the proposed revisions to the NAIC’s Managed Care Plan Network Adequacy Model Act (the “Network Adequacy Model”). We are pleased to offer the following comments.

While DDPA supports the work of the NAIC’s Network Adequacy Model Review (B) Subgroup, we do not believe it appropriate to apply the Network Adequacy Model, as presently drafted, to dental networks.

First, the NAIC’s Model Act is designed for comprehensive major medical coverage and includes provisions that are not applicable to dental networks. For example, the NAIC’s Model Act includes several provisions relating to hospitals. Much of the discussion on the Working Group’s conference call has been devoted to issues relating to care provided in hospitals. Hospitals are referenced approximately thirty times in the revised NAIC Model Act. Most dental benefits do not provide coverage for hospital care expenses.

The Working Group has also spent considerable time discussing issues relating to emergency care. The revised model includes, and the additional comment letters propose, several new provisions relating to protections in hospital and emergency room settings. Dental conditions for which dental networks provide coverage are almost uniformly provided in the dentist’s office, not in a hospital. Care provided in the dental office is routinely scheduled care and is rarely provided in an emergency situation. Even when emergencies arise, the care is not provided in an emergency room setting. Dental networks cannot comply with these hospital and emergency care provisions and holding dental plans to them would burden plans that offer dental benefits with unnecessary compliance and implementation issues surrounding their dental service providers.

Second, the cost of dental treatment is, on average and in the aggregate, much less than medical treatment. Inherent in the NAIC approach is the concept that consumers should have appropriate care when they need it and that if consumers follow insurer’s requirements, the provision of that care should not result in costs that could put a significant financial strain on, or
possibly bankrupt, the consumer. However, the cost consumers incur for out-of-network dental care does not rise to the level of major medical care. There are important provisions in the NAIC Model Act pertaining to disclosures on the impact of out-of-network care and emergency care which provide important protections directly related to the cost impact of this type of care, but these provisions simply do not apply to dental care.

To address these issues, we recommend that the Working Group amend the definition of “health benefit plan” used in the Network Adequacy Model to make it consistent with the definition used in other NAIC ACA Implementation Models. DDPA proposes that Section 3.I. be amended as follows:

(I) (1) “Health benefit plan” means a policy, contract, certificate or agreement offered by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(2) “Health benefit plan” includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.

(3) “Health benefit plan” does not include:

(a) Coverage only for accident, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers’ compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics; and

(h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.

(4) “Health benefit plan” does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(5) “Health benefit plan” does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
(a) Coverage only for a specified disease or illness; or
(b) Hospital indemnity or other fixed indemnity insurance.
(6) “Health benefit plan” does not include the following if offered as a separate policy, certificate or contract of insurance:
(a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;
(b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
(c) Similar supplemental coverage provided to coverage under a group health plan.

These edits would exempt stand-alone dental plans from the requirements of the Network Adequacy Model that have been tailored to more complicated major medical networks. DDPA understands and agrees that access to dental care is vital, and that all dental plans should have sufficient networks to adequately address the need for care. Therefore, DDPA stands ready to work with the NAIC to develop dental network adequacy standards. Such standards would apply to stand-alone dental plan networks and dental networks used by medical carriers that embed dental coverage within their health benefit plans. The development of dental-specific standards would allow the NAIC to take into account the many ways that dental care and dental providers differ from their medical counterparts, while still ensuring that dental plans employ sufficient networks to address patient requirements.

We very much appreciate the opportunity to submit comments on this important proposed rule. If you have any questions, please contact me at (202) 552-7357 or Chris Petersen, our NAIC consultant, at (202) 408-5147.

Sincerely,

Julia Grant
Vice President, Government Relations

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DDPA is the nation’s largest, most experienced dental benefits system. Since 1954, DDPA has worked to improve oral health in the U.S. by emphasizing preventive care, and making quality, cost-effective dental benefits affordable to a wide variety of large and small employers and groups, and individuals, including participation in state Medicaid and Children’s Health Insurance Program (CHIP) dental plan arrangements. DDPA provides a nationwide system of dental health service plans, offers custom programs, and reporting systems that provide individuals, employees, and state Medicaid and CHIP participants with quality, cost-effective dental benefit programs and services. Our nationwide network of 39 companies and 148,000 dentists, serves more than 62 million Americans in over 114,000 group plans across the nation.