National Association of Dental Plans

January 9, 2018

Katharine L. Wade
Insurance Commissioner
153 Market Street, 7th Floor
Hartford, CT 06103

Dear Commissioner Wade,

The National Association of Dental Plans (NADP) is providing comments on proposed regulations concerning network adequacy, sections 38a-472f-1 through 38-472f-6 of the Regulations of Connecticut State Agencies.

A primary concern for our members is 38a-472f-2(l), which would require carriers to:

> *Make a good faith effort to provide written notice, not later than thirty (30) days from receipt of the list of the participating providers' patients who are covered persons, to all covered persons who are patients being treated on a regular basis by such provider. For purposes of this subsection, "treated on a regular basis" means receiving treatment at least once during the previous twelve (12) months;*

Due to the unique position of stand-alone dental plans and dental provider networks, this requirement should not be applied to dental carriers in the same manner as medical carriers.

The scope of services covered by dental and medical plans are distinctly different in several key respects. While medical carriers provide coverage for many different types of conditions that require ongoing regular or chronic care, dental care patients are not typically treated on an ongoing, frequent or "regular basis." Rather, most dental services (e.g. preventive visit, filling a cavity) are provided as a discrete singular service rather than through a course of treatment.

The interpretation of the meaning of "regular basis" in the dental setting is supported by the Center for Medicare and Medicaid Services (CMS)

interpretation of a similar provision codified at 45 C.F.R. § 156.230(d). Regarding this provision, CMS indicated in the preamble to the 2017 Notice of Benefit and Payment Parameters (NBPP) that "Due to the nature of these policies and services provided by SADPs that any instances in which a SADP would need to apply these provisions would be rare." CMS also stated that such a provision is "more suitable to medical services." (81 FR 12204-01, 2016 WL 861587 (F.R.) page 361).

Additionally, the dental benefits industry is comprised primarily of Dental Preferred Provider Organizations (DPPO) products, wherein customers have the freedom to choose from a variety of dentists both in- and out-of-network. There is no requirement to designate a primary provider. Simply because an enrollee may have visited a provider at one point in time does not mean that this is a provider the enrollee has seen or will see on a regular basis. Thus, attempting to notify enrollees who may be impacted would require, for every change, a substantial claims search, with the potential of limited success of identifying those enrollees who would use the provider in the future. Further, the administrative burden and cost of doing this would be significant with no advantage to the enrollee, especially considering in most cases the dentist or dental office is already sending notice to any patient who may be impacted by the dentist's termination from a network),

For these reasons, **NADP urges the Department to exclude stand alone dental plans from application of this requirement.** Short of exemption from this provision, NADP recommends the following alternatives in recognition of the differences between dental and medical benefits and their provision of care.

Adopt a separate notification standard for dental plans whereby:

- The definition of "regular basis" for dental plans is aligned with the CMS approach for Medicare Advantage. The following CMS guidance defines the term as care received within the past three months.

110.1.2.3 – Notification to Enrollees
(Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)
Pursuant to 42 CFR §422.111(e), when an MAO makes changes to its provider network, the MAO must make a good faith effort to provide written notice of a termination of a contracted provider at least 30 calendar days before the termination effective date to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. When a contract termination involves a primary care professional, all enrollees who are patients of that primary care professional must be notified.

Please note that CMS considers "enrollees who are patients seen on a regular basis by the provider whose contract is terminating" to be "affected enrollees." An "affected

enrollee" as an enrollee who is assigned to, currently receiving care from, or has received care within the past three months from a provider or facility being terminated.

OR

- Member notices are required to be sent to patients who have received care from the dentist in the six (6) months prior to the dentist's termination from the network.

Please do not hesitate to contact me directly should you have any questions or concerns. We appreciate your time and consideration of this important issue.

Sincerely,

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National Association of Dental Plans (NADP)

About NADP:
NADP is the largest non-profit trade association focused exclusively on the dental benefits industry. NADP's members provide dental HMO, dental PPO, dental Indemnity and discount dental products to more than 184 million Americans with dental benefits. Our members include the entire spectrum of dental carriers: companies that provide both medical and dental coverage, companies that provide only dental coverage, major national carriers, regional, and single state companies, as well as companies organized as non-profit plans.