November 9, 2015

Jocelyn Samuels
Director, Office for Civil Rights
U.S. Department of Health and Human Services
Attention: **1557 NPRM (RIN 0945-AA02)**
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

RE: Nondiscrimination in Health Programs and Activities Proposed Rule

Dear Director Samuels,

The National Association of Dental Plans (NADP) appreciates the opportunity to provide comments on the proposed rule RIN 0945-AA02: Nondiscrimination in Health Programs and Activities, published in the Federal Register on September 8, 2015. NADP supports the overarching goal of the proposed rule and Affordable Care Act (ACA) section 1557 to ensure equal access to health care and coverage for all individuals without discrimination on the basis of race, color, national origin, sex, age or disability, all attributes dental plans support. The following comments focus on the proposed approaches to implement this goal, specifically the application of the rule extending beyond healthcare products, standards for dental benefits, and proposed timelines.

APPLICATION OF RULE TO NON-RELATED BUSINESS

The proposed rule explains ACA Section 1557 as applying to "all health programs and activities, any part of which receives Federal financial assistance from any Federal agency. In addition, Section 1557 applies to all programs and activities that are administered by an Executive Agency or any entity established under Title I of the ACA."

Federal financial assistance can include Advanced Premium Tax Credits (APTC) and Cost-Sharing Reductions (CSR), which are available through Individual Health Insurance Marketplaces and the small business health care tax credit available in the Small Business Health Options Program (SHOP) Marketplaces. HHS proposes that insurers offering coverage through Marketplaces will be covered entities for purposes of the rule through the availability and distribution of this financial assistance.

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In further defining covered entities, HHS expands this application to include "all of the operations of an entity principally engaged in providing or administering health services or health insurance coverage." This will include, in application, a covered entity's individual and group market business outside Marketplaces.

The proposed rule also provides an example to clarify inclusion of a covered entity's business as third-party administrators (TPA) for self-insured group plans: "an issuer that participates in the Marketplace and thereby receives Federal financial assistance, and that also offers plans outside the Marketplace, will be covered by the proposed regulation for all of its health plans, as well as when it acts as a third party administrator for an employer-sponsored group health plan."

We believe this proposal conflicts with the intent and plain reading of Section 1557, which includes "any health program or activity, any part of which is receiving Federal financial assistance." Carriers and plans in these expanded markets are *not recipients of assistance* under Federal programs and are clearly outside the scope of this regulation. Third-party administrators of ERISA plans also lack determination and control over many of the plan aspects discussed in the proposed rule.

- **Recommendation**: Revise the application to reflect ACA Title 1 and Section 1557 intent to regulate only those health programs directly receiving financial assistance, not all operations of a covered entity. An insurer's individual and group market business outside a Marketplace and other federal programs should be excluded from the purview of the regulation.

EXEMPTION NECESSARY FOR HIPAA EXCEPTED BENEFITS

The organization and delivery of dental care differs from the medical care model. Dental disease is largely preventable. It is limited to well-established conditions—tooth decay and gum disease—that rarely require hospitalization. As a result, the vast majority of dental care is provided in a primary care setting by general dentists, which is markedly different from the medical care model. The provider systems also are dissimilar. More than 80 percent of dentists are owners of a practice and over half are in solo practice, compared to less than 20 percent of physicians. Given the distinct nature of dental care and delivery, effectively organizing dental networks requires an expertise that differs from medical plan management.

Dental premiums are 1/12th or less of medical premiums while dental plans and medical issuers perform the same basic administrative functions with similar costs and structures (e.g. claim payment, customer service, network development, etc.). Dental benefits are discretionary and a voluntary addition to health benefit plan enrollment. Not all employers offer dental benefits, and those who do often require employees to pay part (72.7 percent) or even all of the premiums (22 percent). Thus, dental benefits—and consumer access to dental care—are extremely sensitive to cost pressures.

Recognizing these differences and acknowledging the regulatory definitions of "excepted benefits," Congress and the ACA exempt limited scope dental plans from health insurance market reforms. HHS interpretation and implementation of the ACA have continued to mirror the original legislative intent to limit application of the Public Health Service Act and ACA standards to medical care services. This is further acknowledged by HHS in rulemaking and was clarified in a response from Secretary Sebelius.

Additionally, dental coverage does not present the potential discrimination issues for which the proposed rule is designed to address.

- **Recommendation**: Re-evaluate Section 1557 and the proposed rule's application to limited scope benefit plans given the longstanding regulatory differentiation between medical and dental benefits in many provisions of federal law.

We are certain there is a balance that can be achieved between necessary regulations designed to protect consumers and the avoidance of burdensome regulation that impairs the ability of dental plans to continue to offer balanced and cost-effective dental benefit choices to employers, individuals and families.

IMPLEMENTATION TIMELINE

In the proposed rule's extensive Regulatory Impact Analysis, HHS recognizes the substantial costs across health industries to implement both various provisions and training of the workforce. Unfortunately, the proposed effective dates of 60 days for the regulation and 90 days for the notice standards do not similarly recognize the significant changes required for implementation. Covered entities will need time to change processes, reevaluate and redistribute policies, modify business practices and provide considerable staff training.

An effective date mid-plan year could also complicate ongoing processes with state filings and Exchanges, particularly the notice requirements for significant publications which may not be easily modified on Exchanges mid-year. Given this, an effective date of January 2017 would seem the earliest possible to give appropriate time for system changes.

- **Recommendation**: Postpone the proposed effective date to January 2017 due to the extensive impacts of the regulations and consider a good faith safe harbor period, which would support covered entity and HHS communication and cooperation on issues that arise during implementation.

PROPOSED MODIFICATIONS

NADP appreciates several proposed modifications offered throughout the rule and offers the following recommendations.

- **Recommendation**: Allow covered entities to combine the required notice of the discrimination policy with other notices they are required to disseminate under Federal law.
- **Recommendation**: For websites, allow covered entities to link to a URL and separate page to provide the notice and taglines. HHS could provide sample labels for the URL, including "Nondiscrimination/Accessibility" and "Information in other languages" as is done on healthcare.gov today.
- **Recommendation**: NADP supports the agency's balanced approach in requiring covered entities to provide the notice in English due to space limitations online and in print. HHS should allow

modifications to the notice for significant publications that lack adequate space (i.e. postcards, trifolds, etc.).

- **Recommendation**: Allow covered entities the option to list the taglines in the top 15 languages nationally or list the taglines in the top 15 languages by state. For issuers already offering on Marketplaces, the latter option will allow them to harmonize policies and operations already in place from the Benefit and Payment Parameters Regulations for those programs. As a third option, NADP recommends allowing issuers to publish taglines in languages spoken by at least 10 percent of a population residing in a serviced county as measured by the most recent US Census data. Offering this third option will allow issuers to better provide assistance to individuals with the greatest need.

Allowing modifications such as these will defray additional costs, while keeping consumers informed and protected. It is important to note again that dental plans have premiums that are 1/12th or less of medical premiums and therefore do not have the dollars available for extensive, duplicative regulations. Nor do consumers of dental plans face the same situational needs of medical benefits plans. Allowing dental plans opportunities to comply in a less costly manner will be of benefit to employers, consumers, and plans alike, enhancing the affordability and availability of dental benefits.

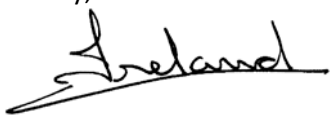
EXCHANGE-CERTIFIED STANDALONE DENTAL PLANS

The proposed rules do not explicitly address carriers seeking certification of standalone dental plans solely for off-exchange policy offerings. These carriers complete a similar process for certifying plans as carriers offering policies on Marketplaces. However the plans that are certified are not offered on the Marketplace, and have no opportunity to receive any financial assistance via Advanced Premium Tax Credits (APTC) as the plans are never available for enrollment through a Marketplace. Cost Sharing Reductions are not available to standalone dental plans at all.

- **Recommendation**: CMS should clarify carriers offering "exchange-certified" dental policies off the Marketplace, in the private/commercial market, are not "covered entities" for the purposes of the rule. The administrative cost to comply would raise premiums significantly and put these plans at a disadvantage compared to their competitors in the small group and individual market outside the Marketplace.

NADP is appreciative of the opportunity to provide comments on the proposed rule. Questions regarding our comments should be directed to Kris Hathaway, Director of Government Relations at khathaway@nadp.org or 972-458-6998 x111. Again, thank you for your consideration.

Sincerely,



Evelyn F. Ireland, CAE
Executive Director
National Association of Dental Plans

NADP DESCRIPTION

NADP is the largest non-profit trade association focused exclusively on the dental benefits industry, i.e. dental PPOs, dental HMOs, discount dental plans and dental indemnity products. NADP's members provide dental benefits to more than 92 percent of the 191 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.

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