July 12, 2017

Seema Verma, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Ave, S.W.
Washington, DC 20201
Sent via regulations.gov

Dear Administrator Verma,

The National Association of Dental Plans (NADP) appreciates the opportunity to provide comments on the request for information, "Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choice to Empower Patients," published in the Federal Register on June 12, 2017. NADP supports the goal of this effort *"to create a more patient-centered health care system that adheres to the key principles of affordability, accessibility, quality, innovation, and empowerment,"* and we believe these principles are reflected in the following recommendations on the offer of dental benefits in the small group and individual markets.

CONSUMER ACCESS TO DENTAL IN THE SMALL GROUP AND INDIVIDUAL MARKET

Under current implementation of the Affordable Care Act (ACA), differences in the way dental benefits are allowed to be offered in the small and large group markets cause confusion for insurers, brokers and consumers, and, in the small group market, separate children from traditional family dental coverage. Federal policy should provide consistency among markets by allowing pediatric dental benefits to be separately purchased by individuals and families through a small employer just as rules allow in the Marketplaces and is the practice in the large group market.

Inside public insurance Marketplaces, families can obtain dental coverage in two ways that mirror how dental coverage is obtained in the large group commercial market, 1) through a standalone dental plan (SADP) or 2) through a medical plan that has pediatric dental embedded in the coverage. Although it was the intent of Congress to allow separate pediatric dental policies inside AND outside the Marketplaces in the small group and individual market, HHS interpreted a provision of the ACA at 2707(a) to require that medical carriers outside exchanges to include pediatric dental in policies offered in the small group and individual market. To address Congressional intent, HHS provided guidance for medical carriers outside a Marketplace permitting policies without pediatric dental coverage if two conditions were met: 1) the medical

carrier is “reasonably assured that an individual has obtained such coverage,” and 2) the coverage obtained is an “Exchange-certified stand-alone dental plan.”

While this option was intended to allow the same choices of dental coverage as offered in the Marketplaces, varied interpretations of “reasonable assurance” by state insurance regulators and medical carriers have complicated, and ultimately limited, the offer of pediatric dental coverage in the small group and individual market outside of Marketplaces. And, to offer pediatric dental coverage, SADPs must become “Exchange certified” which duplicates state regulation of policy forms.

This has led to:

- *Duplicative coverage*: Prior to the Affordable Care Act (ACA), 99% of dental coverage was issued separately from medical coverage. This trend remains the same today although there has been some shift from group standalone dental coverage to individual standalone dental coverage. Rather than provide options for consumer purchasing, HHS guidance has driven another change—duplicative coverage. When an employer offers family standalone dental coverage for adults and children (which is common), the pediatric coverage in the dental policy will likely be duplicative of pediatric dental coverage in the medical policy. This duplication increases the administrative burden on dentists and plans to follow state required “coordination of benefits” processes for payment of dental services—even when the pediatric dental coverage is limited.

- *Unnecessary complexity*: The “reasonable assurance” standard is inconsistent with processes utilized within the benefits community by carriers, agents, brokers and employers. None of these entities can know, at the point of offer, that an individual consumer has dental coverage. State insurance regulators and carriers have interpreted the “reasonable assurance” standard in a variety of ways ranging from a simple notice that the medical policy does not include pediatric dental to actual verification of pediatric dental coverage held by employees in an employer group. So, the HHS guidance, and its varied interpretations, incentivizes medical carriers to primarily offer a medical plan with some level of pediatric dental coverage. And, if the medical carrier wants to offer a choice of health plans, they also develop a complimentary plan that excludes pediatric dental coverage to be offered in instances when the “reasonable assurance” standard can be met.

- *Inappropriate coverage*: The vast majority of medical policies that embed pediatric dental make it subject to the medical deductible—limiting the actual dental benefit significantly. Even if the deductible is waived for preventive services, the pediatric coverage is significantly less than coverage provided through a SADP. And individuals and families without children obtain medical coverage that includes embedded pediatric dental coverage but no adult dental coverage that they can use.

Recommendation: Employers, individuals and families should have the choice of carriers for pediatric dental just as they do in the Marketplaces and in the large group market today. The current HHS guidance for how medical carriers approach the separate offer of pediatric dental does not recognize market realities and should be replaced. HHS should eliminate the “reasonable assurance” guidance and put in its place

commonsense language that allows carriers to rely on market mechanisms for the offer of pediatric dental coverage in the small group and individual market.

Recommendation: The duplicative approval requirement of "exchange certification" for standalone dental plans providing pediatric dental coverage should be eliminated. Medical carriers meet no such standard for the offer of ACA compliant coverage in the small group and individual market.

DECOUPLING MEDICAL AND DENTAL COVERAGE

Currently on healthcare.gov, medical and dental enrollment functions are linked. This is a technical flaw that has caused harm to families with coverage through the Marketplaces and limited choice for perspective enrollees.

On the individual Marketplace, consumers shopping for coverage only have access to a dental plan if they first purchase a Qualified Health Plan (QHP). This limits plan choice, prevents the possibility of direct enrollment through dental carriers and prevents some populations, such as Medicare enrollees, from accessing dental coverage. Once enrolled, when individuals and families make any change to their medical coverage, this technical flaw causes an automatic termination of any standalone dental coverage regardless of the consumer's interest in maintaining the SADP.

Recommendation: NADP strongly encourages HHS to decouple medical and dental enrollment within the individual Marketplace no later than 2019 and allow consumers a suite of options when it comes to their benefits. Separating QHPs from SADPs will allow consumers, upon reenrollment, to keep their SADP and change their QHP or vice versa—ending the automatic terminations that have disrupted coverage and care for many families on healthcare.gov. Uncoupling dental from medical would also allow dental carriers to provide direct enrollment to parallel the capability of QHPs, which they cannot offer now.

MEANINGFUL ACCESS AND ACA SECTION 1557

Carriers that offer products on public insurance Marketplaces and in the broader markets are subject to overlapping and at times, inconsistent requirements related to support for Limited English Proficiency (LEP) populations. These include CMS standards at §155.205(c) related to issuers on the Marketplaces and CMS Office of Civil Rights (OCR) standards at §92.8 to implement ACA Section 1557. The most recent Notice of Benefit and Payment Parameters addressed the inconsistencies in part by deeming issuers that are in compliance with §92.8 to also be in compliance with §155.205(c)(2)(iii)(A). We believe more can, and should be done to reduce the administrative burden and increased costs related to inconsistent tagline requirements.

Recommendation: NADP recommends the elimination or modification of the requirement that covered entities include notices of non-discrimination and taglines in all significant publications.

- In lieu of the current 15 languages which impacts very small—usually a fraction of a percent of the population in a state—NADP recommends that taglines be limited to languages spoken by at least 10 percent of a state's population. This would allow issuers to better provide assistance to individuals with the greatest need.
- Update §92.8 to indicate that issuers have met their obligations to send notices and taglines with written materials if they provide the notice and taglines once a year as well as post the notice and

taglines on their website. This approach is similar to the distribution of privacy information. The distribution of the notice once a year, in combination with the posting of the notice and taglines on websites, should be sufficient to address consumer needs rather than requiring inclusion of the notice and taglines with every significant publication or communication.

STREAMLINE MARKETPLACE PROCESSES

There are several technical transactions and processes on the Marketplaces that could be amended to decrease administrative complexity and better serve consumers.

Recommendation:

- *CMS Health Insurance Casework System (HICS)*: Cases should only be submitted if they are specific to Marketplace functions such as eligibility determinations or coverage terminations. All other member inquiries, such as how to make a payment, and grievances and appeals should be redirected to the carrier.
- *Coverage effective dates*: CMS can make determinations of when a member is eligible for open or special enrollment, but effective dates should be determined by the carrier based on receipt of payment.
- *Effectuation and Reconciliation*: 834 effectuations should only be used for activating coverage. Cancellations and terminations as well as eligibility and payment disputes should be handled in the reconciliation process. Filling out forms of any sort, especially for processes better handled during the reconciliation process, is time-intensive and resource-consuming without clear benefit to consumers.

We appreciate the opportunity to provide our comments and look forward to future discussions. For any follow-up, please contact NADP Director of Government Relations, Eme Augustini at eaugustini@nadp.org or (972) 458-6998 x111.

Sincerely,

Evelyn Ireland, CAE
Executive Director

NADP DESCRIPTION

NADP is the largest non-profit trade association focused exclusively on the dental benefits industry, i.e. dental PPOs, dental HMOs, discount saving plans and dental indemnity products. NADP's members provide dental benefits to more than 92 percent of the 205 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.