February 3, 2014

The Honorable Kathleen Sebelius, U.S. Department of Health and Human Services
Marilyn Tavenner, Centers for Medicare & Medicaid Services
Attention: CMS-9954-P P.O. Box 8016
Baltimore, MD 21244-8010
Re: **HHS Notice of Benefit and Payment Parameters for 2015 – Additional Comments**

Dear Secretary Sebelius and Administrator Tavenner,

The National Association of Dental Plans (NADP) offers the following update to our attached comments relating to stand-alone dental plans in the "Benefit and Payment Parameters for 2015" (proposed rule).

On January 11, NADP was notified that the report titled, "Impact of Changing the Maximum Out-of-Pocket Amounts for Qualified Health Plans and Stand Alone Dental Plans," (the Wakely Report) had been released and was posted on the HHS website. NADP had requested the report prior to filing our comments as we understood that it was in part what HHS relied on to propose lowering the dental maximum consumer out-of-pocket limits within the proposed rule. Since the report was released subsequent to the comment period, we respectfully request your consideration of these additional comments.

- **Wakely – Dental Premiums Will Increase:** Wakely researched how cost sharing changes would impact dental premiums due to induced demand. Wakely estimated the likely use of additional services at each maximum out-of-pocket (MOOP) level. *"For standalone dental plans (SADP), there is a significant change in AV, particularly at the lower MOOP levels. Significant induced demand is possible at these lower levels, increasing premiums."* and restated as, "*A large decrease in the MOOP for SADPs will cause a significant increase in dental premium costs, driven by both a higher AV and projected cost increases due to induced demand.*"

  NADP: Any increase of premiums has a negative impact on consumer purchasing. Significantly higher utilization would likely result from those that purchase a pediatric dental benefit with lower a MOOP level, further increasing premiums and resulting in adverse selection due to the voluntary offer of pediatric dental on most Exchanges. In other words, consumers with the greatest dental needs will purchase the product because of the lower MOOP, while consumers with better oral health will forgo coverage all together due to the higher

premiums. Premiums will continue to increase and the downward spiral due to adverse selection is initiated.

- **Wakely – Dental Plan Design Must Change:** The Wakely Report states there is limited room to decrease the (pediatric dental) MOOP without increasing cost sharing to unreasonable or nearly unreasonable levels. *"Unreasonable cost sharing includes cost sharing that is more than 50% of the average cost of the service. The SADP (single child) MOOP can be decreased from $700 to $400 with a corresponding increase in deductible from $150 to $300. Any additional reductions in MOOP cannot be absorbed by reasonable changes to plan designs."*

  NADP: Despite Wakely's research, HHS has proposed a MOOP for a single child pediatric dental policy below the level at which plan design changes can be reasonably made, i.e. $300. Additionally the $150 and $300 deductible levels cited in this paragraph as the beginning level deductible are already atypical of the marketplace. The average dental plan deductible in the marketplace is $50; these levels are 3 to 6 times a normal deductible.

  In addition, this directly impacts the small group and individual market outside of the Exchanges for dental carriers applying to become "exchange certified". While the application of this regulation is for low-income individuals, it will detrimentally impact a larger scale of individuals and small business than it will assist.

- **Wakely - Additional Data Needed:** Wakely states that its analysis was designed for purposes of assisting CCIIO with making general decisions. *"If CCIIO decides to move forward with changes in maximum allowable MOOPs and integration between medical and SADP MOOPs, we recommend further analysis and refinement of our estimates."*

  NADP: The Wakely Report recognizes there is limited experience so that additional modeling and data is needed to test specific changes.

Wakely's own conclusion states,

- *"We concluded that consumers are most sensitive to premiums and least sensitive to MOOP when making purchasing decisions. Deductibles and copays/coinsurance were of greater importance than MOOP in most consumers' purchasing decisions. The fact that reductions in MOOP on QHPs and some SADPs can be made without impacting premiums but increasing cost sharing elements such as deductibles and coinsurances may affect consumers' decision making process.* ***From the consumer perspective, the least important factor in their purchasing decision (the MOOP) has been improved while the more important factors (premiums and deductibles/coinsurance) have worsened."***

While the Wakely Report supports NADP's original comments, analyses was included which illustrates a relatively low or nonexistent premium increase under certain AV levels for pediatric dental. However, this analyses concerns NADP as the plan design utilized did not reflect industry standards. The Wakely report only looked at one child, not multiple children in a family and also used a standard deductible of $150 applying to all services while the industry standard is $50, which is not applied to preventative services. In

addition, the Wakely Report did not review any family MOOP, and there is no actuarial precedent for a family MOOP that is less than twice the single child MOOP.

The NORC report also stated that lowering the MOOP for medical policies (and providing that separately for dental coverage) will not impact premiums or plan design. In 2011, NADP recommended a proportionate allocation of the MOOP which would not require coordination by carriers. This proportional allocation is supported by the conclusions of the Wakely report over reduction of the dental MOOP.

Overall, HHS's own expert analysis supports the dental benefit industry's concern that increases in premium and cost sharing are more critical factors in purchasing and utilization of dental benefits than the MOOP. MOOP affects a very small percentage of consumers while premiums and cost sharing affect everyone.

In addition to NADP's comments (attached), we are concerned with the significant lowering of the pediatric dental maximum out of pocket to the proposed $300/$400 limit for multiple reasons:

- As the dental premium becomes less affordable and therefore less available, there is concern that preventive services will not be covered at 100% per new plan designs as well as less coverage purchased overall, meaning fewer Americans with dental coverage including preventive benefits.
- From discussions with our members, enrollment within dental policies on Marketplaces is lower than anticipated. While the reports are anecdotal at this point, we suspect it is related to dental being a voluntary purchase, the lack of the IT systems within the Marketplaces encouraging the purchase of dental, and the premium cost.
- We've also heard from members that consumers are choosing dental policies offered at the lower 70% AV level – again, proof that premium cost is key when deciding to purchase a dental product.
- A lower MOOP and higher premiums will have adverse and risk selection issues as enrollees with the highest needs will seek dental coverage.
- The decision to lower the MOOP not only impacts the AHBE/individual Exchanges, but is detrimental to small businesses on the SHOP as well as the markets off the Exchanges.

NADP respectfully reiterates our recommendation NOT to change the dental MOOP in 2015 and to allow time for the analysis of the current benefit structure. Thank you for your consideration of our additional comments.

Sincerely,

Evelyn F. Ireland, CAE
Executive Director

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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 approximately 90 percent of the 187 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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December 26, 2013

The Honorable Kathleen Sebelius, U.S. Department of Health and Human Services
Marilyn Tavenner, Centers for Medicare & Medicaid Services
Attention: CMS-9954-P
P.O. Box 8016
Baltimore, MD 21244-8010
Sent electronically via www.regulations.gov

Re: HHS Notice of Benefit and Payment Parameters for 2015

Dear Secretary Sebelius and Administrator Tavenner,

The National Association of Dental Plans (NADP) as the trade association of dental carriers covering over 90% of Americans enrolled in dental benefits in the United States offers the following comments on the proposals relating to stand-alone dental plans in the December 2, 2013 proposed "Benefit and Payment Parameters for 2015" (proposed rule).

NADP supports the overarching goal stated in the proposed rule to expand coverage and make affordable health and dental insurance available to individuals who do not have access to employer sponsored coverage. Notwithstanding that goal, it is important to also consider the proposed rule's impact on existing dental coverage in the small employer and individual market to ensure a net gain in access to oral health, and to the preventive and diagnostic services that render dental benefits so effective against dental disease in children.

NADP estimates that over 43.7 million individuals, including 22.9 million children are enrolled in dental benefits within the small group and individual market[1]. Under the Affordable Care Act (ACA), the Pew Center on the States estimates about 5.3 million more children will gain some form of dental coverage, mostly through Medicaid and CHIP[2]. The American Dental Association (ADA) estimates 3 million children will gain private dental insurance through Exchanges by 2018, although they stress the lack of a

[1] Estimate is based on 2009 enrollment data which is roughly comparable to today's market.
[2] Gresham, Shelly, et al., "The State of Children's Dental Health: Making Coverage Matter," Pew Center on the States, May 2011, pg. 1.

mandate for families to purchase pediatric dental coverage on Exchanges significantly reduces that assessment[3].

NADP appreciates the goal of HHS cost sharing limitations placed on the newly developed child-only dental benefits as part of the ACA's Essential Health Benefits (EHB) Package to ensure families do not experience catastrophic costs from their children's dental services. Requirements which have been added as conditions of Exchange participation to address consumer cost include no annual or lifetime limits, actuarial values and a consumer maximum out-of-pocket (MOOP) limit. These have been extended to the small group and individual market through the "reasonable assurance" requirements of the EHB rules. These changes are significant departures from typical employer dental coverage that remains in place for the large employer market. Experience with the new structure is needed to assure the goal of expanding pediatric dental benefits to greater numbers of children.

The proposed rule seeks comments on changing the current definition of the pediatric dental MOOP limit from "reasonable" to a specific dollar amount - as the ACA currently places on medical carriers across all markets. While the current dental MOOP within Federally-facilitated Marketplaces (FFM) is $700 for a child and $1400 for a family; the proposed rule suggests $300 for a child and $400 for a family annually. The proposed rule has other provisions, including implementing the MOOP limit across all Marketplaces (federal and state-based), eliminating the dental Actuarial Value (AV) limit, allowing both employer and employee purchasing options in the SHOP, and prohibiting composite rating for stand-alone dental plans (SADPs) in the SHOP.

NADP is concerned premature changes to stand-alone ACA-compliant pediatric dental policies will reduce coverage, and decrease, rather than enhance, affordability for the vast majority of consumers. NADP outlines our concerns with the recommendations and provides alternative solutions to address the core issue of affordability for low income consumers.

Due to a limited 30 day comment period during the holiday seasons, NADP may follow up with additional analysis past the comment period deadline. NADP contracted Milliman for actuarial analysis of the proposed MOOP limits, and has included portions of their preliminary analysis within our comments below.

DECREASE OF MAXIMUM DENTAL OUT-OF POCKET LIMITS

The proposed regulations decrease the MOOP by a significant amount—a drastic change without the opportunity to implement or develop experience on the impact of the 2014 pediatric dental MOOP limits. NADP is open to discussing alternative MOOP amounts at a future date, however prior to 2014 these limits did not exist in the dental market and therefore little is known on the impact to the utilization of dental benefits. A broader perspective of how the MOOP impacts plan design, premiums

[3] Nasseh K, Vujicic M, O'Dell A., "Affordable Care Act Expands Dental Benefits for Children But Does Not Address Critical Access to Dental Care Issues, Health Policy Resources Center Research Brief," American Dental Association, April 2013, pg. 4. Available from: http://www.ada.org/sections/professionalResources/pdfs/HPRCBrief_0413_3.pdf

and the purchasing of dental benefits must also be part of the conversation as these elements are all interrelated.

NADP has a litany of concerns related to decreasing the MOOP limit at this time, including:

- ***Full Coverage of Preventive Care at Risk***
- ***Reductions in Affordability & Coverage***
- ***Lack of Experience to Determine Impacts***
- ***Significant Dissimilarities from Typical Dental Employer Coverage***

Disruption in Pediatric and Adult Dental Coverage

***Full Coverage of Preventive Care at Risk*:** Prevention is the cornerstone to basic oral health. There are only two dental diseases – caries and periodontal disease, both of which are a 100% preventable. Dental coverage has historically focused on full coverage of preventive services, encouraging the establishment of a dental home and regular dental visits by eliminating consumer cost for preventive visits.

Current dental benefits typically cover preventive services at 100% and waive the deductible for preventive coverage. While pediatric dental preventive services in a stand-alone plan are not required to be covered at 100% by the ACA, carriers prefer to keep preventive services fully covered as it clearly impacts the identification and early treatment of both dental diseases.

The limited experience dental carriers currently have within the federal Marketplaces indicates premiums are the key factor in selecting dental coverage. Dental carriers are reporting the majority of new enrollees are purchasing low (70%) AV dental coverage on Marketplaces. In fact, some carriers are seeing a 2 to 1 preference for purchasing 70% AV policies in the individual Marketplaces. This suggests premiums should not be increased to accommodate any reduction in the MOOP. Rather, other factors, like deductibles, co-payment levels, or application of the deductible to preventive services will likely be adjusted. These adjustments will fall disproportionately on preventive care as co-payments for basic services were adjusted in 2014 to implement the MOOP for 70% AV level policies and many states prohibit cost sharing that is less than 50%. Significant increases in deductibles and the application of the deductibles to preventive services are potential results from the reduction in the dental MOOP.

- ❖ Milliman found the proposed reduction of the MOOP in FFM states will increase the deductible from $50 to $90 for 85% AV plans and from $50 to $95 for 70% AV plans to keep premiums at their current levels.

Another alternative would be the development of a catastrophic dental policy with a $300 individual or $400 family deductible paid out of pocket before any service is covered. If policy designs increase cost-sharing on prevention, regular office visits may be curtailed as most consumers have to pay some or all of the cost of preventive care out-of-pocket. Thus, the proposed MOOP could reduce rather than expand access to care for the covered population.

***Reductions in Affordability & Coverage*:** We understand the proposed change of dental MOOP limit is based, in part, on a study conducted for HHS by NORC at the University of Chicago and on the passionate concern of various stakeholders relating to overall affordability of pediatric dental benefits. These concerns have focused narrowly on one aspect of affordability, i.e. the addition of a consumer out-of-pocket expense limit for dental benefits in relation to the statutory medical out-of-pocket limit set by the ACA for medical carriers in all markets.

Affordability is a broader and more complex set of considerations. Affordability begins with the consumers' consideration of premiums, deductibles and co-payments when purchasing the benefit as these affect every consumer. The consumer maximum out-of-pocket however affects smaller segments of the population. Actuarial studies on medical MOOPs have found that 8% to 12% of those with medical insurance reach current medical maximums. Only 3% of children are expected to hit the 2014 pediatric dental MOOP. However, whether this is a high or low estimate and whether these children are in families that also hit medical MOOP is unknown. Experience with the current ACA MOOPs for medical and dental is needed to evaluate the number of consumers that might be impacted by having a dental MOOP in addition to a medical MOOP. Additionally, it should be recognized the medical MOOP applies in all markets, not just the small group and individual market served by Marketplaces. Thus, medical carriers have use of the full medical MOOP in the large group market where pediatric dental is not required.

- Milliman initially estimated 3% of the child population would hit a MOOP of $700 to $1000. They now estimate an additional 2%-5% of children would be expected to incur out-of-pocket costs equivalent to the new MOOP of $300/$400 (mostly for orthodontic needs). As a result the premium, deductibles or co-payment percentages will increase for the remaining 92% to 95% of children who do not hit the proposed MOOP.

Another factor in affordability is the availability of the Advanced Premium Tax Credit (APTC). NADP along with provider and consumer advocate groups have supported Senate efforts to press IRS for clarification on the availability of tax credits for dental coverage on the individual Marketplaces where the 2nd lowest cost silver medical plan on which APTC is based does not include pediatric dental.

NADP recently completed an analysis that found the 2nd lowest cost silver medical plan available in the largest population county or zip code in 33 states does not include pediatric dental. In addition 25 states have a medical plan without dental as the 2nd lowest cost silver plan in both the largest and smallest counties. Only 13 states have medical plans with pediatric dental in their largest and smallest counties. Thus, it is likely that the majority of consumers qualifying for subsidies are receiving tax credits only for their medical policies, not the value of pediatric dental when they purchase a pediatric dental policy. To assist in affordability for the low income populations, NADP urges HHS to pursue this issue further with the IRS so that consumers purchasing pediatric dental coverage have APTC support for that purchase.[4]

[4] NADP Issue Brief: Dental Benefits and Consumer Tax Credits within the ACA.

Consideration of any cost or plan design change must also be informed by the environment that HHS has created within Exchanges for the purchase of the pediatric dental benefit. Rather than require the purchase of pediatric dental benefits by consumers that are covering children through the Marketplaces as have Kentucky, Nevada and Washington, HHS has ruled pediatric dental coverage to be voluntary in the Federally-facilitated Marketplaces. The voluntary nature of the benefit increases the sensitivity of consumers to premiums, deductibles and co-payment levels.

Even small changes in these costs can result in consumers foregoing pediatric dental coverage unless it is critically needed, thereby creating adverse selection. Adverse selection results in higher premiums based on the experience of a group with higher than usual dental needs. Higher premiums create a downward spiral of fewer with coverage—the opposite result of what is being sought. The low uptake of pediatric dental in Exchanges despite the fact that most Marketplaces have few policies embedding pediatric dental coverage could indicate that adverse selection is already in play. At least one year's experience is needed to determine whether this is the case.

Lack of Experience to Determine Impacts: Changing the consumer out-of-pocket maximum is premature. NADP members represent the majority of participating dental plans offered on the federal and state Marketplaces. They report extremely limited enrollment—in the hundreds or thousands per carrier—not the tens or hundreds of thousands that would be needed to get to the estimate of three million children with new pediatric dental coverage by 2018.

Carriers are just beginning to receive complete 834s and technical issues continue to impact enrollment data. Marketplaces need to understand consumer purchasing behavior in 2014 prior to changing the rules for coverage.

A better understanding of experience from the first year of enrollment is needed before significant and disruptive changes are made to current coverage. While the Milliman analysis is worrisome for the impacts of a $300/$400 MOOP limit, experience could illustrate the appropriate limit to strike a reasonable balance of protection from catastrophic out-of-pocket costs and overall affordability for the vast majority of insured families.

Stability is needed to develop experience before changes are made. A change at this time requires redesigning coverage and filing new policy forms for 2015 even before the first month of coverage experience is mature enough for actuaries to be confident in their projections. Data is critical to better understand a consumer's experience and provide them with a tailored plan design at the right price point for their needs.

Significant Dissimilarities from Typical Dental Employer Coverage: HHS's charge in developing the EHB Package is to "parallel typical employer coverage." The Department of Labor provided a report on typical benefits including dental coverage in April 2011 which found that the employer dental plan

design is a dental PPO with 100/80/50 cost sharing[5] and a $50 deductible. This deductible is commonly waived on prevention and diagnostic benefits—making semi-annual visits to the dentist at no cost for consumers.

ACA regulations on pediatric dental coverage have already resulted in significant departures from typical employer coverage as evidenced by increasing deductibles and consumer co-payment levels. Given the known consumer sensitivity to premiums, most dental plans will look to further adjust deductible or co-payments on benefits rather than further increase premiums. In many medical policies that NADP has examined in the Marketplaces, particularly at the Bronze level, applying the full medical deductible to pediatric services is common. This is a path that could be adopted by stand-alone dental carriers to adjust for a decrease in the MOOP limit. The result would be coverage that is catastrophic, the opposite of dental coverage's focus on prevention and early treatment.

Unlike medical policies, the requirements for no annual maximums, AVs and MOOP being applied to pediatric dental in both the Marketplaces and the small group/individual market do not impact the large group market. A shift to catastrophic dental plan designs with the first $300 or $400 being paid out-of-pocket by consumers would increase the disparity between coverage on the Marketplaces and the large group market where typical dental coverage provides 100% reimbursement of preventive care. If small group purchasers both in the SHOP and outside of the Marketplaces embrace the catastrophic pediatric dental benefit, the result could be a benefit which provides access to dental care for primarily the 5% to 7% of children with high dental needs and little to no improvement in access for 92% to 95% of children with routine dental care needs.

Another departure from typical employer coverage and the proposed dental MOOP is the increase of the family MOOP limit by only $100 or 33% to $400 over the $300 dental MOOP limit for an individual child. Actuaries recommend a family MOOP that is 2 to 3 times the limit for one child. Current medical and dental MOOPs under the ACA are both two times the single child amount for families. There is no reasoning or support provided for the limited increment proposed for families in the proposed pediatric dental MOOP.

***Disruption in Pediatric and Adult Dental Coverage*:** The disruption of dental policies purchased on Marketplaces in 2014 for enrollees and their dentists is another negative impact of a reduction in the dental MOOP. Changing the MOOP will require all dental policies to adjust pricing and/or plan design. Thus consumers may not be able to continue with the policies they have recently obtained. If networks are narrowed to adjust to the lower limits, they may also not be able to keep their current dentist.

In addition, the radical changes to pediatric coverage will have a negative impact on the continuation of adult coverage. While overall out-of-pocket costs are critical for low income consumers, premiums are what drive most consumer purchases. NADP internal research indicates that when premiums increase,

[5] 100/80/50 is industry shorthand for the level of payment by the carrier for categories of coverage in a dental PPO, i.e. 100% coverage of prevention and diagnostic services like cleanings, x-rays and sealants; 80% coverage on basic services like fillings, and 50% coverage of major services like crowns.

adults are likely to purchase coverage for their children and forego their own and therefore family coverage.

- Milliman's analysis reports the decrease in the MOOP limit for a national average 70% AV plan, will result in a 5% increase in premium--$55.30 annually for a family with two children. This analysis is based on a theoretical plan design that meets current requirements for the FFM states. Head actuaries of at least two of our largest members are estimating increases of 15 to 17 percent for actual benchmark dental plans they are currently offering in a number of state and federal exchanges at lower premium rates. Whether actual premium impacts occur at the Milliman projected amounts, or the higher range predicted by our members, both are in a range that could result in a significant decrease of enrollees purchasing voluntary dental coverage.

NADP estimates 43.7 million individuals are covered in the small group market—including 22.9 million children[6]. NADP's consumer surveys show that up to 8% of adults would drop their dental coverage if they can just cover their children, In addition as many as 21% of adults would drop if the cost of coverage rises by $75 a year. The percentage of adults that would drop coverage rises to 26% if the cost increases $100 a year. For a family purchasing a 70% AV policy, the total premium increases from the combination of annual utilization adjustments and the proposed reduction in dental MOOP will be in these ranges. This translates to the potential for 6 to 7 million[7] adults dropping dental coverage in the small group and individual market—a greater number than the most optimistic estimated increase in children with private coverage through Marketplaces and small group coverage.

In relation to the decrease of the MOOP limit to a standard $300/$400 rate within the proposed rule, NADP proposes the following:

- **RECOMMENDATION:** HHS should continue the current standard of a "reasonable" dental maximum out-of-pocket limit for 2015 so that experience can be gathered to examine appropriate dental MOOP levels. This would coincide with HHS's EHB Final Rule which requires the benchmarks to remain stable during a two year transitional period[8]. Dental MOOP can be reevaluated for 2016 when experience is available and alternatives can be discussed with all stakeholders.

- **ALTERNATIVE:** One alternative that should be examined for low income consumers is a parallel system of cost-sharing reductions of the dental MOOP under Sec. 1402. The special rule for pediatric dental in Sec. 1402(c) (5) simply prohibits the portion of cost-sharing reductions (CSR)

[6] Estimate is based on 2009 enrollment data which is roughly comparable to today's market.
[7] The 8% that would drop if their children can be separately covered is 1.6 million adults. The 21% to 26% that would drop based on cost increases for coverage range from 4.4 million to 5.4 million adults.
[8] "We proposed that the state's benchmark plan selection in 2012 would be applicable for at least the 2014 and 2015 benefit years and stated that we intend to revisit this policy for subsequent years. This two year transitional period accommodates current market offerings and limits market disruption in the first years of the Exchanges." Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, Final Rule; Federal Register, Vol. 78, No.37, February 25, 2013, p.12841.

applicable for standalone pediatric dental from being applied to a QHP when a consumer enrolls in a QHP without pediatric dental, and therefore CSRs could be applied to dental benefits.

ELIMINATION OF DENTAL AV LEVELS

If HHS reduces the MOOP as prescribed in the proposed rule, AV levels would have to be removed as they would be difficult to meet under the new MOOP requirement. However, eliminating AV levels will remove a critical tool which assists consumers in choosing their dental benefit by differentiating dental policies.

- **RECOMMENDATION:** NADP recommends postponing the elimination of dental AV levels as well as postponing any reduction in the MOOP.

FEDERAL V STATE GUIDELINES

The proposed rule suggested requiring a federal standard MOOP limit be used in both state and federal Marketplaces.

- **RECOMMENDATION:** State flexibility should remain along with the current guidelines for pediatric dental MOOP so experience can be developed and analyzed at multiple MOOP levels.

- **ALTERNATIVE**: Since the current MOOP limit of the Federally-facilitated Marketplaces is predominant across the states, $700/$1400 could be set as the single federal standard for 2015 to reduce administrative costs in complying with multiple AV requirements and gain consistency and experience to examine future MOOP levels.

EMPLOYER & EMPLOYEE CHOICE

The proposed rule suggests allowing an employer to decide whether to choose a dental policy for their employees, or permitting the employees to elect their dental carrier. Unlike medical policies, dental is a voluntary benefit in the Marketplace including SHOP, and in most states there are more dental carriers on the Marketplace than medical carriers. These factors combined will negatively impact the rating of SHOP dental policies if employee choice is allowed for pediatric dental.

In addition, billing experience by our members suggests that the complexity of employee choice for employers, the federal government as the administrator, and in turn the issuers, will be dramatically more complex than employer choice. We strongly recommend employee choice not be implemented until the SHOP is stable and has at least a year's operational experience before implementing the employee choice approach to benefit offering.

- **RECOMMENDATION:** For 2015 employers should select a specific dental carrier for their employees. By allowing employee choice, SHOP policies become individual products and priced accordingly, i.e. more expensive. Once more experience is developed; the issue of employee choice for dental can be revisited.

COMPOSITE RATING

HHS proposes to prohibit composite rating in the FF-SHOPs when an employer selects the employee choice option within a level of coverage. The proposal requests comments on whether this prohibition should also be extended to standalone dental plans, how it affects current market practices for dental plans, whether the prohibition should apply to all SADP offering methods or just when an employer chooses to offer more than a single SADP, as well as how such a prohibition would affect choice and competition in the small group dental market.

Composite rating is used in the SADP market for groups that offer a single SADP. It is only appropriate where the employer group can provide a census of enrollees and there is consistency in the demographics of that group over time.

- **RECOMMENDATION:** NADP supports the prohibition of composite rating in the instances where **employee** choice is the option selected by the employer on the SHOP.

As stated in the beginning of our comments, due to the timeframe of the comments, NADP may forward additional analysis and recommendations. We greatly appreciate this opportunity to provide our expertise, and look forward to working together to improve access to affordable and quality dental care through expansion of pediatric dental benefits.

For any follow up, please contact NADP's Director of Government Relations, Kris Hathaway at khathaway@nadp.org or (972)458-6998x111.

Sincerely,

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