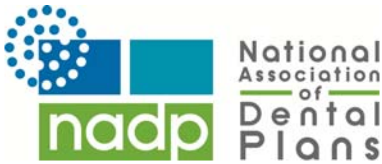

January 17, 2016

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Andy Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Ave., SW
Washington, DC 20201
Sent via FFEcomments@cms.hhs.gov

Re: Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces

Dear Administrator Slavitt,

The National Association of Dental Plans (NADP) appreciates the opportunity to provide comments on the *Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces* (Letter) released on December 23, 2015. Much of what is included in the Letter to Issuers originated from the December 2, 2015 *Notice of Benefit and Payment Parameters* (NBPP) proposed regulation. Our comments on the proposed Notice are attached as they still remain a critical concern to the dental benefits industry.

Ch.2 Sec.3 Network Adequacy / Federal Default Standards: The mileage and timing standards as proposed for dental providers is appropriate and a feasible option as a network adequacy metric for the FFMs. As network adequacy standards are not typically utilized within the dental benefits industry, NADP requests a year delay with any application of new measures for Plan Year 2018. In addition, the continued availability for written justification on rare instances when the CEAC may not be attainable is appreciated. CMS must also be cognizant when applying new network adequacy metrics to minimize confusion of differing standards with each state amid the markets for both consumers and issuers. **Recommendation**: Dental plans need additional time to assure their network systems can incorporate these new administrative metrics and geographical access mapping software can correctly identify and utilize the five listed categories.

Ch.2 Sec.4 Essential Community Providers (ECP): The ECP standards were designed for medical providers where ECPs are more common than in the dental provider community. While dental plans continue to work towards increasing networks with ECPs, the medical ratio of 30 percent remains a difficult target. There are few incentives for dental providers to apply and be listed as an ECP, and providing deadlines for their participation is unreasonable. If CMS collects the write-in providers as included by dental plans and adds them to the full ECP list, or contacts the

providers to encourage participation as an ECP that would go a long way towards reaching a 30 percent target. In addition, CMS should allow for different ECPs located in different locations be counted separately regardless if they work for one company; currently, the location of the company's headquarters is the only location allowed to be utilized. **Recommendation**: Until CMS initiates a proactive strategy in this regard, CMS must continue to allow the write-in process by carriers without an unnecessary deadline on providers to petition in becoming an ECP. In addition, the ECP template needs to remain separate from the main network template.

Ch.2 Sec. 15 Data Integrity Tool: The data integrity tool does not pull all dental-related errors, such as the dental maximum out-of-pocket calculation. **Recommendation**: A separate tool for dental should be considered or adjustments related to the dental data should be corrected immediately.

Ch.4 Sec.4 Display of Adult Dental Benefits Icon: The Letter explains that for an icon to correctly display an adult dental benefit, the dental policy must have services in all three categories of Routine, Basic and Major. While the requirement is understandable for the pediatric dental Essential Health Benefit (EHB), adult dental is under the purview of the state insurance agency, who decides what non-EHB policies and benefits are appropriate for offering in their state. In addition, pediatric dental is based on a benchmarking tool chosen by the state; adult dental does not have a benchmark. Carriers are offering a variety of adult benefits on FFMs and many consumers are interested and purchasing preventive-focused benefits, in which there are not services included in the Major category, which the consumer may not want or need. The FFM should continue to offer and display a variety of dental options so consumers can best choose the coverage that is most beneficial to their oral health needs. **Recommendation**: CMS must correct the dental icon and continue allowing for flexible, affordable adult dental benefits on FFMs.

Ch.6 FF-SHOP: Recommendation: Carriers need termination transactions instead of utilizing switch files, which add the potential for mistakes.

Ch.7 Sec.3 Meaningful Access: As our consumers, dental plans appreciate and support Limited English Proficient (LEP) individuals. We encourage and educate our LEP clients to use telephonic oral interpretation services as a matter of our routine business practices and in accordance with state based requirements. Telephone service is simple for consumers and affordable for issuers.

Per the 2015 Notice of Benefit and Payment Parameters which are reiterated in this year's NBPP and Letter, CMS is requesting taglines in the top 15 languages of a state be added to multiple documents. NADP examined the Census Bureau 2013 data tables from the American Community Survey (ACS) 2009-2013 which tracks not just the population speaking another language but whether those speaking another language are proficient in English. Only those individuals that are not proficient in English would need taglines in another language. Based on that data, only Hawaii has more than three languages where one percent or more of the population that speaks a language other than English is not also proficient in English. Most states have only two languages. In Texas, the 13 additional languages (other than English and Spanish) that would be required for taglines represent only 1.32% of the population.

Tracking different languages for different states across multiple documents is a costly administrative burden; multiple systems must be reprogramed for compliance. Some national companies estimate that the first year's compliance will be more than a million dollars with subsequent years tracking and updates costing hundreds of thousands annually. The mandate will greatly impact dental premiums – a voluntary benefit which needs to remain affordable. Few people will be served by the burdensome requirement of printing taglines on materials in the Top 15 languages, but everyone will see the cost in higher premiums to cover additional administrative cost.

Recommendation: CMS should limit the required taglines to websites and rely on the languages spoken in call centers to serve LEP consumers. If taglines are required on documents, those taglines should be limited to languages where 1% or more of the population speaks a language other than English and is not proficient in English. In addition, this requirement should not be applied to off-Exchange certified dental plans as they will have already met a state's requirement and must be able to compete on the same playing field as commercial policies offered on the private market.

In addition to the new issues raised above, NADP remains concerned with the requirements in the Letter introduced in the Notice of Benefit and Payment Parameters regulations, which NADP commented on in the attached letter. Brief highlights of our **recommendations**, included:

Dental Maximum Out of Pocket §156.150:

- The consumer dental index baseline should be initiated from 2014.
- The methodology needs to be clear that CPI increments are cumulative starting from January 2014 and not renewed each year.
- Any change to the MOOP calculation and methodology must also be applied to dental plans seeking off Exchange certification.

Network Adequacy §156.230

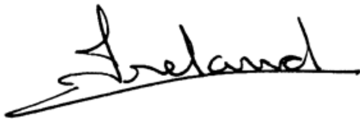
- NADP broadly recommends the NBPP network adequacy requirements not be placed on dental plans and allow the states' oversight of insurance issuers to continue.
- Network requirements should be applied the same regardless if the policy is an SADP or a dental network embedded within a QHP.
- Dental plans should not have to provide written notice to enrollees 30 days prior to the discontinuation of a provider if an enrollee is seen on a regular basis by the provider. This standard will be unmanageable and extremely costs for dental PPOs, as a consumer can choose and change providers at their will and "regular basis" would be very difficult to define in the dental space.
- Network requirements should not be applied to off-Exchange policies, as these should remain under state purview.

Enrollment Data: NADP continues to be concerned over the lack of transparency in reporting dental plan enrollment. In the latest Exchange enrollment numbers, separate dental selections were released; however, state specific information was not included. CMS has yet to release 2014 and 2015

effectuated enrollment which is the most critical data point, as purchase of dental is voluntary, unlike medical. **Recommendation**: CMS needs to provide timely dental updates on the purchase of pediatric dental, whether embedded in a medical plan or offered separately through a dental plan, effectuated AND selected, and with age and geographical groupings.

NADP appreciates the opportunity to provide our comments to the Draft 2017 Letters to Issuers as it relates to dental plans, and is thankful for the continued support from CMS staff. We look forward to future discussions. If you have any questions, please direct them to NADP's Director of Government Relations, Kris Hathaway at (972)458-6998x111 or khathaway@nadp.org.

Sincerely,



Evelyn F. 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 dental plans and dental indemnity products. NADP's members provide dental benefits to more than 90 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.

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December 21, 2015

Andy Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Humans Services
P.O. Box 8016
Baltimore, MD 21244-8016
Sent via www.regulations.com

Re: **CMS-9937-P**; Notice of Benefit and Payment Parameters for 2017

Dear Administrator Slavitt,

The National Association of Dental Plans (NADP) appreciates the opportunity to provide comments on the proposed Notice of Benefit and Payment Parameters for 2017 (NBPP) as published in the Federal Register December 2, 2015. NADP appreciates the multiple issues the NBPP addresses and is commenting on those areas that specifically impact our dental plan members. Our comments include recommendations we believe are critical in developing quality and affordable dental policies for consumers.

DENTAL MAXIMUM OUT OF POCKET §156.150: The NBPP proposes tying the annual maximum out of pocket (MOOP) limit to the consumer price index for dental services (dental CPI). The amounts will increase by multiples of 25 dollars, with the dollar modification for one child doubled for two or more children. Current regulations set the dental MOOP at $350 per child and $700 per family but have not included a method for increasing this cost, whereas the Affordable Care Act established the medical MOOP and included a specific formula for its increase over time.

Recommendation:

NADP supports the proposal; however, there are several factors which need to be clarified in the NBPP prior to adoption:

- The consumer dental index baseline should be initiated from 2014. This will parallel the initial medical baseline as well as provide an increase to the MOOP sooner. It will take a significant increase of the MOOP if CMS wants to promote coverage with no cost sharing for preventive and diagnostic services at a 70 percent AV level as mentioned in the preamble.

National Association of Dental Plans
12700 Park Central Drive • Suite 400 • Dallas, Texas 75251
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- The methodology needs to be clear that CPI increments are cumulative starting from January 2014 and not renewed each year; i.e. for 2016 filings which carriers file mid-year in 2015 (through their respective Departments of Insurance), they will review the increase of the dental CPI of January 2015 from January 2014 for their calculation. Issuers need the ability to accurately estimate the increase per year for their filings.

- Any change to the MOOP calculation and methodology must also be applied to dental plans seeking off Exchange certification.

NETWORK ADEQUACY §156.230: The NBPP proposes multiple new network adequacy requirements for Qualified Health Plans (QHPs) on the Federally-facilitated Exchanges (FFE). The regulations specify two requirements CMS is considering applying to Stand Alone Dental Plans (SADPs) but offers comments on applying other requirements. CMS also asked for comments on applying other QHP network mandates to SADPs and whether CMS should require their network standards on all QHPs (and SADPs) regardless if they are on the FFE.

Recommendation:

There is an increase of scrutiny on health plans as they develop new policies which offer narrow networks to better manage costs. This type of network design is not generally consistent with the structure of the dental industry, and we have not seen issuers narrowing dental networks. The NBPP also addresses continuity of care and balance billing within this section, both of which are also non-issues within the dental industry.

NADP recommends the NBPP network adequacy requirements not be placed on dental plans and allow the states' oversight of insurance issuers to continue. It is within their purview and a state's right to adopt network adequacy requirements for carriers operating in their states. Adding an additional layer of federal review is unnecessary and causes administrative chaos while increasing costs with no clear benefit.

- One of the two proposals CMS requested comment on is application of a notification requirement to dental plans. Issuers will need to provide written notice to enrollees 30 days prior to the discontinuation of a provider if an enrollee is seen on a regular basis by the provider. Within a DHMO, this action is necessary and consistent with current practice as enrollees are assigned to a provider; however, in a DPPO a consumer can choose and change providers at their will and a "regular basis" would be very difficult to define in the dental space. Dentists can prescribe bi-annual or annual visits with 'ongoing' treatment usually taking less than a month or just a few visits. Currently, the dentist is aware of which patients are enrolled in a carrier's plan and will notify those enrollees when they leave a network.

  This type of notification is not provided by dental plans today and would be very difficult and expensive to implement. The cost estimate provided for QHPs would be much higher for SADPs due to the relative cost of premium, which was not estimated in the NBPP. Additional time for comments would be necessary for NADP to provide an accurate calculation.

- Another section on continuity of care also requires issuers to pay at in-network levels during active treatment should a provider be terminated without cause, and continue to do so until the treatment is resolved or 90 days – whichever is less. The NBPP proposes defining 'active treatment' with four different scenarios that are related to emergencies, which does not incorporate dental services. Dental plans already have continuity of care clauses within their filings as dentists are required to complete a course of treatment or episode of care that begins prior to termination, thereby making this requirement redundant and unnecessary.

- The second proposal applied to dental plans is related to balance billing. CMS requests issuers provide notices to enrollees when there is a possibility of charges from an out-of-network provider at least 10 business days prior to the benefit being provided.

  There are no general circumstances in which enrollees of a dental plan would be faced with out-of-network billing. Dental emergencies or procedures done within a hospital or facility are covered by medical insurance. Orthodontia is a potential add-on policy but not required as an Essential Health Benefit, and those costs are always discussed prior to moving forward with treatment. Per discussion by the National Association of Insurance Commissioners, dental plans should be exempt from requirements related to hospital and facility services.

Additional Network Adequacy Standards: The NBPP includes numerous network requirements for QHPs and request comments on whether they should be applied to dental plans. As CMS evaluates these mandates and applicability to SADPs, the Agency should consider:

- Dental network standards or requirements should be applied consistently regardless if the policy is an SADP or a dental network embedded within a QHP. From a dental network administration perspective, a carrier's dental network supporting Essential Health Benefits (EHB) is the same, and rules should be equivalent in order to maintain a level playing field for carrier's networks supporting dental EHB in both SADPs and QHPs.

- Network requirements should not be applied to coverage offered on the commercial market, and should remain under state purview. Application to these policies would place an unfair advantage between dental plans in the private market and issuers offering off-Exchange certified dental policies. In addition, it will cause unnecessary administrative challenges when determining state regulations versus federal regulations, Exchange requirements versus the commercial market, and tracking requirements which apply to EHB coverage and dental policies that do not offer these benefits.

- The NBPP requested feedback on metrics for network standards. Currently, there are no network standards within the dental industry and very few states require time or distance standards. These types of requirements are usually considered after complaints are filed with the state, which has not been the case with dental networks. A factor unique to dental networks is many dentists perform specialty services, but are typically counted as 'General Dentists' for network adequacy calculations. NADP is working with states that are interested in dental requirements to make sure

they are appropriate to the industry in which ratios would be different for both dentists and dental specialists.

Exchange Functionality: Throughout the NBPP, CMS offers additions and changes to the Marketplaces which have a direct impact on issuers operating on those Exchanges. Dental plans within Exchanges are essential - consumer surveys continue to illustrate the importance of having those options, as well as the capacity to earn revenue for the Exchanges. CMS must keep in mind the importance of dental plans and the particular impact the NBPP regulations could have on the industry. Following are recommendations from the dental plan industry:

Recommendation:

- **Selective Choice (preamble):** Within the NBPP preamble, CMS requests feedback on allowing FFE states to become selective contractors, allowing them to choose which issuers can offer plans within their states. NADP opposes this suggestion due to the multiple complexities it creates. If there are rotating issuers on an Exchange how would enrollees be transferred from different issuers each year? Issuers do not have the capacity to negotiate with each individual state; they would need to concentrate on populous states, leaving smaller states with less options and competition. At this time, CMS should continue to encourage issuers to remain on Exchanges. If there have been complaints from consumers on too many options, then consider adding additional consumer tools or slightly limiting the policies offered; selective contracting would not be the answer to this issue.

- **User Fees §156.50**: As CMS considers a new State Based Exchange-Federal Platform (SBE-FP) to allow greater flexibility for states, there is a potential for duplicative user fees from CMS, healthcare.gov and the state leasing the platform. NADP encourages CMS to be cautious with this issue as these types of additional costs increase premiums overall.

- **Essential Community Providers (ECP) §156.235**: While the NBPP does not change ECP requirements, NADP encourages CMS to continue its flexibility and allowance for justification as dental issuers cannot meet the current ECP ratios. As noted in our August 4, 2015 comments, it has been difficult to encourage dental ECPs to join networks, and dental plans have provided documentation to CMS on their efforts. NADP advocates for continued review of the dental ECP listing and flexibility on this issue as CMS waits for additional data collection.

- **Open Enrollment §155.410**: Per the NBPP, NADP encourages CMS to shorten the enrollment period to end on December 15. From discussion with issuers, enrollees who purchase coverage after the December 15 deadline for coverage starting on January 1 are less likely to pay the premium. An extended open enrollment does not equate to additional effectuated enrollees. While NADP supports a shorter enrollment period, this must be accompanied with adequate time frames for plan certification and plan preview.

  Each year there are new features within the FFE and the response rate on problem tickets continues to be problematic for dental plans. Just this year, dental plans were informed at the conclusion of plan preview that a new dental icon was put into place that would erroneously

display certain dental policies. While a sentence describing the error was included on the consumer-facing portal, the issue was never resolved nor have we been informed how CMS will address the issue for 2017 plans. These perpetual bumps in the road are concerning and even more so with inadequate plan preview time and dental ranking low on the priority list of technical fixes.

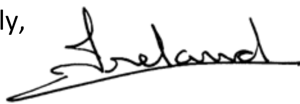
- **SHOP Vertical Choice §155.705**: The NBPP has proposed a vertical option for employees within the Small Business Health Options Program (SHOP) in which an employer can choose a carrier and offer all metal levels to their employees. Comments are invited on this proposal as well as allowing states to determine whether they want to offer this option within their SHOP. NADP approves of providing broader options and offering a vertical choice for employees but opposes allowing individual states to opt in or out of this option. The FFE-SHOP needs to remain as streamlined as possible to contain costs and lessen administrative mistakes by issuers, states and CMS.

- **Notice of Errors §156.1256**: The NBPP proposes when a display error occurs, the issuer should be responsible for the error and allow for a special enrollment period to the enrollee. While that is understandable, it should be clear this only applies to issuer error; if the error is due to the lack of a response from a vendor, regulator or an IT error that the issuer could not correct within CMS or state timeframes, this cannot be required of issuers.

- **Enrollment Data**: While not part of the NBPP, NADP continues to be concerned over the lack of transparency in reporting dental plan enrollment. NADP encourages CMS to provide effectuated (in addition to selected) enrollment by state, age group, and embedded versus separate dental policies to parallel the data offered regarding QHPs.

NADP appreciates the opportunity to provide our comments to the NBPP as it relates to dental plans, and is thankful for the continued support from CMS staff. We look forward to future discussions. If you have any questions, please direct them to NADP's Director of Government Relations, Kris Hathaway at (972)458-6998x111 or khathaway@nadp.org.

Sincerely,



Evelyn F. Ireland, CAE
Executive Director

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