November 27, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Attention: CMS-9930-P; Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019; Proposed Rule (45 CFR Parts 147, 153, 154, 155, 156, 157 and 158)

Dear Administrator Verma,

On behalf of the American Dental Association (ADA) and its 161,000 members, and the American Academy of Pediatric Dentistry (AAPD) and its 10,000 members, we appreciate the opportunity to comment on the proposed rule, CMS-9930-P, the Notice of Benefit and Payment Parameters for 2019.

§155.21 Navigator Program Standards
Navigator programs established under the Affordable Care Act (ACA) that receive grant awards were designed to conduct public education activities to raise awareness of the availability of qualified health plans (QHPs), distribute fair and impartial information regarding enrollment in QHPs and tax credit availability, and facilitate enrollment. Understanding a plan’s benefits as well as cost, including premiums and additional out-of-pocket costs, can be challenging for many consumers and is an important part of selecting an appropriate health insurance coverage option. Individuals with limited English proficiency, low health literacy, physical or cognitive disabilities, and those with limited access to computers may require additional assistance. On average, it takes 90 minutes to help consumers enroll for the first time and 60 minutes to help renewing consumers.¹

The proposed rule seeks to remove the existing requirement that each Exchange have two navigator entities, with one being a community and consumer-focused nonprofit group. The rule also proposes in §155.210(e) (7), to eliminate the requirement that each Navigator maintain a physical presence in the Exchange service area where assistance can be provided in-person. We believe this proposed change will limit consumers’ abilities to take advantage of coverage that may be available, including pediatric dental services. We support maintaining the current Navigator standards and funding, including the requirement for a physical presence to support in-person assistance to ensure consumers have access to necessary assistance as they select their medical and dental plan coverage.

Oral health is an essential part of an individual’s overall health and tooth decay remains one of the most common, chronic childhood diseases. Coverage for dental services can provide necessary preventive and oral health education services that may prevent and manage disease. Our organizations have addressed the need to maintain and improve pediatric oral health services as part of the essential health benefits requirements included in the ACA in many of our comment letters. As part of the implementation process, HHS recognized that the employer market typically provides coverage for dental services through separate plans and required states to choose a supplemental plan as part of the benchmark plan if pediatric dental services were not part of the benchmark plan selection. All but one state opted to choose between the supplemental options, the Children’s Health Insurance Program (CHIP) or the Federal Employees Dental and Vision Insurance Plan (FEDVIP), which provide comprehensive benefits for children. Pediatric oral health coverage can be offered within a QHP or separately, through a stand-alone dental plan (SADP). It is a complex set of options and many consumers do not fully understand their benefit options, including out-of-pocket costs and coverage limitations.

The proposed rule would allow states three new options to alter their essential health benefit (EHB) benchmark: states could select another state’s 2017 benchmark; states could select one or more EHB categories from another state’s 2017 benchmark; or states could select an EHB benchmark plan equal in scope to a “typical employer plan” (but no more generous than specified comparison plans). Our organizations have concerns regarding the proposed rule’s stated definition of a typical employer plan. The rule proposes to define “typical” as a small or large employer plan sold in one or more states with enrollment of at least 5,000 enrollees; or a self-insured group health plan sold in one or more states with enrollment of at least 5,000 enrollees. We are concerned that this proposed definition may lead to the selection of benchmark plans that have limited or less than comprehensive coverage for pediatric oral health services.

For example, we have previously expressed concern over Utah’s benchmark selection of a state employee health plan. The plan provides only limited pediatric dental services including routine exams, X-rays, cleanings and sealants. The plan does not provide coverage for restorative services such as fillings or root canals, which may be necessary to treat and manage dental disease. Additionally, Colorado, Michigan and Arkansas do not provide coverage for medically necessary orthodontia in their benchmark plans. Orthodontia may be part of a treatment plan for a child who has undergone surgery for a cleft lip and/or cleft palate, as an example. Our organizations support the offering and availability of comprehensive dental services as part of the EHB as intended under the ACA.

The proposed rule allows states to limit their EHB package, as outlined in §156.115, yet requires states to defray costs for any EHB package that is more comprehensive or provides for coverage of a new or necessary treatment. We believe this will restrict benefit designs and offerings, potentially adversely impacting pediatric dental coverage. The rule also proposes that for plan years after 2019 states may be limited to a new, federal default EHB definition and would be required to defray any additional costs. We are concerned this proposal will incentivize states to adhere to minimal benefit packages, which may exclude access to necessary services.

3 Patient Protection and Affordable Care Act Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, CMS-9980-P. Submitted December 19, 2012 to CMS.
such as restorative dental benefits, dental anesthesia or other services. If the purpose of this proposal is to grant states greater flexibility to choose their benefit packages, we believe states should also be able to add benefits as deemed necessary without having to defray the costs.

§156.150 Stand Alone Dental Plans (SADPs)
In the final rule on EHBs in 2013, HHS finalized the requirements for the calculation of actuarial value (AV). SADPs are required to adhere to a low AV of 70 +/- 2 percentage points or a high AV of 80 +/- 2 percentage points. The proposed rule is seeking to eliminate AV requirements for SADPs to facilitate additional flexibility around plan design but maintain the annual limits on cost-sharing. Our organizations are concerned that this will negatively impact the benefit design and suggest that a minimum AV of 70 percent remain in place for SADPs. We recognize the challenges of designing a dental benefit plan within the existing parameters but believe that a balance can be made that will provide an affordable benefit which includes both preventive and restorative services.

We are concerned that the proposed elimination of AV standards would impact the consumer experience when considering marketplace plans and inhibit the ability of consumers to understand the value of a plan. Additionally, we believe without a minimum AV threshold, benefit designs may shift in a manner that will reduce the overall benefit in an effort to reduce costs, leaving consumers with less than comprehensive benefits such as in the previously stated example of Utah’s plan.

§156.230 Network Adequacy
The ADA and AAPD support network adequacy standard requirements for both SADPs and medical plans with embedded pediatric dental coverage, specifically focused on adequacy of in-network pediatric and general dentists. Timely access to dental services for children and families can help prevent dental disease as well as address emergencies, including children experiencing dental pain and/or infection. While we appreciate the effort to continue to provide increased flexibility to states, including allowing states to review plan network adequacy standards, we are concerned that the continued use of the “reasonable access standard” may be inadequate to ensure all children have access to an appropriate provider for pediatric dental services. This concern is even greater among more vulnerable children who may live in rural or less populated areas or for children with special and/or complex health care needs.

The proposed rule would permit states that do not have the authority to conduct sufficient network adequacy reviews to rely on an issuer’s accreditation. Unaccredited issuers would be permitted to submit an access plan that has standards at least as consistent as those included in the National Association of Insurance Commissioners (NAIC) Health Benefit Plan Network Access and Adequacy Model Act. The NAIC model act does not address network adequacy standards for dental plans. We remain concerned that issuers may not meet a reasonable access standard that ensures access for all pediatric patients. We request that CMS provide clarification in future rulemaking that every QHP and SADP that offers pediatric dental coverage in the marketplaces include a range of dental providers, including pediatric dentists and other dental specialists. We also request that CMS clarify how the agency will determine that networks are sufficient and that networks contain sufficient numbers and types of providers to assure that all services will be accessible to enrollees without unreasonable delay.

§156.235 Essential Community Providers
The ACA included requirements for issuers of QHPs and SADPs to include a sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income,
medically underserved individuals in the plan’s service area. The proposed rule reduces the requirement for issuers to contract with available ECPs from 30 percent in a service area to 20 percent. ECPs include rural health clinics, safety-net and children’s hospitals, community health centers, and other safety-net entities that provide care to underserved and vulnerable individuals. We urge CMS to reconsider the proposed 10 percent reduction to ensure that individuals have access to a wide range of ECPs to help ensure that timely and necessary oral health services are available without delay for all patients.

Other Considerations

The proposed rule seeks comment on ways in which HHS can foster market-driven programs that can improve the management and costs of care that provide consumers with quality, person-centered coverage. As previously stated to the agency, the ADA and AAPD support the requirement for quality improvement from SADPs and plans providing dental benefits. The Dental Quality Alliance\(^5\) officially endorsed a set of pediatric oral health measures in 2013 that are applicable across public and private programs. The measures closely align with CMS’s oral health strategy and have been endorsed by the National Quality Forum. As the agency moves forward with incorporating additional quality improvement strategies (QIS), we urge the use of DQA-endorsed measures as well as encourage the agency to rely on the expertise of the DQA when implementing any QIS or additional quality requirements for oral health services and dental benefit plans.

We appreciate the opportunity to provide comment on the proposed rule. Should there be any questions, please feel free to contact Ms. Janice E. Kupiec with the ADA, kupiecj@ada.org, or Mr. C. Scott Litch with AAPD, slitch@aapd.org.

Sincerely,

/s/ Joseph Crowley D.D.S.  
President  
American Dental Association

/s/ James D. Nickman D.D.S.  
President  
American Academy of Pediatric Dentistry

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\(^5\) The Dental Quality Alliance (DQA) was established by the ADA at the request of CMS and is a collaborative partnership of more than 30 entities interested in advancing performance measurement to improve oral health, patient care and safety.