December 18, 2014

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9944-P
P.O. Box 8016
Baltimore, MD  21244-8016

Via Electronic Submission

**RE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Proposed Rule (45 CFR Parts 144, 146, 147, et al.)**

Dear Administrator Tavenner:

On behalf of the American Dental Association (ADA) and its 158,000 members and the American Academy of Pediatric Dentistry (AAPD) and its 9,300 members, we appreciate the opportunity to comment on the proposed rule, CMS -9944-P, the Notice of Benefit and Payment Parameters for 2016.

**155.335 Annual Eligibility Redetermination**

The rule proposes to alter the re-enrollment process by allowing consumers to opt-into a re-enrollment hierarchy, at the time of initial enrollment, which would allow the consumer to be re-enrolled into a low-cost plan by default for the subsequent year.

**Comment:** We are concerned that this may negatively impact the ability of consumers to maintain dental coverage for themselves and their dependents. The essential health benefits (EHB) include coverage for pediatric dental services for children up to age 18. We request clarification on whether re-enrollment would apply to stand-alone dental plans if consumers were enrolled in such a plan during the previous year. If pediatric dental coverage were included one year in a qualified health plan (QHP) with an embedded dental benefit, what guarantees would be in place that the issuer would offer similar coverage at similar cost-sharing levels for subsequent years?

While we appreciate the convenience such a process may provide for consumers to ensure no one is without health coverage, we are concerned that this may have a negative impact on continuity of care for consumers if plans alter benefits, shift cost-sharing and adjust networks. If auto re-enrollment is adopted for the 2017 plan year, we recommend that CMS ensure that
consumers who have been enrolled in a policy that provides the pediatric dental benefit do not lose this benefit coverage as a result of this process. The ADA and AAPD also strongly recommend that CMS work with stakeholders to continue to increase the health literacy of consumers so that they can be more engaged going forward on the value of coverage and the scope of benefits, including pediatric dental, and auto re-enrollment mechanisms become unnecessary.

§156.115 b. Provision of EHB
CMS is proposing new EHB requirements that issuers must meet in order to be considered as offering an EHB. Specifically, CMS is proposing to establish a uniform definition of habilitative services and whether the agency should include specified services in its definition of habilitative. In addition, the agency is proposing that pediatric coverage, which must currently be provided up to age 19, be continued through the end of the plan year in which the individual turns 19.

Comment: The ADA and AAPD support removing the option for issuers to determine the scope of habilitative services. This would provide a uniform definition for all issuers. The ADA and AAPD support the inclusion of speech-language pathology and similar services that will assist children who may require such services as a result of a craniofacial anomaly, a cleft-lip, cleft-palate or children who have been diagnosed with trauma affecting their oral cavity.

We concur with the proposal to extend EHB services for pediatric services for those enrolled through the end of the year in which the enrollee turns 19. This would ensure that the enrollee has continuity of coverage through the end of the calendar year.

§156.120 c. Collection of Data to Define Essential Health Benefits
The proposed rule would allow each state to select a new EHB benchmark for the 2017 plan year. A state would need to supplement the new base-benchmark to ensure all ten categories of benefits are covered.

Comment: The ADA and AAPD believe it is vital that the agency require comprehensive pediatric oral health services to be part of any new base-benchmark services requirement, offered either as an embedded benefit within a QHP and/or through a stand-alone dental plan offered in the exchange. Utah is an example of how the current flexibility granted to states in this regard has worked to the disadvantage of dental consumers, the current benchmark plan offers only minimal preventive oral health services.

The ADA and AAPD seek clarification from HHS regarding data submission requirements. All of the current requirements are written specifically for QHPs but it is not clear whether HHS requires QHPs to submit specific data related to dental claims. We urge HHS to consider this requirement for all covered dental services offered by QHPs, which includes stand-alone dental plans.

§156.130 Cost-Sharing Requirements
This section clarifies that issuers have the option to count the cost-sharing for out-of-network services towards the annual limitation on cost-sharing, though issuers are not required to do so.
Comment: The ADA and AAPD believe this is a step in the right direction, as it would supersede the current prohibition on counting out-of-network costs toward the annual cost-sharing limit. However, it does not go far enough. Network integrity would still be protected if consumers were permitted to apply all out-of-network services towards the annual cost-sharing limits as issuers would still be able to offer other inducements to ensure consumers are likely to stay in network.

§156.230 Network Adequacy Standards
The agency states that strong network access is a high priority but is waiting for work to be completed by the National Association of Insurance Commissioners (NAIC), which has appointed a workgroup that is currently considering amending its model act relative to network adequacy standards, before proposing significant changes to HHS network adequacy policy. The agency does point out it will continue the “reasonable access” standard adopted in 2015. It is also encouraging issuers to adopt a policy that accommodates consumers undergoing treatment with a provider that is not in the new issuer’s network. Finally, HHS is proposing to strengthen the provider directory requirement by requiring that the information be easily accessible to plan enrollees and the directory be updated at least once a month.

Comment: The ADA and AAPD believe maximum plan transparency for consumers is vitally important, not just with regard to provider networks, but all aspects of plan purchase decision making. Every consumer should be able to fully understand what they are buying, how much it will cost out-of-pocket, and which dentists, physicians and other providers are participating in the network. We also stress the importance that network adequacy plays in serving all consumers, specifically those individuals with physical or developmental disabilities. We believe such standards should apply to all plans to ensure that there are providers participating in-network that are both willing and capable of treating these individuals. Lastly, we strongly believe that issuers should be required to adopt a policy that accommodates consumers undergoing treatment with a provider that is not in the new issuer’s network. Children undergoing treatment related to a craniofacial anomaly or other abnormality to the oral cavity frequently require coordination between medicine and dentistry. Policies should be implemented by HHS that ensure such children receive continuity of care during their entire treatment.

§156.1130 Quality Improvement Strategy
The agency is proposing in §156.1130(a) to apply the Quality Improvement Strategy (QIS) to all types of QHPs offered through the exchange, including SADPs, or it is inquiring if other standards should be developed for the different types of QHPs.

Comment: We applaud and support the agency for its focus on incorporating a Quality Improvement Strategy. We encourage the agency to require quality improvement from SADP’s. The ADA and AAPD have been working closely with the Dental Quality Alliance (DQA)[1], which officially endorsed a set of pediatric oral health measures in 2013 that are applicable across public and private programs. The measures also align closely with the agency’s current oral health strategy and are now endorsed by the National Quality Forum. We encourage the

[1] The Dental Quality Alliance, established by the ADA at the request of CMS, is a partnership of 30 entities interested in collaboratively advancing performance measurement to improve oral health, patient care and safety.
agency to require QIS strategies to align with these NQF endorsed pediatric oral health measures.

We appreciate the agency’s continued effort to implement the provisions of the Affordable Care Act and the opportunity to comment throughout the process. Should there be additional questions please feel free to contact Ms. Janice E. Kupiec at the ADA, kupiecj@ada.org/202-789-5177; or Mr. C. Scott Litch at the AAPD, slitch@aapd.org/312-337-2169.

Sincerely,

President                                                  President
American Dental Association                                American Academy of Pediatric Dentistry