

January 4, 2024

Chiquita Brooks-LaSure  
Administrator, Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9895-P  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**Re: Notice of Benefit and Payment Parameters for 2025 [CMS-9895-P]**

Dear Administrator Brooks-LaSure:

On behalf of the 159,000 members of the American Dental Association (ADA), America's leading advocate for oral health, we are writing to you regarding the proposed rule, the Patient Protection and Affordable Care Act (ACA); Notice of Benefit and Payment Parameters for 2025. The ADA appreciates the Centers for Medicare and Medicaid Services' (CMS) and the Department of Health and Human Services' (HHS) efforts to provide quality, affordable coverage to consumers while minimizing administrative burden and advancing health equity.

The ACA included major health care reforms such as establishing the concept of Essential Health Benefits (EHB) and Qualified Health Plans (QHP). As an organization dedicated to advancing the oral health of the public, we appreciate the opportunity to share our thoughts with CMS specifically on Essential Health Benefits (EHBs).

The EHB package is the minimum package of benefits to be offered through ACA Marketplaces and in the small group and individual market outside of Marketplaces. EHB's are required to follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meet other requirements. The ACA also requires non-grandfathered health plans in the individual and small group markets to cover EHBs. Among the standard list of EHBs, pediatric dental services are already included. Now, CMS is proposing beginning in plan year 2025 *"to remove the regulatory prohibition...on issuers from including routine non-pediatric dental services as an EHB, which would provide States the option to add routine adult dental services as an EHB by updating their EHB-benchmark plans."* **The ADA supports allowing states to include adult dental services in their EHB-benchmark plans.**

**Defining EHB benchmark for plan design for adult dental services**

CMS stated in their proposal that, "oral health conditions can increase risk for and complicate the management of other chronic [medical] conditions." While removing the prohibition and allowing states to include adult dental services as an EHB is the first step, the ADA believes that **the Secretary should clearly define the benefit design that would be an acceptable benchmark for EHB dental plans.** ADA believes that CMS must establish a mechanism to ensure that the EHB benchmark plans selected by the states to certify plans as meeting EHB requirements should include all the necessary services that are reasonable and appropriate for diagnosis, treatment, and follow-up care (including supplies, appliances and devices) as determined and prescribed by qualified, appropriate

health care providers in treating any condition, illness, disease, injury or birth developmental malformations for the purpose of: controlling or eliminating infection, pain and disease; and restoring facial configuration or function necessary for speech, swallowing or chewing. A dental benefit plan should include the following categories:

- A. Diagnostic. Provides the necessary procedures to assist the dentist in evaluating the conditions existing and the dental care required.
- B. Preventive. Provides the necessary procedures or techniques to assist in the prevention of dental abnormalities or disease.
- C. Emergency Care. Provides the necessary procedures for treatment of pain and/or injury. It should also cover the necessary emergency procedures for treatment of the teeth and supporting structures.
- D. Restorative. Provides the necessary procedures to restore the teeth.
- E. Oral and Maxillofacial Surgery. Provides the necessary procedures for extractions and other oral surgery including preoperative and postoperative care.
- F. Endodontics. Provides the necessary procedures for pulpal and root canal therapy.
- G. Periodontics. Provides the necessary procedures for treatment of the tissue supporting the teeth.
- H. Prosthodontics. Provides the necessary procedures associated with the construction, replacement, or repair of fixed prostheses, removable partial dentures, complete dentures and maxillofacial prostheses.
- I. Orthodontics. Provides the necessary treatment for the supervision, guidance and correction of developing and mature dentofacial structures.

### **Ensuring that existing consumer protections apply to dental EHB**

Within the ACA, dental benefits were the only benefits that could be offered outside of a QHP through Stand Alone Dental Plans (SADPs). **The ADA continues to support this model for adult benefit plans. Consumers should have access to dental benefits either through a QHP (embedded or bundled policies) or SADP on the federal and state Marketplaces.**

CMS and HHS should ensure that states apply the following consumer protections to dental plans offered either as a QHP (embedded or bundled policies) or an SADP. The ADA notes that most Marketplaces already offer plans – both family plans and plans with adult benefits. These plans are currently not regulated because they are not considered EHB. **These plans should not be “grandfathered” and should be subject to existing consumer protections defined in the ACA for all EHB’s.**

- Cost Sharing
  - There should be no cost sharing provisions for preventive or diagnostic dental care services. When a QHP with dental coverage has a shared deductible or a Stand-Alone Dental Plan (SADP) has a deductible, the deductible should not apply to any preventive or diagnostic dental care services. There should be first-dollar coverage for all preventive or diagnostic dental care services, especially periodontal care (i.e. periodontal maintenance). Preventive and diagnostic dental care services are unfairly excluded as a coverable

preventive service because it does not meet United States Preventive Services Task Force (USPSTF) A or B Recommendation standard. However, the methodology used to evaluate oral health screening and prevention by USPSTF has traditionally only included research or studies in the primary care physicians' offices. There was little to no consideration about preventive dental care services in primary care dentists' offices, where dental diagnostic and preventive oral health interventions are delivered.

The ADA believes that at least the following dental services as applicable to pediatric and adult populations must have first dollar coverage within the EHB:

- Comprehensive and periodic evaluation
  - necessary diagnostic radiographs
  - prophylaxis.
  - topical fluoride applications.
  - application of pit and fissure sealants and reapplication as necessary.
  - interim caries arresting medicament application (e.g., silver diamine fluoride).
  - space maintainers at appropriate developmental stages.
  - oral health risk assessments.
  - screening and education for oral and oropharyngeal cancer and other dental/medical related conditions.
  - preventive resin restorations.
  - resin infiltrations.
  - periodontal maintenance
  - fixed and removable appliances to prevent malocclusion.
  - athletic mouth guards
  - anesthesia as necessary
  - prescription or use of supplemental dietary or topical fluoride for home use; and
  - in-office patient education, (i.e., oral hygiene instruction, dietary counseling, dental- and medical-related conditions, and tobacco cessation counseling with regard to the promotion of good oral and overall health).
- The Advance Premium Tax Credits (APTC) should be available to consumers purchasing QHPs or SADPs with dental coverage.
  - When a dental benefit is included within a QHP as an embedded policy, the dental benefit must always be subject to a separate deductible. The ADA believes that the current market supports a deductible of up to \$75 and sees this as an acceptable benchmark for deductibles.
  - There should not be onerous co-insurance requirements included for essential dental services. The ADA does not support the traditional 100/80/50 benefit model wherein the consumer/patient is subject to a 50% cost share for services classified as "major dental services". Procedures should not have more than a 20% co-insurance to support affordability and value of plans.

- Annual and Life-time Plan Limits
  - There should be no annual and life-time limit on what plans pay out for covered dental care services.
- Out of Pocket (OOP) Max
  - There should be an annual limit on out-of-pocket spending for dental care by beneficiaries.
  - The OOP limit should be defined for both individuals and families and should be similar to the 2024 OOP maximums on pediatric dental patients for SADPs. These OOP maximums are \$400 for one child/individual and \$800 for families with more than one child/individual. The ADA believes that similar ranges would be acceptable for OOP maximums for adult benefits.
- Network Adequacy
  - QHPs with dental benefits or SADPs should be subject to network adequacy requirements with transparent reporting of network adequacy metrics to the beneficiary. Such metrics might include provider-beneficiary ratios within geographic catchment areas (i.e. S, M, L, XL scoring) or appointment wait times (gathered through secret shopper surveys)
  - Utilization of services and quality of care must also be reported through the Quality Reporting System (QRS) for Marketplace plans.
- Dependents
  - Dependent children should be allowed to remain on their parents plans until age 26 in QHPs with dental benefits as well as SADPs.

The ADA also believes that all plans sold on both the Federally-facilitated Exchange as well as the State-based Exchange Marketplaces should be certified as EHB conforming plans so as to limit any confusion for consumers and allow the above detailed consumer protection to apply to such plans.

### **Assuring consumers purchase adult dental benefit coverage**

In the small group and individual market outside of Marketplaces, the ACA requires medical plans to include pediatric dental coverage, or the medical carrier must get “reasonable assurance” that the consumer purchases a certified dental SADP that includes pediatric benefits. **The ADA would support stronger policies with regards to reasonable assurance to ensure individuals and small groups both inside and outside the Marketplaces include an offer of adult dental benefits for consumers.**

Due to the unique nature of dental benefits, implementation of the “pediatric dental EHB” was vastly different from how other EHBs were handled. The pediatric dental EHB has been implemented as an “optional” rather than mandatory coverage element unlike every other EHB. For example, with someone 18 or younger, dental coverage must be available but does not need to be purchased. Given this, the dental industry has not seen very large impacts since the ACA was enacted. **The ADA also strongly believes that the**

**implementation issues related to the pediatric benefits (e.g. treating them as “optional” benefits) should not occur if adult dental is classified as an EHB. The ADA urges CMS to provide guidance to states to assure purchase of adult benefit coverage in the individual and small group markets.**

### **Adult dental benefit in Medicaid and EHB**

For many Americans, gaps in coverage of adult dental services will remain in place even if a state chooses to add these services to their state EHB-benchmark plan. The patchwork of Medicaid coverage for adult dental services is a barrier that adults have in access to the essential health care coverage that CMS has now determined should include dental services. Questions remain especially for states that don't have comprehensive adult dental services as part of their Medicaid program or even emergency only, or limited coverage. Should a state choose to introduce adult dental services as an EHB, what access if any will the Medicaid population receive to a newly installed dental EHB on an exchange plan and why should barriers to accessing EHB coverage remain in place because of income level, including through use of APTCs?

Given that the approach that the Secretary has taken is to *“to remove the regulatory prohibition...on issuers from including routine non-pediatric dental services as an EHB, which would provide States the option to add routine adult dental services as an EHB by updating their EHB-benchmark plans”*, **the ADA urges CMS and HHS to provide guidance on how States that offer a limited or no Medicaid adult benefit could incorporate affordable dental benefit plans for purchase by consumers through the Marketplace.**

### **Creation of Dental Loss Ratio (DLR) parallel to Medical Loss Ratio (MLR)**

If adult dental services are interpreted as an EHB, this means that QHPs with embedded dental coverage would continue to be subjected to MLR requirements. There is no requirement for SADPs or QHPs that bundle dental benefits to file a comprehensive DLR report annually. Requiring SADPs and QHPs that offer a bundled product to file a comprehensive DLR report annually would meet the same aims of using a larger share of premiums for high-quality care instead of administrative expenses and executive salaries. **ADA strongly believes that CMS and HHS should require SADPs and QHPs that offer bundled products to file a comprehensive report annually. CMS and HHS should also establish a specific loss ratio for dental plans. The ADA is aware that Medicaid Managed Care regulations use a loss ratio of 85% and ADA supports a similar benchmark for a loss ratio for EHB certified dental plans.**

### **Incentives for States that Maintain State-Based Marketplaces**

Whether or not CMS chooses to interpret adult dental services as ambulatory services, CMS states they believe *“this proposal would incentivize States to add routine non-pediatric dental services as an EHB.”* **We believe that for state-based marketplaces, CMS should provide some technical assistance and funding for states to update their systems accordingly in order to make this transition successful.**

As CMS notes, this proposal seeks to mitigate barriers to accessing dental care by removing the prohibition on issuers from including routine adult dental services as an EHB in furtherance of efforts *“to improve adult oral health and overall health outcomes, which are*

*disproportionately low among marginalized communities such as people of color and people with low incomes.”* **The ADA applauds these efforts and wishes to highlight for CMS ongoing workforce shortage issues in health care, specifically dentistry, which could hinder these efforts to expand access. Because dentistry is currently facing capacity limits due to workforce shortages, we recommend additional funding to increase training capacity for hygienists and assistants, including underrepresented groups.**

#### **Adjusting the EHB Defrayal Policy**

Under current regulations, states have been required to defray the cost of state-mandated benefits that are beyond the scope of benefits provided by plans consistent with the state’s EHB benchmark plan. This defrayal can be costly to states and can be a hurdle in implementing adult dental benefits requirements. CMS is now seeking to clarify that a covered benefit in a state’s EHB-benchmark plan would be considered an EHB and that there would be no defrayal requirement beginning in plan year 2027. **The ADA supports this clarification as states will now be able to add adult dental services to their EHB-benchmark plans without having to defray the costs.**

#### **Improvement of pediatric essential health benefits**

The ADA urges CMS to require a health insurance issuer offering health insurance coverage to provide coverage for outpatient and inpatient items and services related to the diagnosis and treatment of a craniofacial, oral or maxillofacial congenital anomaly or birth defect.

Coverage provided should include any medically necessary item or service to functionally improve, repair, or restore normal body functioning or appearance, as determined by the treating physician (as defined in section 1861(r) of the Social Security Act), due to congenital anomaly or birth defect.

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The ADA looks forward to continuing to work with CMS and we would welcome the opportunity to speak with you in more detail and answer any questions you have regarding these comments. Please contact Mr. David Linn at the ADA at (202) 789-5170 to facilitate further discussion.

Sincerely,

Linda J. Edgar, D.D.S., M.Ed.  
President

Raymond A. Cohlma, D.D.S.  
Executive Director