



January 31, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-9898-NC, Request for Information; Essential Health Benefits

Dear Administrator Brooks-LaSure:

On behalf of the 159,000 members of the American Dental Association (ADA) and the 10,800 members of the American Academy of Pediatric Dentistry (AAPD), we are pleased to provide a response to the request for information (RFI) on issues related to the Essential Health Benefits (EHB) under the Affordable Care Act (ACA). As noted in the RFI background, the ACA provides for the establishment of this “EHB package” to include coverage of the EHB as defined by the Secretary of Health and Human Services (HHS), which must include certain general categories such as pediatric services, including oral and vision care. Our aim is to highlight areas where the consumer experience of purchasing pediatric dental benefits can be improved and ways the coverage provided supports adequate access to care.

Our organizations overall agree with the sentiment of this RFI, which seeks to streamline and make consumers’ choices easier by giving them greater ability to differentiate between plans and understand the benefit descriptions more easily. Oral health is an essential part of overall health and tooth decay remains one of the most common, chronic pediatric diseases. Coverage for pediatric dental services can provide necessary preventive and oral health education services that may prevent and manage disease. The ADA has previously addressed the need to maintain and improve pediatric oral health services as part of the EHB requirements included in the ACA. In a list of our priorities sent to CMS in 2021, the ADA said that we support making pediatric oral health coverage mandatory within the ACA exchange plans for families with children.

Additional Benefits as EHB

To address disparities in maternal health outcomes, CMS recently expanded dental coverage for pregnancy in the Medicaid system. **We strongly urge CMS to include benefits for maternal oral health as an EHB for one-year postpartum within the ACA Marketplaces.**

Issues with Benchmark Plans

As part of the original implementation process for EHBs, 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.¹ Currently, it appears 33 states and the District of Columbia 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.² Benefit packages within these benchmark plans are often not similar. Age limits (e.g., sealants are only covered until age 13) and frequency limits (e.g., only 2 fluoride applications in a year) are often barriers to achieving optimal oral health. Further, the variation of descriptions and plans by states is significant and as noted in the RFI, has not always been meant to be included as a state’s EHB as originally written. The lack of coordination among states’ benchmark plans could use further regulation to alleviate concerns that there is currently too much variation among plans that results in confusion and lack of comprehensive coverage. Though CMS does not believe this to be a consumer harm issue, if states have difficulty making changes to benchmark plans and CMS is not able to easily review and update EHBs periodically, consumers are not best served. **We strongly urge CMS to undertake a study to compare these benchmark plans and assure that benchmark plans cover services to adequately meet the dental needs of the beneficiaries across all states with first dollar coverage for evidence-based preventive services.**

Dental Benefits as Optional

Pediatric oral health coverage can be offered within a qualified health plan (QHP) or separately, through a stand-alone dental plan (SADP). Pediatric dental EHB is the only EHB that is treated as optional, rather than being required as part of an EHB package. QHPs can sell plans without the pediatric dental EHB as long as there are SADPs on the state exchange that offer the pediatric dental EHB. A consumer can purchase a QHP without dental and is not required to choose a SADP – even if the consumer has a child. The voluntary purchase of the pediatric dental EHB makes it subject to adverse selection and carriers charge higher premium rates, which likely accounts for this higher expected utilization. **We strongly urge CMS to close regulatory loopholes that allow pediatric dental benefits to be regarded as optional benefits for families with children.**

QHPs versus SADPs

QHPs continue to result in cost barriers for consumers, especially when cost sharing reductions (CSRs) are not made available to all consumers resulting in higher deductibles for those consumers choosing silver or bronze plans.³ When embedded within a QHP, dental coverage adds to the overall costs for consumers while not always maintaining a comprehensive pediatric dental benefit. The out-of-pocket maximum (OOPM) and actuarial value (AV) requirements associated with SADPs are not applicable to pediatric dental EHB embedded in QHPs. Instead, the value of the dental benefit just gets incorporated in the overall plan AV, and dental can be subject to the medical OOPM. Consequently, embedded pediatric dental plans can be sold with a wide range of benefit richness. Some embedded plans may have their own separate dental deductible or have preventive dental services waived from any deductible to ensure coverage of routine preventive dental care. Other plans, however, may require the patient to incur substantial out of pocket expenses because dental care is lumped together with the medical deductible before any dental services are covered. There are some benefits to embedded dental coverage in a QHP, including a

¹ Essential Health Benefits Bulletin, issued December 16, 2011, CMS Center for Consumer Information and Insurance Oversight (CCIIO).

² CMS, [Overview of Current Essential Health Benefits \(EHB\) Benchmark Plans](#).

³ ASPE Office of Health Policy, [Health Insurance Deductibles Among HealthCare.Gov Enrollees, 2017-2021](#), January 13, 2022.

guarantee that pediatric dental benefits are included in the plan, however, additional standardization of the embedded dental benefit coverage and requiring a separate dental deductible would vastly improve the “embedded dental” plan design for consumers as would a plain language benefit summary for consumers at time of purchase. **Given that more children are enrolled in QHPs rather than a SADP,⁴ we urge CMS to take steps to evaluate dental benefits offered as bundled or embedded products within the QHP with regards to application of deductibles and OOPMs.**

Dependent Coverage

The ACA also extended dependent coverage to age 26 and we believe that many commercial dental policies should make this extension as well. Dental policies have typically defined “children” based on clinical concerns. For example, child orthodontic coverage is often available to children up to age 19 or 21. These differing rules and standards among ACA medical plans, ACA dental plans, and commercial dental policies can cause further confusion. **We urge CMS to ensure that dependent coverage up to age 26 applies to the dental plans regardless of whether benefits are purchased as part of a QHP or a SADP.**

Coverage Criteria

We support coverage for comprehensive pediatric dental services as part of the EHB as intended under the ACA, including routine exams, X-rays, cleanings and sealants, and restorative services such as fillings or root canals, which may be necessary to treat and manage dental disease similar to the EPSDT benefit under Medicaid. Additionally, medically necessary orthodontia (MNO) coverage is required as part of the pediatric dental EHB. However, because the medical necessity criteria for orthodontia are not well defined, dental plan issuers generally determine their own criteria, resulting in varying levels of coverage and, as a result, access to care across plans in the ACA market. Requiring that plans provide coverage for MNO is appropriate in a benchmark plan as orthodontia may be part of a treatment plan for a child who has undergone surgery for a cleft lip and/or cleft palate. **However, we urge CMS to adopt standardized coverage criteria across all dental plans.**

Emerging Evidence-Based Services

We also support modifying/updating EHBs for changes in medical evidence and scientific advancement, including, as mentioned in the RFI, the use of silver diamine fluoride (SDF) for arresting progression of dental caries.

We would welcome the opportunity to meet with you to discuss how we can meet these challenges together. If you have any questions, please contact Mr. David Linn at 202-789-5170 or linnd@ada.org.

⁴ CMS, [2022 OEP State-Level Public Use File \(ZIP\)](#), June 2022.

Sincerely,

George R. Shepley, D.D.S.
ADA President

Amr M. Moursi, D.D.S., PhD
AAPD President

GRS:AMM:dl