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November 7, 2024

Chiquita Brooks-LaSure, M.P.P.
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9888–P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Notice of Benefit and Payment Parameters for 2026 [CMS–9888–P]

Dear Administrator Brooks-LaSure,

On behalf of the 159,000 members of the American Dental Association (ADA), the nation's leading authority on oral health, we are writing regarding the proposed rule, the Patient Protection and Affordable Care Act (ACA); Notice of Benefit and Payment Parameters for 2026. The ADA appreciates the Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services (HHS) for their efforts to provide quality, affordable coverage to consumers while minimizing administrative burdens and ensuring program integrity.

Advance Premium Tax Credits (APTCs)

Given that 13% of the population faced cost barriers to dental care in 2023, the reduction of premiums and costs to low-income consumers who use marketplace exchanges is essential in ensuring access to dental care.[1] The ADA recognizes that adult dental care was previously excluded from essential health benefits (EHB), which made it difficult in reducing the cost burden around dental insurance. However, the recent removal of the prohibition of adult dental as an EHB and CMS's emphasis on oral health's linkage to overall health provide more opportunities to make adult dental coverage available to low-income consumers. ADA believes one opportunity that exists is to extend APTCs towards both adult and pediatric dental care included in Qualified Health Plans when setting up future parameters around "silver loading" as discussed in the proposed rule.

"Silver loading" is the practice of increasing premiums on silver plans offered on the individual marketplace exchanges. Silver plans are unique on the exchanges because their actuarial value is increased for consumers at or below 250% of the federal poverty level. This actuarial value was maintained through cost-sharing reduction payments that would allow the plans to maintain such as lower deductibles, co-payments, and co-insurance. When cost-sharing reduction payments were eliminated in 2019, many insurers raised silver plan premiums in anticipation of maintaining actuarial value required by law without cost-sharing reduction payments. CMS is now proposing to provide operational rules to the practice of silver loading, which requires higher APTC payments to cover higher premiums for a legally mandated actuarial value that benefits low-income consumers. In creating these rules, **ADA asks CMS to allow higher advance premium tax credits**

[1] American Dental Association Health Policy Institute. (2024, September). National trends in dental care use, dental insurance, and cost barriers. https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/national_trends_dental_use_benefits_barriers.pdf

(APTCs) for silver-level plans be applied toward adult and pediatric dental care when included in silver-level Qualified Health Plans (QHPs).

Furthermore, leftover APTCs can now be directed towards the pediatric dental benefit, whether it is delivered through a QHP or Stand Alone Dental Plans (SADP). **ADA additionally advocates that CMS should also permit any leftover APTCs for silver-level plans to be directed adult dental care toward SADP premiums.**

Doing so would allow low-income consumers to use APTCs for necessary dental care, which aligns with CMS's acknowledgment that oral health significantly impacts overall health and quality of life.

Essential Community Providers (ECPs)

The ADA fully supports CMS's efforts to review Qualified Health Plans (QHPs) offered on federally funded marketplaces to ensure these plans include a sufficient number of Essential Community Providers (ECPs), especially those serving low-income and underserved populations.

We ask that CMS extend this review process to Stand Alone Dental Plans (SADPs), as these plans are also subject to the ECP requirement under the ACA. Additionally, given ongoing workforce shortages, many Federally Qualified Health Centers (FQHCs) offering dental services may not be accepting new patients[2]. **We request that CMS ensure dental ECPs in these plans are actively accepting new patients before certifying them.**

Non-Standardized Plan Options

The ADA supports CMS's proposed limitations and flexibility regarding non-standardized plan options. The proposal to cap the number of plan designs offered by an issuer to two, while allowing variation by network type, metal level, and dental or vision coverage, strikes a balance between consumer choice and simplicity. Limiting the number of plan designs will help prevent consumers from becoming overwhelmed by too many options, which often results in confusion regarding cost-sharing obligations.

We also appreciate the inclusion of adult and pediatric dental coverage as part of the flexible options within non-standardized plans, ensuring that these services are integrated into the marketplace in a way that benefits both consumers and issuers.

Medical Loss Ratio (MLR)

While CMS's proposed revisions to the medical loss ratio (MLR) primarily relate to qualifying issuers in the context of risk adjustment, there is little applicability for dental services. No standard risk adjustment model currently exists for dental plans because diagnosis coding is not widely used in the insurance market. Furthermore, dental costs are generally much lower than medical costs, which makes it challenging for dental services to be factored into risk-adjustment changes to the proposed MLR calculation. With its proposal to include definition of "issuing plan" in the statute to accommodate risk-adjustment payments, ADA

[2] American Dental Association Health Policy Institute. (2022). Dental workforce shortages: Data to navigate today's labor. https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/dental_workforce_shortages_labor_market.pdf?rev=e6025d77df184e6c95dc7cefde4adee3&hash=225FCBBCCB67174AAFC760FE2287322D

believes that further clarification is necessary for Section 158 of the Affordable Care Act, particularly regarding the definition of a "health plan" under §158.103.

The ADA requests that CMS interpret the definition of "health plan" regarding Medical Loss Ratio in Section 158 of the Affordable Care Act to include Stand Alone Dental Plans (SADPs). While CMS removed the prohibition on non-pediatric dental benefits as an essential health benefit in the Notice of Benefit and Payment Parameters for 2025, the agency recognized that there is a growing recognition of the importance of dental coverage in the broader health insurance landscape. In this final rule, the agency reinterpreted how it views dental plans in connection with employer plans in statute. CMS stated that it interpreted SADPs as part of employer plans because they consider employer plans as one that "considers all the benefits typically covered by employers, regardless of whether such benefit is historically considered a ''health benefit'' or whether such benefit is ''typically covered'' by an employer's major medical plan or, for example, by a limited scope excepted benefits plan."

We ask CMS to extend this evolving understanding to the interpretation of SADPs within the MLR framework. SADPs, particularly when purchased in conjunction with QHPs, should be viewed as part of the overall health insurance coverage package when applying MLR by statute. Dental services should not be exempted from MLR in SADPs as QHPs offering dental services must abide by MLR regulations, even though QHPs have higher administrative costs in risk and utilization management.

This interpretation would help ensure that consumers' premium dollars are appropriately directed toward care as was the intent of the Affordable Care Act. As reporting on available California shows, many dental plans currently fail to meet ACA-level MLR requirements, with only 9% - 9.3% of the dental plan products offered in the state achieving these standards.[3,4] A broader interpretation of "health plan" would provide consumers with greater financial support to access necessary dental treatments.

Public Data from the Federally Facilitated Marketplace

While not addressed in the proposed rule, ADA believes the CMS datafile on dental offerings through the federally-facilitated marketplace can be enhanced to better understand the dental market and cost-sharing. Currently, co-insurance is reported in the datafile as either percentages or a dollar amount. ADA believes restricting the reporting of coinsurance in the datafile to percentages and excluding co-payments or dollar amounts as part of co-insurance will reduce confusion for researchers. ADA additionally requests that annual limits for dental offerings to adults be reported in the data file as they are currently provided in plan submissions to CMS but not reported in the datafile. ADA also asks that out-of-pocket maximum amounts in the datafile be labeled as being only applicable to pediatric dental patients in the datafile.

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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 may have

[3] Finocchio, L., & Connolly, K. (2018). Medical Loss Ratios For California's Dental Insurance Plans: Assessing Consumer Value And Policy Solutions. Health affairs (Project Hope), 37(9), 1517–1523. https://doi.org/10.1377/hlthaff.2018.0441
[4] California Department of Managed Health Care (2023), 2022 Dental Medical Loss Ratio (MLR) Summary.

regarding these comments. Please contact Mr. David Linn at the ADA at (202) 789-5170 to facilitate further discussion.

Sincerely,

/s/

Brett Kessler, D.D.S.
President

/s/

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

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