



Q & A on Affordable Care Act

Adult Dental & Essential Health Benefits (EHBs)

Update on 3/3/2026: This guide was released in 2024 upon the removal of the prohibition on adult dental benefits as an EHB. In 2026, CMS has proposed a rule to reinstate the prohibition for states to make adult dental as an EHB. This guide explains potential benefits of states to include adult dental as an essential health benefit, which are forfeited if CMS moves forward with its proposal.

MAJOR TAKEAWAYS

- With the release of the 2025 rule on the Affordable Care Act, States now have the option to include adult dental as an Essential Health Benefit (EHB), beginning in Plan Year 2027.
- Adult dental included as an EHB would have to meet some federally guaranteed consumer protections such as no annual limits, cost-sharing limitations, network adequacy, and medical loss ratio (MLR) requirements. Adult benefits sold through Stand Alone Dental Plans (SADPs) will remain “excepted benefits” and will not carry the same EHB consumer protections.
- Development and implementation will come down to the states. State Dental Associations/Societies who want this regulatory change should strategically advocate for an adult dental benefit with their state officials, and closely monitor developments to ensure successful implementation. The ADA is available to assist in any manner.

QUESTIONS & ANSWERS

What are Essential Health Benefits (EHBs) and EHB-Benchmark Plans?

- EHBs are a set of 10 categories of services health insurance plans must cover under the Affordable Care Act (ACA). These include doctors’ services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more. Plans must offer dental coverage for children.
- With each EHB, there is a prohibition on annual and lifetime limits, and limitations on cost-sharing.
- The 10 **service categories** are a framework, and each State must annually select **specific covered services** and cost-sharing (i.e. deductibles, copayments & co-insurance) standards. States usually accomplish this through the selection of an “EHB-Benchmark Plan”. Any qualified health plan offered on the Marketplace must meet these criteria to be certified.
- The EHB-Benchmark Plan selected by each state, defines the set of specific covered services that comprehensive individual and small group health insurance plans must cover. Each state determines the EHB-Benchmark Plan within the framework set by federal law. A state may change its EHB-Benchmark Plan annually. Some states have chosen the Federal Employees Dental and Vision Insurance Program (FEDVIP) or Children’s Health Insurance Program (CHIP) plans as their benchmark plans to define the coverage for pediatric dental EHB.

How does the Marketplace function?

- The “ACA Marketplace” can be thought of as a website through which individuals and small group employers can purchase health insurance.
- Medical plans also called as “Qualified Health Plans” (QHP’s) must be certified as meeting the EHB benchmark in order to be sold on these Marketplaces. However, cost sharing such as copayments, co-insurance and deductibles will vary between the different “metal types” sold on the exchange. (i.e. Bronze, Silver, Gold, Platinum). The pediatric benefit within SADP’s must meet some similar requirements.

- Many States use a federal platform or website i.e. the Federally Facilitated Marketplace (FFE) while others built out their own Marketplace (state-based Marketplaces) following the adoption of the ACA.
- Because pediatric dental benefit was classified as an EHB in the ACA, the ACA also allowed SADPs meeting EHB requirements for the pediatric dental benefit to be offered on the Marketplaces. So, in the Marketplaces, anyone choosing to purchase a dental benefit for their child could purchase it as part of a Qualified Health Plan (QHP) that offers all 10 EHB's or could purchase a QHP without dental and then optionally purchase a stand-alone dental plan. Until now, although adult dental benefits were not classified as EHB, carriers have been allowed to sell plans with adult benefits on the Marketplaces but without any regulations.
- Consumers can only purchase a dental plan AFTER they purchase a QHP for medical insurance. The purchase of the pediatric dental plan remains optional.

What changes are happening with dental coverage with the new CMS rule published in April 2024?

- The ACA did not list routine adult dental services as part of the 10 named essential health benefits. However, the ACA does allow States to recognize other benefits as state mandated benefits. With this new rule, CMS has removed the prohibition to include routine non-pediatric dental benefits as an EHB. With this removal of the prohibition, States can offer adult dental benefits as an Essential Health Benefit in Plan Year (PY) 2027 by applying to the federal government by May 7, 2025
- The finalization of this regulation does not require any State to add adult dental services as an EHB. If a State's current EHB-Benchmark Plan includes language about adult dental services, that does not automatically make the adult dental benefit an EHB. Each State will need to take specific affirmative action through either legislative action or an administrative process to add the adult dental benefit as an EHB
- By law, the ACA recognized SADP's specifically for the provision of pediatric dental benefits i.e. pediatric dental plans could be offered and purchased separate from the medical insurance policy. For this reason, pediatric dental benefits could be "embedded" or "bundled" within a QHP or sold separately through an SADP. As a regulatory agency, CMS did not recognize SADP's for the provision of adult dental benefits as an EHB.
- If States decide to add an adult dental benefit as an EHB then the State must select an EHB-Benchmark Plan that includes adult dental benefit and all QHPs (certified plans on the Marketplace) will have to provide adult dental benefits as part of their benefits package. This adult dental benefit, like every other EHB, will have no annual limits or lifetime limits and limitations on cost-sharing, and will be subjected to network adequacy standards and MLR.
- Any adult dental benefit offered through an SADP will likely be considered an "excepted benefit" and would not automatically have to meet standards set by an EHB-Benchmark Plan. This means that there are no regulatory changes to SADPs as they currently are in the Marketplaces. *[NOTE: Limited scope dental benefits provided under a separate policy, certificate, or contract of insurance is defined as an "excepted benefit".]* Whether a state will continue to allow SADP's to sell adult dental plans and family dental plans in the Marketplace as separate policies with no regulations applicable to the adult benefits remains unclear. ADA will continue to monitor this issue as states adopt policies.

What about pediatric dental benefits?

- There are no changes being made to pediatric dental benefits as there are previous rules dictating how pediatric dental benefits were incorporated in the Marketplaces as an Essential Health Benefit.
- Previously, if an SADP offered a pediatric dental benefit, then QHPs would be exempted from have to include this benefit when sold within the same marketplace exchange. This still remains true for pediatric dental benefits.

How will this affect the insurance marketplace?

- These ACA regulations typically affect the individual and small group employer markets inside and outside the Marketplaces.
- [Based on CMS guidance](#), under the Affordable Care Act, large group market health plans are not required to offer EHB. However, the prohibition in PHS Act section 2711 on imposing annual and lifetime dollar limits on the categories of services classified as EHB's does apply to large group market health plans. These plans are permitted to impose non-dollar limits (e.g. frequency limitations etc.), consistent with other guidance, on EHB as long as they comply with other applicable statutory provisions. If a state chooses to include non-pediatric dental benefits (adult benefits) as an EHB, then it appears that the following interpretation may apply:
 - (1) Large group plans are not mandated to offer adult dental benefits as an EHB.
 - (2) Currently large group employers offer dental benefits as separate policies through SADP's and under this structure these benefits will not need to conform to regulations governing EHB's.
 - (3) However, if a large employer plan selects the EHB-Benchmark Plan and includes a combined medical with dental insurance plan under a single policy for its employees then annual and lifetime dollar limits may be prohibited. It is unclear what this might mean for employers functioning across multiple states with differing adoption of EHB standards.
- ***The ADA is currently (as of April 12th, 2024) seeking clarification from CMS and will update this document as more clarity emerges on this issue.***

Who is typically enrolled in Marketplace plans?

- An estimated 21 million Americans are enrolled in marketplace plans. The table below shows the approximate share of how many adults are enrolled in these plans along with other demographics. For example, most individuals enrolled in Marketplace plans are between 100 and 400% federal poverty level (FPL).
- Marketplace enrollment in 2023 and 2024 is expected to be significantly greater than in previous enrollment years because of the re-determination of eligibility in Medicaid following a pause instituted during the COVID pandemic.

Figure 1: Demographics of Marketplace Exchange Consumers (by %)

	% of Total ⁷ 2023	% of Total ⁷ 2022	% of Total ⁷ 2021
Age			
< 18	9	9	9
18 - 34	25	25	25
35 - 54	37	36	36
55+	29	29	30
Gender			
Female	53	54	54
Male	47	46	46
Location: HealthCare.gov States			
Rural	18	18	18
Non-rural	82	82	82
Household Income⁸			
< 100%	1	2	2
≥ 100% and ≤ 150%	37	32	32
≥ 100% and ≤ 138%	26	23	NA
> 150% and ≤ 250%	29	32	34
> 250% and ≤ 400%	19	20	20
> 400% FPL	8	8	3
Other Household Income ⁹	5	6	9

Source: CMS

What could happen on the state-level?

- States that choose not to include adult dental as an EHB will maintain the status quo.
- If your State acts to include adult dental as an EHB, the EHB-Benchmark Plan submitted to the federal government (18 months before plan’s effective date) would include adult dental benefit as determined by either legislation or the state’s insurance commissioner.
- When crafting these EHB-Benchmark Plans, States are required to solicit public comment. It is important that State Dental Associations/Societies convene appropriate stakeholders in their State to take a position on the plan submission.
- This new rule noted that it will be up to the States to determine coverage levels (i.e. what to cover, such as root canals, dentures, etc.). It is important that State Dental Associations/Societies are communicating with appropriate State insurance regulators on the appropriate level of coverage.
- Many States do not offer additional benefits in their EHB-Benchmark Plan because the ACA dictates that the State will have to cover defrayal costs. However, CMS clarified in this rule that States will not have to defray the costs of adult dental benefits if they are part of the EHB-Benchmark Plan. This is an incentive for States to include these benefits as part of their EHB-Benchmark Plan.
- When the pediatric benefit was classified as an EHB, initially, dental policies included in QHPs did not allow separate dental deductible or first dollar coverage for preventive services. Later, separate deductibles and first dollar coverage was instated to make the pediatric dental coverage more meaningful. Further, the ACA has very specific requirements to mandate first dollar coverage (i.e. procedure is 100% covered before deductible is reached with no copayment or coinsurance). Only procedures shown to improve health outcomes (e.g. mammograms, colorectal screening etc.) have first dollar coverage in medical plans. It will be important for state dental associations to ensure appropriate implementation of these cost sharing parameters within any dental plans should adult services be added to EHB benchmark plans.



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- Further, State Dental Associations should also monitor network adequacy and fee schedules. With the pediatric benefit, most carriers offering Marketplace dental plans used their existing commercial network contracts to provide network access within these plans. State dental associations should monitor emerging network agreement trends to ensure adequate reimbursement to support access.
- Following the introduction of the pediatric benefit, pediatric dental offices experienced more situations where a patient has two dental policies that resulted in the need for coordination of benefits. State dental associations should again seek to work with their States to educate consumers purchasing QHPs in States that choose to include adult dental as an EHB.
- Introduction of an adult dental benefit as an EHB in the Marketplaces may create confusion for families and consumers. For example, QHPs with adult dental plans as EHB's would not have annual and lifetime limits, and would have reduced cost-sharing but SADPs offering adult dental plans as excepted benefits would still have limits. Most consumers in the Marketplaces are familiar with purchasing their dental plan separately and would not realize that the QHP plan may have dental coverage with no annual limits.
- Other issues such as benefits for dependents up to age 26 apply to QHP but do not apply to SADPs. According to the provision of EHB at 45 CFR 156.115 all SADPs must cover pediatric dental benefits for individuals until at least the end of the month in which the enrollee turns 19 years of age. However, states can impose requirements to provide pediatric services to individuals up to a higher age but not lower.

Figure 2: Demonstration of New Adult Dental Benefit if Added by State in as an EHB and included in the EHB-Benchmark Plan (*Only applicable to individual and small group plans*)

Plan Features	For Qualified Health Plans (Adult)	For Stand Alone Dental Plans (Adult)	For Qualified Health Plans (Pediatric)	For Stand Alone Dental Plans (Pediatric)
<i>Benefit Category</i>	State can choose to include as EHB	Excepted benefit	Pediatric benefit included as EHB in ACA	Pediatric benefit included as EHB in ACA
<i>Specific Covered Services</i>	As defined in the EHB- Benchmark plan as selected by the state	As defined by each carrier	As defined in the EHB-Benchmark Plan as selected by the state	As defined in the EHB-Benchmark Plan as selected by the state
<i>Cost Sharing Limits, specifically deductibles, copayments and co-insurance</i>	Cost sharing can apply to specific covered services. Services that must have first dollar coverage could likely be determined by the state.	Cost sharing for individual procedures limits will likely be determined by carriers.	Cost-sharing limits can apply to specific covered services and are listed separately from medical services. Plans, as a whole, are held to specific actuarial value (AV) requirements and cost-sharing for specific procedures is determined by carriers but should conform to the AV requirements.	Cost sharing limits appear to follow traditional commercial benefits. Plans are not held to a specific AV requirement, but plans are required to report AV to state insurance regulators.



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<i>Annual/Lifetime Limits</i>	No annual/lifetime limits will be applicable if state adopts as EHB	There can be annual/lifetime limits applicable.	Cannot have annual or lifetime limits	Cannot have annual or lifetime limits
<i>Maximum Out of Pocket (MOOP)</i>	Out-of-Pocket Maximums will be applicable to adult dental benefits and cannot be categorized separately from medical services. States could choose to impose MOOP limit.	Out-of-Pocket Maximums may not be applicable in adult benefits.	Out-of-Pocket Maximums are applicable to pediatric dental benefits, but may have its own maximum separately from medical package. MOOP is set at \$400 for one child, \$800 for more than one child in family.	Out-of-Pocket Maximums are applicable to pediatric dental benefits. MOOP is set at \$400 for one child, and \$800 for more than one child in family.
<i>MLR/DLR</i>	Adult benefit will be incorporated as part of required MLR/DLR reporting .	Unless state legislation is passed, no requirement for reporting MLR/DLR	Pediatric benefit is incorporated as part of required MLR/DLR reporting	MLR/DLR reporting is not required, even with the pediatric dental benefit
<i>Network Adequacy</i>	Must meet and demonstrate network adequacy standards. States will likely need to determine any allowed exclusions	May not be required to meet network adequacy standards	Must meet and demonstrate network adequacy standards although many exclusions were allowed by the ACA.	Must meet and demonstrate network adequacy standards although many exclusions were allowed by the ACA.