



January 8, 2024

Via www.regulations.gov

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9895-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Patient Protection and Affordable Care Act, Notice of Benefit and Payment Parameters for 2025 (CMS-9895-P; RIN 0938-AV22)

Dear Ms. Brooks-LaSure:

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) 2025 Notice of Benefit and Payment Parameters Proposed Rule, 88 FR 82510 (November 24, 2023), and for your proposal which would allow states to add non-pediatric routine dental services as an essential health benefit (EHB). As the largest state dental association, the California Dental Association (CDA) represents the profession of dentistry in California with 27,000 member dentists. For over 150 years, CDA has been an innovative and vocal advocate for dentists, their teams, and their patients, with the goal of advancing oral health in local communities, at the state level, and nationwide and is committed to ensuring health equity for all.

CDA's commitment to advancing oral health underpins our strong support for CMS' proposal to remove the regulatory prohibition at § 156.115(d) on issuers from including routine non-pediatric dental services as an EHB. We strongly believe this proposal will significantly improve access to oral health services and increase overall population health and address health equity in both California and across the country.

As noted by CMS, this proposal would give states the opportunity to improve adult oral health and overall health outcomes, while reducing health disparities and advancing health equity. CDA offers comments to support the proposal and to provide additional information on how CMS could implement this proposal in the most efficient and effective way, while providing the widest possible impact for patients across the country.

I. CMS' Rule Reinterpretation Authority

In the proposed rule, CMS stated that the previous decision to not include routine non-pediatric services as an EHB was based on the definition of the EHB in the ACA to ensure that they are only equal in scope to the benefits provided under a typical employer plan, and CMS had concluded that dental services are not typically included in medical plans offered by employers and are often provided as excepted benefits by the employer.

CDA strongly believes that CMS' reinterpretation represents a more reasonable and less restrictive reading of the ACA, furthering the intent of the ACA to ensure that the full scope of benefits typically provided by employer plans be included as EHBs to ensure that marketplace plans align with employer-sponsored plans. In the latest National Association of Dental Plan (NADP) data, 293 million Americans, or 88% of the population are covered by some form of dental benefit with 51% of that coverage being employer sponsored.¹ Furthermore, given that this reinterpretation is based on the plain reading of the statute, CMS' decision to remove this regulatory prohibition on routine dental services as an EHB is within the scope of authority.

II. Background

The overall health benefits of dental services have been well established for decades; however, the health care system has historically removed the mouth from the rest of the body. In recent years, oral health has been spotlighted in numerous platforms – from studies connecting good oral health to improved outcomes for common diseases, recent action by CMS to redefine Medicare coverage of medically necessary dental services, many states expanding their Medicaid coverage to include adult dental services and health plans in some states starting to cover some dental services in certain situations for some enrollees. All these actions are built on a fundamental truth – that the mouth and body cannot be separated. These actions also highlight how we have historically thought about oral health needs to change to improve health outcomes for all Americans.

The pediatric dental EHB has been essential in ensuring that children have the necessary access to dental care. Studies show that the pediatric EHB in the ACA had a positive impact through increased dental coverage and higher rates of annual dental visits.^{2,3} In California, this impact can be seen in the decrease of common dental health diseases, such as caries or tooth decay. According to the California Office of Oral Health's Smile Survey (2018-20), since 2004-5, children who experience caries has dropped by 10%, untreated decay has dropped by 7%,

¹ National Association of Dental Plans, NADP Knowledge Center: 2023 Dental Benefits Report: Enrollment. December 2023. <https://knowledge.nadp.org/products/2023-dental-benefits-report-enrollment>

² JAMA Pediatric. "Improvement in preventive care of young adults after the affordable care act: the affordable care act is helping." December 2014. <https://pubmed.ncbi.nlm.nih.gov/25347766/>

³ Health Services Research. "Changes in pediatric dental coverage and visits following the implementation of the affordable care act." April 2019. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6407347/>

and dental sealants, which prevent cavities from forming, have increased by 9%.⁴ Nationally, according to the Centers for Disease Control and Prevention (CDC), the percentage of children with untreated dental caries (ages 5-19) is about 13.2%.⁵ Comparatively, adults with untreated dental caries nearly doubles with about 25% for those ages 20-64, and about 20% for those over 65.⁶ Adults also utilize dental visits at a much lower rate, with 64.1% having a cleaning or exam in the past year, compared to 86.9% of children.⁷

Even with the recent expansions of coverage, adult oral health has historically been largely placed low on the priority list of health benefits, which has particularly affected communities of color, older adults, and low-income adults. In a University of California, Los Angeles (UCLA) oral health study published in 2020, 27% of California adults reported their oral health as poor while 21% reported their overall health as poor. When broken down by demographics, 30% of African Americans and 34% of Latinx reported their oral health as poor, compared to 21% of white Californians. Poor oral health was also reported more frequently as people age – 35% by those 65 and over, versus 25%. Even among those who are at or above the FPL, according to the study, 37% still reported poor oral health.⁸

These oral health disparities in communities of color, in socioeconomically disadvantaged populations and in older adult has effects that reach far outside the mouth. Loss of teeth impact the ability to chew food, which can result in nutritional deficiencies.⁹ Periodontal disease has been linked to many chronic diseases, many of which communities of color are often at a higher risk for, such as heart disease and diabetes. Creating greater access to oral health care will have a positive impact on overall health and well-being of individuals.

III. Dental Plan Policies and Regulations

During the initial implementation of EHBs, HHS acknowledged that dental services are usually covered separately in the employer market. Therefore, states were required to select a supplemental plan as part of the benchmark plan if pediatric dental services were not included in the benchmark plan selection. This has led to a high variation in pediatric dental benefits.

⁴ California Department of Public Health, California 2018-20 3rd Grade Smile Survey. June 2021. https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/Oral%20Health%20Program/California_2019_3rd_Grade_Smile_Survey_20210730.pdf

⁵ Center for Disease Control and Prevention. Fast Stats - Oral and Dental Health (cdc.gov). Accessed December 2023. <https://www.cdc.gov/nchs/faststats/dental.htm>

⁶ Ibid.

⁷ Ibid.

⁸ UCLA Center for Health Policy Research, Income Disparities Widen the Gap in Oral Health of California Adults. November 2020. <https://digirepo.nlm.nih.gov/master/borndig/101777603/OralHealth-policybrief-nov2020.pdf>

⁹ Centers for Disease Control and Prevention. Tooth Loss (cdc.gov). Accessed December 2023. <https://www.cdc.gov/oralhealth/fast-facts/tooth-loss/index.html>

While CDA supports a state's flexibility to choose the specific type of dental benefits, we strongly urge CMS to consider a uniform dental standard which states would have the ability to build upon with the adult dental EHB. Currently there is a significant variation across the dental insurance market of services covered and plan policies, but no standard benefits or "floor" required of plans. This often leaves consumers purchasing inadequate dental coverage, coverage inappropriate to their dental needs, or simply receiving little value for their premiums.

The ACA established patient protections and transparency requirements for health plans. Unfortunately, dental plans have been nearly completely exempted from the ACA consumer protection rules and regulations. For example, dental plans are able to deny claims related to a patient's pre-existing condition, like a missing tooth or cleft palate. Similarly, dental plans can implement arbitrary waiting periods on patients before receiving care. Requiring consumers to pay premiums for sometimes up to a year before all benefits are available to consumers would be completely unacceptable with health insurance. However, this is not unheard of with dental coverage. California recognized that consumers need these basic dental plan protections and in 2023 passed AB 1048 (Wicks), which among other items prohibits dental plans from implementing waiting periods on large group products and bars preexisting condition provisions.¹⁰ These types of issues are pervasive around the nation with exemptions and loopholes enabling dental plans to operate in ways that undermine good oral health and deny consumers a meaningful benefit.

The lack of regulations in place for dental plans paired with no minimum requirements for benefits covered creates inequitable dental coverage for consumers. CDA reiterates the American Dental Association's (ADA) comments regarding categories that should be included in a dental benefit plan. We often hear from dental providers that their patients are frequently frustrated that much needed dental work is not covered or is only partially covered. Having dental insurance creates a false sense of security for consumers as they have come to expect medically necessary services to be covered, which is not the case with dental coverage. There is no guarantee that dental plans will cover necessary restorative or more complex services.

CDA echoes ADA's comments and urges CMS to clearly define a minimum benefit design to ensure EHB dental benchmark plans are reasonable and set an appropriate level of care for consumers. We applaud CMS' commitment to improving access to care through removing the regulatory prohibition. However, without creating minimum standards or putting in place greater regulation and accountability for dental plans, this will not go far enough to ensure equitable dental care.

Additionally, CDA also recommends the implementation of a required dental medical loss ratio (MLR) applied to adult dental benefits included in a Qualified Health Plan (QHP) as well as any

¹⁰ California Health and Safety Code § 1374.194 and California Insurance Code § 10120.41

Stand Alone Dental Plans (SADPs). QHPs with embedded dental coverage would have to continue to follow existing MLR requirements, however, there is no requirement for SADPs or QHPs that provide a bundled product to file a Dental Loss Ratio (DLR) report annually. An annual DLR report should meet the same goal of using a large share of premiums for patient care and establish a specific loss ratio for dental plans. **The ACA requirement on major medical plans is set at approximately 85% and CDA supports matching the benchmark loss ratio for adult dental in QHPs and SADPs at that level.**

V. Cost of Dental Care

Health care costs and premiums across the country are rising, and dental care is no exception. Nationwide dental costs rose 16% in 2021 and in California's state health insurance exchange dental premiums rose 4.3% for this current plan year.^{11,12} Last year, the California Health Care Foundation survey found that 38% of Californians have a family member who skipped dental care last year due to cost.¹³ Not only should Advance Premium Tax Credits be available to consumers to help mitigate the cost of dental coverage, but the overall structure of cost-sharing in dental care should also be addressed. A contributing factor is how dental insurance is currently structured.

Unlike other EHBs, in the Covered California marketplace, pediatric dental care can be offered within a QHP or separately, through a SADP. The embedded dental plans have a combined medical and dental deductible which creates high-cost barriers for individuals needing dental services. By comparison, someone purchasing a standalone family dental plan through Covered California will have an annual out of pocket maximum of \$350, separate from their medical out-of-pocket maximum. The unintended consequence of embedding pediatric dental in a QHP is that dental care can end up being less affordable for those who have not already used up some or all of their medical out-of-pocket maximum. **For these reasons, CDA urges CMS to require a separate dental deductible for embedded dental benefit not only in the proposed adult dental EHB, but also close this loophole for the pediatric dental EHB.**

Preventive and diagnostic dental services are crucial in maintaining good oral health and preventing dental disease. On the medical side, preventive care is not subject to deductibles or copays which has been vital to increasing the overall health of society. Eliminating cost barriers

¹¹ Health Affairs. National Health Care Spending in 2021: Decline in Federal Spending Outweighs Greater Use of Care. December 2022. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.01397>

¹² Covered California. Covered California Announces Premium Change for 2024 Dental Plans. August 2023. <https://www.coveredca.com/newsroom/news-releases/2023/08/30/covered-california-announces-premium-change-for-2024-dental-plans/>

¹³ California Health Care Foundation. The 2023 CHCF California Health Policy Survey. February 2023. <https://www.chcf.org/publication/2023-chcf-california-health-policy-survey/>

for preventive and diagnostic dental services is going to be significant for consumers and signal what has been reiterated for many decades that oral health is essential to general health and well-being.

Rather than capped annual out-of-pocket maximums set in place by the ACA, dental insurance plans continue to set both annual and lifetime benefit caps, usually at a very low annual maximum – about \$1,500 to \$2,000 on average – a number that has not changed since the 1970s. When adjusted for inflation, a \$2,000 annual maximum benefit in 1970 would be equivalent to \$15,745 in 2023 dollars.¹⁴ A single major procedure, like a root canal and crown, can cost over \$2,000 – far exceeding a patient’s annual maximum benefit.¹⁵ Similarly, it is common practice to see lifetime limits on services, such as orthodontics, which only exacerbate cost barriers for dental care. As dental costs continue to rise, consumers are faced with paying high out-of-pocket costs or foregoing much-needed dental care. An annual out-of-pocket maximum encourages consumers to seek necessary dental services without the worry of excessive costs. **CDA recommends that there be no annual or lifetime limit on covered dental services and CMS should set an annual out-of-pocket maximum for consumers.** While ensuring coverage is an important factor, changing the cost-sharing infrastructure is equally important to creating a meaningful benefit.

VI. EHB Defrayal Policy

Under current regulations, states must defray the cost of any state-mandated benefits that are above the scope of benefits provided by plans consistent with the state’s EHB benchmark plan. This defrayal requirement creates a costly hurdle for state’s ability to implement an addition of adult dental benefits to their EHB benchmark plan. In order to make this change fiscally possible for states to implement, **CDA strongly supports CMS’ proposed clarification that states will be able to add adult dental services to their EHB benchmark plans without having to defray the costs.**

VII. Conclusion

We applaud CMS for considering allowing states to include an adult oral health essential health benefit. While this proposed rule will be a huge step forward for access to care for many Americans, **CDA strongly believes that in conjunction with allowing this addition, standards and protections should be included in the final rule.** The current system of dental insurance is fundamentally broken, so simply allowing states to include a benefit in the wild west of dental insurance would fall short of the potential impact this final rule could have

¹⁴ Dollar Times. Calculate the Value of \$2,000 in 1970. Accessed January 2024.

www.dollartimes.com/inflation

¹⁵ ADA Health Policy Institute. Analysis of IBM Market Scan Dental Database. 2018.

on creating a meaningful oral health benefit throughout a patient's life, and in turn, drastically improving the quality of life for all Americans.


CDA believes there is significant opportunity for an adult dental EHB to improve patient health outcomes and increase health equity. We appreciate your consideration of our comments above and CMS' willingness to seek feedback on ways to better understand the inclusion of non-pediatric routine dental services.

Please contact Brianna Pittman-Spencer at brianna.pittman@cda.org if you have any questions about the above comments, or if we can provide any further information.

Sincerely,



Dr. Carliza Marcos
CDA President



Peter DuBois
CDA Executive Director