March 12, 2026

Mehmet Oz, M.D., M.B.A.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Notice of Benefit and Payment Parameters for 2027 [CMS–9883–P]

Dear Administrator Oz

On behalf of the Organized Dentistry Coalition (ODC), we appreciate the opportunity to comment on the proposed rule, *Patient Protection and Affordable Care Act (ACA); Notice of Benefit and Payment Parameters for 2027*. The ODC recognizes the Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services (HHS) in their commitment to reducing administrative burden and promoting innovation to streamline processes within healthcare. We offer the following comments on provisions of this rule that affect oral health coverage, patient access, and health outcomes.

Prohibition on Non-Pediatric Dental Services as an Essential Health Benefit

The ODC strongly opposes reinstating the prohibition on non-pediatric dental services as an essential health benefit. The ODC believes that coverage should be made available through both Qualifying Health Plans (QHPs) and Stand-Alone Dental Plans (SADPs), and that all dental benefits, both pediatric as well as adult benefits should be considered "Essential Health Benefits". Coverage inside and outside of the Marketplace Exchanges must include pediatric and adult dental benefits and should not include dollar-value annual and lifetime maximums.

In the proposed rule, it is noted that a prohibition on non-pediatric dental services as an essential health benefit is being reinstated due to concerns around original intent of legislative language, market volatility, and lack of possible infrastructure. However, the ODC submits that these concerns outlined in the proposed rule do not reflect the original legislative intent, current market adaptations, or current plan infrastructure since adoption of the Affordable Care Act.

CMS suggests in this proposed rule that reinstating the prohibition on non-pediatric dental services as an EHB is necessary to align with the original legislative intent of the Affordable Care Act. CMS would like to mirror the statutory definition of typical employer plans and adopt a theory of intent of permanent prohibition of the adult dental benefit. **However, this interpretation appears inconsistent with the evolution of typical employer plans, and how EHBs have been implemented in practice**. For example, mental health and substance use disorder services were designated as EHBs notwithstanding the pre-existing availability of limited benefit arrangements offered by employers, such as Employee Assistance Programs (EAPs), that historically provided behavioral health services outside of comprehensive medical coverage. Congress nevertheless ensured that mental health and substance use disorder services were included, reflecting an intent to elevate comprehensive coverage rather than defer to fragmented or limited benefit structures. The existence of separate or limited-scope dental benefits not being directly bundled with the typical employer medical plan, such as

Stand-Alone Dental Plans (SADPs), should not be similarly construed as evidence that Congress intended to exclude adult oral health services from comprehensive essential coverage. Rather it wanted to establish existing coverage frameworks without causing too much market volatility.

Additionally, in this year's proposed rule, CMS states that reinstating the prohibition on non-pediatric dental benefits is reflective of a meaningful choice made by Congress to include pediatric dental services but not include non-adult dental services. During the initial implementation of the ACA, limiting EHB to pediatric dental services reflected a measured policy choice designed to mirror the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) dental benefit in Medicaid while not imposing significant market disruption during the early years of Marketplace plan adoption. At the time, only 8 states and the District of Columbia offered comprehensive adult dental coverage within their Medicaid program[1].

More than a decade after implementation of the ACA, the individual and small-group markets have matured substantially. Health plan sponsors offering medical coverage in the large-group, small-group, and individual Marketplace markets including national carriers (i.e. UnitedHealth Group, Cigna, and Blue Cross Blue Shield Association) began to administer adult dental benefits, either embedded within medical plans or through coordinated offerings, without evidence of market destabilization. More than 38 states now provide enhanced or comprehensive adult dental benefits within their Medicaid programs, reflecting a growing recognition of the connection between oral health and overall systemic health.[2] In addition, 36 states currently have Qualified Health Plans (QHPs) in the Marketplace that embed both pediatric and adult dental benefits, demonstrating that inclusion of adult dental services promotes competition and consumer choice rather than volatility.[3]

The initial decision by Congress not to expressly include adult dental services within the Essential Health Benefit (EHB) categories should not be interpreted as a permanent or purposeful exclusion. Rather, it reflected the structure and stability concerns of the commercial market at the time of the ACA's enactment. Importantly, Congress granted the Secretary of Health and Human Services broad authority under Sections 1302(b)(4)(G) and 1302(b)(4)(H) to periodically review and update EHB standards through rulemaking to reflect evolving medical evidence, market practices, and consumer needs. That delegation of authority demonstrates congressional intent that EHB standards remain dynamic and responsive.

Finally, **there is little evidence to suggest QHPs would have difficulty administering a dental benefit as stated in the proposed rule**. As previously stated, there are 36 states in which QHPs have both pediatric and adult dental benefits into their plans. Additionally, major health plan sponsors who participate in the Marketplace Exchanges, such as Blue Cross Blue Shield, Humana, UnitedHealthcare, CVS/Aetna, already offer a dental supplemental benefit as part of their Medicare Advantage plans in the state. This indicates that QHPs not only have the

[1] Medicaid adult dental benefits by state. PBS NewsHour. Published November 16, 2011. Accessed February 16, 2026. https://www.pbs.org/newshour/spc/multimedia/20111116-dental/#2010
[2] American Dental Association. Dental care in Medicaid programs. Health Policy Institute. December 2025. https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/dental_care_in_medicaid_programs.pdf
[3] Elani HW, Rahman MS, Wallace J, Rosenthal MB, Sommers BD. Availability Of Adult Dental Plans In The Affordable Care Act Marketplaces, 2016-Health Aff (Millwood). 2024;43(11):1587-1596. doi:10.1377/hlthaff.2024.00307

infrastructure and means to offer this benefit, but that they should be empowered, rather than hindered, to offer dental benefits in the Marketplace Exchanges. In this context, continued prohibition of non-pediatric dental services as an EHB no longer serves its original purpose and would go against evolving markets and adult dental coverage in states. Similarly to how states may choose to offer a Medicaid adult dental benefit, states should be given the choice to establish adult dental as an essential benefit within their EHB-benchmark plan. Given the substantial evolution and stabilization of the insurance markets, along with clear evidence demonstrating the feasibility of integrating adult dental coverage, **the ODC strongly supports the continued removal of the prohibition on non-pediatric dental services as an Essential Health Benefit.** Doing so would be consistent with current market realities and congressional intent, while fostering greater competition, lowering overall health care costs, and reducing fragmentation in healthcare for consumers — which are priorities reflected in President Donald Trump's health care agenda.

Stand Alone Dental Plans & Reducing Percentages for Essential Community Providers (ECPs)

Currently, QHPs and SADPs are required to include a certain percentage of Essential Community Providers (ECPs), which are designated in-network providers that are primarily treating underserved or low-income patients. **The ODC does not support CMS's proposal to lower required ECP percentages from 35% to 20%.** The ECP requirement ensures that lower-income consumers who purchased QHPs or SADPs in the Marketplace Exchanges will have access to providers who can treat them at lower costs or treat their family members who utilize programs like Medicare or Medicaid. It also ensures that providers who take on financial losses are more regularly included in commercial networks to help offset the losses from sliding fee scales or low reimbursements they must take on as safety-net providers.

CMS characterizes the proposed reduction in the ECP threshold as a reduction in regulatory burden, which allows plan sponsors to redirect resources for innovation or consumer savings. However, the fundamental purpose of ECP standards is access for patients. The ODC believes that there is already a limited network of ECPs in QHPs or SADPs as many might not be accepting new patients. Currently, many dental clinics and Federally Qualified Health Centers who serve as ECPs are not able to accept new patients due to workforce constraints.[4] By lowering the ECP percentage, CMS may inadvertently create a limited or ghost network for already underserved or low-income patients. Underestimating the need for ECPs risks placing plan design flexibility over ensuring access for vulnerable or struggling policyholders.

Medical Loss Ratio (MLR)/Dental Loss Ratio (DLR)

As mentioned in the proposed rule, CMS is seeking comment on whether modifying the federal MLR standard and criteria used to assess MLR adjustments, with the aim of reducing administrative burden and allowing states more flexibility in tailoring MLR approaches to their individual markets. While the ODC supports efforts to streamline reporting and reduce administrative burden in the healthcare system, **we strongly oppose any changes to current**

[4] 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

MLR reporting requirements for QHPs which would further allow for state-based adjustments. Weaker enforcement and reporting for MLR will possibly deprive beneficiaries of the full "bill of goods" they were sold when selecting their plan on the Marketplace Exchanges. Preserving MLR reporting remains essential in maintaining meaningful incentives for plans to increase access to care for their policyholders.

Instead of the changes mentioned in the proposed rule, **the ODC believes that CMS should go further and require MLR/DLR reporting requirements for SADPs**. At a minimum, CMS should require annual, public DLR reporting for SADPs using a standardized methodology, and ensure appropriate consumer relief, including rebates, when plans fail to meet the applicable loss ratio standard. As evidenced in states like California, 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.[5,6] Requiring MLR for SADPs would align with pledges by President Donald Trump to mandate price transparency across the healthcare system.

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The ODC 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 regarding these comments. Please contact Mr. David Linn (linnd@ada.org) at the American Dental Association (ADA) to facilitate further discussion.

Sincerely,

American Dental Association
American Academy of Oral & Maxillofacial Pathology
American Academy of Orofacial Pain
American Academy of Pediatric Dentistry
American Academy of Periodontology
American Association for Dental, Oral, and Craniofacial Research
American Association of Endodontists
American Association of Oral and Maxillofacial Surgeons
American Association of Orthodontists
American Association of Public Health Dentistry
American Society of Dentist Anesthesiologists
American Student Dental Association
National Dental Association
National Network for Oral Health Access

[5] 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
[6] California Department of Managed Health Care (2023), 2022 Dental Medical Loss Ratio (MLR) Summary.