ADEA THE VOICE OF DENTAL EDUCATION

AMERICAN DENTAL EDUCATION ASSOCIATION

The mission of ADEA is to develop an inclusive, future-ready oral health workforce prepared to improve the health of all people and communities through leadership, education and collaboration.

655 K Street, NW, Suite 800
Washington, DC 20001
Phone: 202.289.7201
Fax: 202.289.7204
adea.org

March 12, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

The American Dental Education Association (ADEA) appreciates the opportunity to submit comments on the proposed rule regarding the *Patient Protection and Affordable Care Act (ACA), HHS Notice of Benefit and Payment Parameters for 2027* and *Basic Health Program (CMS-9883-P; 0938-AV62)* issued by the Centers for Medicare & Medicaid Services (CMS).

I. Introduction

As *The Voice of Oral Health Education*, ADEA is the sole national organization representing more than 65,000 oral health faculty, staff, administrators, students, residents and fellows. Our members include all 87 U.S. and Canadian dental schools, more than 800 allied and advanced dental education programs, more than 50 corporations and over 15,000 individuals.

Our activities encompass a wide range of research, advocacy, faculty and leadership development, meetings, news and publications, including the peer-reviewed *Journal of Dental Education*. We also offer the following dental education centralized application services: ADEA AADSAS®, ADEA CAAPID®, ADEA DHCAS® and ADEA PASS®.

ADEA respectfully urges CMS not to finalize the proposed reinstatement of the prohibition on adult dental services as an Essential Health Benefit (EHB). Maintaining flexibility for states to include adult dental services in their EHB benchmark plans aligns with the statutory framework established by the ACA, improves health outcomes, reduces health care expenditures and supports the long-term sustainability of the oral health workforce.[1]

Though many issues are raised in the Notice, ADEA will focus its comments on the proposed reinstatement of the prohibition on including routine, non-pediatric dental services as an EHB under 45 CFR §156.115(d).

II. CMS's Proposed Interpretation of ACA §1302 Is Difficult to Reconcile With the Statutory Text and Structure

CMS proposes to reinstate the prohibition based on its interpretation of ACA §§1302(b)(1) and 1302(b)(2), arguing that the statute's explicit reference to pediatric oral care implies that Congress intended to exclude routine, non-pediatric dental services from EHB.[2] This interpretation is challenging to reconcile with the statutory text, structure and purpose of

the ACA. The statute establishes minimum benefit categories and delegates to the HHS Secretary authority to define the scope of EHB consistent with benefits provided under a typical employer plan. Read in context, the ACA permits, rather than prohibits, states from including adult dental services in benchmark plans.

A. The 10 EHB Categories Establish a Minimum Floor, not a Maximum Ceiling

Section 1302(b)(1) establishes ten minimum categories of essential health benefits, including pediatric services with oral care.[3] The statute does not state that this list is exhaustive; rather, the categories create a baseline framework.

CMS has historically interpreted these categories as minimum standards, allowing states flexibility to include additional services in benchmark plans so long as they satisfy the statutory "typical employer plan" standard.[4] Including routine adult dental services as an EHB is therefore consistent with the statutory framework, provided that a state's benchmark plan satisfies the "'typical employer plan' standard" under ACA §1302(b)(2).[5]

B. The "Typical Employer Plan" Standard Supports Inclusion of Dental Coverage

The proposed rule interprets a "typical employer plan" under ACA §1302(b)(2)(A) to refer solely to a major medical plan.[6] However, employer-sponsored benefits frequently include dental coverage as part of the overall compensation package.[7] The fact that benefits are sometimes offered through separate insurance products does not render them atypical.

CMS previously recognized this reality when finalizing the 2025 Payment Notice, recognizing that dental benefits are commonly included in employer-sponsored packages and meaningfully contribute to health and well-being.[8] CMS's prior interpretation, that "typical employer plans" consider the broader set of benefits, is therefore reasonable and supported by evidence.

C. The Structure of the ACA Demonstrates That Distinguishing Pediatric Services Does Not Prohibit Adult Coverage

The structure of the ACA further confirms that the statute does not prohibit the inclusion of adult dental services within an EHB benchmark plan. Section 1302(b)(1) establishes 10 minimum categories of EHB, including "pediatric services, including oral and vision care." However, the statute's reference to pediatric oral care does not imply that adult oral health services are excluded from coverage. Rather, Congress frequently used pediatric-specific language throughout the ACA to ensure that children received guaranteed access to certain benefits without simultaneously prohibiting coverage for adults.

For example, the ACA separately identifies pediatric preventive services and immunizations while also requiring coverage of preventive services for adults. In the same manner, the inclusion of pediatric oral care ensures that children have guaranteed access to dental services but does not establish a statutory prohibition on adult dental coverage. Had Congress intended to categorically exclude routine adult dental services from EHB benchmark plans, it could have done so explicitly. The statute contains no such prohibition. See also 42 U.S.C. §300gg-13 (preventive health services requirements under the ACA).

Moreover, Section 1302(b)(1) establishes the EHB categories as a minimum floor of benefits rather than an exhaustive list of permissible services. The ACA repeatedly grants the HHS Secretary discretion to define the scope of benefits within these categories and to ensure

that EHB coverage is equal in scope to that provided under a typical employer plan. The statutory framework therefore anticipates that additional services may be included in benchmark plans where consistent with the "typical employer plan" standard. Interpreting the pediatric oral care provision as implicitly prohibiting adult dental services would conflict with this broader statutory structure and would unnecessarily constrain the Secretary's authority to define EHB in a manner consistent with evolving evidence regarding preventive care and population health.

D. The ACA Emphasizes Preventive Care and Integrated Health

The ACA aims to improve preventive care and reduce avoidable health care spending.[9] Oral health is increasingly recognized as essential to overall health, and expanding access aligns with these goals.[10] Interpreting ACA §1302 to allow states to include adult dental benefits, advances these statutory objectives.

III. CMS's Operational Concerns Regarding Current Dental Terminology (CDT) Codes and Provider Networks Do Not Justify Reinstating the Prohibition

CMS expresses concern that including routine adult dental services as an EHB could create operational challenges, including the use of dental coding systems and provider network development.[11] These concerns, while noted, do not justify a categorical prohibition.

A. Use of CDT Codes Is a Long-standing Administrative Standard

Dental services are reported using the CDT coding system maintained by the American Dental Association.[12] CDT codes are the national standard for documentation and claims processing, widely used in Medicaid, Children's Health Insurance Program (CHIP) and commercial insurance programs.[13] Existing administrative infrastructure supports coding for dental services, and including dental benefits in EHB plans would not require a new system.

B. Additional Considerations Regarding CDT Infrastructure and Administrative Feasibility

The notice of proposed rulemaking (NPRM) suggests that including adult dental services within EHB benchmark plans could require medical plans to develop new operational infrastructure to process claims using the CDT code set. While administrative considerations are relevant to implementation, the existence of a separate dental coding system does not present a significant barrier to integrating dental services into health coverage.

CDT codes have long served as the national standard for reporting dental procedures across both public and private insurance programs. Medicaid programs in many states administer adult dental benefits using CDT codes through managed care arrangements or contracted dental benefit administrators. Similarly, commercial insurers routinely coordinate benefits with stand-alone dental plans, which already process claims using CDT codes.

Health insurers frequently administer benefits that rely on specialized coding systems or provider networks distinct from traditional medical services. Pharmacy benefits, behavioral health services and vision coverage are commonly administered through separate claims processing systems or specialized vendor arrangements. The existence of a dedicated

coding framework for dental services is therefore not unique within the health insurance market.

The NPRM also raises the possibility that operational investments associated with CDT coding could increase premiums. However, evidence suggests that improved access to dental care may reduce overall health care expenditures by preventing costly complications and reducing avoidable emergency department utilization for dental conditions. Studies have shown that treatment of periodontal disease among patients with chronic conditions, such as diabetes and cardiovascular disease, is associated with measurable reductions in total medical spending.

Concerns regarding the development of dental provider networks are similarly manageable within existing insurance market structures. Many insurers already contract with dental provider networks through stand-alone dental plans or third-party, dental benefit managers. These arrangements demonstrate that provider network infrastructure for dental services is well-established and can be readily integrated into broader coverage offerings.

Taken together, these considerations indicate that operational concerns regarding CDT coding, administrative infrastructure and provider networks do not present a meaningful barrier to including adult dental services in EHB benchmark plans. Health insurance markets routinely adapt to incorporate new benefits and provider types, and existing dental administrative systems provide a strong foundation for integrating oral health services within comprehensive coverage.

C. Provider Network Concerns Are Manageable

Dental provider networks are widely established across public and private insurance markets. Insurers routinely coordinate with stand-alone pediatric dental plans, demonstrating the feasibility of integrating adult dental services.[14] Existing network structures are sufficient to support inclusion of adult dental coverage in EHB benchmark plans.

D. CMS Previously Recognized Integration Benefits

CMS previously acknowledged in the 2025 Payment Notice that expanding access to dental services could improve health outcomes and system efficiency.[15] Reinstituting a prohibition based on administrative coding concerns would reverse policy despite prior recognition of these benefits.

E. Administrative Considerations Do Not Justify Reversal

Health insurance markets routinely adapt to new services, and the benefits of adult dental coverage, improved chronic disease management, reduced emergency department utilization and lower overall costs, far outweigh administrative considerations.[16]

IV. Access to Dental Care Improves Health Outcomes and Reduces Health Care Costs

A. Dental Treatment Reduces Medical Costs for Chronic Disease

Treatment of periodontal disease significantly reduces medical costs. Patients with diabetes saved $1,814 annually, and those with coronary artery disease saved $2,832

following periodontal treatment.[17] Additional studies report savings of $2,840 – $5,691 per patient.[18]

B. Lack of Dental Access Drives Costly Emergency Department Use

Over two million emergency department visits occur annually for dental conditions.[19] Emergency departments provide temporary relief, resulting in repeated visits.[20] Nationally, such visits cost $2 billion, with potential savings of $1.7 billion if treated in dental offices.[21] Medicaid spent $520 million on dental emergency department visits in 2012.[22] Expanding access shifts care to lower-cost preventive settings.

C. Adult Dental Coverage Improves System Efficiency

Evidence shows emergency department utilization increases when dental coverage is limited.[23] Expanding adult dental access reduces avoidable spending and improves system efficiency.

V. Maintaining State Flexibility Supports Health Accessibility and a Strong Oral Health Workforce

Allowing states to include adult dental services in EHB plans is an important tool for addressing persistent oral health disparities and strengthening the oral health care system. Low-income adults, rural populations and communities of color experience significantly higher rates of untreated dental disease, underscoring the need for expanded access to coverage and care.[24] Expanding adult dental coverage can help improve population health outcomes while also reinforcing the oral health workforce pipeline. Dental schools and allied dental education programs train the next generation of dentists, dental hygienists and specialists, and broader coverage increases opportunities for clinical training and integrated care delivery.[25] [26] Conversely, restricting adult dental coverage risks perpetuating existing access gaps and limiting opportunities for oral health professionals to meet the needs of underserved populations.

VI. Policy Consistency and Reliance Interests

When agencies change regulatory interpretations, they must provide reasoned explanations and consider reliance interests.[27] CMS's prior rulemaking allowed states greater flexibility, and stakeholders have acted in reliance on that policy.[28] Reinstating a prohibition could disrupt integration efforts and insurance planning.[29] Agencies must justify reversals with evidence.[30] Given existing administrative frameworks and CMS's prior recognition of integration benefits, we encourage additional consideration of reliance interests in evaluating the proposed change.

VII. Conclusion

ADEA urges CMS not to finalize the prohibition on routine non-pediatric, dental services as an EHB. Evidence demonstrates that adult dental coverage:

- Improves chronic disease management,
- Reduces preventable emergency department visits,
- Lowers overall medical spending and
- Strengthens oral health integration into whole-body health care.

Maintaining flexibility for states promotes preventive care and population health, lowers medical costs and promotes workforce stability.

ADEA appreciates the opportunity to submit these comments and looks forward to collaboration with CMS.

Sincerely,

Karen P. West

Karen P. West, D.M.D., M.P.H.
President and CEO

ENDNOTES

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1302, 124 Stat. 119 (2010).

2. Id. §1302(b)(1).

3. Id. §1302(b)(1).

4. Centers for Medicare & Medicaid Services, Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, 78 Fed. Reg. 12,834 (Feb. 25, 2013).

5. Patient Protection and Affordable Care Act §1302(b)(2).

6. Id.

7. Kaiser Family Foundation, Employer Health Benefits Survey (2023).

8. Centers for Medicare & Medicaid Services, HHS Notice of Benefit and Payment Parameters for 2025, 89 Fed. Reg. 26,290 (Apr. 12, 2024).

9. Public Health Service Act §2713, 42 U.S.C. §300gg-13.

10. Institute of Medicine, Advancing Oral Health in America (2011).

11. Marjorie Jeffcoat et al., Impact of Periodontal Therapy on General Health, 93 J. Am. Dent. Ass'n 1 (2014).

12. Marjorie Jeffcoat et al., Does Treatment of Oral Disease Reduce Medical Costs?, 33 Health Affairs 1729 (2014).

13. Health Resources & Services Administration, Oral Health Workforce Projections (2022).

14. American Dental Association, Emergency Department Visits for Dental Conditions—A National Crisis (2021).

15. ADA Health Policy Institute, Emergency Department Visits for Dental Conditions (2019).

16. Centers for Medicare & Medicaid Services, Medicaid Emergency Department Utilization for Dental Conditions (2014).

17. Association of State and Territorial Dental Directors, Emergency Department Use for Dental Conditions and Medicaid Adult Dental Benefits (2019).

18. U.S. Department of Health and Human Services, Oral Health in America: Advances and Challenges (2021).

19. American Dental Education Association, U.S. Dental School Applicant and Enrollment Data (2023).

20. ADA Health Policy Institute, Integration of Medical and Dental Benefits (2022).

21. Centers for Medicare & Medicaid Services, HHS Notice of Benefit and Payment Parameters for 2027, Notice of Proposed Rulemaking (2026).

22. American Dental Association, Current Dental Terminology (CDT) Code Set (latest ed.).

23. Centers for Medicare & Medicaid Services, Medicaid Dental Benefits Overview (2023).

24. Centers for Medicare & Medicaid Services, Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond, 79 Fed. Reg. 30,240 (May 27, 2014).

25. Centers for Medicare & Medicaid Services, HHS Notice of Benefit and Payment Parameters for 2025, 89 Fed. Reg. 26,290 (2024).

26. Patient Protection and Affordable Care Act §1302.

27. Department of Homeland Security v. Regents of the Univ. of California, 591 U.S. 1, 30–31 (2020).

28. Centers for Medicare & Medicaid Services, HHS Notice of Benefit and Payment Parameters for 2025, 89 Fed. Reg. 26,290 (2024).

29. FCC v. Fox Television Stations, Inc., 556 U.S. 502, 515–16 (2009).

30. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1302, codified at 42 U.S.C. §18022.