ADA American Dental Association®

1111 14th Street, N.W.
Suite 1200
Washington, DC 20005

T 202.898.2400
F 202.898.2437
www.ada.org

May 16, 2023

The Honorable Brett Guthrie
Chair, Health Subcommittee
Committee on Energy & Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Anna Eshoo
Ranking Member, Health Subcommittee
Committee on Energy & Commerce
2232 Rayburn House Office Building
Washington, DC 20515

Re: Subcommittee on Health Markup, Wednesday, May 17, 2023

Dear Chairman Guthrie and Ranking Member Eshoo:

On behalf of the American Dental Association (ADA) and our 159,000 members, we appreciate your work on the issue of transparency and consolidation and we look forward to working together to advance these issues. The ADA continues to fully support Congress and the Administration pursuing transparency and consolidation in health care, specifically as it applies to dental insurance markets.

Transparency

One of the areas in health care worth exploring a greater focus on transparency is from the health insurance industry and whether a particular insurance carrier that administers claims for the Employee Retirement Income Security Act of 1974 (ERISA) plan is operating as plan fiduciary. Clarification of fiduciary status could help clarify whether and to what extent states may regulate the activities of those insurance companies. The Supreme Court of the United States clarified in Rutledge v. Pharm. Care Mgmt. Assoc., 141 S. Ct. 474 (2020), that ERISA preemption is primarily concerned with state laws that regulate what benefits a plan provides, who can be a beneficiary, and the core administrative functions of an ERISA plan, such as plan design and federal reporting obligations. The issue of whether an insurance company is a plan fiduciary is relevant to the preemption analysis because only fiduciaries can exercise discretion in the administration of a plan. If an insurance company is not a plan fiduciary, it legally cannot exercise discretion on behalf of the plan, and thus state regulation of a non-fiduciary is less likely to encumber the kind of core administrative functions that Congress sought to insulate from state regulation.

Congress specified in 29 U.S.C. § 1002(21)(A) that any person who exercises discretion in the administration or management of a plan must assume the fiduciary duties that a plan owes to its beneficiaries. Section 1002(21)(A) states in pertinent part: "a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, … or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan." ERISA requires plan fiduciaries to act solely in the interests of the plan's participants and beneficiaries. *See* 29 U.S.C. § 1104(a)(1).

Historically, companies that manage claims for the ERISA plans, have sought to avoid declaring their fiduciary status because they want to enjoy the benefits of being considered part of the plan (such as for preemption purposes) without incurring a fiduciary's potential liability and restraints

on profit-seeking behavior. We believe that if carriers must be made to declare their fiduciary role much like financial advisors must, then consumers will ultimately benefit by being able to differentiate who to seek assistance from regarding the regulation of their plan, whether at the state or federal level. There has been confusion on a state regulatory level as to the extent of ERISA preemption of the consumer protections found under state insurance laws.

It is for this reason we propose the following update to ERISA:

SEC. 1.—Title I Part 5 of the Employee Retirement Security Act of 1974 is amended by inserting after section 731(a)(2) (29 U.S.C. §1191(a)(2)) Continued applicability of State law with respect to health insurance issuers, the following new subparagraph:

‘‘(3) The administrator of each group health plan or a health insurance issuer offering group health insurance coverage shall cause to be furnished to each participant covered under the plan or coverage and to each beneficiary who is receiving benefits under the plan or coverage information as to:

(a) whether the particular insurance company that administers claims for the plan or coverage is operating as plan fiduciary pursuant to section 3(21)(A) (29 U.S.C.§1002(21)(A)), and

(b) the applicability of State insurance laws with respect to such plan or issuer, and whether the plan or issuer is not subject to the requirements of State insurance laws due to the preemption provisions of section 514 (29 U.S.C. §1144).”

Subparagraph (3)(a) is designed to require insurers and plans to state expressly who is a fiduciary and is exercising discretion for the plan which would be beneficial in defining the relationship between the beneficiaries and the companies who process their claims, as well as the authority of the states to regulate the companies who provide such services. Subparagraph (3)(b) is designed to clarify for state regulators and beneficiaries which plans do and which plans do not offer the consumer protections found under state insurance laws. Finally, section 731(a) of ERISA was selected for the above amendments since it specifically pertains to **‘‘**Continued applicability of State law with respect to health insurance issuers.”

Consolidation

Dentists and their patients are negatively impacted by the non-covered service provisions among entities in the health insurance industry, stifling competition. Non-covered services provisions in dental and vision plans disadvantage enrollees and providers because they interfere with the patient-doctor relationship, skew the pricing charged to non-subscribers, and encourage the consolidation of the dental and vision insurance industries, resulting in higher premiums overall. Consolidation occurs because larger plans leverage their greater market share to push doctors into accepting provisions, such as non-covered services, as part of their “take it or leave it” contracts. These practices place the smaller dental and vision carriers at a competitive disadvantage and shift costs rather than reducing them.

The result is a dental plan market dominated by only a few national carriers in many states, and a shifting of costs to patients who are paying for their coverage out of their own pockets or whose dentist or optometrist is out of network. The ADA and the dentists we represent are not opposed to dental plans building strong networks and seeking discounts for their subscribers, but we seek less consolidation and greater competition.

The Dental and Optometric Care (DOC) Access Act, H.R. 1385, would prohibit dental and vision plans from setting the fees network doctors may charge for services not covered by the insurers, from providing unreasonably minimal compensation for services rendered, and from forcing doctors into participating in contracts of excess of two years. This bill is narrowly drawn to apply only to the business of dental and vision insurance plans regulated by the federal government.

****

Thank you again for your work to improve transparency and consolidation in health care. We would welcome the opportunity to speak with you in more detail and answer any questions you have regarding these efforts. Please contact Ms. Natalie Hales at (202) 898-2404 or halesn@ada.org to facilitate further discussions.

Sincerely,

George R. Shepley, D.D.S.
President

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

GRS:RAC:nh