

January 22, 2026

The Honorable Brett Guthrie  
Chairman, House Committee on Energy  
and Commerce  
2125 Rayburn House Office Building  
Washington, D.C. 20515

The Honorable Jason Smith  
Chairman, House Committee on Ways  
and Means  
1139 Longworth House Office Building  
Washington, D.C. 20515

The Honorable Frank Pallone Jr.  
Ranking Member, House Committee on  
Energy and Commerce  
2323 Rayburn House Office Building  
Washington, D.C. 20515

The Honorable Richard E. Neal  
Ranking Member, House Committee on  
Ways and Means  
1129 Longworth House Office Building  
Washington, D.C. 20515

**Re: ADA comments for the record for January 22, 2026, hearings with health insurance company CEOs, dental market reforms including ERISA and third-party administrator transparency**

Dear Chairman Guthrie, Chairman Smith, Ranking Member Pallone, and Ranking Member Neal:

As the leading authority on oral health in the United States, the American Dental Association (ADA) appreciates the opportunity to provide comments for the record in connection with the House Energy and Commerce and House Ways and Means hearings with chief executive officers of five large health insurance organizations. While the stated focus is overall commercial affordability, these hearings are a timely opportunity to examine market reforms that directly affect patients' access to dental care and the ability of dentists to deliver that care efficiently and transparently.

Commercial dental coverage is commonly structured with substantial cost shifting to families for major services. Large insurers' consumer-facing materials describe a common commercial dental benefit design in which preventive services are covered at higher levels, while major services such as crowns are often covered at around 50 percent, leaving substantial patient cost sharing.<sup>123</sup> Our ADA policy recognizes that co-insurance is a major contributor to out-of-pocket costs and that significant co-insurance creates cost

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<sup>1</sup> UnitedHealthcare, "Dental insurance," accessed Jan. 14, 2026, <https://www.uhc.com/dental-vision-supplemental-plans/dental-insurance>

<sup>2</sup> Delta Dental, "What Does My Dental Insurance Cover?" DeltaDentalks, accessed Jan. 14, 2026, <https://deltadentalks.com/knowledge/what-does-my-dental-insurance-cover>

<sup>3</sup> Delta Dental of Ohio, "Dental Benefits for Individuals," accessed Jan. 14, 2026, <https://www.deltadentaloh.com/Member/Plans>

barriers to care. Additionally, we support coverage of diagnostic and preventive services at 100 percent, without counting those services toward annual maximums.

Against that backdrop, the ADA urges the Committees to use these hearings to obtain concrete, plan-level dental information and to advance reforms that improve transparency, accountability, and competition, particularly in ERISA self-funded arrangements where insurers operate as third-party administrators (TPAs) and where, in practice, plan participants and providers often cannot determine who set the rules that drove a denial, reduction, down coding, bundling, or recoupment.

Below are the ADA's recommended oversight priorities and reform considerations.

### **1) Require standardized dental affordability and performance reporting (insured and ERISA-administered)**

The ADA recommends that the Committees request, at a minimum, standardized plan-level reporting for commercial dental (insured products and ERISA-administered) that enables an apples-to-apples comparison across issuers and products. We support transparency tools for plan purchasers and enrollees, including requiring dental plans to provide an easily accessible summary of benefits on the payer's web portal and specifying core elements that should be included.

At minimum, the Committees should request:

- Premiums and benefit value (including annual maximums, deductibles, co-payments, co-insurance, limitations, waiting periods, out-of-network coverage, and alternate benefit provisions).
- Patient liability drivers, with a focus on co-insurance for major services and the interaction of co-insurance with annual maximums.
- Denial rates, claim reduction rates, overturn rates on appeal, and payment timeliness (see Section 4).

The ADA also supports transparent reporting of Medical (Dental) Loss Ratios (MLR/DLR) for dental plans, including a comprehensive report of plans and enrollees meeting the required ratio.

### **2) Lift the "TPA veil" in ERISA dental: who set the rules, who is accountable, and who benefits financially**

For ERISA self-funded dental arrangements, the Committees should require clarity on governance and accountability, including who controls key policies and outcomes: coverage rules, claim edits and payment policies, downcoding and bundling logic, and appeals decision-making.

Our ADA policy on ERISA plans supports reforms to protect patients and dentists, including:

- Ensuring patients have freedom of choice, including reimbursement for services provided by the dentist of the patient's choice.
- Eliminating missing tooth clauses after one year.
- Establishing meaningful remedies for insurer bad faith.
- Making insurers responsible for negligent utilization review, including negligent reduction or denial of a claim for necessary treatment.
- Providing "substantially equal" external review under ERISA.

In addition, the Committees should require standardized disclosure to plan sponsors of all direct and indirect compensation and incentives tied to claims volume or outcomes. This objective aligns with the broader ADA position that contractual and administrative practices should not obscure responsibility or undermine patients' ability to understand benefit determinations.

### **3) Stop non-consensual network expansion and "rate leasing" in dental**

Network leasing, rental networks, and repricing arrangements raise acute transparency and consent concerns in dental contracting. We feel strongly that dentists should not be forced into new contractual relationships without affirmative agreement.

Our ADA policy on third-party payer contracting practices provides:

- Contract amendments should require the dentist's signature and should be presented as an opt-in contract, with at least 90-days advance notice.
- When a payer uses a dentist's "name, image and likeness" for a new plan or new provider network, the dentist should have the option to opt in.

Accordingly, the ADA recommends the Committees seek policies that:

- Require affirmative, written provider consent before a contracted rate is leased, rented, repriced, or otherwise made available to an entity the dentist did not contract with directly.
- Require clear, advance disclosure to plan sponsors and beneficiaries when dental network access is provided through leased or rented arrangements, including the identity of all entities that can access contracted rates.
- Require that Medicare Advantage plan sponsors have to opt-in in treating Medicare Advantage beneficiaries, rather than being automatically enrolled into Medicare Advantage supplemental dental benefits when a dentist is in-network for their commercial plans.

#### **4) Claims administration reforms: timely payment, clear explanations, licensed review, and limits on recoupments**

##### *A. Timely payment and remittance transparency*

We support requiring third-party payers to process and pay clean claims within 15 business days, with penalties for failure to do so. The ADA also supports claim reimbursement within 15 business days and preserving a dentist's ability to receive payments by paper check.

##### *B. Standardized explanation of benefit reductions and accountability*

When a payer reduces or denies a claim, the patient and provider should be able to understand precisely what happened and why. We are calling for:

- EOB reporting that includes the CDT codes as submitted and a statement indicating how the submitted procedures were adjudicated.
- A national standard grounded in the ADA model EOB statement. Identifying a specific individual acting on behalf of the carrier, with contact information, in correspondence to the patient regarding dental claims.
- Ensuring dentists reviewing claims submissions are licensed in the United States, preferably in the treating dentist's jurisdiction consistent with state law.

##### *C. Post-payment reviews and recoupments*

Our ADA policy limits retroactive denials and adjustments and establishes process protections for dentists, including:

- No retroactive denial or adjustment beyond six months from the date the claim was adjudicated, absent fraud or duplicate payment.
- Providing notice with claim and patient identifiers and allowing at least 30-days for the dentist to contest the payers' contention of overpayment.

#### **5) Protect freedom of choice and ensure networks are adequate in practice, not only on paper**

We believe a patient's right to choose any licensed dentist must be preserved and oppose arrangements that eliminate or limit freedom of choice. The ADA further opposes closed panel, EPO-only, or DHMO-only approaches as the only dental options available and recommend that sponsors offering such designs also offer a freedom-of-choice plan with equal benefits and permit periodic opportunities to change plans, with premium dollars increasing annually.

Accordingly, we recommend the Committees:

- Demand audit-ready evidence of directory accuracy and appointment availability.
- Require disclosure when network limits may require a patient to change dentists to use coverage.
- Examine how network adequacy is assessed across both insured products and ERISA-administered business, given that self-funded enrollment can materially affect real-world network capacity.

#### **6) Address benefit designs that create predictable cost barriers**

The ADA does not support annual or lifetime maximums in dental benefit programs and recognizes total out-of-pocket costs as a barrier to care. When annual maximums are used, the ADA supports requiring issuers to evaluate utilization and out-of-pocket costs annually and to increase annual maximums at least based on the CPI for dental services. This is particularly salient given ongoing increases in the dental services CPI reported by the Bureau of Labor Statistics.<sup>4</sup>

The ADA also supports eliminating waiting periods for children in dental benefit plans.

#### **7) Modernize administration through standards that reduce friction and support affordability**

Finally, administrative burdens raise costs for providers and patients. ADA policy supports encouraging movement toward real-time claims adjudication and supporting development of electronic standards for electronic data interchange to enable it. These same principles support Committee inquiry into eligibility and benefits tools, clearer remittance and reduction coding, and interoperability investments that reduce administrative costs and improve patient experience.

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<sup>4</sup> U.S. Bureau of Labor Statistics, "Table 7. Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, by expenditure category and commodity and service group," news release, accessed Jan. 14, 2026, <https://www.bls.gov/news.release/cpi.t07.htm>

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Ranking Members Pallone and Neal  
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The ADA appreciates the Committees' attention to commercial affordability and urges focused oversight of the dental market, especially where vertical integration and ERISA-administered arrangements can obscure decision-making, limit competition, and shift costs to families. We would be pleased to serve as a resource as the Committee continues this work, or to assist in identifying practicing dentists who can speak directly to how benefit design and financing affect patients' ability to obtain care. If you have any questions, please contact Natalie Hales at [halesn@ada.org](mailto:halesn@ada.org).

Sincerely,

/s/

Richard Rosato, D.D.S.  
President

/s/

Elizabeth Shapiro, D.D.S., J.D., C.A.E.  
Interim Executive Director