ADA American Dental Association®

400 C Street N.E.
Washington, D.C. 20002
202.898.2400 • ADA.org

November 19, 2025

The Honorable Mike Crapo
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

Re: "The Rising Cost of Health Care: Considering Meaningful Solutions for all Americans"

Dear Chairman Crapo, Ranking Member Wyden, and Members of the Committee:

As the leading authority on oral health in the United States, the American Dental Association (ADA), representing more than 150,000 dentists nationwide, writes to provide the Committee with our perspective on how oral health fits into the broader discussion of health care costs and coverage. The ADA strongly urges that any discussion of health care costs must explicitly include oral health. Oral health is inseparable from overall health, and preventable dental disease continues to drive avoidable pain, lost productivity, and emergency department visits, especially among low-income and medically vulnerable populations.

Below, we offer several recommendations to help the Committee address costs while improving value and access to dental care.

1. Make prevention and early intervention central to any cost strategy

Long-term cost containment in health care is not possible without robust investment in prevention. We emphasize that prevention is the key to improving and maintaining oral health, and that community-based measures, like water fluoridation and school-based prevention programs, are proven, cost-effective strategies that reduce disease burden.

For dentistry, cost-effective reforms should:

- Ensure diagnostic and preventive dental services are covered in a way that does not create financial barriers.
- Avoid benefit designs that disincentivize preventive care, such as high coinsurance or deductibles on preventive and diagnostic services.
- Support public health infrastructure and community-based prevention programs that reduce the need for more expensive restorative and surgical care.

These approaches can reduce long-term spending by preventing disease progression and avoiding high-cost settings like emergency departments.

2. Reduce out-of-pocket costs by reforming dental benefit design

The ADA explicitly recognizes that out-of-pocket costs are a major barrier to dental care and opposes the use of annual and lifetime maximums in dental benefit programs. Further, when benefit issuers rely on annual maximums as a cost-control mechanism, those limits should at minimum keep pace with inflation in dental service costs, and that significant coinsurance should not be used in a way that creates cost barriers.

We recommend that Congress and federal agencies examining health care costs:

- Encourage or require dental benefit designs that:
  - Do not rely on low annual or lifetime maximums that quickly exhaust coverage for patients with higher needs.
  - Adjust any remaining annual maximums at least annually based on inflation in dental service costs.
  - Cover diagnostic and preventive services at 100 percent and exclude them from any annual maximums.
- Promote plan designs that avoid excessive coinsurance and deductibles that shift costs to patients rather than improving efficiency.
- Require clear, comparable summaries of dental benefits so that employers and families can understand the true out-of-pocket implications of competing plans, including annual maximums, copays, coinsurance, limitations, waiting periods, network adequacy, and other key features.
- In Medicare Advantage, standardize supplemental dental benefit categories and disclosures so beneficiaries can make meaningful comparisons across plans, including clear information on covered services, cost-sharing obligations, network participation, and whether the dental offering is a capped allowance or a true insurance benefit with out-of-pocket protections.[1]

These reforms can reduce surprise costs for families, help purchasers choose high-value coverage, and better align plan incentives with prevention and appropriate care.

3. Improve value and transparency through Medical (Dental) Loss Ratios

The ADA supports a dental “medical loss ratio” (MLR) concept for dental plans, defining it as the share of premium revenue spent on clinical dental services and certain activities that improve oral health, relative to premium revenue net of taxes and required regulatory fees.

The ADA further calls for:

- Requiring dental plans to publicly report the share of premiums spent on treatment versus administration, marketing, and profit (or reserves for non-profits).

[1] *Kamal Nasseh, DDS, PhD; et al. “Benefit Design and Access to Dental Care Among Seniors With Medicare Advantage Dental Benefits.”* JAMA Health Forum, 2025.

- Annual filing of comprehensive MLR reports, including enrollee counts, cost-sharing, deductibles, annual maximums, and the number of enrollees who hit those limits.
- Establishing a specific loss ratio for dental plans, calculated as the average dental loss ratio for each market segment in a given state.

In the Affordable Care Act context, the ADA also supports requiring Marketplace dental plans to transparently report dental loss ratios.

We urge the Committee to consider:

- Extending and strengthening MLR-style transparency requirements for dental plans in individual, small group, large group, and public program markets.
- Ensuring that reported data are detailed enough for policymakers and consumers to see the relationship between premiums, benefits actually delivered, and patient cost-sharing.
- Exploring whether minimum dental loss ratio standards, calibrated to the dental market, could reduce excessive administrative costs and improve value for patients and purchasers.

Better transparency around where premium dollars go is an essential tool for tackling health care costs without reducing needed care.

4. Strengthen Medicaid dental programs to avoid higher downstream costs

For Medicaid, the ADA calls for comprehensive adult dental benefits, higher federal matching rates for dental services, and program structures that support adequate provider participation and robust advisory input. The ADA also recommends that CMS publish state-by-state assessments of what share of Medicaid funds actually reach dental services and require states to monitor dental loss ratios among their contractors.

To reduce costs and improve value, we recommend that Congress:

- Support comprehensive, adequately funded adult dental benefits in Medicaid and other public programs, recognizing the high cost of untreated dental disease. The current costs of untreated dental disease can be significantly mitigated by incentivizing providers with more financially-sustainable reimbursement rates.[2]
- Improve transparency and accountability for how much Medicaid funding actually reaches dental services, including adoption of dental-specific loss ratio monitoring.

[2] ADA Health Policy Institute, *What Happens if the Adult Medicaid Dental Benefit Goes Away?* Research brief, 2025. The brief estimates that the total one-year increase in U.S. health care costs due to removing adult Medicaid dental benefits is $1,913,968,753, accounting for increased costs from emergency department visits for dental conditions and unmet periodontal needs among pregnant beneficiaries and beneficiaries with diabetes and coronary artery disease.

- Encourage program structures that support professional input, streamline administration, and ensure fair provider reimbursement, which in turn improve access and reduce avoidable high-cost care.

5. Use tax policy and accounts to support coverage and affordability, not new taxes on care

The ADA's explicitly supports Health Savings Accounts, Flexible Spending Accounts, and other tax-incentive programs that help individuals and employers fund health care costs through alternative, tax-favored mechanisms.

We recommend that the Committee:

- Preserve and, where appropriate, strengthen HSAs, FSAs, and similar tax-favored accounts so that families can better manage out-of-pocket health and dental expenses.
- Avoid new or expanded taxes on health care services or products, including dental care, and on employer-paid health benefits, which could increase costs for patients and small practices.
- Consider how account design, eligibility rules, and contribution limits can better reflect the real cost of dental and medical care amidst increased cost of living.

Looking ahead, if Congress considers reforms that redirect premium tax credits or create new, federally funded health accounts, we urge the Committee to structure those subsidies so they can be used, at the patient's discretion, for dental care including direct primary dental care arrangements. Any new accounts or subsidies should clearly allow spending on dental services that qualify as "medical care" under the Internal Revenue Code, including direct dental care arrangements that meet that standard.

****

We encourage the Committee to ensure that any proposals to address rising costs reflect these recommendations and meaningfully incorporate oral health into the broader health policy discussion. Thank you again for the opportunity to submit comments for the record. The ADA and our member dentists stand ready to serve as a resource to the Committee as you examine the drivers of health care costs and consider reforms affecting dental benefits, public programs, and tax policy. For further discussion or if you have any questions, please contact Natalie Hales at halesn@ada.org.

Sincerely,

/s/

Richard J. Rosato, D.M.D.
President

/s/

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