

May 21, 2025

Anticompetitive Regulations Task Force  
Antitrust Division, U.S. Department of Justice  
950 Pennsylvania Avenue NW  
Washington, DC 20530

**Re: Public Comment on Lack of Competition in the U.S. Dental Insurance Market**

Dear Members of the Anticompetitive Regulations Task Force:

As the leading authority on oral health in the United States, the American Dental Association (ADA), representing over 159,000 dentists across the country, appreciates the opportunity to share our perspective on competition in the dental insurance market, as part of our longstanding commitment to improving access to high-quality oral health care for all Americans. We applaud the Department of Justice's (DOJ) renewed focus on competition in health care and offer our perspective on how historically limited competition in dental insurance harms patients and dental professionals. This letter outlines the factors contributing to this problem and recommends actions to promote fair competition and protect consumers.

In particular, we highlight: (1) the role of the McCarran-Ferguson Act's antitrust exemption in shaping the dental insurance landscape; (2) the Competitive Health Insurance Reform Act of 2020 and its implications for dental insurance; (3) state-level laws and regulatory structures that may reinforce anticompetitive practices; (4) the practical consequences for dental providers and patients of a market with few competitors; and (5) recent evidence and examples illustrating these concerns. We write in a policy-focused, technical spirit, urging the Task Force to take steps that ensure dental insurance markets serve the public interest, not just entrenched incumbents.

**Background: McCarran-Ferguson Act and Historical Lack of Competition**

For decades, dental insurers, like other health insurers, operated under a unique antitrust exemption established by the McCarran-Ferguson Act of 1945. This law delegated regulation of the "*business of insurance*" to the states and exempted insurance companies from federal antitrust scrutiny for most conduct related to core insurance activities. In effect, insurers enjoyed immunity from federal antitrust laws for 75 years, except in cases of boycott or coercion. Courts interpreting McCarran-Ferguson defined the "*business of insurance*" broadly enough that a range of potentially anticompetitive practices avoided federal oversight.

Under this regime, dental insurance markets became highly concentrated and resistant to competition. While state insurance commissioners supervised insurer solvency and consumer protection, active antitrust enforcement was minimal. Many dental insurers grew from state-level dental service corporations into dominant regional players without fear of federal intervention. The result, in our assessment, has been a persistent lack of meaningful competition in many state dental insurance markets, exemplified by one carrier often

capturing the lion's share of enrollees. For instance, in numerous states a single dental insurer controls well over half of the market for dental benefit plans. A recent federal antitrust case consolidated in Illinois noted that the nation's largest dental insurer system (the Delta Dental network of 39 state-based companies) collectively held an average 59–65% market share of dental insurance nationwide in the mid-2010s.<sup>1</sup> In some states, this dominant insurer's market power is even greater, effectively making it a gatekeeper for patients seeking insured dental care and for dentists seeking to serve those patients.

The historical exemption from antitrust laws contributed directly to this consolidation. Insurers could engage in coordination that, in any other industry, might have invited federal enforcement. Notably, certain large dental insurers organized themselves into federations of state-licensed affiliates that agreed not to compete with one another across geographic territories.<sup>2</sup> Under McCarran-Ferguson, such territorial market allocations and collective rate-setting arrangements were shielded from Sherman Act review so long as they were part of the "business of insurance" regulated by state law. This environment fostered an *"uneven playing field"* in which emerging or smaller insurers struggled to gain a foothold. The ADA believes this lack of competition has deprived consumers of the benefits a competitive market normally provides lower costs, greater choice, and innovation while enabling insurers to impose onerous terms on providers.

### **The Competitive Health Insurance Reform Act of 2020: Restoring Antitrust Oversight**

Congress took a landmark step to address this imbalance with the passage of the Competitive Health Insurance Reform Act (CHIRA) of 2020 (Pub. L. 116-327). Enacted with overwhelming bipartisan support, CHIRA narrowed the McCarran-Ferguson antitrust exemption for health and dental insurers, making federal antitrust laws fully applicable to their business conduct (with only limited exceptions). In particular, CHIRA amended 15 U.S.C. §1013 *"to restore the application of Federal antitrust laws to the business of health insurance (including the business of dental insurance and limited-scope dental benefits)"*. In plain terms, as of 2021 dental insurers must "play by the same rules" as companies in other industries. Price-fixing, bid-rigging, market allocation, and other collusive practices by dental insurers are no longer immune from federal scrutiny.

The ADA strongly supported CHIRA's enactment signed into law by President Donald J. Trump on January 13, 2021. We commend Congress for recognizing that there was *"absolutely no justification"*<sup>3</sup> for a blanket antitrust exemption that had shielded egregious anticompetitive conduct in insurance markets. The intent of CHIRA is clear, to eliminate outdated protections for anticompetitive behavior and thereby inject competition into health and dental insurance for the benefit of consumers. The DOJ itself welcomed this reform with Assistant Attorney General Makan Delrahim noting that Americans *"deserve competition in health insurance markets just as they do in any other industry,"* and that CHIRA will strengthen DOJ's ability to investigate and prosecute anticompetitive behavior in insurance.<sup>4</sup>

While CHIRA's text is straightforward, we note a few important nuances in its implementation:

- **Limited Safe Harbors Retained:** CHIRA does *not* repeal McCarran-Ferguson outright. It preserves immunity for certain benign, collaborative activities that can improve insurance services, for example, collecting historical loss data, developing pure risk models, or creating standard policy forms. These exceptions

allow insurers (including dental insurers) to continue pooling data and expertise for actuarial purposes, so long as they do not restrain trade. The ADA recognizes the value of data-sharing to predict risk and set fair rates; our concern is with *anticompetitive collusion*, not legitimate statistical collaboration.

- **State Regulatory Role:** CHIRA explicitly does not disturb the states' authority to regulate insurance. State insurance laws and regulations remain in force. However, critically, any state laws or regulatory directives that purport to authorize conduct violating federal antitrust laws would need to meet the stringent requirements of the "*state action*" doctrine to offer any shield. In practice, this means that unless a state actively supervises a clearly articulated policy to displace competition (a high bar set by the courts), dental insurers can no longer hide behind state regulation as a defense for anticompetitive agreements. CHIRA thus creates a dual regime: dental insurers are subject to both state insurance oversight and federal antitrust enforcement. The ADA views this dual oversight as complementary, as states will continue to ensure solvency and consumer protection, while federal authorities and private plaintiffs can address collusion, monopolization, and other competition issues that states may have been unable or unwilling to tackle under the old law.
- **Enforcement and Guidance:** With CHIRA in effect, it is imperative that the DOJ Antitrust Division and the Federal Trade Commission actively enforce the antitrust laws in the health and dental insurance sector. CHIRA also empowers private litigants (providers, consumers, or competing insurers) to bring federal antitrust claims where harm is suspected. We are already seeing this play out: dentists and dental practices have pursued class-action litigation alleging anticompetitive conduct by major dental insurers, something that was far more difficult prior to CHIRA. The ADA urges DOJ to provide guidance to the industry on compliance with antitrust laws post-CHIRA and to signal that anticompetitive conduct in insurance will face serious scrutiny. Early and visible enforcement actions will help realize Congress's intent in passing CHIRA.

In summary, CHIRA removed a longstanding impediment to competition. Simply changing the law, however, is not enough – it must be followed by vigilant enforcement. Historical inertia and existing industry structures built under the old exemption will not disappear overnight. The Task Force should treat CHIRA's implementation as an opportunity to re-examine the dental insurance market and identify practices (including those historically tolerated) that now warrant intervention.

### **State-Level Regulatory Factors Reinforcing Limited Competition**

While CHIRA addresses the federal antitrust landscape, state laws and regulatory structures also influence competition (or the lack thereof) in dental insurance. We wish to highlight several state-level factors that have historically reinforced limited competition or allowed anticompetitive practices to persist:

- **Geographic Market Segmentation:** Many dental insurers, particularly legacy "Delta Dental" plans and some Blue Cross Blue Shield affiliates offering dental coverage, have traditionally operated within exclusive state or regional territories. These territorial arrangements were often an outgrowth of state charters or licensing restrictions (e.g., a nonprofit dental service corporation established to serve a specific state). In some cases, insurers agreed (formally or tacitly) not to encroach on each other's areas. State regulators did not view it as their role to

police such arrangements as antitrust matters, especially under McCarran-Ferguson. The net effect at the state level was little to no competition between the dominant incumbent and out-of-state insurers. Even now, without the federal exemption, a dominant in-state dental insurer might invoke the *state action doctrine* to defend territorial exclusivity if it can claim the state authorized and supervises it, but such claims should be carefully scrutinized. We caution that state inaction must not be mistaken for state authorization: absent clear state mandates, territorial market division among insurers is subject to federal antitrust law (per CHIRA) and should be viewed as per se anticompetitive.<sup>5</sup>

- Limited Consumer Choice and Entry Barriers: In many states, insurance regulations focus on solvency and basic consumer protections (e.g., requiring certain standard provisions in policies), but do not actively foster competition. For example, state insurance approval processes for new insurers or new insurance products can be lengthy and complex, inadvertently discouraging new entrants. A startup dental plan must navigate 50 different regulatory regimes to operate nationally, a hurdle favoring large established players. Additionally, incumbent insurers often enjoy strong brand recognition (especially if they long operated quasi-exclusively in the state), making it hard for a new competitor to sign up employer groups or subscribers even if it enters the market.
- Lack of “Any Willing Provider” Protections: Some states have enacted “any willing provider” or “freedom of choice” laws in dentistry, requiring dental benefit plans to accept any dentist who meets their network terms. However, many states do not have such laws specific to dental plans. In those states, dominant insurers have broad discretion to exclude providers from their networks or to impose onerous participation terms. The absence of any-willing-provider rules can be exploited to keep networks artificially narrow or to discipline dentists who resist low fee schedules, knowing that being out-of-network means losing a large patient base due to the insurer’s market power. This dynamic limits competition on the provider side (dentists cannot easily turn to alternative plans for patient volume) and ultimately harms patients who find fewer in-network choices. We encourage the Task Force to consult with state officials on whether stronger any-willing-provider requirements in dental insurance would enhance competition and patient access.
- Contract Clauses Restricting Competition: State oversight has often not extended to scrutinizing specific insurance contract clauses that may be anti-competitive. For instance, until recently it was common for dental plan contracts to include “most-favored-nation” clauses (insurers demanding to be charged the lowest fee rates a dentist offers any insurer) or caps on fees for services not covered by the plan. These clauses benefit dominant insurers by locking in the lowest possible rates and limiting dentists’ ability to offer competitive pricing to other payers or cash patients. Recognizing the harm, numerous states have outlawed the practice of capping fees for non-covered services, and some have restricted most-favored-nation clauses in insurance contracts. But where such reforms have not occurred, large insurers continue to use these contractual tools to cement their advantage. We recommend DOJ review whether the presence of these clauses in dental insurance contracts has anticompetitive effects and support state efforts to ban any that unreasonably restrain trade.
- Exemption from Medical Loss Ratio (MLR) Rules: Unlike comprehensive medical insurance, stand-alone dental plans are often classified as “excepted

benefits” under federal law and thus not subject to ACA medical loss ratio requirements. Many states likewise do not mandate minimum loss ratios for dental coverage. The result is that dental insurers may retain a higher share of premium dollars as profits or administrative costs than health insurers could. In a competitive market, insurers might be compelled to either lower premiums or improve benefits to attract customers if their payout ratios are low. But in a concentrated market, a dominant dental insurer with no strong competitors can operate inefficiently or with high margins without losing business. Indeed, data collected in California (one of the few states to require dental MLR reporting) revealed that among 52 dental insurers, only 6 had a loss ratio of at least 80% (the typical standard for health plans), and fully 8 insurers had loss ratios below 50% – meaning they spent less than half of premium revenue on patient care.<sup>6</sup> Such figures suggest that lack of competitive pressure allows some dental insurers to keep premiums higher or claims payouts lower than they might be in a truly competitive environment. The ADA submits that transparency around metrics like MLR in dental plans is important. We encourage regulators to consider reporting requirements or guidelines so that excessive administrative costs or profits, potential signs of inadequate competition, can be identified and addressed.

In summary, various state-level policy gaps and historical practices have created a patchwork environment where dental insurer competition is often stifled. While some states are proactive in promoting fair markets, others have yet to address these issues. We urge the Task Force to work with state insurance regulators, through forums like the National Association of Insurance Commissioners (NAIC), to identify and rectify state policies that inadvertently perpetuate anticompetitive conditions. Removing or reforming such state-level barriers will complement federal efforts under CHIRA to open up the dental insurance market.

### **Consequences for Dental Providers and Patients**

The practical consequences of limited competition in dental insurance are felt on the ground by both dentists and the patients they serve. When one or two insurers dominate a market, dentists face a take-it-or-leave-it scenario, and patients have few alternative coverage options. Below we detail the key harms observed:

- **Suppressed Reimbursement Rates:** A dominant insurer with a large market share can dictate the fees paid to dentists for covered services, knowing that most providers must accept its terms or lose access to a significant pool of patients. Over time, this market power has caused reimbursement rates to erode in real terms, with dentists receiving payments that, while nominally flat or only modestly increased, have failed to keep up with inflation and growing operational expenses. When reimbursement rates fail to keep pace with costs, insurers may also limit the scope of covered services, avoid adopting new procedures or technologies, or restrict specialist access. In competitive markets, plans might seek to differentiate themselves by offering broader benefits or more inclusive networks, providing consumers with meaningful choices beyond just the lowest premium. But in many areas, dentists report that contractual fee schedules have stagnated or even dropped, not keeping pace with inflation or rising practice costs. Notably, in California a multi-year analysis found that inflation-adjusted reimbursement rates to dentists declined in recent

years across all dental insurers.<sup>7</sup> The alleged cartel conduct of Delta Dental's member plans (discussed further below) is reported to have "*artificially lowered the reimbursement rates*" paid to dentists nationwide.<sup>8</sup> Such depressed payments can threaten the financial viability of dental practices, especially smaller or solo practices, and can disincentivize providers from participating in insurance networks. Ultimately, patients may be harmed as well if dentists drop out of networks due to unsustainable fees, patients may struggle to find in-network providers or face higher out-of-pocket costs to see out-of-network dentists.

- Narrow Networks and Patient Access Restrictions: In markets with little competition, the dominant insurer's network effectively defines which providers patients can reasonably choose from. If that insurer's network is narrow (whether by design or due to providers leaving over low fees), patients have limited options for care under their insurance. They may have to travel farther or endure longer wait times for an in-network appointment. In some cases, an insurer's dominance can also lead to gaps in specialty care. For example, if the insurer's contracts with specialists (oral surgeons, pediatric dentists, etc.) are not sufficient in a region, patients might not have in-network specialty care at all. Under competitive pressure, insurers typically would broaden networks or improve provider terms to attract more enrollees; without that pressure, network adequacy may suffer. The ADA is concerned that patients in highly concentrated insurance markets effectively have their choice of dentist curtailed, undermining the free choice that should be a hallmark of dental benefits.

- Higher Premiums and Out-of-Pocket Costs: Economic theory and empirical evidence suggest that less competition among insurers can lead to higher premiums for consumers. Although dental premiums are generally more modest than medical premiums, they are meaningful to family budgets. If one insurer controls most of the employer group market in a state, it faces little incentive to lower premiums or improve coverage levels, since consumers (or employers) have few alternative carriers to switch to. While some data (e.g., California's experience) indicate dominant insurers might hold premiums stable and instead leverage power to reduce provider payments,<sup>9</sup> the outcome still does not clearly benefit patients: either patients pay more for coverage than they should in a competitive market, or the cost control comes at the expense of provider compensation (which, as noted, can indirectly harm patients via reduced access or quality). In a well-functioning market, savings from cost control should be passed along to consumers. However, evidence suggests this often has not happened and instead, insurers in uncompetitive markets have accumulated excess reserves or executive compensation. In the Delta Dental litigation, for example, dentists allege that the company "*rather than pass on to consumers the savings [from its market dominance] ... paid exorbitant salaries to executives and padded ... inflated capital reserves*".<sup>10</sup> Such allegations, if proven, underscore that patients do not reap benefits when competition is lacking.

- Administrative Burdens and Unilateral Policies: Dominant insurers can impose onerous administrative requirements on dental practices such as complex pre-authorization rules, restrictive coverage policies, and cumbersome claims processes without fear of losing providers or clients to a competitor with a more user-friendly policy. Dentists frequently voice frustration that some insurers deny or delay needed treatments by rigidly applying coverage rules or by requiring excessive documentation. In a competitive scenario, insurers might seek to

differentiate themselves by reducing red tape and building goodwill with providers and patients. But in a monopoly or duopoly situation, insurers have less incentive to streamline; providers must simply comply or risk non-payment. This not only increases the cost of doing business for dental offices (which must hire extra billing staff, etc.), but can also compromise patient care when treatment is postponed or alternative, less optimal procedures are chosen to align with coverage limitations. Innovation suffers as well, for instance, an insurer with near-total market control can be slow to cover new evidence-based treatments or technologies, knowing patients and employers have nowhere else to go for coverage.

- Market Consolidation and Fewer Choices: Lack of competition can become a self-perpetuating cycle. A powerful incumbent can acquire competitors or block new entrants, further consolidating its hold on the market. We have observed dental insurers merging or being acquired in recent years (for example, Sun Life Financial's acquisition of DentaQuest, consolidating two significant players in the public dental insurance market).<sup>11</sup> When such consolidation goes unchecked, it reduces the already limited choices for consumers and employers. It can also lead to monopsony power over providers – i.e., one buyer of dental services (the insurer) dominating the purchasing market from many small sellers (dentists). In economics, a monopsony can depress payment rates below competitive levels and reduce the quantity or quality of services supplied. We believe many dental practitioners operate today in an environment of effective monopsony, especially in states or regions where one insurer covers a majority of privately insured patients.
- Erosion of Patient-Provider Relationship: Finally, the imbalance of power can interfere with clinical decision-making. In a competitive market, if an insurer unduly interferes with treatment decisions or refuses to cover certain services, patients and dentists could seek a more accommodating insurer. But where one insurer's policies essentially set the standard, providers may feel pressured to practice "by the insurance book" rather than according to their best clinical judgment. Patients may sense that insurance rules crafted by a dominant payer overly constrain their care options. This dynamic can undermine trust in both insurers and the healthcare system at large. Restoring competition would compel insurers to be more responsive to patient satisfaction and oral health outcomes, not just cost containment.

In sum, the harms from lack of competition are concrete: patients face potential increases in cost and decreases in choice, while dentists face financial pressures and constraints that can impede patient care. Importantly, these harms do not occur in a vacuum as they are two sides of the same coin. Squeezing provider payments might save money in the short term, but if taken too far it reduces the network and ultimately hurts patients. Likewise, if premiums are inflated or coverage is skimpy, patients may skip needed care, impacting oral health. The ADA's concern is that an uncompetitive insurance market shifts costs and burdens in ways that reduce overall welfare, to the detriment of public health.

### **Evidence of Anticompetitive Practices in Dental Insurance**

The ADA's concerns about anticompetitive forces are not merely theoretical. Recent litigation and research provide evidence suggesting that some dental insurers have engaged

in behavior that limits competition and harms providers and patients. We draw the Task Force's attention to a prominent example and related findings:

- Delta Dental Antitrust Litigation: In 2019, a coalition of some 240,000 dentists and dental practices initiated a federal antitrust lawsuit against Delta Dental – the largest dental insurance system in the U.S. – and its 39 independent member companies (*In re Delta Dental Antitrust Litigation*). The case, now a consolidated multi-district litigation, alleges a systemic scheme to monopolize the dental insurance market in violation of the Sherman Act. According to the complaint (which survived a motion to dismiss in 2020), Delta Dental's member companies agreed among themselves to divide the national market into exclusive territories, with each state or region allocated to a single Delta member who promised not to compete outside its area. They further allegedly conspired to fix reimbursement fee schedules at artificially low levels across those territories, leveraging their dominant market position to force providers to accept below-market rates. Another element of the conspiracy involved limiting competition from any Delta member's potential rivals. For example, by agreeing that no Delta member would derive more than a small portion of its revenue from insurance products outside the Delta brand (thus preventing any one member from becoming a broader competitor). These arrangements were coordinated through Delta's national association and related entities that facilitated the conspiratorial agreements.<sup>12</sup>

If proven, the allegations paint a stark picture of a cartel-like structure dominating dental insurance. Not only did Delta Dental's average market share nationally reach approximately 60% during the relevant period, but the complaint contends that this dominance was maintained by agreements not to compete and to keep payments to dentists low. Crucially, the plaintiffs assert that the savings from such cost suppression were not passed on to consumers in the form of lower premiums; instead, they were retained as surplus or executive compensation. While the case is ongoing, it has already yielded important insights through court filings. It demonstrates that dental insurance is sufficiently concentrated to allow a coordinated scheme to potentially flourish, something that could only have happened under the old antitrust immunity. Now, with CHIRA in place, this litigation also serves as a test of the new law's effectiveness. It seeks to hold insurers accountable under federal antitrust standards that should have always applied. We urge DOJ's Task Force to examine the issues it raises, as they may warrant parallel investigation or enforcement action by the Antitrust Division if evidence supports the plaintiffs' claims.

- Market Data from California – ADA Health Policy Institute (HPI) Study: The ADA's Health Policy Institute has attempted to study dental insurance market concentration, though comprehensive data are scarce. A revealing example comes from California's dental insurance market (2015 data), which was studied after the state began requiring certain market disclosures. The findings mirror the national Delta Dental allegations: one dominant insurer and a "long tail" of tiny competitors. Specifically, Delta Dental of California held about 40.3% of the covered lives, with the next largest carrier (MetLife) at just 8.0%. Fully 31 of the 52 tracked dental insurers in California each held less than 1% market share. The Herfindahl-Hirschman Index (HHI) for the California dental market was calculated at approximately 1,813, indicating a "moderately concentrated" market by DOJ/FTC merger guidelines (an HHI above 2,500 is highly concentrated). While not extreme on its face, this HHI masks the practical reality that one carrier

is far ahead of all others in influence. The HPI analysis posited that such concentration could lead to “higher premiums for consumers or lower reimbursement for providers” – indeed, both of these are classic outcomes when competition wanes. The study noted preliminary evidence that, in California, average premiums for the dominant carrier’s enrollees did not rise (they slightly fell after inflation adjustment from 2014–2016), implying that cost savings were realized. However, concurrently, reimbursement rates to dentists had been declining, suggesting those savings may have come largely from provider payment cuts rather than increased efficiency. This aligns with the allegations in the Delta litigation: market power was used primarily to control costs (benefiting the insurer’s bottom line) rather than to enhance benefits or significantly reduce consumer prices.<sup>13</sup>

- Blue Cross Blue Shield Antitrust Settlement (Analogous Context): Although not the focus of this letter, we note by analogy that the Blue Cross Blue Shield (BCBS) insurance system which, like Delta Dental, historically operated with exclusive service areas for each member company and was recently the subject of a major antitrust class action. In 2020, the BCBS companies reached a settlement exceeding \$2.5 billion and agreed to curtail certain practices that restricted competition among the Blues, including relaxing their territorial exclusivity for national accounts. This development in the health insurance realm underscores a broader recognition that market allocation agreements among nominal competitors are anticompetitive. The ADA believes a similar lens should be applied to dental insurance arrangements. Insurers dividing markets or agreeing not to compete head-to-head is fundamentally at odds with antitrust principles and harms purchasers of insurance and providers. The DOJ Task Force should consider whether the dental insurance industry warrants a comprehensive review akin to what the BCBS case prompted in the medical insurance industry.
- State Attorney General and Regulator Actions: We also encourage the Task Force to survey if any state attorneys general or insurance departments have raised concerns about dental insurer conduct. In some states, dental associations have petitioned insurance regulators regarding certain insurer policies (for example, abrupt fee schedule cuts or unfair network practices). While these are often framed as contractual or regulatory disputes, there may be underlying competition concerns. To the extent states have taken action (or attempted to) against dental insurers for anticompetitive effects – perhaps under state antitrust laws or consumer protection statutes – those records could inform the Task Force’s understanding of the issue’s scope. Given CHIRA, state AGs now have stronger grounds to partner with DOJ in tackling these issues federally as well.

Collectively, the evidence available suggests that the dental insurance market has been neither transparent nor truly competitive for many years. The ADA’s own attempt to obtain multi-state market share data was met with obstacles, indicating a lack of transparency that itself can hide anticompetitive structures. Only through litigation discovery or state investigative powers have some of these facts come to light. We believe the DOJ can play a crucial role in shedding further light on this industry and ensuring that competition laws are fully enforced moving forward.

### **Recommendations for DOJ Action**

To address the concerns outlined above, the ADA respectfully offers the following recommendations to the DOJ's Anticompetitive Regulations Task Force. These actions, in our view, would help foster a more competitive dental insurance marketplace and protect the interests of patients and providers:

1. Prioritize Enforcement of CHIRA in Dental Insurance: We urge DOJ to make clear, through statements and actions, that dental insurers are now fully subject to federal antitrust law. The Antitrust Division should actively investigate potentially anticompetitive arrangements among dental insurers, including any agreements on market division, price-fixing of reimbursement rates, or joint boycotts of certain providers or technologies. If the ongoing Delta Dental litigation uncovers evidence of illegal conduct, DOJ should be prepared to take enforcement action or file amicus briefs to support the application of antitrust law in that case. Swift enforcement will send a message to the industry that the era of immunity is over and that collusion will be prosecuted just like in any other sector.

2. Conduct a Market Study on Dental Insurance Competition: We recommend the DOJ (potentially in collaboration with the Federal Trade Commission and NAIC) undertake a comprehensive study of competition in the dental insurance market. Such a study could collect data on market shares in each state, prevalence of certain contractual clauses (e.g. most-favored-nation requirements), claims payout ratios, network adequacy, and other indicators of market health. Given the difficulty the ADA's researchers faced in obtaining data, a government-led inquiry with compulsory information gathering may be necessary to truly understand the landscape. The findings should be published to increase transparency. This will not only illuminate where competition is lacking but also guide policy. For example, if certain states or regions have healthier competition (perhaps due to specific laws or the presence of multiple strong carriers), that could model solutions for more concentrated markets.

3. Review and Update Guidance on Insurance Collaboration: The DOJ should review any existing antitrust guidance for the insurance industry (some of which may date back prior to CHIRA) and update it to clarify permitted vs. prohibited conduct. For instance, issuing guidance or advisory opinions on what types of data sharing or joint ventures are acceptable under the retained McCarran-Ferguson exceptions, and which activities (such as exclusive territorial agreements) are per se unlawful post-CHIRA, would be extremely helpful. Clear guidance will encourage compliance as insurers will be less likely to engage in dubious collaborations if DOJ has explicitly labeled them as antitrust violations. Conversely, insurers will feel more comfortable innovating or entering new markets if they know what collaborative actions (if any) are safe. This is particularly relevant for dental insurers that might consider, for example, multi-state expansion or partnerships with smaller carriers, arrangements that could *enhance* competition if done right, but that might be chilled by uncertainty. In short, DOJ should both deter anticompetitive conduct and encourage pro-competitive initiatives through updated policy statements.

4. Challenge Anticompetitive Mergers and Alliances: We urge vigilant review of any mergers or acquisitions in the dental insurance space. While CHIRA did not change merger review (insurer mergers were always subject to Hart-Scott-Rodino and antitrust review), the newfound understanding of how concentrated

this market is should inform a tougher stance. The Task Force should recommend that the Antitrust Division closely scrutinize deals such as a large insurer acquiring a regional competitor, or cross-market mergers that could entrench a national giant's power. Also worth examining are vertical arrangements. For instance, if a dental insurance carrier were to acquire a major dental practice management company or dental service organization (DSO), would that give it the ability to foreclose competition by funneling patients to its owned clinics? While such vertical integration in dentistry is nascent, now is the time to be alert. Similarly, any alliances or joint ventures among major insurers (e.g., sharing networks or co-administering plans beyond the narrow data-sharing safe harbors of CHIRA) should be reviewed for anticompetitive effects. The message should be that any consolidation or collaboration that harms competition and consumers will not be permitted.

5. Support Pro-Competitive State Reforms: The DOJ, even as a federal enforcer, can influence state policy by advocacy and partnership. We recommend that the Task Force identify key state-level reforms that would improve competition in dental insurance and endorse those efforts. This could include:

- *Encouraging "Any Willing Provider" statutes for dental plans*: This ensures open networks and prevents dominant insurers from excluding competitors (the providers) arbitrarily.
- *Advocating for bans on anti-competitive contract clauses*: As discussed, prohibiting clauses like non-covered service fee caps or most-favored-nation clauses through state law can remove tools used to hinder competition.
- *Promoting transparency requirements*: For example, states could require dental insurers to report annual loss ratios, executive compensation, and other financial data to regulators or the public. Such transparency can shame or deter exploitative practices in highly concentrated markets.
- *Strengthening state antitrust enforcement*: DOJ could offer to collaborate with state attorneys general in investigating local dental insurance market issues. Sometimes state AGs have better on-the-ground knowledge of how a dominant insurer operates in their state. A joint federal-state task force specific to insurance competition could be beneficial.
- *Revisiting state action exemptions*: If any state laws explicitly authorize collective rate-setting or territorial division among insurers (a rarity, but possible through older statutes governing rating bureaus or service corporations), DOJ should encourage those states to repeal or amend such laws, as they are no longer necessary or tenable under modern antitrust norms.

6. Engage Stakeholders for Continuous Input: Finally, we suggest DOJ maintain an open line of communication with stakeholders including professional associations like the ADA, consumer advocates, and the insurance industry as it addresses these issues. Public workshops or hearings focused on competition in health care insurance (with a dedicated panel on dental insurance) could surface additional evidence and perspectives. The dental sector has unique characteristics (for example, high rates of small-business providers, and the

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elective nature of some services) that merit discussion in crafting tailored remedies. By engaging stakeholders, DOJ can ensure that any actions taken (enforcement or advocacy) will genuinely improve the competitive landscape while maintaining the viability of insurance risk-pooling that benefits patients.

The ADA is ready to assist the DOJ in these endeavors. Our organization can serve as a resource for data, provider experiences, and industry expertise as needed. The ultimate goal we share is a dental care system where robust competition among insurers leads to better outcomes for patients: affordable premiums, fair reimbursement to sustain provider networks, and dental benefit innovations that enhance oral health.

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The ADA appreciates the Task Force's attention to the long-standing competition deficits in the dental insurance market. Dentistry occupies a critical role in overall health, and dental benefits are the vehicle through which millions of Americans access necessary care. It is vital that the market for dental insurance operate fairly and competitively, rather than being dominated by legacy arrangements that advantage insurers at the expense of patients and providers.

Historically, federal law and state practices allowed dental insurers to function with minimal competition and oversight, a situation that led to concentrated markets, suppressed provider payments, and potential under-service to patients. With the passage of CHIRA, Congress and the Administration have signaled that this status quo must change. The letter of the law has changed, but realizing its promise requires diligent follow-through. We urge the DOJ to use all available tools from enforcement actions to advocacy for regulatory reform to promote competition in dental insurance.

By addressing anticompetitive regulations and practices now, the DOJ can help usher in a new era where innovation, efficiency, and consumer welfare drive the dental insurance industry. Patients will benefit from more choices and better coverage, dentists will be able to negotiate on a level playing field, and ultimately oral health outcomes will improve when market forces align with the public interest.

Thank you for considering our comments. We are confident that, working together, we can eliminate anticompetitive barriers and ensure that dental insurance truly serves the needs of American families. Please contact David Linn, Director of Federal Affairs, at [linnd@ada.org](mailto:linnd@ada.org) for further discussion.

Sincerely,

Brett Kessler, D.D.S.  
President

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