

December 3, 2025

Via Electronic Submission

The Honorable Bill Cassidy, M.D.  
Chair  
Committee on Health, Education, Labor,  
and Pensions  
United States Senate  
Washington, DC 20510

The Honorable Bernie Sanders  
Ranking Member  
Committee on Health, Education, Labor,  
and Pensions  
United States Senate  
Washington, DC 20510

**Re: “Making Health Care Affordable Again: Healing a Broken System”**

Dear Chairman Cassidy, Ranking Member Sanders, and Members of the Committee:

As the leading authority on oral health in the United States, the American Dental Association (ADA), on behalf of our more than 150,000 member dentists, appreciates the Committee’s focus on the rising cost of health care and the strain it places on patients, families, employers, and taxpayers. Oral health is inseparable from overall health, and the design and financing of dental benefits have a direct impact on whether individuals can obtain timely, appropriate care or instead delay treatment until problems become more serious, painful, and costly, 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 sustained investment in prevention and early intervention. Oral disease is largely preventable, yet dental conditions remain a leading cause of avoidable emergency department visits and lost work and school hours. Proposals to “heal a broken system” should include 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 subjecting preventive and diagnostic services to annual maximums, coinsurance, or deductibles.
- Support public health infrastructure and community-based prevention, including community water fluoridation and school-based programs that reduce the need for more expensive restorative and surgical care.

## **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 obtaining needed dental care, and that insurance should not be used in a way that creates cost barriers. Patients with chronic conditions and higher oral health needs are often the most exposed to benefit design features that shift costs onto them.

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 consumers can understand cost-sharing, annual limits, exclusions, waiting periods, network adequacy, and other key features.
- In Medicare Advantage, standardize supplemental dental benefit categories and disclosures so that enrollees can readily determine whether they are purchasing meaningful dental coverage or a true insurance benefit with out-of-pocket protections.

These reforms can reduce surprise costs for families, help purchasers compare plans on value, 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 that is appropriately calibrated to dental markets and data. At its core, this initiative brings transparency and ensures that a reasonable share of premium revenue is devoted to patient care, rather than administrative costs, marketing, and profit just as medical insurers are required to do.

The ADA calls for:

- Requiring dental plans to publicly report the share of premiums spent on clinical services versus administration, marketing, and profit (or reserves for non-profits).
- Annual filing of comprehensive MLR reports, including enrollee counts, premium revenue, claims paid, distributions across benefit categories, use of annual maximums, and the number of enrollees who hit those limits.
- Establishing a specific loss ratio for dental plans, calculated separately from medical plans, and reporting the average dental loss ratio for each market segment in a given state.
- In the Affordable Care Act context this provision requires Marketplace dental plans to transparently report dental loss ratios.

We urge the Committee to consider:

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

In addition, we encourage the Committee to apply any new transparency or MLR standards explicitly to employer-sponsored and other plans subject to the Employee Retirement Income Security Act (ERISA), not only to fully insured or Marketplace products. Many Americans receive dental benefits through ERISA plans that are often shielded from state-level consumer protections. Requiring ERISA dental plans to report dental-specific loss ratios and basic utilization, network, and denial data would give employers and beneficiaries a clearer picture of how much of their premium dollars are reaching patient care. Requiring ERISA dental benefits to report these dental-specific loss ratios and basic utilization, network, and denial data would give employers and beneficiaries a better sense of how much of their plan spending is reaching patient care.

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

#### **4. Support in-office dental membership arrangements as an affordable option for patients**

Many dental practices have developed in-office membership or subscription arrangements, similar to Direct Primary Care Arrangements for physician services, that allow patients to pay a predictable monthly or annual fee in exchange for a defined package of preventive and basic services at transparent prices putting the power of care and financial management directly in the hands of the patient. These arrangements can improve affordability and predictability where insurance is absent or limited, particularly in rural communities and among small employers. These plans frequently do not limit coverage and instead provide a fuller benefit to meet the patient where their needs are.

We encourage the Committee to:

- Recognize in-office dental membership arrangements as a legitimate option for delivering affordable, prevention-oriented care, while applying reasonable consumer protections and respecting patients' freedom to choose their dentist.
- Clarify, consistent with existing tax law, that patients may use tax-favored accounts such as HSAs and FSAs to pay for qualifying in-office membership fees and services that meet the Internal Revenue Code definition of medical care, subject to appropriate safeguards.

By supporting responsible in-office membership models, Congress can help patients manage out-of-pocket dental costs and maintain access to timely preventive care, especially in communities where traditional dental coverage is limited or unavailable.

## **5. Explore Direct Reimbursement dental plans as a cost-effective option for employers**

The ADA has long supported Direct Reimbursement dental plans as a simple, cost-effective way for employers to provide dental benefits that prioritize prevention, patient choice, and administrative efficiency. In a Direct Reimbursement arrangement, the employer typically self-funds dental benefits and reimburses employees based on a percentage of dollars actually spent on dental care, rather than on a complex schedule of covered procedures. Patients can see the dentist of their choice, and employers have flexibility to set benefit levels that fit their budgets.<sup>1</sup>

We urge the Committee to consider Direct Reimbursement as one of the models that can:

- Reduce administrative overhead compared with traditional fully insured dental products.
- Align incentives with prevention and early intervention since benefits are tied to actual spending rather than narrow procedure lists.
- Preserve patient and provider choice by allowing employees to see any licensed dentist.

As the Committee evaluates ways to make health care more affordable, it should ensure that any federal standards or incentives for employer-sponsored coverage do not disadvantage Direct Reimbursement dental plans and similar employer-funded models that can deliver high value and expanded coverage with relatively low administrative cost.

## **6. Strengthen Medicaid dental programs to avoid higher downstream costs**

For Medicaid, the ADA calls for comprehensive adult dental benefits and adequate reimbursement as key strategies for reducing downstream costs, including avoidable emergency department visits and preventable complications of chronic disease. When adults lack access to routine dental care, relatively inexpensive problems can progress into advanced infections that require hospitalization or complex surgical care.

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

- Support comprehensive, adequately funded adult dental benefits in Medicaid, coupled with payment rates that enable dentists to participate sustainably.
- Improve transparency and accountability for how much Medicaid funding actually reaches dental services, including adoption of dental-specific loss ratio monitoring where appropriate.
- Encourage program structures that support professional input, streamline administration, and reduce unnecessary burdens on providers, which in turn improve access and reduce avoidable high-cost care.

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<sup>1</sup> American Dental Association, *Dental Benefits: An Introduction*, American Dental Association, accessed December 1, 2025, [https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/practice/dental-insurance/dental\\_benefits\\_an\\_introduction\\_final.pdf](https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/practice/dental-insurance/dental_benefits_an_introduction_final.pdf).

Given this Committee's jurisdiction over key public health and workforce programs, we also encourage continued support for evidence-based prevention efforts, including community water fluoridation and school-based dental programs, which can reduce Medicaid expenditures over time by preventing disease before it requires costly intervention.

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

The ADA supports Health Savings Accounts (HSAs), Flexible Spending Arrangements (FSAs), and other tax-favored accounts as important tools that allow individuals and families to manage out-of-pocket health and dental costs through alternative, tax-favored mechanisms. Well-designed tax policy can help families budget for needed care and reduce unanticipated financial shocks.

We recommend that the Committee:

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

We also encourage the Committee to ensure that tax rules clearly allow patients to use these accounts to pay for a broad range of evidence-based dental services, including preventive and restorative care, medically necessary oral health services for patients with chronic or complex conditions, and, as noted above, qualifying in-office membership and Direct Reimbursement arrangements that meet appropriate standards.

Looking ahead, if Congress considers reforms that redirect premiums, subsidies, or other public funds toward alternative coverage or care models, we urge you to ensure that dental care is explicitly included in any such frameworks and that new models preserve consumer protections, transparency, and meaningful access to care, including direct dental care arrangements that meet that standard.

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Chair Cassidy  
Ranking Member Sanders  
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We encourage the Committee to ensure that any proposals to address rising health care costs recognize that ignoring oral health ultimately raises, rather than lowers, overall spending. When patients can access affordable, preventive-focused dental care, they are less likely to require expensive emergency treatment, hospitalizations, or complex interventions that strain families and public programs alike.

Thank you for your attention to these issues and for the opportunity to share the ADA's perspective. 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 [haesn@ada.org](mailto:haesn@ada.org).

Sincerely,

/s/

Richard Rosato, D.D.S.  
President

/s/

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