

September 14, 2026

The Honorable Scott Fitzgerald
Chairman
Subcommittee on Administrative State,
Regulatory Reform, and Antitrust
Committee on the Judiciary
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Jerrold Nadler
Ranking Member
Subcommittee on the Administrative State,
Regulatory Reform, and Antitrust
Committee on the Judiciary
U.S. House of Representatives
Washington, D.C. 20515

Re: Examining Healthcare Markets: Fraud and Competition

Dear Chairman Fitzgerald and Ranking Member Nadler:

On behalf of the American Dental Association (ADA), the nation's leading authority on oral health, we appreciate the opportunity to submit comments for the record for the Subcommittee's September 14, 2026, field hearing, "Examining Healthcare Markets: Fraud and Competition." The hearing's focus on mergers, regulation, vertical integration, competition, and insurance practices is directly relevant to dental care. Dental insurance markets are often treated as ancillary in broader health policy discussions, yet market structure and insurer conduct can materially affect patients' access to care, provider choice, benefit value, and dentists' ability to sustain community-based practices.

The ADA supports vigorous, evidence-based enforcement against fraud and anticompetitive conduct. At the same time, policy responses should be targeted to the source of the problem and should not impose broad new burdens on independent dental practices that are unlikely to improve program integrity or competition. We urge the Subcommittee to consider the following dental-specific issues.

Dental insurance market concentration warrants sustained antitrust scrutiny.

Recent federal analysis reinforces longstanding ADA concerns about concentration in stand-alone dental insurance. The U.S. Government Accountability Office found that the combined market share of the three largest stand-alone dental insurers in the group market ranged from 38 percent to 97 percent across states and reached 80 percent or more in 11 states.¹

¹ U.S. Government Accountability Office, Private Dental and Vision Insurance: Market Concentration Varied Among States, GAO-26-107787 (Mar. 9, 2026).

Concentration can affect patients even when premiums alone do not reveal the full impact: patients may face narrower networks, reduced provider choice, opaque benefit limitations, and administrative barriers, while dentists may have limited practical contracting alternatives and reduced negotiating leverage.

Congress and the federal antitrust agencies should therefore continue examining competition in dental insurance, including mergers and acquisitions, vertical integration and affiliations, network design and patient steering, and contracting practices that may weaken independent negotiation.² The Competitive Health Insurance Reform Act of 2020 clarified that federal antitrust laws apply to the business of health and dental insurance; that reform should be followed by active oversight and enforcement where the facts warrant.

Opaque network leasing and contracting practices can undermine meaningful competition.

The ADA has urged the Federal Trade Commission to examine network leasing and related arrangements in dental benefits.³⁴ Shared-network arrangements are not inherently harmful, but arrangements that extend a dentist's contracted rates to additional entities without clear disclosure and affirmative consent can reduce transparency and make it difficult for dentists and patients to understand which network and fee terms apply. The ADA supports clear advance notice of material contract and fee-schedule changes and a dentist's affirmative opt-in to new network arrangements. Greater transparency would preserve legitimate network efficiencies while protecting independent contracting and patient choice.

ERISA preemption should not create an accountability gap for self-funded dental plans.

A substantial share of employer-sponsored dental coverage is self-funded and governed by the Employee Retirement Income Security Act (ERISA). Carriers and third-party administrators have at times asserted ERISA preemption to avoid state dental insurance protections that apply to fully insured plans. The ADA is aware of more than 360 state dental insurance reform laws intended to protect patients and providers. When substantially similar dental networks serve both fully insured and self-funded populations but state protections apply only to one group, patients and dentists can face inconsistent rules and diminished accountability.

The ADA supports preserving ERISA's core role while clarifying that state laws regulating the provision and payment of dental care are not displaced merely because a carrier is administering a self-funded plan. Congress should also advance federal baseline

² American Dental Association, Public Comment to the U.S. Department of Justice Antitrust Division on Lack of Competition in the U.S. Dental Insurance Market (May 21, 2025).

³ American Dental Association, Input for the FTC Healthcare Task Force (Apr. 29, 2026).

⁴ American Dental Association, Comments to the Federal Trade Commission, RFI on Anticompetitive Regulations, Docket No. P859900 (May 21, 2025).

protections where appropriate, including greater transparency for third-party administrators and fair contracting practices.⁵

Medicare Advantage supplemental dental benefits require stronger transparency and oversight.

Dental benefits are widely marketed as a feature of Medicare Advantage (MA), but the value of those benefits can be difficult for beneficiaries to evaluate. Dental benefits can also play a significant role in beneficiary plan selection: 52 percent of Medicare Advantage beneficiaries have reported selecting their plan based on the inclusion of a supplemental dental benefit.⁶ Yet analyses published in JAMA and Health Affairs have found that, despite the prevalence of advertised dental benefits, comprehensive dental coverage is available in only a small share of MA plans. The ADA continues to urge CMS and Congress to improve dental-specific reporting on benefit design, utilization, network adequacy, claims payment, and spending so beneficiaries and policymakers can distinguish meaningful coverage from nominal benefits

Additionally, the variation of plan design for supplemental dental benefits requires manual verification of a patient's benefit design, which adds unnecessary administrative burden. According to the 2024 CAQH Index, dental practices could save up to \$580 million nationally each year on eligibility and benefit verification alone by transitioning fully from manual and portal-based processes to standardized electronic transactions.¹ To address these inefficiencies, the ADA urges CMS and Congress to require Medicare Advantage plans to automate dental administrative transactions in a manner consistent with expectations for medical and pharmacy services. At a minimum, MA plans should be required to support standardized electronic eligibility and benefit verification and related dental transactions. Doing so would enable dental practices to accept medical referrals electronically, accurately confirm dental benefits in real time, and reduce delays, fragmentation, and administrative complexity that frequently impede timely patient care

The ADA has urged CMS and Congress to improve dental-specific reporting on benefit design, utilization, network adequacy, claims payment, and spending so beneficiaries and policymakers can distinguish meaningful coverage from nominal benefits. In addition to these requests, the ADA also supports clear, separate opt-in processes for dentists participating in MA supplemental dental networks.

Fraud prevention should be targeted, evidence-based, and accompanied by due process.

⁵ [American Dental Association, Comments for House Energy and Commerce and House Ways and Means hearings with health insurance company CEOs \(Jan. 22, 2026\)](#).

⁶ Deft Research, [2024 Medicare Age-In Study](#) (2024), as cited in [American Dental Association, Comments on Contract Year 2026 Policy and Technical Changes to the Medicare Advantage and Medicaid Programs, CMS-4202-P, at 2 \(Jan. 27, 2025\)](#).

The ADA supports strong efforts to eliminate fraud, waste, and abuse. However, anti-fraud tools should be calibrated to the risks they are intended to address. In comments to CMS on its CRUSH initiative, the ADA cautioned against requirements that would add substantial administrative burdens to dentists providing only MA supplemental dental benefits. The suggestion provided in the Request for Information for the CRUSH Initiative provided no evidence that those requirements would materially improve fraud detection.⁷ Similarly, payment suspensions, artificial-intelligence tools, and automated claims reviews should include appropriate validation, transparency, appeal rights, and human review. Insurers should not use AI as the sole basis for claim denials or prior authorization decisions.

The same principle should guide congressional oversight: enforcement should focus on actual misconduct and demonstrated vulnerabilities, while avoiding policies that inadvertently reduce provider participation or patient access. Independent dental practices are generally small businesses and should not be conflated with large, consolidated health systems when Congress considers remedies aimed at provider market power.

Congress should prioritize practical transparency and patient-centered dental market reforms.

The ADA supports transparency that helps patients understand expected out-of-pocket costs and enables employers, plan sponsors, regulators, and policymakers to assess whether dental coverage delivers value. For dentistry, the most useful transparency is payer-facing and patient-specific, available in real time, and tied to the Code on Dental Procedures and Nomenclature (CDT Code). Congress should focus on information controlled by dental benefit plans and administrators—coverage status, deductibles, annual maximums, frequency limitations, network status, and patient responsibility—rather than imposing hospital-style public price-posting requirements on small dental practices that do not control the benefit information needed to calculate a patient’s final cost.⁸

The ADA urges the Subcommittee to ensure that dental markets are included in its examination of health care competition and insurance practices; support active antitrust oversight of concentrated dental insurance markets; improve transparency and consent in network contracting; address gaps created by overly broad assertions of ERISA preemption; strengthen accountability for Medicare Advantage supplemental dental benefits; and ensure fraud-prevention policies are targeted and do not create unnecessary barriers to patient care.

⁷ [American Dental Association, Comments to CMS on the CRUSH RFI, CMS-6098-NC \(Mar. 27, 2026\).](#)

⁸ [American Dental Association, Comments to House Energy and Commerce, “Lowering Health Care Costs for All Americans” \(June 9, 2026\).](#)

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Thank you for considering the ADA's views. We look forward to working with the Subcommittee to promote competitive, transparent, and patient-centered dental markets. To facilitate further discussion, please contact Natalie Hales, Senior Congressional Lobbyist, at halesn@ada.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Richard J. Rosato".

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

A handwritten signature in black ink, appearing to read "Nader A. Nadershahi". To the right of the signature, the text "DDS, MBA, EdD" is written.

Nader A. Nadershahi, D.D.S., M.B.A., Ed.D.
Executive Director

RJR:NAN:nh