



Regulatory & Legislative Policies Reshaping Dental Utilization

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Executive Summary

The dental care landscape is being reshaped by **converging regulatory, legislative, and economic forces**. This paper examines how policies directly impacting dental care, health care regulations with indirect effects on dental care, and broader economic pressures are collectively **creating significant headwinds for dental utilization**. At the same time, incremental changes that support primary care delivery in new ways may create a **stronger baseline infrastructure for medical-dental integration** through enhanced primary care payments.

Key Policy Developments

Federal policy is moving in two directions simultaneously. On one hand, new regulations are expanding access and integration, signaling **that oral health is becoming more embedded in broader primary healthcare delivery:**

- HHS removed prohibitions on adult dental benefits in marketplace plans (effective 2027);¹
- CMS mandated the KX modifier for medically-linked dental services to strengthen integration tracking,² and
- Medicare now covers dental services for dialysis patients.³

On the other hand, other policies enacted in the past year are expected to **reduce the number of people with insurance across the US, while simultaneously putting greater stress on state budgets:**

- H.R.1 (“One Big Beautiful Bill”) and the expiration of the enhanced Advanced Premium Tax Credits (APTC) together are expected to increase the number of uninsured individuals by nearly 17 million over the next decade;^{4,5} and
- Restrictions on state provider taxes may force over \$225 billion in state Medicaid cuts, with dental benefits historically among the first to be eliminated during state budget contractions.⁶

Economic and Workforce Pressures

The economic environment compounds the policy landscape and may create further pressure to **drive down utilization of dental services and practice profitability:**

- Section 301 tariffs on dental supplies increased 50% in 2025, with research showing consumers and producers bear nearly the entire cost.⁷ In response, practices cannot easily pass increased product costs to consumers due to elastic demand; and
- Provider capacity is further constrained by workforce shortages and approaching retirements across dentists, hygienists, and support staff.⁸

The convergence of coverage losses, state budget constraints, rising input costs, and workforce limitations creates a challenging environment for dental utilization growth through 2026. However, the strengthening regulatory framework for medical-dental integration presents strategic opportunities for stakeholders who can align with integrated care models. **Emergency department utilization for dental conditions will likely increase** as preventive care becomes less accessible, and market tightness will persist across multiple fronts. Proactive monitoring of regulatory developments and engagement in policy discussions will be essential for navigating this complex landscape and identifying emerging opportunities in an increasingly interconnected healthcare ecosystem.

Introduction

Regulatory and legislative decisions continually redefine the structure, financing, and accessibility of dental care in the United States. Each year, federal agencies such as the Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services (HHS) issue rulemaking that directly and indirectly alters how dental care is covered, who can access it, and how services are delivered. These policy actions collectively shape the market environment in which dental providers, insurers, and suppliers operate. Even when federal or state initiatives are not explicitly targeted at dentistry, they can have powerful downstream effects. Broader reforms in healthcare payment, Medicaid financing, or workforce regulation often influence patient behavior and provider capacity within the dental sector.

This paper examines three interrelated categories of policy and economic factors that are shaping dental utilization and market dynamics in 2025 and are likely to continue influencing the landscape into 2026:

1. Policies directly targeting dental care, including new benefit expansions and documentation requirements designed to strengthen medical–dental integration.
2. Broader healthcare regulations with indirect effects on dental utilization, such as payment reforms, eligibility changes, and administrative rules affecting patient access and plan participation.
3. Economic and fiscal pressures shaping overall health service use, including macroeconomic conditions, labor market trends, and state budget constraints that influence both coverage levels and patient spending behavior

Together, these forces illustrate how the dental sector’s trajectory is increasingly linked to broader health policy and economic trends. It underscores the need for continuous policy monitoring and strategic engagement by stakeholders across the oral health ecosystem.

Policies Directly Impacting Dental Care

Several recent federal actions directly affect dental coverage, integration, and reimbursement. These policy changes reshape both the scope of services available and the operational requirements for dental providers. In the final 2025 Notice of Benefit & Payment Parameters (NBPP), HHS and CMS removed the regulatory prohibition on including routine adult dental services as an Essential Health Benefit (EHB) in marketplace plans.⁹ As of benefit years beginning January 1, 2027, states may select benchmark plans that include routine non-pediatric dental services in their EHB benchmark. This is a landmark for adult dental access in commercial insurance markets with implications for both provider volume and supplier demand.

CMS also finalized the requirement to use the KX modifier for certain dental claims in the CY 2025 Physician Fee Schedule (PFS). Effective beginning July 1, 2025, dental services that are “inextricably linked” to covered medical services have to be billed with the KX modifier and include an ICD-10 diagnosis code when submitted via the 837D (dental) claim format.¹⁰ This enforcement strengthens compliance, billing accuracy, and medical-dental integration (MDI) data tracking. For example, failure to include the KX modifier may lead to claim denial as statutorily non-covered. By mandating this documentation, CMS signals that dental services tied to medical conditions will receive closer oversight, forcing dental practices and suppliers to coordinate more tightly with medical counterparts and to track utilization metrics more precisely.

Under the same 2025 PFS final rule, CMS also added payment for dental services for patients with end-stage renal disease during dialysis under specified conditions. The rule states that dental or oral examinations performed as part of a comprehensive workup prior to or contemporaneously with dialysis services are eligible when medically necessary.¹¹ While the rule stops short of broad routine dental coverage, this targeted expansion for dialysis patients marks a meaningful shift toward recognizing oral health as part of systemic care. It expands preventive and restorative access for a high-risk population, which may raise dental utilization in that subgroup.

Staffing changes for roles dedicated to oral health within the Trump administration will be important to monitor following the departure of Dr. Natalia Chalmers, DDS.

Dr. Chalmers previously served as the first Chief Dental Officer of CMS, having been appointed to the newly create role in 2021 and serving until November 2025. As of the publication of this paper, there have been no publicly-available updates on the administration's intent to continue or re-staff the role. How this departure affects oral health policy at CMS will be important to monitor.

Over the last decade, federal initiatives have increasingly recognized the role of oral health in chronic disease management, fostering infrastructure for deeper medical-dental integration. The KX modifier enforcement, ESRD dental coverage expansion, and expanding adult dental EHB flexibility all point to a broader strategy of aligning dental care with medical systems. For instance, the enhanced emphasis on documenting dental services linked to medical care and the targeted coverage expansions for medically high-risk populations build the operational and data infrastructure needed for future integrated care and reimbursement models.

Indirect Policies Impacting Dental Care

The health care delivery system is highly interconnected and policies not explicitly targeting dental services can significantly influence dental coverage levels, provider reimbursement, and patient access to oral health care. The 2025 policy landscape demonstrates this effect; specifically, how broader health and economic reforms may indirectly shape the dental market.

Signed into law on July 4, 2025, H.R.1, commonly referred to as the "One Big Beautiful Bill," includes significant health care provisions across four main areas of impact: Medicaid, Medicare, ACA Marketplaces, and health savings accounts.¹² While the mechanisms of action are far-reaching, taken together, these actions are expected to increase the number of people who are uninsured by nearly 12 million individuals over the next decade.¹³ This is largely driven by changes that formalize the inclusion of work requirements and eligibility restrictions that are expected to drive coverage losses in Medicaid and ACA Marketplaces. These coverage losses will be compounded by the expiration of the ACA expanded tax credits at the end of FY 2025, leading to a further 5 million people becoming uninsured, bringing the expected total to just under 17 million.¹⁴

While these projections are not specific to dental insurance coverage, historically, dental coverage rates have lagged behind medical coverage.¹⁵ As a result, it is expected that a similar, or even greater, number of individuals will lose dental coverage. Loss of coverage will likely dampen demand for preventive dental services and drive utilization in hospital emergency departments.¹⁶ When California suspended its adult dental benefit in 2009, emergency department visits for dental conditions increased more than 30% as people substituted emergency care for more routine preventive care that was no longer covered.¹⁷

H.R.1 also includes a provision that restricts the ability of states to use provider taxes and fees to finance their share of Medicaid costs. This is expected to force state Medicaid agencies to cut over \$225 billion from their budgets.¹⁸ How states address this shortfall will vary, however, this will make Medicaid dental benefits especially vulnerable. Historically, states have reduced adult dental benefits or lowered reimbursement rates during fiscal shortfalls, leading to sharp utilization declines.¹⁹ Dental benefits have been among the first to be cut during times of state and Medicaid budget stress.²⁰ With states signaling tighter fiscal circumstances for 2026, the risk of benefit reductions is non-trivial. There are currently 32 states with adult dental benefits that cover both preventive and restorative care.²¹ However, it is difficult to project which states will target dental benefits and for which populations. Still, if these cuts occur, we should expect measurable declines in preventive and restorative utilization. Lastly, these cuts may also lead to higher levels of unemployment, as poor oral health reduces the probability of employment.²²

The 2025 CMS Marketplace Integrity & Affordability Rule, which was finalized on June 20, 2025, provides general updates to ACA Marketplace eligibility, reenrollment, and actuarial value tolerances.²³ While this rule does not directly alter the optional status of adult dental benefits, it does affect the administrative and fiscal environment for all Marketplace plans, including those that may offer dental plans (both standalone and integrated with medical). While data on dental plan enrollment in Marketplace plans is limited, there are an estimated 1.2 million people who get standalone dental plans via the Marketplace.²⁴ Across all plan types, the rule increases standards for eligibility verification, shortens the enrollment period in future years, and makes changes to automatic reenrollment processes, among others. While not directly related to the final rule, the sunseting of enhanced

premium subsidies for Marketplace plan enrollees originally established in the American Rescue Plan of 2021 and extended in the Inflation Reduction Act of 2022, will also have an impact on overall plan enrollment. In aggregate, these changes may dampen overall enrollment and influence insurer participation, plan pricing, and benefit design decisions that could indirectly affect dental coverage. It may also have a compounding effect on health care coverage losses, leading to a spillover effect on dental plan adoption, as described previously.

The 2026 Calendar Year Medicare Physician Fee Schedule (MPFS) rule, finalized on October 31, 2025, contains several provisions that support enhanced payment rates for primary care delivery, which may create downstream benefits for medical-dental integration. The rule finalizes an estimated net 3% increase in total allowed charges for primary care physicians and exempted evaluation and management codes, which are among the most common codes billed in primary care practices, from downward efficiency adjustments that will cut the relative rates of many procedural codes.²⁵ These modifications, though not dental-specific, can affect referral pathways and coordination between medical and dental providers, reinforcing the interconnectedness of the broader healthcare delivery ecosystem. By exempting these codes from further payment reductions, it protects primary care payment rates and may allow physicians additional time and reimbursement to screen for oral health issues during routine visits and coordinate appropriate follow-up with a dentist.

The 2025 policy landscape illustrates how policies ostensibly focused on health care cost containment and program integrity can fundamentally reshape access to oral health care, even when dental services are not their primary target. The convergence of coverage losses, state budget constraints, and administrative barriers creates a broader environment that threatens to widen existing disparities in dental care access and utilization. However, the modest payment enhancements for primary care in the 2026 MPFS demonstrate that strategic policy interventions can strengthen the infrastructure for medical-dental integration, even amid broader retrenchment. As these policies take effect, monitoring their impact on dental coverage, provider capacity, and patient outcomes will be essential to understanding the full scope of their consequences for oral health equity.

Economic Factors Affecting Health Care Utilization

The current dental market is being shaped by converging economic, policy, and labor-market pressures. While none of these pressures are unique, the combination will likely make the environment tighter for practices, suppliers, and payers. Utilization of dental services responds to a number of fundamental factors, including input costs and workforce capacity.

Section 301 tariffs on dental and medical supplies increased 50% in 2025, with a 100% increase expected in 2026, impacting input costs for dental practices.²⁶ The extent to which tariffs raise costs for either consumers or producers depends on the characteristics of supply and demand in a particular market. More specifically, if consumers can easily switch their consumption from affected goods to “non-tariffed” goods, then consumer prices will be less impacted by tariffs and producers will tend to bear more of the cost. Incident to these pricing dynamics are constraints imposed by long-term contracts between purchasers and supplies. Multi-year contracts between dental practices and dental support organizations (DSOs) with locked-in rates for goods and services are common in the industry. Contracts of this structure may simultaneously shield some parties from impact, while creating prolonged exposure to price increases for others.

If consumers cannot easily switch consumption, then producers can pass the tariff cost on to the consumers in the form of higher prices.^{27,28} Economics research indicates that in markets with limited substitutes, tariff costs are typically passed to downstream purchasers. In the dental industry, this effect will be different across products. For example, if practices and their suppliers can easily switch from composite resins being produced in highly tariffed countries like China to those with lower tariffs, like Germany or Japan, then the effect will be minimal on providers and patients, but will represent a substantial loss of revenue for the manufacturers in China. However, if there are specialized products, like digital scanners, that are only produced in China practices will need to either bear the acquisition cost entirely or pass it on to patients.

In modern global supply chains, where production is highly specialized and not easily reconfigured, the presence of substitutes from “non-tariffed” locations is

often limited and, as such, there is substantive evidence that the effect is passed mainly onto consumers. In Multiple studies have found that consumers and domestic producers who rely on foreign inputs ultimately paid for nearly the entire cost of tariffs that were imposed during the first Trump administration.^{29,30} The practical outcome of this is that we would expect to see higher prices for dental equipment manufactured in China, which represents a sizable portion of the overall market.

On the supply side, there is expected to be general market tightness and reduced dental provider capacity across the US. According to the ADA Health Policy Institute's 2025 Outlook, longer appointment wait times and declining network participation are emerging across several markets. Respondents reported a mean wait time of between 14 and 17 days and 20% of practices said they dropped at least one network within 2025. This will compound access barriers, further moderating utilization growth.³¹ Dental care delivery also faces structural workforce constraints. A growing number of older dentists are approaching retirement, while many practices report difficulty recruiting dental hygienists, assistants, and laboratory technicians.³² This mirrors trends across the broader health-care sector, where retirements and persistent staffing shortages have limited provider capacity.

Conclusion

Dental utilization trends cannot be understood in isolation. They reflect the combined effects of direct regulation, broader health policy, and macroeconomic pressures. The 2025 policy landscape underscores how both explicit dental reforms and indirect systemic changes shape access and demand. For DTA members and other stakeholders in the dental supply chain, staying attuned to these regulatory dynamics is essential. Legislative and rulemaking cycles not only determine care delivery and reimbursement but also define the areas of market opportunity in the dental sector. Proactive monitoring and engagement in policy discussions will position industry participants to adapt to the next wave of dental and healthcare reform.

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