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To: House Committee on Health and Human Services

From: Dr. David Hamel, DDS

RE: 1. Support for HB 2119 - clarifying that de minimis coverage and exhausted coverage do not qualify as covered dental services.
2. Offering an amendment to remove vague language.

Good Afternoon Chairman Hawkins and members of the Committee,

I am David Hamel DDS, a general dentist of in Marysville, KS and current Chair of the Kansas Dental Association Council on Dental Benefit Programs. I am also a member of the American Dental Association Council on Dental Benefit Programs.

During my 40 years of practice, I've been an advocate for my patients' oral health first, and additionally as an advocate for them in what seems like their constant battle to receive the decreasing benefits that are available to them under their dental benefit plans. Even transparency for them is impossible to see in their plan. Most people do not know what is or is not covered and they are always asking for their dentist's help. Insurance confusion probably interferes with more dentist to patient relationships than any one other thing.

One effort to create more transparency and clarity was through previous legislation KSA 40-2,185, regarding non-covered services. That bill reads: *"No contract issued or renewed after July 1, 2010, between a health insurer and a dentist who is a participating provider with respect to such health insurer's health benefit plan shall contain any provision which requires the dentist who provides any service to an insured under such health benefit plan at a fee set or prescribed by the health insurer unless such service is a covered service".*

The intent of that bill, was to clarify and provide transparency to what is and is not covered. It would give consumers a clear understanding of their benefits when services of the patient's choice were selected as treatments. The intent of this non-covered services bill seemed clear, until it was not.

The general public, knows what "non-covered" means in reality. They define it as no payment or reimbursement equals no coverage. Even with that understanding the non-covered services bill allowed some defined limitations to be in place. These limits apparently were not well enough defined as nationally there has been a trend to circumvent the intent of these bills.

There are over 40 states with non-covered services in place and there is a growing issue with services being classified as "disallowed" as well as de minimis amounts being paid then claiming the service was "covered". (I did bring a copy of a processing policy with me as an example of the denials and disallows that are being imposed on so-called "covered" services.)

The clause in the current bill KSA 40-2, 185 which is being used as a basis for these changes is the subject of my proposed amendment. **I'd like to offer up the amendment to HB 2119** to strike the clause, in line 11 of the bill which states: "~~or other contractual limitation contained in the health benefit plan.~~" Removing this clause has already occurred in other states and will remove vague, undefined language from the statute which may again be used to circumvent the intent of this law.

I fully support, the remainder of the bill with the clarifications on limitations including the yearly maximum clarification of non-covered. $1,000 dental benefit plans originated about 1952. 95% of plans are equal to or not much more than that now. Since then, a natural, reduction in real dollars has lowered dental benefits just due to inflation. In about 1954, 3rd party administrators appeared. They grew larger and larger while enjoying some government protections on their business. What happened thus is that in addition to natural devaluing of benefits from inflation, over the years 3rd parties changed focuses and imposed more and more restrictions, so there are less and less benefits paid out per premium dollar funding those benefits. That continues today with changes in business models and shifting of expenses to other consumers or contracted dentists. Everything has increased the cost of business and administration for dental offices and pushed more costs onto consumers.

I'm sure you will hear insurance representatives will use the claim of "higher costs" to oppose any change. But I'd have a hard time understanding why?

First, it is not a mandate to do anything more than clarify definitions of what is a covered service.

Secondly, there is already a diminishing value to consumers for dental benefit plans even in the face of a perceived high desirability for them. Including yearly limits in the non-covered services, would encourage plans to increase their yearly limit giving consumers a potential greater value. Remember, people pay a lot of money to prefund their benefit plans.

Nationally, the numbers are showing that most dental plans cost more than dentistry. That is like being upside down on your house by owing more than it is worth.

Finally, I offer you this consumer written perspective on dental insurance to shine some light and levity while being very accurate in his description.

Gene Weingarten: Let's get to the root of AARP's (ANY) dental insurance

June 16 at 9:00 AM Washington Post.

Like most of you, I have health insurance. Like most of you, my health insurance says it covers dental work. As with most of you, this is basically a fiction. Insurance companies are famously stingy at the dentist.

Whenever I leave my dentist's office, he and I follow a ritual. He solemnly informs me he will first bill my insurer, and I agree that would indeed be prudent. Then, about six weeks later, I get a letter notifying me that my insurance company has completely paid for all but $328 of my $341 bill.

So you can imagine my excitement when I recently got a letter from AARP, informing me it has a dental plan for which I qualify, as a new member in good standing.

(I resisted joining AARP for years, for the same reason everyone resists, which is that even though AARP ads feature photos of "seniors" of a certain physical type — think Paul Newman and Sophia Loren — deep down, when most of us think of AARP, we think of Grandpappy Ned, who sometimes forgets to close the bathroom door. I am ashamed to admit I finally gave in and joined only after AARP offered a free tote bag. In my mind it was going to be made of supple leather, the sort of tote bag Paul and Sophia would take to the spa in Cannes; what arrived in the mail had the dimensions of a tote bag but appeared to be made of cellophane. True fact: I stepped on a bathroom scale, then picked up the tote bag, and the needle did not stir.)

Anyway, could it be that the sheer size of AARP — its numbers are mighty — has cut through the insurance companies' tooth parsimony? I sent away for the dental plan, and AARP emailed it to me. It was customized under my name! At the end was an enrollment form, and it was *already filled in* with my name and address. They make it so easy for a senior to sign on. But first I had some questions.

Me: Hi. I'm afraid this plan is not for me.

AARP Lady: Okay.

Me: I can't see how it is for anyone. Is anyone actually enrolled in this?

AARP Lady: It's a very popular choice!

Me: Okay, the premium is $72.20 a month, which comes out to $865.20 a year. And there is a yearly deductible of $50, so I'll basically start out paying $915 a year.

AARP Lady: Okay.

Me: Most years, I don't pay anywhere *near* that much for dental care, except for the occasional year when I have real problems and need a root canal and crown, which can cost close to $4,000. So I'm thinking this is where the stiff monthly premiums pay off, when my insurance company rides in and rescues all us wrinklies, shouldering our deep financial burdens, taking on our risks, enveloping us in the warm bosom of its protection. Except … at best you pay less than half of my bill for a root canal and crown.

AARP Lady: That's typical for the industry.

Me: Noted. But that's not the really bad thing, which is this: You have a $1,500 yearly cap on what you will pay me. For *anything, and everything*. So for my $915, you are promising to bear risks in any given year all the way up to a theoretical grand total of $1,500, which works out to a net risk to you, *tops*, of $480. If my dental bills exceed that by $5,000, that's my burden. Now, to be fair, I do notice you also cover, separately, tooth-shattering traffic accidents and such, which could be huge — jaws rebuilt, and whatnot.

AARP Lady: That's a complimentary benefit, but only if you pay in advance for the whole year.

Me: So I see. But that's not my real problem. "Accident" coverage maxes out at $1,000 *for your entire lifetime*. Second accident? It's on you. AARP Lady, who *buys* this policy?

AARP Lady:

Me: I'm thinking Grandpappy Ned.

Thank-you for allowing me to testify in support of HB 2119 and offer an amendment to help further clarify it.

David Hamel DDS