# David Hamel DDS

February 20, 2019

To: Chair, Brenda Landwehr and The House Committee on Health and Human Services

From: David Hamel DDS

RE: **Support for 2307** - clarifying that de minimis coverage and exhausted coverage do not qualify as covered dental services and requiring action to change contracts from both parties.

Good Afternoon Chairman Landwehr and members of the Committee,

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

During my 41 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 for them to receive the decreasing benefits available to them under their dental benefit plans.

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 single thing.

The intent of non-covered services bills in Kansas and over 40 other states was to clarify and provide transparency to what is and is not covered. It would give consumers a clearer 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 money - no coverage. Even with that public understanding, the non-covered services bill allowed some defined limitations to be in place and included as "covered". These limits apparently were not well enough defined, as nationally there has been a trend by insurance companies to circumvent the intent of these bills.

In the end the public suffers when companies can collect a premium and then say things are "covered" without ever providing a benefit or reimbursement. Aside from paying for something they do not receive, people make more informed choices about care when they know what coverages they actually have.

Because of this trend by companies to circumvent the existing laws with tactics like providing only a minimal dollar amount or even claiming a service is "disallowed", more and more of the 40 plus states are seeking and enacting de minimis clauses to give consumers more transparency and better benefits from their benefit plans.

(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.)

Now think about it. The average dollar amount of dental benefits paid out per person covered by a plan is about $280 per year. One major insurance company in Kansas, reported that average to be $264 per person per year. Our own state of KS employee plans reports that kind of figures. So here is a policy coverage book with 72 pages with what is not covered highlighted in yellow, and this policy coverage manual is never sent to the consumer. Why?

As a comparison, my guess is that the vacation benefit plan at your work or here at the state is contained in just a few paragraphs and it provides thousands of dollars in benefits to each person.

Including yearly limits in the non-covered services, could lead to plans being more competitive with their yearly limit thus potentially giving consumers a greater value. Remember, people pay a lot of money to prefund their own benefit plans. More of it needs to be distributed for their benefits. (P.S. the "90+% is paid out in claims… " you hear from insurance companies uses some hocus pocus accounting and is not really true)

There is already a diminishing value to consumers for dental benefit plans even in the face of a perceived high desirability for them. Premiums have significantly outpaced benefits provided over the years.

The most recent tactic among 3rd party companies for lowering value to consumers is to keep premiums about the same but to drastically cut benefits for enrollees in those plans. One company recently cut benefits by at least 15% while their published lowest premium changed only about 1%. Some companies have made benefit cuts across the board and others have cut benefits in a piecemeal manner with more and more cuts over time.

How have they gotten dentists to participate in these contracts? They do it back handedly and in many perspectives, unethically. Up to now, companies have sent a letter that notified dentists – on the 3rd page – they were required to "Opt OUT" of this new plan in order to not be in the plan. Or there are companies that have dentists under one contract and don't send a letter at all but just lower benefits with no agreement by the dentists.

That is an unethical approach to business. It happens because some companies enjoy a monopsony in many markets whether it be singly or in collusion with a few others, but It serves no one except the 3rd party.

This is not a mandate to do anything more than clarify definitions of what is a covered service and making sure you have dentists in a network that have agreed in a positive manner to be in that network.

Finally, I offer you this consumer written perspective on dental insurance to shine some light and levity while being very accurate in his description. For those of you who were on the committee 2 years ago this is a repeat but still holds so true today. I hope you enjoy but also become aware of reality.

# 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 2307 to further clarify it.

David Hamel DDS