



May 10, 2016

The Honorable Earl L. "Buddy" Carter  
423 Cannon House Office Building  
Washington D.C. 20515

Re U.S. H.R. 3323 "Dental and Optometric Care Access Act, DOC Access Act"

Dear Congressman Carter;

The National Association of Dental Plans (NADP) and our members have extensive concerns with the provisions of H.R. 3323. The complexities and consumer impacts of our concerns merit exploration in a meeting with you or your staff and would appreciate the opportunity to discuss the issues presented below in more detail. NADP works closely with the American Dental Association and other dental organizations, so we appreciate providers wanting to simplify administrative processes and protect their income; however, the legislation has broader impacts than may be readily apparent. In addition, many of the bill's provisions will result in higher dental premiums and out of pocket costs for your constituents.

Health insurance, including dental, is heavily regulated by state insurance departments. Provisions within this bill conflict with current state law and usurp state insurance market standards. Following are NADP's specific concerns listed by bill section:

- *Sec. 2719B (a)(1)(A) prohibits carriers from offering discounts to their consumers unless the plan is reimbursing the provider for that specific service.*

This approach denies insureds the benefit of discounts negotiated for both covered and non-covered services which negates one of the primary values of insurance. A consumer within a plan network should be able to pay the same fee that the carrier would have paid for the service. As an example, if a dental plan covers the cost of two cleanings a year and the consumer wants or needs a third cleaning, the policy and provider contracts would require the provider to charge the same price to the consumer as they would have charged the carrier for that service. A consumer's expectation when using network providers is lower out of pocket costs. These provisions incent the consumer to use a network provider which lowers overall dental care cost and the individual consumer's out-of-pocket cost.

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Dentists have agreed to a fee schedule and in return they receive an opportunity to reach an abundance of new clients, and therefore should not be able to circumvent certain contractual obligations of providing additional discounts. The industry believes if the provider agreed to a discount on a service that may not be covered in all policies, consumers should also receive those discounts regardless if their policy covers a particular procedure. These are discounts which directly benefit consumers.

- *Sec. 2719B (a)(1)(B) allows plans to cover a procedure only if the reimbursement rate is reasonable, not nominal, and may not take a consumer's cost sharing into consideration.*

The provider and carrier negotiate reimbursement levels—either on a specific fee schedule or a percentage of UCR, prior to the provider signing a contract to join a carrier's network. If the provider feels the fees are inadequate, they do not need to join the network or may request to negotiate a new discount reimbursement level that still would provide less out of pocket expenses for consumers. Consumers are very sensitive to the cost of dental coverage and carriers need to illustrate to employers that are the primary purchaser of dental benefits both competitive pricing and broad networks. Carriers must provide fair payments to providers and adequate payments for a portion of the services to be competitive.

NADP is also concerned with how a “reasonable,” or “nominal” fee would be determined. Many states now have standards for the level of payment for services or groups of services. Is this federal standard to be incorporated in state oversight or is a new federal regulatory system anticipated? If the latter, how is that system of regulation to be funded as federal oversight of dental benefits does not now exist outside of pediatric dental care offered in state and federal Marketplaces? The public, providers, and carriers have access to Fair Health Data (a national, independent, not-for-profit corporation based in New York) which provides usual and customary rates (UCR) information used to set payment levels for dental services. If the dentists find that the carrier is not providing an appropriate fee schedule or reimbursement levels compared to this data, they do not join the network or may request to negotiate a new discount reimbursement level that still would provide less out of pocket expenses for the Consumers.

- *Sec. 2719B (a)(2) only allows reimbursement rates to be changed with an agreement signed by the provider.*

There are two common ways for payment rates to be set in dental plans:

- One is a fee schedule that is agreed to at the time of contracting.
- The other is an agreed percentage reimbursement based on UCR fees.

Often UCR is determined based on FAIR Health data, although a dental plan may have enough data of their own to base UCR on their data with FAIR Health as a reference point. FAIR Health data is updated twice annually and carriers often adjust the underlying charge on which the percentage payment is based - adjustments are most often advantageous to dentists. Dental plans facing the cost of getting every dentist in a network to agree to every incremental change in fees for each service on which percentage reimbursements are based, carriers may simply

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stop making the incremental adjustments. With annual dental premiums often being 1/12th or about a month's medical premium, the dollars available for complex administrative processes required in these are limited.

Fee schedules may not change as frequently because of the low inflation rate for dental services. When fee schedules do change, dentists have the opportunity to accept the new fee schedule, negotiate new fees within the schedule, or leave the network. In short, the administrative costs to follow up with each of the 193,370 dentists participating in networks for adjustments to underlying UCR rates would be so burdensome as to eliminate these adjustments. Otherwise carriers would have to increase rates to cover the costs of compliance and administration which is not a realistic path when premium for Dental PPOs in 2015 decreased by 1.5% across all employer groups. In the small employer market where the most opportunity is to increase the number of Americans with dental coverage that provides access to dental offices, a large portion of dental premium is paid by the employees who are also sensitive to the out of pocket cost for premiums.

- *Sec. 2719B (a)(3) requires provider contracts to be limited to two years.*

Currently, provider contracts are continuous or automatically renewed each year. In most cases the only terms of the contract which change with any frequency are the payment levels as described above. The additional expense for re-contracting every two years only adds cost without a benefit to the consumer. There is no reason to renew contracts with that frequency. Additionally, providers always have the option to discontinue their contract with a carrier at any time. Since most dentists participate in about 6 networks, there would also be an administrative cost burden for the dentists as well as the dental plan without any gain in the value of the dental benefit to the consumer.

- *Sec. 2719B (a)(4) does not allow a carrier to remove a provider from the network if the provider fails to accept the terms and conditions of the contract.*

The section completely negates a legal contract and would render various quality standards and consumer protections included in contracts null and void. A contract between provider and carrier is negotiated between the two parties, if there is disagreement on a specific section and that section is negotiable, it can be altered. But there are contract provisions that are requirements to meet various state laws and regulations. These are not negotiable and if the dentist will not comply, the dental plan would be out of compliance by continuing a provider under a previous contract. Without contractually binding dentists to network standards and payment levels dental plans could not establish premiums, nor enforce multiple regulations as required by state insurance departments.

- *Sec. 2719B (a)(5) prohibits carriers from requiring providers to be credentialed prior to joining a network.*

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Credentialing is a basic consumer and legal safeguard for establishing health care networks. Federal and state contracts for public programs, employer contracts and all systems of standards for health care require credentialing of network providers. Checking the background of a provider, including their current licensing status, education background, board certification, liability coverage, pharmacy license, felony or drug charges, etc. is a basic step in assuring quality of care and prevention of fraud. Several state insurance regulations require dental carriers to credential providers as a protection to the consumer. To prohibit such an action would require carriers to violate state law and neglect a critical function to consumers in making sure all the providers on their network are properly licensed.

- *Sec. 2719B (b) requires carriers to pay a fine up to \$1000 daily if found in violation of the Act.*

The proposed fee amount is arbitrary and without basis. It is also unclear who will police these requirements and administer the fee. In addition, this fee could negatively impact premium costs over time.

- *Sec. 2719B (c) makes the DOC Access Act applicable to only excepted benefits, not medical or other health related policies.*

The focus on excepted benefits is an acknowledgement that many of the standards established by the bill are not appropriate in health care. If the elimination of credentialing, the limits on payment changes as well as requirements for re-contracting were applied across the health care spectrum, the cost of health insurance would skyrocket. The processes that are eliminated or imposed by this bill rarely differ between medical and dental carriers. The application to only excepted benefits places the interests of two health care professions above consumers of dental and vision coverage.

Dental premiums are 1/12 of medical premiums and can range \$18 - \$40 monthly. About 25% of group dental policies are also voluntary benefits and individuals are not mandated to maintain such coverage under the Affordable Care Act. The bill as drafted is so onerous that the administrative costs alone would impair the operation of smaller dental carriers and reduce competition in the market. If implemented, these requirements would increase dental premiums so as not to be affordable for employers to offer, or individuals to purchase. More employers would move to self-insurance so that these burdensome regulatory requirements would not be applicable. Dental premiums need to stay affordable as consumers with dental plans are more likely to visit the dentist and receive critical oral health preventive care which may decrease the cost of medical expenses over time.

NADP appreciates your review of our concerns and look forward to discussing any legislative efforts which would provide consumer protections, flexibility for providers and reduce administrative costs so that premium dollars are spent on oral health and not regulatory processes that provide no value to the consumers that dental plans and dentists serve. At this time, H.R. 3323 runs counter to all these objectives.

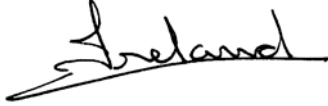
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Sincerely,



Evelyn F. Ireland, CAE  
Executive Director  
National Association of Dental Plans

The National Association of Dental Plans (NADP) is the largest non-profit trade association focused exclusively on the dental benefits industry, i.e. dental PPOs, dental HMOs, discount dental plans and dental indemnity products. NADP's members provide dental benefits to more than 92 percent of the 205 million Americans with dental benefits. Our members include the entire spectrum of dental carriers: companies that provide both medical and dental coverage, companies that provide only dental coverage, major national carriers, regional, and single state companies, as well as companies organized as non-profit plans.

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