Approved: March 18, 2010
Date

MINUTES OF THE HOUSE INSURANCE COMMITTEE

The meeting was called to order by Chairman Clark Shultz at 3:29 p.m. on March 11, 2010, in Room 152-S of the Capitol.

All members were present except:
Representative Olson - excused

Committee staff present:
Bruce Kinzie, Office of the Revisor of Statutes
Sean Ostrow, Office of the Revisor of Statutes
Melissa Calderwood, Kansas Legislative Research Department
Amanda Nguyen, Kansas Legislative Research Department
Sue Fowler, Committee Assistant

Conferees appearing before the Committee:
Kevin Robertson, Kansas Dental Association
Dr. Dave Hamel, Dentist
Dr. Hal Hale, Dentist
Dr. Ted Mason, Dentist
William W. Sneed, America's Health Insurance Plans
Larrie Ann Brown, Aetna, Inc.

Others attending:
See attached list.

Hearing on:
SB 389 **Dentists; prohibition on limiting payment for services not covered under insurance policy**

Melissa Calderwood, Kansas Legislative Research Department, gave a brief overview on **SB 389**.

Proponents:
Kevin Robertson, Kansas Dental Association, (Attachment 1), appeared before the committee in support of **SB 389**.
Dr. Dave Hamel, Dentist, (Attachment 2), gave testimony before the committee in support of **SB 389**.
Dr. Hal Hale, Dentist, (Attachment 3), presented testimony before the committee in support of **SB 389**.
Dr. Ted Mason, Dentist, (Attachment 4), appeared before the committee in support of **SB 389**.

Opponent:
William W. Sneed, America's Health Insurance Plans, (Attachment 5), gave testimony in opposition to **SB 389**.
Larrie Ann Brown, Aetna, Inc., (Attachment 6), presented testimony before the committee in opposition to **SB 389**.

Hearing closed on **SB 389**.

Discussion and action on:
HB 2671 **Fire marshal; investigation of crimes**

Representative Swenson moved to amend **HB 2671** with balloon language provided. Seconded by Representative Hermanson. Motion carried.

Representative Neighbor moved **HB 2671** favorable for passage as amended. Seconded by Representative Hermanson. Motion carried.

Minutes of the House Insurance Committee at 3:30 p.m. on March 11, 2010, in Room 152-S of the Capitol.

SB 388 **Changing the effective date for NAIC rules relating to risk-based capital**

Representative Brunk made a motion to adopt the amendment as presented to include a technical amendment on page 1, line 9 and a study to be conducted by KHPA. Seconded by Representative DeGraaf. A vote was taken and a division was called for with an outcome of 6 in favor and 4 in opposition. Representative Brunk moved to pass out **SB 388** favorable as amended. Seconded by Representative Hermanson. After discussion, Representative Brown made a motion to table the bill to a later date. Seconded by Representative Neighbor. Motion to table bill passed.

Representative Grant moved without objection to pass the March 9, 2010 committee minutes as written.

The next meeting is scheduled for Tuesday, March 16, 2010.

The meeting was adjourned at 5:40 p.m.

House Insurance Committee
Guest Sign In Sheet
Thursday, March 11, 2010

Name	Representing
Marlee Carpenter	KAHP
Rose Remit	KSSFMO
Bill Sneed	AHIP
Alex Kotoyantz	P.I.A.
[illegible]	VHG
Leigh Keck	Hein Law Firm
David Ramer	Kearney & Assoc.
Anne Lambertson	KANSAS HEALTH CONSUMER COALITION
Michelle Butler	Cap. Strategies
Kerri Spielman	KAIA

KANSAS DENTAL ASSOCIATION

Date: March 11, 2010

To: The House Committee on Insurance

From: Kevin J. Robertson, CAE
Executive Director

RE: **Support of SB 389** – prohibiting provider contracts from setting fees on non covered dental services

Chairman Shultz and members of the Committee, I am Kevin Robertson, Executive Director of the Kansas Dental Association (KDA). KDA membership totals 1,244 dentists and represents about 78% of the licensed practicing dentists in the state of Kansas.

The member dentists of the KDA are fully in support of SB 389!

The KDA requested introduction of SB 389 to overt a new and impending policy that will soon be seen in dental provider contracts that is sure to negatively impact patient care and the dentist patient relationship. This new policy will interfere with basic free market forces as it will artificially establish fees on dentists' services that are not even covered by insurance plans. Let me say that again...the insurance carrier would set the fees on what a dentist could charge a patient for mutually agreed to dental services - on services the insurer doesn't even cover!

This is the actual policy that Delta Dental (national) has adopted as a nationwide policy and is MANDATING its state plans (like Delta Dental Plan of Kansas) to amend provider contracts in a way that allows Delta to control what dentists charge, even for services Delta DOES NOT cover.

Delta Dental Plan of Kansas actually voted in opposition to this national policy, and as such asked for and received an extension from Delta (national) to hold off implementation of this policy for its Kansas providers until January 1, 2011. The KDA thanks Delta Dental of Kansas for their bold position versus Delta (national) on this issue. Though Delta Dental of Kansas is not actively supporting SB 389, the KDA worked with Delta Dental of Kansas during the drafting of SB 389 and I hope their neutral or "no position" on SB 389 is a telling sign to the committee.

SB 389 is not a mandate as it does not require an insurance carrier to cover any certain type of claim, condition, illness, etc. It prohibits certain language in insurer-provider contracts. It is presumed that other insurers will soon follow Delta's (national) lead unless the playing field can be leveled for all insurance companies by SB 389.

Those representing the insurance industry will argue that SB 389 is simply state interference with their right to contract with willing arties. Dentists, however, do not "negotiate" contract provisions with insurance companies. Dentists are simply given the option to take-it-or-leave-it. "Leaving it" is often not a viable option for dentists as their patient base and existing patients may already be covered by the insurance program in question with a long established dentist-patient relationship.

House Insurance
Date: 3-11-10
Attachment # 1

Also, under anti-trust laws, dentists cannot organize to collectively fight or complain against such contract provisions – the existing insurance code exists for this very reason and in this case legislation like SB 389 is the only remedy.

Some may say that an insurance policy that sets fees on noncovered services will reduce healthcare costs to dental patients, but will it? The zero-sum theory that we learn about in high school economics will surely play out...costs are simply passed on; they do not evaporate.

I would suggest that such contract policies will result in watered-down dental benefits to employees whereby a minimal dental benefit program is wrapped around a dental discount program that essentially pays nothing to the covered insured/employee. This would ultimately result in higher (not lower) out of pocket costs to employees.

Presumably the reduced fees will help insurers attract customers and improve the insurer's bottom line...a bottom-line that that has received Congressional attention of late for record profits and huge premium increases in 2009-10 at a time when the average employer and employee has been struggling to make ends meet.

Dentists will solely bare the financial burden of this marketing approach and assume all the financial risk as the insurer pays out nothing to the covered insurer for these procedures - high or low utilization is not an issue to them. The private practice dentist/small business owner/employer providing jobs in your local communities will be forced to put their fees on permanent "sale" and find some way to make up for the loss in revenue. As the legislature is only too aware this can only come from reducing costs (possible dental office staff layoffs) or increasing income on others' services.

According to the study, "The Economic Impact of Dentistry," published in the Journal of the American Dental Association in 2004, the average dental office contributes $1.2 million annually to a local community's economy through salaries, purchases, etc.

Finally, the ability to compete and attract dentists into Kansas is a real issue. With ZERO dentists actually educated in Kansas, we must continually work to maintain relations and "resell" Kansas to our dental students who have left our state to be educated. According to the 2009 Dental Workforce study by our own KDHE Bureau of Oral Health, 54% of dentists practicing in frontier communities plan to retire within the next five years. As the KDA, KDHE Bureau of Oral Health and other public and private entities look for incentives to attract new dentists to these communities, the passage of SB 389 could be a decided advantage as practice environment is a factor in dental student practice location selection.

Drs. Dave Hamel, Ted Mason and Hal Hale will also be testifying to discuss the importance of continuity of patient care and the effects such a contract provision could have on their practices and the well being of their patients.

Thank you for the opportunity to testify today in support of SB 389! I will be happy answer any questions you may have at this time.

House Committee Testimony **supporting** Bill 389
David Hamel DDS
Marysville, KS 66508

Each day, dentists help patients obtain their due coverage from their insurance plans or companies. These coverages have been prepaid for with their insurance premiums then somehow get lost in the interpretations and choices by the insurance company or plans to not cover the treatment. Unfortunately many times we have to do more than just be advocates for our patients or provide information. We have to help them fight for their benefits that are due and payable. It is an unneeded step that adds to a consumer's cost of dental care.

When there is an opportunity for a company or plan to decide between covering treatment for a patient or not covering treatment, many times the decision is to deny coverage. Here is such and example.

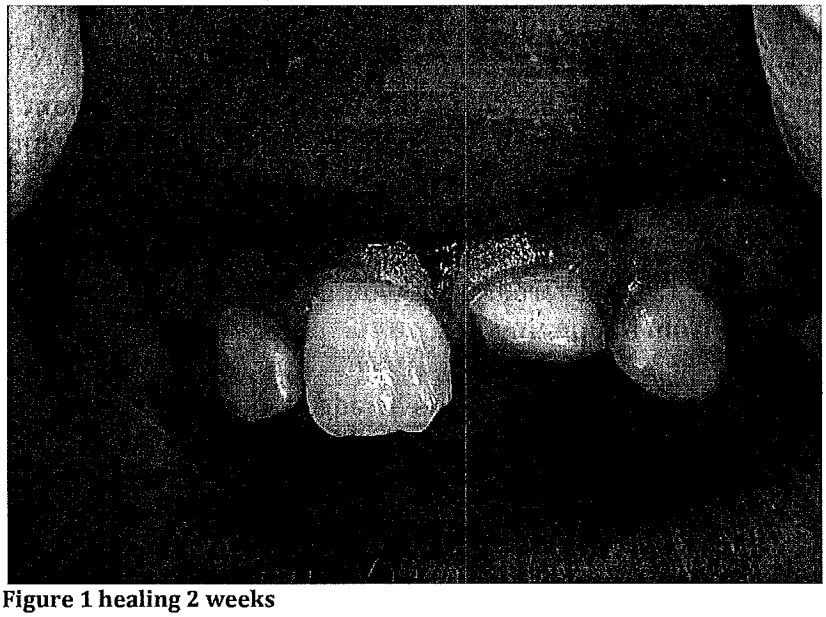

Figure 1 healing 2 weeks

You may think, no problem, dad is employed by a major employer and they have dental "insurance" through a major dental insurance company. And after all this is a playground accident. This is what you have dental insurance for, right?

Dad's insurance plan allows maximum coverage for this accident as part of the contract. It also allows less coverage since the original claim was rejected for any coverage. $0 coverage was the determination by the insurance.

Fortunately for the patient, the dental office persisted and the patient also got involved in the time consuming and overhead raising process of fighting for the patients' benefits. Even though $1,600 dollars could have been the benefit for the employee they finally received a benefit of $290.

House Insurance
Date: 3-11-10
Attachment # 2

It is commonly stated that if coverage goes up then costs must go up. However in this case, several million dollars more was prepaid into the plan for coverage than what was paid out in benefits coverage. That is typical for the dental insurance industry.

The point of my introduction is to let you know that when given a choice, it is common for the choice by insurance plans to be no coverage. It is a real occurrence and happens in everyday life of patients. Insurance companies and insurance plans are not the champions of patients. There are already too many excuses and loopholes to not provide coverage.

Insurance companies want us to believe they are only providing what the employer wants. I don't believe that to be true. In the case I showed, you and I are the employer. The plan that covers this family is the State's employee benefit plan. Is that really how you and I want our state employees and families covered? We've already prepaid millions of dollars extra to be used for coverage so it does not increase our cost in any way.

In recent months there has been an introduction among insurers to add a new avenue of providing no benefit payment while saying there is coverage. They want to list non-covered treatment as covered procedures in their plans. They then want to place a "cap" on the fee and provide no benefit payment for that treatment.

Permitting this phantom coverage on procedures provides an incentive to decrease the number of treatments that are truly covered. That would cost consumers even more and this bill prevents that from happening.

Supporting senate bill 389 costs no money and it adds no additional costs to consumers. This bill is not a mandate; it makes no requirement for mandatory coverage. It does say to insurance companies that if they want to "cover" a procedure, then actually cover the procedure.

I am asking you to support this bill.

Respectfully,
David Hamel DDS
1200 Broadway
Marysville, KS 66508

House Committee on Insurance
Testimony of Dr. Hal E. Hale, DDS on SB 389
Thursday, March 11, 2010

Chairman Shultz members of the committee,

I want to thank you for the opportunity to offer my testimony in **support of Senate Bill 389**. As you are aware, this bill would prevent dental insurance companies from capping the fees of dental services that they do not cover. This plan of capping non-covered services proposed by the dental insurance companies is, I believe, unjust and unfair. If the insurance companies are not interested in covering these services, they should have no interest in the fees established by dentists for actually providing these services.

Of course, the insurance companies say that they are proposing this plan to save patients money. I agree that capping non-covered services will reduce the fees for these services slightly. However, I refute that the insurance companies are doing this out of any sense of benevolence toward patients. Instead, I believe the motivation behind their plan is to increase their own profits. If they truly had the interest of patients at heart, they would actually cover the services in question. That would truly save patients money. But of course, covering these services would increase the amount of money the insurance companies would have to pay out and thus decrease their bottom line profits. That is why they want to cap rather than cover the services in question.

I hope to show that there are detrimental effects to allowing the capping of non-covered fees. Moreover, I hope to show that these detrimental effects outweigh any benefits that might be gained from allowing this practice to go into effect.

Lastly, the only remedy to this flawed proposal is through legislation like SB 389. Due to the domination of the dental marketplace by the dental insurance companies, individual dentists cannot protect themselves from having this policy of capping non-covered services imposed upon them. Due to the domination of the dental

marketplace by the insurance companies, simply refusing to participate in insurance plans is not a viable economic option for most dentists. Therefore, the only recourse to preventing the capping of non-covered services is through legislation.

First, I will attempt to show that it is profit, not patient savings that motivates the insurance companies to propose the capping of non-covered dental services. Let us begin with a little background on the subject.

Under the existing dental insurance model, insurance companies agree to provide coverage for certain dental services in return for receiving a premium. Dentists agree to accept a write-off, a type of cap, on the services the insurance companies cover. In return, the insurance companies send the dentists patients and a direct co-payment for the services the dentist provides to those patients. The patients benefit from both the dentist accepting the write-off or cap, and the insurance company paying its co-payment.

Under the capping of non-covered services proposal, insurance companies will still receive their premiums, of course. However, the dentists are forced to accept a cap on additional services, but are not reimbursed by insurance company co-payments on these additional services. Moreover, while patients still benefit from the fee capping, they do not receive the co-payment benefits. In almost every case, the co-payment benefits are greater than the capping benefits.

Additionally, under the capping of non-covered services proposal, the insurance companies have no claim forms for re-imbursement to process. They have no co-payment checks to process or pay. In other words, their administrative costs under this plan are minimal. Additionally, they eliminate the cost of paying a co-payment. However, they still charge a fee for delivering this so-called "service." The result is a nice profit for the insurance companies. Thus, although both dentists and patients lose the benefit of insurance company co-payments, insurance companies see additional profits.

Let us look at how benefits are distributed under the proposed capping of

non-covered services proposal. In this example, we will consider a procedure which costs $1,000 full price. In this example, the service becomes downgraded to a capped, non-covered procedure. Let us further say that the insurance company caps the fee for this service at $800. Since the dentist has to accept the cap, but does not receive a co-payment, the dentist loses $200 in collections. The patient benefits from the $200 reduction in fee, but does not receive a co-payment from the insurance company. The patient would still be left owing $800.

Now let us look at benefit distribution under the current system. We will use the same procedure that costs $1,000. However, this time the insurance company actually covers the procedure. In this instance, let us say the insurance company requires a 20% write-off (or cap) from the dentists, but covers the service at 50%. The dentist would still have to accept the 20% write-off or cap, which would amount to $200. However, this time, the insurance company would directly pay the dentist a $400 insurance co-payment. More importantly, the patient receives both the benefit of the cap ($200) and the benefit of the insurance company's co-payment ($400). Please note that the co-payment benefit is much greater than the cap benefit. As a result of receiving both benefits, the patient is only left owing $400 instead of the $800.

At an out of pocket expense of only $400, the patient is much more likely to accept treatment than at $800. In other words, insurance co-payments result in increased patient utilization of services. Increased patient utilization of services is what I believe this is all about. Insurance companies see profits decreased when they have to pay for increased patient utilization of covered services. In other words, insurance companies enjoy collecting increased premiums, but do not enjoy paying out money to cover services received by the patient. Their profits increase when they can keep premiums, but do not have to pay out benefits for services. That sounds a lot like the capping of non-covered fees scheme!

Thus, we return to my belief that the insurance companies' motive for this capping of non-covered services scheme is insurance company profit, not patient savings. We

have seen that under this proposal, dentists are forced to accept a cap without receiving the insurance co-payment that comes with service coverage. We have seen that although patients receive a little benefit from the capping of fees, they are denied a much greater benefit of co-payment of covered services. We have also seen that insurance companies benefit greatly from this capping of non-covered fees business model. Insurance companies will benefit hugely by eliminating their co-payment, which would be required if they covered the services. Insurance companies also benefit from decreased overhead by reducing administrative costs under this plan. Insurance companies benefit hugely whenever patient utilization of covered services is decreased. However, from their perspective, the cost of patient utilization of services is eliminated if you simply eliminate coverage of services. That is what really is being capped under this plan- patient utilization of services. Thus, it is insurance company profitability, not patient savings that motivates the capping of non-covered services business model.

Secondly, I fear the expansion of the policy of capping non-covered services will actually result in decreased patient access to dental care and increased patient out of pocket expenses. As the insurance companies discover the capping of non-covered services is an increasingly profitable business model for them, they will want to expand this business model. If SB 389 is not passed, I believe we will see dental insurance companies decreasing the number of dental services that they actually cover. Unless SB 389 is passed, preventing the capping of non-covered services, we will see dental insurance plans devolving into dental discount plans. Dental patients will be the true losers if this is allowed to happen. We have seen that patients pay more out of pocket when services are capped but not covered. Currently, the dental insurance companies are only proposing the capping of non-covered services such as gingivectomies, implants, tooth whitening and other cosmetic procedures. However, once this policy is allowed, there is nothing to prevent insurance companies from expanding this process, and eliminating coverage for services currently covered. If this practice is extended to procedures such as extractions, root canals, and fillings, the patients' out-of -pocket expenses for these essential services will be greatly increased. Such increases would greatly diminish the access to dental care for the public. Personally, I do not want to see decreased patient access to care in the

name of increased insurance company profits.

Thirdly, if insurance companies are allowed to cap non-covered dental procedures, many long established doctor-patient relationships will be interrupted. Most of the non-covered services involve the newest and the most technique sensitive procedures. These include cosmetic services and dental implants. Most of these services require the dentist to take several additional continuing education courses, purchase expensive new equipment and pay unusually expensive lab bills. Thus, many of these non-covered services are the services with the highest overhead costs for the dentist.

By capping what the dentist can charge, without reimbursing the dentist for these high overhead services, the insurance companies will reduce the dentist's profit margin to the point where many participating dentists will be forced to no longer offer these important services to their patients. In such situations, patients desiring these services will have to go to new dentists, such as out of network dentists in order to receive the desired care. The doctor-patient relationship is a very special relationship. It is a relationship of trust, and friendship that develops over many years. Doctors and patients become comfortable with each other. We know each other's histories. Often we become extended members of each other's families. We get to know each other's children, parents, and sometimes-even grandchildren. We attend each other's weddings and funerals. These relationships should not be interrupted simply to allow insurance companies to make larger profits.

Additionally, by going to a non-participating dentist, patients would incur a greater out of pocket expense. Again, this would decrease the patients' access to care and actually increase the patients' cost of dental care.

Fourthly, if dentists are forced to practice under the unjust terms the insurance companies are now trying to mandate, some of the positive impact that dentists make upon their communities at large may be diminished or endangered. The Legislature has expressed its concerns about access to healthcare issues, especially in underserved areas

such as rural Kansas. Programs such as Wichita State University's Advance Education in General Dentistry have been promoted and funded in an attempt to recruit dentists to practice in Kansas, especially in these underserved areas. Since capping the fees of non-covered services will reduce the profit margin of dental practices, if Kansas allows non-covered services to be capped and neighboring states do not, then Kansas will be put at a disadvantage when it comes to recruiting new dentists. If the list of capped non-covered services is expanded, then Kansas might actually lose some existing dentists to neighboring states with legislation preventing the imposition of such onerous provisions. We have all seen how access to care has been diminished by the effects of increased malpractice insurance premiums upon medical doctors wishing to deliver babies. In both metropolitan and rural communities, most family practice medical doctors no longer deliver babies. Even some OB-GYN specialists no longer perform obstetrics. Families have been effected everywhere, but the effect has been particularly acute in rural communities. Surely, no one wants to see access to dental care affected in a similar manner.

Obviously, reducing the profitability of dental practices will force many dentists to make some very difficult business decisions. Dentists may have to delay equipment upgrades, and delay introducing new technologies and techniques into their practice. I believe that Kansas' patients deserve nothing less than the best, newest, and most innovative dentistry available. Don't you agree?

Dental practices are employers. Ask the dental assistants, dental hygienists, and dental front office personnel who live in your districts whether they believe it is a good thing or a bad thing for their employers to become less profitable.

Dental practices pump money into their local economies. Again, ask the dental equipment manufactures, the equipment sales force, the dental lab technicians, the lab deliverymen, the medical waste employees, and the many other employees of dental related businesses in your districts if they favor reduced dental profitability.

In addition, by diminishing the ability of dentists to make a profit, the ability of dentists to provide charitable services to the most needy may be diminished. Dentists are very charitable people. I am sure that most of you are familiar with the Kansas Mission of Mercy, or KMOM program. Under this annual or bi-annual program, volunteer dentists and other providers donate one or two days of service at no charge. Needy patients from all over the state are welcome to attend the KMOM event and receive dental care at no charge. The KMOM events have resulted in millions of dollars of free patient care over the years. However, dentists are involved in many other charitable projects such as Project Access, Donated Dental Services, Give Kids A Smile and countless other programs. Many of your constituents have benefitted from these programs. Most dentists volunteer their services at no charge in various charitable clinics located in their local communities. I am sure most of you are aware of such clinics in your districts. Additionally, without fanfare or recognition, dentists treat in their office on a regular basis, patients who are in need of services they are unable to pay for. Dentists routinely treat many of these patients without charge. If economic necessities prevent dentists from performing the charitable work they love, the very poorest of the poor will suffer the most. These constituents in need are counting on you to prevent this calamity from happening.

To summarize, if insurance companies are allowed to implement the policy of capping non-covered dental procedures, the insurance companies will profit. However, this policy will be detrimental to both dentists and patients. Unless the policy is stopped, the number of non-covered services will be increased, ultimately resulting in decreased patient access to care and increased patient out of pocket expenses. Additionally, as a result of this policy, many dentist-patient relationships will be disrupted. Decreased dental practice profitability could decrease the number of practicing dentists in Kansas and thus decrease patient access to care, damage local economies, delay the implementation of state-of-the-art dentistry in Kansas, and diminish the ability of dentists to provide charitable service to Kansas' poorest constituents. All of these detrimental effects would occur in order to allow increased insurance company profits.

I do not believe dental insurance companies should be allowed to impose their

unfair policy of capping non-covered dental services upon the dentists and the patients of Kansas. This imposition can only be prevented legislatively. Dentists are not allowed to negotiate with insurance companies due to the way current anti-trust laws are written. Of course, dental insurance companies are immune from these anti-trust laws due to the McCarran-Ferguson Act. Dental insurance companies virtually monopolize the market share of patients. Additionally, around 90% of dentists accept dental insurance. Because of this monopoly by the dental insurance companies, the decision to simply "opt out" and not accept insurances is not a viable option for most dentists. Thus, the only way to prevent the dental insurance companies from imposing their unjust and heinous policy of capping non-covered fees upon the public is by passing Senate Bill 389. Therefore, I urge the committee to support Senate Bill 389.

Again, I thank you for your attention, and for the privilege of addressing this august body.

Ted Mason, D.D.S.

General Dentist from Wichita. Graduated from UMKC School of Dentistry in 1986.

In support of SB 389:

- The relationships we have with our patients are something we cherish. Generally speaking, dentists can provide the best patient care when outside forces do not interfere with this relationship.
- Many dental services are not only related to dental health but also a patient's well being through their smile and appearance. These are usually non-insurable, non-covered services.
- Needed care and elective services like cosmetic veneering, elective orthodontic treatment and dental implants are sought after by many patients. There is NOTHING to be gained by insurance intrusion into fee arrangements that rightfully exist between a patient and a provider. It will hinder the flexibility and freedom dentists have to offer those desired services. Is free enterprise still alive and well or is it not?
- If the incentive to provide requested services is chilled, some dentists could decide that offering the service isn't worth it, and stop offering those services to their patients. Here's an example:

  Suppose I wanted to go and have a fine dining experience, with a prime cut of meat, and some choices among fine wine. How would I be able to do this if some big, powerful outside agency came along and said: "Sorry, we are going to tell the restaurant industry how much they can charge their customers for this meal." Where is their incentive to serve the best products? Would this not eventually restrict my choices and the quality of service? Likewise, how will dentists be able to continue to provide the most advanced products and services? Our patients could lose in this scenario. They could lose because their ability to choose the best products, materials and services would be restricted. It could drive the quality of dentistry in Kansas down.

- Our expenses do nothing but go up. Capping non-covered services will undoubtedly reduce total collections in the average dental office. Dentistry is the most expensive health care education there is. 4 years at the UMKC School of Dentistry is now about $200,000 dollars. Many areas of Kansas are currently underserved. Is taking more profit out of dentistry a good incentive to further promoting the profession to future generations? As we continue to address access to dental care in Kansas we do not want

there to be new and more roadblocks to the ability to settle here, repay loans or run a business and pay employees.

- One of our popular trade publications showed that it costs at least a million dollars to become a dentist. Eight years of college, buying or establishing a practice, and the lost ability to earn while in school easily adds up to such a number. Insurance intrusion into elective services is done for one reason: to help insurance providers sell their policies. The insurance companies are the only ones who would benefit from this. They stand to gain market share and increase their profits. Our patients will lose because dentists will be reluctant to offer some important services. The dental industry will lose because it will be increasingly difficult to offer jobs and buy new technology. It makes absolutely no sense.
- As providers, we do have the option of simply terminating our participation with insurance companies. If we did drop our participation, we would be free to offer our patients all of the options that modern technology has to offer, without insurance interference. Our patients would have open access to the kind of care the dentists of Kansas want to provide. However, our patients would lose the benefits of reduced fees for services that ARE covered, resulting in an overall increase in their dental care expenses. Our patients would have the option of changing their dental home to another provider, thereby upsetting the relationship dentists and patients alike now enjoy.
- We need the help of the legislature to put a stop to this. Dentists as a group have no collective bargaining power; in fact, we all tend to cringe at the idea of banding together in any way for fear of being sued for collusion by a much bigger and more powerful insurance industry. We don't want patient choices or the quality of dentistry in Kansas to go down. The people of Kansas do not need their choices restricted, or more problems with access to care.

Polsinelli Shughart PC

Memorandum

TO: The Honorable Clark Shultz, Chair
House Insurance Committee

FROM: William W. Sneed, Legislative Counsel
America's Health Insurance Plans

SUBJECT: S.B. 389

DATE: March 11, 2010

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I am Legislative Counsel for America's Health Insurance Plans ("AHIP"). AHIP is a trade association representing nearly 1,300 member companies providing health insurance coverage to more than two million Americans. Our member companies offer medical expense insurance, long-term care insurance, disability income insurance, dental insurance, supplemental insurance, stop-loss insurance and reinsurance to consumers, employers and public purchasers. We appreciate the opportunity to present testimony in opposition to S.B. 389.

In recent times my client has seen a growth of these proposals in various state legislatures. These proposals will cause consumers to pay more for these services, would potentially impact the ability to negotiate fees for covered services, and thus, should not be supported by this Committee.

Before considering any prohibition on the ability of a dental plan or dental care provider to negotiate a consumer discount for non-covered services, a benefit to consumers must be demonstrated. It is plain to see that consumers benefit through reduced costs from this service. Without a demonstration of a countervailing benefit, we question how some consumers would ever be able to pay less for non-covered services with a discount negotiated on their behalf. Further, the potential loss of business by network providers for these non-covered services suggests that these providers may be less willing to offer as substantial a discount for covered services after enactment of such a prohibition. Under either of these scenarios, consumers will be harmed through a combination of higher prices for non-covered services and higher premiums for their dental coverages.

Next, it is always important to remember that at issue here is a contract between two private parties. States are historically very hesitant to be involved in prescribing contract terms between two private parties.

Finally, if a provider does not wish to join the network and receive the benefits of being a network provider, that provider has the right to do so and can charge whatever he or she wishes to charge. We could contend that providers who support this type of legislation wish to have the benefit of large groups through an in-network provider status, and at the same enjoy the benefits

555 South Kansas Avenue, Suite 101
Topeka, KS 66603
Telephone: (785) 233-1446
Fax: (785) 233-1939

House Insurance
Date: 3-11-10
Attachment # 5

of a non-network provider who is not directed as to what is to be covered under non-covered services.

However, if the Committee does decide to work S.B. 389, we would urge the Committee to consider the attached amendment. Simply put, S.B. 389 would prohibit my clients from establishing fee schedules for any non-covered services. This amendment would allow companies to offer such policies and could be entered into if the dentist elected to do so. Since the proponents of S.B. 389 continue to argue for fair contract negotiation between the dentist and patient, they should have no objection to fair contract negotiations between the dentist and the employer.

Thus, based upon the foregoing, my client respectfully submits that S.B. 389 should not be acted on favorably by this Committee. I am available for questions at your convenience.

Respectfully submitted,

William W. Sneed

WWS:kjb

5-3

As Amended by Senate Committee

Session of 2010

SENATE BILL No. 389

By Committee on Financial Institutions and Insurance

1-19

AN ACT concerning dental benefits under health insurance.

Be it enacted by the Legislature of the State of Kansas:

Section 1. No contract 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.~~

Sec. 2. For the purposes of this act:

(a) "Covered service" means a service which is reimbursable under the health benefit plan subject to any deductible, ~~waiting~~ period, frequency limitation or other contractual limitation contained ~~in the~~ health benefit plan.

(b) "Health benefit plan" ~~shall have the~~ meaning ascribed to it in K.S.A. 40-4602 and amendments thereto. Health benefit ~~plan~~ shall also include ~~a subscription agreement issued by a nonprofit dental service corporation:~~

(1) Any subscription agreement issued by a nonprofit dental service corporation.

(2) Any policy of health insurance purchased by an individual.

(3) To the extent permitted by law, the health insurance plan for Kansas children established pursuant to K.S.A. 38-2001 et seq. and amendments thereto.

(4) To the extent permitted by law, the state medical assistance program under medicaid established pursuant to K.S.A. 39-708c and amendments thereto.

(c) "Health insurer" shall have the meaning ascribed to it in K.S.A. 40-4602 and amendments thereto. Health insurer shall also include a nonprofit dental service corporation as such term is used in K.S.A. 40-19a01 et seq. and amendments thereto.

(d) "Insured" shall have the meaning ascribed to it in K.S.A. 40-4602 and amendments thereto. Insured shall also include a subscriber to a

(a) the services are covered services under the applicable health benefit plan; or
(b) any fee or discount set by the health benefit plan for services that are not covered services under the applicable subscriber agreement is disclosed in the contract or in the exhibits or attachments if applicable, and agreed to by the dentist.

coinsurance,

, including but not limited to annual or lifetime benefit maximums or alternative benefit payment.

subscription agreement issued by a nonprofit dental service corporation as such term is used in K.S.A. 40-19a01 et seq. and amendments thereto.

(e) "Participating provider" shall have the meaning ascribed to it in K.S.A. 40-4602 and amendments thereto. Participating provider shall also include any dentist who has entered into a participation agreement with a nonprofit dental service corporation.

(f) "Provider" shall have the meaning ascribed to it in K.S.A. 40-4602 and amendments thereto. Provider shall also include any dentist licensed by the Kansas dental board.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

Larrie Ann Brown
Attorney at Law
319 N Eaton Drive
Lawrence, KS 66049
785-640-2747
larrie_ann@yahoo.com

Testimony before the House Insurance Committee
SB 389
Aetna, Inc.
March 11, 2009

Mister Chair and members of the Committee. Thank you for allowing me to appear before you today on behalf of Aetna, Inc. Built on our 154-year heritage, Aetna will be a leader cooperating with doctors and hospitals, employers, patients, public officials and others to build a stronger, more effective health care system. Aetna is one of the nation's leaders in health care, dental, pharmacy, group life, and disability insurance, and employee benefits. Our membership includes: 17.668 million medical members, 14.117 million dental members and 11.054 million pharmacy members. Aetna's health care networks include: more than 874,000 health care professionals, more than 506,000 primary care doctors and specialists and 4,987 hospitals. In Kansas, Aetna serves as the health insurance carrier to 80,500 Kansans. Aetna provides fully insured dental coverage to 12,149 Kansans and we contract with approximately 442 dentists in Kansas.

As a growing company hoping to serve the health and dental insurance needs of more Kansans we ask that you oppose SB 389. This legislation is being introduced in many states throughout the country in response to a private, negotiated, contracting issue between some dental plans and dentists. To our knowledge, to date the legislation has passed in only one state (RI) and has been defeated in another (CO). The issue was also brought before the National Conference of Insurance Legislators but the model bill was tabled due to voiced concern from several legislators on the interference of business contracts. This bill prohibits a dental plan from requiring a contracting dentist to accept a negotiated fee set by the dental plan unless the dental plan compensates the dentist for such services. It appears to be a simple concept, but please carefully consider the ramifications this bill may have on some of your constituents who currently benefit from this provision and those who could benefit from it in the future.

*Consumers' out-of-pocket expenses my increase due the loss of the discounts on certain dental procedures.

*Employers may experience complaints from their employees due to employee dissatisfaction and surprise with the increased costs for non-covered services when this provision is no longer allowed in the dental contract.

*Employers will have fewer choices in benefit designs and those benefit designs will now include one less benefit to consumers.

*Fewer consumers may seek needed oral health care that may not be a covered service through their dental plan due to the increased cost.

House Insurance
Date: 3-11-10
Attachment # 6

SB 389, which prohibits contracted discounts for non-covered services could be financially harmful to the consumer and could lead to higher costs for oral health care for our customers. The primary purpose of this legislation is to increase dentists' fees, which ultimately raises out-of-pocket costs for consumers. We respectfully request that you allow basic contracting negotiations to continue that may help to lower the cost of oral health care by opposing SB 389.

However, should the Committee decide to pass this legislation we ask that you consider amending the bill to clarify that the bill affects only those contracts that are newly issued or renewed after the effective date of this act as is common in our insurance statutes.

Thank you for your consideration and I'll be happy to answer any questions you may have.