Approved: 2-16-10
Date

MINUTES OF THE SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

The meeting was called to order by Chairman Ruth Teichman at 9:30 a.m. on February 4, 2010, in Room 152-S of the Capitol.

All members were present.

Committee staff present:
Ken Wilke, Office of the Revisor of Statutes
Melissa Calderwood, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Beverly Beam, Committee Assistant

Conferees appearing before the Committee:
Kevin Robertson, Kansas Dental Association
Dr. Dave Hamel,
Dr. Ted Mason,
Dr. Hal Hale,
Bill Sneed, AHIP
Marlee Carpenter (written only), Kansas Association of Health Plans

Others attending:
See attached list.

Kevin Robertson, Kansas Dental Association (Attachment 1)
Dr. Dave Hamel, (Attachment 2)
Dr. Ted Mason, (Attachment 3)
Dr. Hal Hale, (Attachment 4)
Bill Sneed, AHIP (Attachment 5)
Marlee Carpenter (written only), Kansas Association of Health Plans (Attachment 6)

The Chair called the meeting to order.

Hearing on

SB 389 - Dentists; prohibition on limiting payment for services not covered under insurance policy.

Melissa Calderwood gave an overview of the bill. Ms. Calderwood stated that **SB 389** would prohibit health insurers from setting fees for services provided by dentists that are not covered by the contract. She said passage of this bill would have no fiscal effect.

Kevin Robertson, Executive Director, Kansas Dental Association, testified in support of **SB 389.** Mr. Robertson stated that 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. He said this bill is not a mandate as it does not require an insurance carrier to cover any certain type of claim, condition, illness, etc. He said it does prohibit certain language in insurer-provider contracts. He said as the KDA, KDHE Bureau of Oral Health and other public and private entities look for incentives to attract new dentists to frontier communities, the passage of **SB 389** could be a decided advantage as practice environment is a factor in dental student practice location selection. (Attachment 1)

2/4/10

Dr. David Hamel testified in support of **SB 389.** In summary, Dr. Hamel stated that supporting **SB 389** costs no money and it adds no additional costs to consumers. He said this bill is not a mandate; it makes no requirement for mandatory coverage; however, it does say to insurance companies that if they want to cover a procedure, then actually cover the procedure. He said the consumer/patient benefits when that happens. He added that this bill, when passed, will eliminate one opportunity to reduce coverage by removing the possibility that insurance companies can provide less real benefits while claiming they are providing a benefit. He said it is time insurance plans paid their fair share. (Attachment 2)

Dr. Ted Mason testified in support of **SB 389.** He stated that the relationships dentists have with their patients is something they cherish. He said if the incentive to provide requested services is chilled, some dentists could decide that offering the service is not worth it and stop offering those services to their patients. He said insurance intrusion into elective services is done for one reason, to help insurance providers sell their policies. He said the insurance companies are the only ones who would benefit from this. He said dentists as a group have no bargaining power. He added that as providers, they don't want patient choices or the quality of dentistry in Kansas to go down. (Attachment 3)

Dr. Hal Hale testified in support of **SB 389.** Summarizing, Dr. Hale stated that if insurance companies are allowed to implement the policy of capping non-covered dental procedures, the insurance companies will profit. This policy will be detrimental to both dentists and patients, he stated. He added that 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, he said as a result of this policy, many dentist-patient relationships will be disrupted, and all would occur in order to allow increased insurance company profits. He said the only way to prevent the dental insurance companies from imposing their policy of capping non-covered fees upon the public is by passing **SB 389**. (Attachment 4)

Bill Sneed, Legislative Counsel, America's Health Insurance Plans, testified in opposition to **SB 389.** He stated 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. He noted that it is plain to see that consumers benefit through reduced costs from this service. He stated it is always important to remember that at issue is a contract between two private parties. He added that states are historically very hesitant to be involved in prescribing contract terms between two private parties. He noted that 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. (Attachment 5)

Marlee Carpenter, Kansas Association of Health Plans, provided written testimony only in opposition to **SB 389.** (Attachment 6)

The Chair asked for questions from the committee.

Senator Kelsey asked why it is considered collusion if 50% of the dentists sign a letter that says, "If you put that in the contract, we're out of here?" Mr. Robertson said because that is an anti-trust violation.

Senator Steineger asked if it explicitly states in the contract of the health plan provider that it has a right to control prices on other services provided or is it silent?

Dr. Hamel answered that he recently investigated another contract with another company. He said he asked them to tell him what services are covered and which ones are not. They said pretty much everything that is on the fee schedule is covered. He said he told them OK, so if somebody wants to have their teeth straightened or have a cosmetic procedure done, that service is listed on your fee schedule, but it also states very clearly that you do not have coverage for a cosmetic procedure, so is it covered or is it not? He said the answer was, we have to review that on an individual basis and if our panel deems it is not medically necessary, it would not be covered and you cannot charge them at all. He said he asked them if their dental panel decides a service is not medically necessary and you don't pay, you mean I cannot even charge them? The person from the company he was pursuing said, "That is correct."

The same question was asked of Bill Sneed. Mr. Sneed said if you are getting your teeth straightened because of an accident rather than for cosmetic reasons, that's a differential within the contract. He added that the issue at hand is, there is a list of items that are covered and a list that are not and what they (the dentists) are fearful of is that the health care plan will dictate what they can charge for those items not covered by the plan.

Senator Brownlee said to Mr. Sneed, that she has a good friend who is a general contractor and when he goes into contract negotiations on a build job, both sides get to negotiate that contract. The owner gets to say what he wants in the contract and the builder gets to say what he wants, and they come to a point of agreement. Who gets to do that in these contracts?

Mr. Sneed said, generally speaking, it's between the employer and the health care provider.

Senator Brownlee said to Mr. Sneed, you made the comment that the dentists should just not sign the insurance contract. So when it's the dentist and the insurance company, who gets to negotiate? Is it only the insurance company?

Mr. Sneed answered that in fairness, what the dentists get out of it then, is the multitude in the network coming to them as opposed to being out of network.

Senator Brownlee said to Mr. Sneed, I think it's a fatal flaw in the health insurance industry – the Anti-trust Act that was mentioned in Dr. Hale's testimony – both in medical and in dental, because I think it is unfair that the doctors who participate don't get to negotiate at all and I think that's a fatal flaw across the country. You made a point that they could just choose not sign the contract, but they haven't even been allowed to have a voice in it. And whose business is it anyway? It is not the business of the Dental Insurance Company. If they are not even going to cover a service, then it is none of their business what the dentist is going to charge for it, it's the dentist's. When the patient is the one going to pay for the non covered service, then I think it is none of the insurance company's business what the charge is.

Senator Taddiken asked Mr. Sneed what the benefit is to the insurance company of capping a fee for a non covered service.

Mr. Sneed said the insurance company can continue to help their employees keep their costs down on uncovered services. He said as far as a benefit to us, there is very little benefit to us, the insurers.

Senator Barnett asked how the Anti Trust Act is impacting this bill?

The Chair asked that the revisor get back with the answers to this and other questions the committee members' had.

The Chair said the committee will address the bills on the agenda for action today at another time.

The next meeting is scheduled for February 9, 2010.

The meeting was adjourned at 10:30 a.m.

SENATE FINANCIAL INSTITUTIONS & INS. COMMITTEE
GUEST LIST

DATE: 2-4-10

NAME	REPRESENTING
SHAWN MITCHELL	COMMUNITY BANKERS
Lori Church	KS Life & Health Assoc.
Alex Kotsiopoulos	P.I.A.
Hub E. Hale, DDS	Kansas Dentists + Patients
JASON E. WAGLE, D.DS	KDA
Dean A. Troyer DDS	KDA
Bill Sneed	AHIP
Ros Sorenson	Federicks Consulting
James G. Pratt DDS	KDA
Kari Presley	Kearney & Associates
Rick Wilborn	Farmers Alliance
Wallace Glen Sowers	KCMHA
Malea Carpenter	KAHP
M Lethoffles	Oral Health Ks
John Kuether	Ks. Chiropractic Assn
Tom Carlos	KDHA
KEVIN GRIESTON	KANSAS DENTAL ASSN

KDA
KANSAS DENTAL ASSOCIATION

Date: February 4, 2010

To: The Senate Committee on Financial Institutions and Insurance

From: Kevin J. Robertson, CAE
Executive Director

RE: Testimony in **support of SB 389** – prohibiting caps on non covered services

Madame Chair 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 national trend will interfere with the basic free market model of supply and demand and set caps on dentists' fees for services not covered by the insurance plan. Let me say that again...the insurance carrier would set limits on what a dentist could charge a patient for their dental services - on services the insurer doesn't even cover!

This is not some made up fiction, but is 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.

FI&I Committee
2-4-10
Attachment 1

5200 SW Huntoon | Topeka, KS 66604-2398 | 785.272.7360 ph | 785.272.2301 fax | www.ksdental.org

Those representing the insurance companies will argue that this policy will reduce healthcare costs to dental patients, but will it? Reducing the amount allowed to be charged is an erroneous method to reducing costs. This is the simple zero-sum theory that we learn in high school economics....costs are simply passed on; they do not evaporate. Artificially reducing the cost of a product or service most certainly has an economic impact, but at whose expense? Reducing the maximum allowable charge is not a logical and proper method to reduce ACTUAL costs.

The KDA does not believe it is appropriate for a 3rd party insurer to minimize financial barriers when the very same 3rd party has no participation in sharing in the real cost. They accept no financial participation—but certainly enjoy the benefits of the marketing at no expense to them. This potential new policy is a marketing tool that is financed solely upon the backs of the private practitioner / small business owner. The employer providing jobs in the community is forced to put their private 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 our dental students who have left our state to be educated. According to the 2009 Dental Workforce study by the 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.

Senate Committee on Financial Institution and Insurance
Feb 4, 2010
Testimony supporting Bill 389
David Hamel DDS
1200 Broadway
Marysville, KS 66508
785-562-5529

Each day, dentists help patients obtain their due coverage from their insurance companies or plans. These coverages have been prepaid for with their insurance premiums then somehow get lost in the interpretations and choices by the insurance company 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.

Johnny (alias) went to school doing the normal things kids do during playtime. During recess, his parents get the emergency call that activities got too active and in all the fun, Johnny managed to fracture 3 teeth. Fractures occurred from a mild enamel fracture all the way up the scale to an advanced fracture involving the nerve. Multiple appointments were needed to treat the damage.

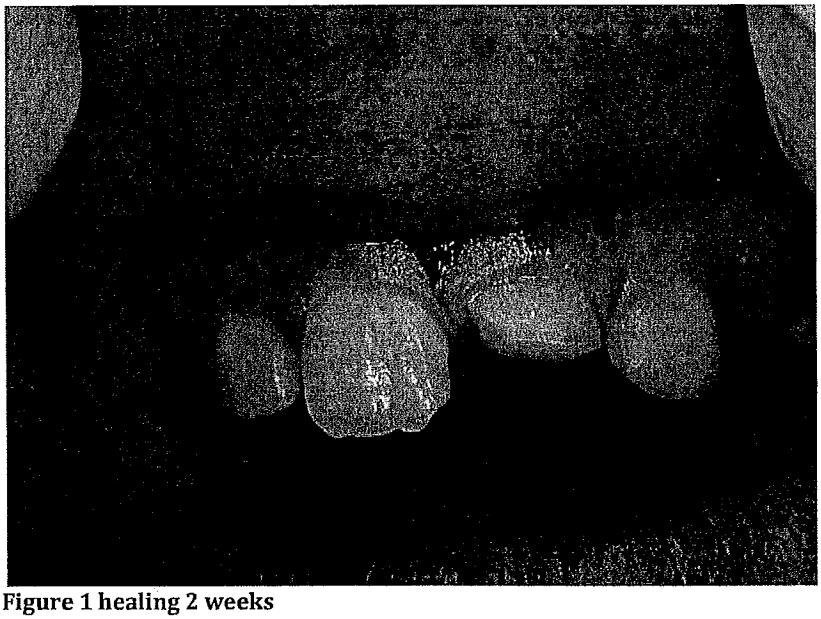

Figure 1 healing 2 weeks

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?

FI:I Committee
2-4-10
Attachment 2

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

However the dental office persisted and the patient also got involved in the time consuming and overhead raising process of fighting for the patients' benefits. Finally, a benefit of $290 was covered. By contract, the amount of coverage that qualified for payment and could have been paid was over 5 times the amount that was covered. When given the choice, the plan chose not to help the patient with the best insurance coverage.

Holding down costs is a common theme among presentations for buying dental insurance. However for dentistry just using addition and subtraction, which include premiums paid, shows that not to be the case. Keep in mind that an average total yearly insurance coverage for dentistry is about $250 dollars per person. And most of dentistry is voluntary. While it is possible for a single medical claim to reach $1.5 million dollars, the maximum single coverage for dentistry insurance is typically $750 – 2,000 and has been that level for nearly 40 years.

It is also commonly stated that if coverage goes up then costs must go up. However in this case, several million more in premiums were paid into the plan than 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 are not the champions of patients. In my experience working with patients, insurance plans already find too many excuses and loop holes to not provide coverage.

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.

If they are permitted to place this phantom coverage on procedures, it provides an incentive to actually decrease the number of treatments that are truly covered costing consumers even more. It is one more opportunity for them to provide less coverage for procedures while keeping more of the prepaid premiums.

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. The consumer, patient benefits when that happens.

This bill, when passed, will eliminate one opportunity to reduce coverage by removing the possibility that insurance companies can provide less real benefits while claiming they are providing a benefit. It is time insurance plans paid their fair share.

I am asking you to support this bill.

Respectfully,
David Hamel DDS
1200 Broadway
Marysville, KS 66508
785-562-5529

Information obtained from:
Kansas Insurance Dept
Kansas Health Insurance Association
Kansas Health Policy Authority
American Dental Association
Delta Dental Plans
Agency on Healthcare Research and Quality

Ted Mason, D.D.S.

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

Regarding 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

FI & I Committee
2-4-10
Attachment 3

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. 8 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.

Testimony of Dr. Hal Hale, D.D.S
Senate Committee on Financial Institutions and Insurance
Support of SB 389
February 4, 2010

Madame Chair and Senators,

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.

FI:I Committee
2-4-10
Attachment 4

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 that 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.

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. 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 policy of capping non-covered fees upon the public is by passing Senate Bill 389. Therefore, I urge all of the Senators on this committee to vote for Senate Bill 389.

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

Polsinelli Shughart PC

Memorandum

TO: The Honorable Ruth Teichman, Chair
Senate Financial Institutions and Insurance Committee

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

SUBJECT: S.B. 389

DATE: February 4, 2010

Madam Chair, 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

FI&I Committee
2-4-10
Attachment 5

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

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

Kansas Association of Health Plans

815 SW Topeka Boulevard, Suite 2C
Topeka, Kansas 66612

(785) 213-0185
marlee@brightcarpenter.com

February 4, 2010

SB 389
Written Testimony Before the Senate Financial Institutions and Insurance Committee
Marlee Carpenter, Executive Director

Chairman Teichman and members of the Committee;

I am Marlee Carpenter, Executive Director of the Kansas Association of Health Plans (KAHP). The KAHP is a nonprofit association dedicated to providing the public information on managed care health plans. Members of the KAHP are Kansas licensed health maintenance organizations, preferred provider organizations and other entities that are associated with managed care. KAHP members serve the majority of Kansans enrolled in private health insurance. KAHP members also serve the Kansans enrolled in HealthWave and Medicaid managed care. We appreciate the opportunity to provide comments to this committee.

KAHP is here today to oppose SB 389. KAHP members are concerned about the precedent set by SB 389. This legislation places the state government in the middle of a legal relationship between two private parties. We strongly oppose this type legislation and respectfully encourage legislator and policymakers carefully consider this measure.

To keep coverage affordable, dental insurance plans typically provide benefits on a scheduled basis within the network, with an emphasis on preventive services. This means that some non-preventive services are only partially covered or not covered at all. For this reason, unlike major medical coverage, when a dental plan enters into a contract with a dental care provider, it is common for the dental plan to negotiate fee discounts, not only for covered services, but also for non-covered services. These discounts are made available to consumers as part of their dental plan. Prohibiting such arrangements hurts consumers, who will need to pay the provider's full billed charges without the benefit of the discount negotiated on their behalf by their dental plan.

The KAHP requests that as you look at this measure and that you consider the impact it will have on the health insurance market and ability to offer cost effective insurance products to Kansas citizens.

Thank you for your time and I will be happy to answer any questions.

FI&I Committee
2-4-10
Attachment 6