

April 24, 2017

The Honorable Greg Walden
Chairman
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
House Committee on Energy and Commerce
2322A Rayburn House Office Building
Washington, DC 20515

RE: "Dental and Optometric Care Access Act" (DOC Access Act), H.R. 1606

Dear Chairman Walden and Ranking Member Pallone,

The American Dental Association (ADA) strongly supports the "Dental and Optometric Care Access Act (DOC Access Act)," H.R. 1606, introduced by Representative Buddy Carter (R-GA), which prohibits "non-covered services" provisions that dictate what a doctor may charge a plan enrollee for items or services not covered by the plan. H.R. 1606 is narrowly drawn to apply only to the business of dental and vision insurance plans regulated by the federal government. Its passage would bring needed balance to contract negotiations between providers, who are often small business owners, and large dental insurance companies. This legislation would not interfere with the states' ability to maintain and enforce their own insurance regulations and laws, but rather complements the work already done by most state legislatures across the country.

In an April 3 letter from the National Association of Dental Plans (NADP) to Rep. Carter, the NADP stated that H.R. 1606 "denies insureds the benefit of discounts negotiated for both covered and non-covered services which negates one of primary values of insurance."

The ADA disagrees with the above statement and believes it is in the public's interest to oppose non-covered services provisions because:

- Imposing discounts on providers for services an insurance company doesn't cover is a marketing ploy, designed to gain a competitive advantage over smaller carriers. The larger plans can be successful because they have greater market share and negotiating leverage. This adversely affects competition among plans in a dental plan market dominated by a few national players in many states. When competition is not robust, consumers are less likely to see high levels of innovation and variety in the marketplace.
- The larger plans are using their "monopsony" market power to dictate pricing on services for which they bear no financial responsibility. As a result, the normal contractual give-and-take between health care professionals and the larger plans breaks down, potentially adversely affecting provider network adequacy, especially in rural areas.
- There is no empirical evidence that non-covered services provisions benefit the individuals covered by the plan, but they do have a negative impact on those paying out

of pocket for their care. In some cases dentists and doctors of optometry have reported that they had to increase the prices on other services in an effort to cross- subsidize losses on non-covered services. Seeking such discounts unfairly shifts risk to health care professionals and non-insured patients without reducing the cost of providing care¹ and may also reduce investments in technology or training. According to the ADA's Health Policy Institute, after adjusting for inflation, the average net income for a general practice dentist in 2014 was at a level comparable with that in 1997.²

- It appears that the reduction in payments to dentists is not passed on to consumers. Dental premiums have been increasing steadily.³ In fact, the dental payer industry enjoyed a profit of \$3.3 billion in 2016.⁴
- Consumers ultimately care about the total cost of care including premiums, deductibles and co-insurance/copays. As excepted benefits, dental plans were exempted from providing transparency on loss ratio requirements. If cost is an issue, insurers should first be transparent about how much of consumers' premium dollars go to paying for care and not administrative costs.
- Forty states agree that dental and/or vision insurance plans should not be permitted to impose fees on services they don't cover. But these laws do not apply to federally regulated plans, a loophole insurers exploit. The primary purpose of this bill is closing that loophole.

In its April 3 letter, the NADP also states: "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."

- Payer contracts are between unequal partners and thus always one-sided. While payers make many demands of dentists, including assent to heavily discounted fee schedules, they do not assume responsibility of assuring "an abundance of new patients" in their contract with the dentist. In fact, more than one in three adults, ages 19 through 64, with private dental benefits did not have a single dental claim in 2013.⁵
- Nationally, there was a 10.4% reduction in payment rates provided to dentists through private dental benefit plans between 2005 and 2014 with a strong correlation (0.77) between dentists' participation in PPO networks and payment rate changes.⁶ This demonstrates the payers' ability to effectively control reimbursement rates.

H.R. 1606 also prohibits plans from communicating with enrollees in a manner that interferes with the doctor-patient relationship and establishes some "rules of the road" for provider network

¹ The effects of insurance carrier market power on dentists and patients, L. Jackson Brown, DDS, PhD, Albert H. Guay, DMD Albert H. Guay, Donald R. House, PhD, January 2009 Volume 140, Issue 1, Pages 90–97

² Why are payment rates to dentists declining in most states? Marko Vujicic, PhD, September 2016 Volume 147, Issue 9, Pages 755–757

³ September 27, 2016 2017 Segal Health Plan Cost Trend Survey, Read more at: <https://www.segalco.com/publications-videos/data/2017-health-plan-cost-trend-survey#Multiemployer>

⁴ IBISWorld Industry Report OD4760; Dental Insurance in the US, October 2016

⁵ Yarbrough C, Vujicic M, Aravamudhan K, Blatz A. An analysis of dental spending among adults with private dental benefits. Health Policy Institute Research Brief. American Dental Association. May 2016. Available from: http://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0516_1.pdf.

⁶ Why are payment rates to dentists declining in most states? Marko Vujicic, PhD, September 2016 Volume 147, Issue 9, Pages 755–757

participation. This bill would prevent retaliatory measures such as strong-arming doctors to participate in plans for network access, providing unreasonably minimal compensation for services rendered, and forcing doctors into participating in contracts in excess of two years.

NADP objects to several of the above provisions in its April 3 letter:

- Reimbursement rates must be reasonable, not nominal. NADP argues that provider and carriers negotiate reimbursement rates and if they are unacceptable dentists “do not need to join the network.”
 - This section merely seeks to ensure a plan will not be able to give a “covered service” status by offering a nominal reimbursement (i.e., \$1.00).
 - Secondly, as noted above, payer monopsony does not really provide dentists with a meaningful choice when asked to make a business decision on whether to sign a contract. As payers steer more patients into using network providers, the small businesses become even more sensitive to discounts.
- The bill only allows for reimbursement rates to be changed with an agreement signed by the provider. NADP argues that when the new fee schedule comes out that the dentist has an “opportunity” to assent to the new fee schedule, negotiate new fees within the schedule, or leave the network.
 - This assertion by NADP is false. Dentists do not currently have this opportunity, and as small business owners they should be able to fully evaluate the effects of modified fee schedules on their practices before agreeing to continue the contractual relationship.
- The bill requires prior acceptance by the provider of any extension to a provider contract for limited scope dental and vision plans beyond two years. NADP argues that the only terms of the contract that change with any frequency are fees and reimbursement rates. The additional expense for re-contracting every two years only adds cost without benefit to the consumer.
 - The bill does **not** require that re-contracting take place. All it requires is that if a contract is to be renewed that the doctor express his/her consent to continue in the contract.
 - Regarding the NADP claim that the only terms of the contract that change with any frequency are fees and reimbursement rates, this assertion is false. Dentists are often contractually obligated to abide by the payers processing policies which are usually independent documents posted on the payers website that are revised annually. These “policies” in fact control the rules by which a claim may be paid or denied by the payer and directly affect the revenue to the dental offices. And the abundance of rules imposed by the payer on dental offices greatly increases the dentists’ administrative burdens. Given that payers have the ability to revise their policies each year, dentists should at least be given the right to consciously assent to remain part of the network every two years.

Dentists, their patients, and the public at large are disadvantaged by the negative impact non-covered service provisions have on competition among entities in the health insurance industry.

The large number of states that have already passed non-covered services legislation demonstrates the need for the federal government to take action on this matter. The passage of H.R. 1606 would foster competition in the insurance industry, benefit consumers and bring balance to contract negotiations that are currently skewed unfairly to advantage dental insurance companies.

If you have any questions, please contact Ms. Mindi Walker of the American Dental Association at 202-898-2404 or walkerm@ada.org.

Sincerely,

/s/

Gary Roberts, D.D.S.
President

/s/

Kathleen T. O'Loughlin, D.M.D., M.P.H.
Executive Director

GR:KO:mw