TESTIMONY OF THE MASSACHUSETTS DENTAL SOCIETY
BEFORE THE JOINT COMMITTEE ON FINANCIAL SERVICES
NOVEMBER 28, 2017

S.504/H.582 – AN ACT RELATIVE TO DENTAL BENEFIT PLAN TRANSPARENCY AND PATIENTS' BILL OF RIGHTS

Improving health and access to quality, affordable health insurance has been a major policy objective both in Massachusetts and in the United States as a whole. Thanks to reforms first enacted here in the Commonwealth, we have seen significant improvements in the health insurance marketplace. Unfortunately, however, dental benefit plans have largely been exempted from these reforms. S.504/H.582 ensures residents of the Commonwealth have access to dental benefits that are easy to understand, meet minimum standards, and guarantee the rights of patients and providers are protected by applying the same requirements that must be met by medical plans.

S.504/H.582 shines a light on dental benefits carriers while also ensuring minimum standards are met. The bill requires that all carriers file annual reports with the Division of Insurance ("Division"), including detailing self-funded lines of business. S.504/H.582 also gives the Division oversight over dental benefit plan premiums by requiring that the Division approve such plans. While these provisions alone would do much to reform the dental benefits markets, there are still more areas to address to bring dental benefits in-line with medical plans.

Healthcare reform in Massachusetts introduced the concept of "minimum creditable coverage," a policy mirrored as "essential health benefits" in the ACA. Minimum standards have

not, however, been established for dental plans outside of the pediatric dental essential health benefit. This lack of oversight permits a wide range of dental plans offered in the state, including those with an annual maximum benefit as low as $500. S.504/H.582 gives the Division greater oversight in terms of patient protections in six ways. First, it requires the Division to set standard definitions for four categories of dental services. As a result, plan purchasers will be able to accurately compare the coverage offered by each plan. Second, the bill requires 100% coverage of preventive and diagnostic procedures for both children and adults. Third, carriers will be prohibited from offering plans with an annual maximum of less than $1,000 in benefits. Fourth, subscribers will be allowed to roll-over any unused benefits from one calendar year to the next. Fifth, all waiting periods will be eliminated, allowing subscribers to access care as soon as coverage is purchased. Finally, S.504/H.582 allows the Division to require that certain procedures be covered for certain populations beyond what is generally allowed under dental benefit plans. For example, the Division could find that there is a cost-benefit to having diabetic patients receive three cleanings per year instead of the standard two cleanings per year. Each of these requirements will help ensure that patients have access to quality dental benefits that they can understand.

While protecting patients' rights is of paramount importance, in Massachusetts we have also seen that market participants do not develop disproportionate power. Unlike medicine, where the conglomeration of providers is viewed by many to be increasing costs, dentistry is still largely focused around solo- and small group-practices that compete directly with each other. Dental benefits companies, however, have secured large shares of the market, often leaving

providers with a "take it or leave it" situation regarding contract negotiations. In an effort to preserve the competition in the dental provider market, S.504/H.582 gives the Division greater oversight of the contracts between carriers and providers in a number of areas. First, the bill ensures that reimbursement rates reflect the costs associated with delivering services by tying fee methodologies to the regional dental Consumer Price Index. Second, the Division is required to review reimbursement fee methodologies that use geographic regions for the purpose of area rate adjustments and disapprove any methodology that uses too few regions, has to great of a range in adjustments, or is not conducive to accomplishing public policy goals, such as drawing providers to certain regions of the state. Third, S.504/H.582 allows patients to have greater choice in providers by allowing them to direct the payment of benefits to non-participating providers while also ensuring that non-participating providers are reimbursed at the same rate as participating providers. Finally, carriers would not be able to set nominal fees for the sake of "covering" a service. These provisions will help to ensure that carriers do not exploit their disproportionate market power and thus disrupt the competitive nature of the dental provider market here in Massachusetts.

Oral health is a critical component of overall health. *S.504/H.582 – An Act Relative to Dental Benefit Plan Transparency and Patients' Bill of Rights* ensures that all residents of the Commonwealth have access to dental benefit plans that are transparent and provide high-quality health benefits. It accomplishes this goal by applying many of the same requirements already met by medical insurers to dental benefits carriers. The members of the Massachusetts Dental Society look forward to working with the General Court to advance this important legislation.