TEETH ON EDGE: THE DEBATE ON DENTAL INSURANCE IN HAWAI`I

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Report No. 4, 1997

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State Capitol
Honolulu, Hawaii 96813
Internet: www.state.hi.us/lrb/

This report has been catalogued as follows:

Jaworowski, Susan.
Teeth on edge: the debate on dental insurance in Hawai`i. Honolulu, HI: Legislative Reference Bureau, December 1997.

1. Insurance, Dental - Hawaii.
KFH421.5 L35A25 97-4

FOREWORD

This study was generated in response to Senate Resolution No. 118, S.D. 1 (1997). The resolution asked the Legislative Reference Bureau to study nine issues relating to dental insurance in the State. The study involves a review of state statutes similar to the proposed changes in the resolution, as well as a review of the current dental insurance system in the State and its key players.

The Bureau wishes to extend its appreciation to all those who assisted in this study, especially Stacy Evensen, Stacy Sugimura, Mike Stollar, Steve Lung, Wesley Park, Raleigh Awaya, Dr. Norman Chun, Dr. Glen Okihiro, Dr. Mark Greer, and Deputy Attorney General Rod Kimura.

Wendell K. Kimura
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December 1997

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Chapter 1

INTRODUCTION

Nature of the Study

The Senate of the Nineteenth Legislature of the State of Hawai`i, Regular Session of 1997, adopted Senate Resolution No. 118, S.D. 1, entitled, "Requesting a study of the impact of provider reimbursement assignment practices of health insurers, health/dental plans, and health maintenance organizations on dental costs and competition among dental care providers." A copy of the Resolution is contained in Appendix A.

Objective of the Study

Senate Resolution No. 118, S.D. 1, requests the Bureau for:

1. Descriptions and comparisons of the quality, accessibility, costs, and choice of dentists' services in states similar to Hawai`i.

2. Descriptions and comparisons of freedom of choice, equal reimbursement, and similar statutes in other states.

3. An analysis of the effect of these statutes in the other states.

4. A determination of the expected impact in Hawai`i if similar legislation is adopted.

5. An assessment of whether the legislation will conflict with state or federal law concerning competition.

6. An assessment of whether passage of the legislation would reduce competition or cause companies to go out of business, by looking at other states.

7. An assessment as to whether the legislation would cause dental fees to rise significantly, by examining other states.

8. An assessment of whether the legislation will eliminate the incentive for a dentist to participate, thereby reducing access and quality while raising costs.

9. An assessment of a "take all comers" law.

Organization of the Study

The study is organized into eight chapters. Chapter two sets forth basic information about dental benefit plans. Chapter three discusses equal reimbursement laws and assignment of payment laws in other states. Chapter four looks at the issues from the dentists' perspectives, and reports on a survey sent out to the dentists in the State. Chapter five discusses the legal issues, and presents the opinion of the Department of the Attorney General on the issues presented in the resolution. Chapter six presents the positions of Hawaii Medical Services Association (HMSA) and Hawaii Dental Service (HDS), as well as others requested to be contacted by the resolution, and analyzes the issues. Chapter seven discusses the proposed "take all comers" provision. Chapter eight lays out the allegations stated in the study and reviews them for accuracy, and presents the findings and recommendations.

Chapter 2

GRIT YOUR TEETH: UNDERSTANDING THE BASICS OF DENTAL BENEFITS

George Washington wore false teeth made from hippopotamus tusks.[1] Paul Revere made the first known legal identification of a corpse based on a dental bridge that he had made for the deceased.[2] A fifteenth-century illuminated manuscript pictures Saint Appollonia, patron saint of those suffering from toothache, with a pair of dental forceps.[3] The Chinese were constructing full dentures in the twelfth century.[4] An ancient Greek dentist has the indicia of his trade — forceps and a tooth — engraved on his tombstone.[5] Egyptians before the birth of Christ passed down papyrus scrolls recording recipes for treating toothache.[6]

Humanity's trouble with its teeth extends back to the dawn of recorded time. However, only in modern times has dental care been institutionalized so that it is paid for by others. In America, prior to 1954, a person's dental care was that person's financial responsibility. However, in that year, the International Longshoremen's and Warehousemen's Union-Pacific Maritime Association won a dental benefits program from the west coast shipping industry.[7] The plan had narrow benefits and was limited to children under the age of fifteen, but it was the start of an industry that, forty-three years later serves millions of people across the country.

The importance of this humble beginning to the dentist-patient relationship cannot be overstated. In previous times, a patient visited the dentist, had work done or planned for it, winced at the bill, and either paid it, worked out payments, or decided that the tooth did not really hurt. But with the advent of these dental benefit programs, a third entity — called, in this study, third party payors — moved into the picture as an interface between the dentist and patient.

Who are these third party payors? Primarily, they are commercial insurance companies, dental service corporations, and Blue Cross/Blue Shield.[8] Commercial insurance companies became involved when their clients to whom they sold medical and hospital coverage started to ask for dental coverage. To keep the business, the commercial insurance companies began to offer dental coverage. In some respects, this put an unfortunate connotation on the dental benefits business, as they became lumped together with medicine and associated with insurance.

However, dentistry is quantitatively different from the practice of medicine and dental benefits are significantly different from insurance. The insurance industry is premised around the concept of risk: it is known, for example, that a certain number of homes will burn down in a given year. What is not known is which ones. Insurers enable individual homeowners to protect themselves against that risk of loss by pooling their assets. Insurers therefore must assess the likelihood of a specified event happening, whether it be a person dying before age 65, a teenage driver getting into a car accident, or the sinking of the Titanic. Actuaries establish the statistical probability of these events occurring, and insurance rates are set accordingly. In medicine, this works: statistics can be compiled on the frequency of heart attacks, or the likelihood of developing breast cancer. Not all people get all diseases, so actuaries can examine risk factors, determine statistics, and play the odds. But dentistry

is different. Everyone with teeth is prone to plaque, cavities, impacted wisdom teeth, and gum disease. When the risk of some or all of these approaches one hundred percent certainty, and the need for regular (annual, semiannual, or even more frequent) office visits is established, there is little point for insurance companies in calculating the odds and trying to beat them.

But if the medical model is discarded and if dentistry is appraised with a fresh eye, some type of benefits plan makes great good sense. Medicine as practiced today in America is treatment-oriented, both in terms of practice and in insurance payments. The majority of physicians are specialists who treat conditions after a patient comes in with a complaint. There is little focus on prevention. Insurance companies routinely refuse payments for physicals — when the patient comes in without a specific complaint and wants a health checkup to see if something might be wrong — but pay for treatment of specific complaints. It is not uncommon for plans to offer zero coverage for physicals and one hundred percent for some hospital stays. One reason medical costs have soared in America is because costly treatment, and not the cheaper prevention, is emphasized.

But the majority of dentists are generalists, and their focus is prevention. They stress regular visits for plaque and tartar removal, fluoride treatment, and use of sealants to prevent tooth decay, and flossing. They will treat, of course, but treatment is seen as a failure of the first line of defense, which is strongly prevention-oriented.

> Dentistry has had a long history of excellent service and cost containment in the private enterprise system. The dental delivery system in America is not in need of major change. Health maintenance organizations, preferred provider organizations and similar groups have had easy access into other parts of medicine because of the need to contain costs and the catastrophic nature of some medical problems. Dentistry does not have either of these problems.[9]

It makes sense to have a dental **benefits** — not insurance — plan that stresses relatively cheaper prevention to avoid more serious and much more expensive treatment down the line. So while insurance companies do offer dental plans — and some may even call it insurance — this study will refer to such plans as dental benefit plans instead of insurance as the former is a more accurate reflection of the intent of such plans.

This study will also refer to the individuals who receive care as "patients," rather than as the perhaps more technically correct terms "subscribers" or "insureds." "Patient" is actually a more descriptive term as some of those who receive care under plans are the subscriber or insured's beneficiaries rather than the actual subscriber or insured. But more importantly, the term "patient" is used to keep in mind the fact that this study revolves around people and their health care. There is nothing more intimate than a person's self. Providing benefits for a person's health should not be placed in the same class as insuring their car or home. An insured does not need to have a personal relationship with his or her insurance agent to be satisfied with the car insurance coverage that is purchased. But a patient does not generally go to a dentist the patient does not trust,[10] and so tampering with the patient-dentist relationship should be approached conservatively.

The first dental benefits plan was viewed cautiously at first. The commercial insurance companies were slow to pick up on the difference between medicine and dentistry and the need for dental benefits plans — one commentator characterized the early insurance posture as "sluggish and deficient in imagination." [11] — once the concept of a dental benefits plan was initiated in 1954, some type of administrative system was needed. In 1955, the first of the dental service corporations, California Dental Service, was established.[12] These state-based, nonprofit, membership organizations[13] later linked up into a nationwide network called the Delta Dental system.[14] The major difference between the dental service corporations and commercial insurance carriers is that the carriers are in it for the money. They play the dental benefits game strictly for the return it can give them and their role is limited to indemnifying their allotted portion of the dental costs. The dental service corporations, however, all grew up out of state dental societies, and their members are dentists practicing in that state.[15] Their role includes guaranteeing that a number of specific services for beneficiaries are performed during a contract period. Also, the involvement of dentists in these corporations keeps the corporation from having a strictly business, bottom-line mentality.

The third major player in the dental benefits area are the Blue Cross-Blue Shield (BCBS) plans, upon which the Delta plans were loosely modeled.[16] The BCBS plans are organized in a similar fashion to Delta in that they have affiliate members at the state and local levels who actually run the plans. Apparently, in the early days, some Delta plans were actually linked to Blue Cross-Blue Shield plans in their states, to the extent that BCBS would provide marketing and actuarial experience and shoulder the risk, while Delta would handle claims, review them, and lend professional advice.[17] However, in the late 1970s the national BCBS formally called a halt to such associations and entered the dental benefits marketplace on its own.[18]

Other types of payment arrangement exist, such as employer-run dental clinics, and direct benefits plans under which the employee pays the dentist directly and is reimbursed directly from the employer, thereby cutting out the third party.[19] However, these are relatively rare.

It is easy but incorrect to refer to companies that offer dental benefits plans as insurance companies. Some are, but some are not. For the sake of accuracy, in this study entities that indemnify dental reimbursement plans, whether they are insurance companies, Delta Dental organizations, or BCBS affiliates, will be referred to as third party payors.

Types of Dental Benefits Programs

Fee-for-Service

The growth in types of dental benefits programs reflects the increasingly business-oriented spectrum that has been imposed on the practice of dentistry by the third party payors. The first of the types of plans was the "fee-for-service" plan (sometimes called an "indemnity plan"). Generally, in a fee-for-service plan, the third party payor either pays a predetermined percentage of the dentist's usual and customary fee,[20] or the payor establishes a table of allowances for each procedure. The dentist is allowed to charge the patient for the difference between the actual fee and the fee paid by the payor or permitted in the table of allowances.[21] There is no prescreening or preauthorization

necessary: the dentist and the patient together decide on a treatment plan, which is funded until completed or until the plan maximum is spent. These plans are the most expensive plans to purchase.

It is widely acknowledged that medical care costs in America have spun out of control.[22] The same is not true of dentistry, but it was probably inevitable that some of the same cost-cutting tools used in medicine would find their way into dentistry. The fee-for-service plan imposed very little of itself in the dentist-patient relationship, raising the concern that there was no control over potential overcharging or overtreatment. A plan with a moderate amount of interface in the patient-dentist relationship was developed, the "preferred provider organization" (also called the "participating provider organization"), or PPO.

Preferred Provider Organizations

In a PPO, the third party payor contracts with a number of dentists to provide dental services at discount rates called "UCRs," which stands for "usual, customary, and reasonable" fees for that area. The dentists who contract with the third party payor are termed "participating providers," or "pars" for short. The third party payor sets up a fee reimbursement schedule based on the UCRs. A patient may use either a par provider or a dentist who has not contracted with the third party payor (a non-participating or "non-par" dentist). If a patient sees a par dentist, the patient will be charged only the UCR for that procedure, and the third party payor will pick up a predetermined percentage (in some cases, 100%) of the charge. If a patient chooses to go outside the par network and see a non-par, the patient will be charged the non-par's usual fee, but the third party payor will base its payment on the UCR, and pay a smaller percentage than it would pay for a par dentist, leading to higher out-of-pocket costs for the patient (see chart).

Hypothetical Cost Comparison: Par v. Non-par		
	Participating Provider	**Non-participating Provider**
Total charge for service	**$100** (based on UCR)	**$110** (non-par's normal fee)
Third party payment	**$80** (80% of the UCR)	**$70** (70% of the UCR)
Patient pays	**$20**	**$40**

Some areas have "exclusive provider organizations" (EPOs), in which the employee must use par providers, or receive no third party payor benefits,[23] but those types of organizations are extremely rare in the Hawai`i dental arena.[24]

PPO plans impose restrictions on their par dentists. The most obvious is that the dentists agree to payment at a set percentage of the UCR fees, which in many, if not all, cases are lower than the dentists' normal fees. The percentage of the UCR that the third party payor pays generally depends on category of service. As dentistry is prevention-based, and as prevention can curtail the need for more expensive treatment, preventative treatments — cleaning, fluoride, etc., are reimbursed at the highest percentage, often as high as 100%. Treatment, such as filling cavities, has the next

highest percentage, perhaps around 80%. Restorative treatment such as crowns and bridges has the lowest, at about 50%. Some services, such as orthodontics, are not covered at all by some plans. For all services covered under the UCR agreement, par dentists are forbidden to "balance bill" the patient for anything in excess of the UCR fee.

Why would a dentist join a PPO? The discounted fee is offset by several factors. The first is that the lower rates make par dentists more attractive to consumers looking to minimize their out-of-pocket dental costs. The plans publicize, or at least notify their subscribers of, the names of the par dentists, thus providing a certain amount of free publicity and a potential client pool to par dentists. Another reason given, at least in this State, is that par dentists are able to receive payments directly from the third party payor. Non-par dentists receive payments from their patients. Some third party payors will allow patients to assign their benefits — the payment that the third party payor will contribute toward the payment of a non-par dentist's fees — directly to the dentist, but others — including the two major Hawai`i payors — will not. The ability to receive the payments directly from the third party payor can be a major incentive for dentists to join PPOs when patient payment history is that of unreliability.

However, some dentists refuse to join PPOs as they believe that PPOs interfere with the patient-dentist relationship. In some situations, but not in Hawai`i, patients with a dental benefits plan are forced to obtain services only from par dentists. In this State, patients with a plan may obtain services from any dentist willing to provide them services: the only difference is a lower proportion of payment from the third party payor. Apparently, that is a choice some patients and some dentists are willing to make.

PPOs are sometimes referred to as "managed care" plans. While in a literal sense it is true that dental care is managed in a PPO, the similarities of PPOs to a fee-for-service plan are much stronger than they are to a DMO, a true managed care plan.[25]

Dental Maintenance Organizations (DMOs)

Dental maintenance organizations (DMOs) (sometimes called "dental HMOs") are dentistry's equivalent of the well-known HMOs in the medical field. DMOs spell managed care. DMOs impose maximum control on the patient-dentist relationship. The patient must use only the DMO dentist, or lose all insurance benefits. But that restriction is only the outward manifestation of the true difference between PPOs and DMOs: capitation. Capitation is a compensation mechanism that pays a dentist a specified sum of money, each month, for every patient enrolled with that dentist, whether or not the patient ever comes in for a checkup or treatment. This is a good deal financially for the dentist when the patient does not come in, or comes in only for regular, routine preventative care. It is not a good deal financially for the dentist if the patient turns out to need a lot of expensive work done, because the dentist receives only the capitation payment, no matter how costly the work.

The pernicious element to DMOs (and HMOs as well) is that the dentist is no longer just the dispassionate professional deciding what the appropriate dental work is; the dentist also becomes, in some sense, the patient's insurer, playing the odds that his or her patients will never all need expensive work at once.[26] If the dentist loses the game, the dentist will have to spend more money than the dentist receives, receiving no personal income that month and even having personally to

expend money to meet overhead expenses. Thus, it is an incentive for a DMO dentist to undertreat to save money, or to accept more patients than the dentist can comfortably or competently handle just to keep receiving additional capitation money to keep operations afloat.

The differences between fee-for-service, PPOs, and DMOs can be likened to ordering at a restaurant. In a fee-for-service plan, you are ordering off the entire menu with an expense account. Order what you like, from any restaurant you like, and someone else will pay for a certain percentage of it, no questions asked. A PPO also lets you order from any restaurant you like, but if you order from one of theirs, the food will be cheaper. A DMO offers an "all-you-can-eat" buffet — but only in their restaurant.

The Hawai`i Experience

Hawai`i has three major players in the dental benefits area: Hawaii Dental Services (HDS), Hawaii Medical Service Association (HMSA), and the state-run QUEST program. Approximately 82% of Hawai`i residents have dental benefits,[27] and of those, approximately 88% are covered by either HDS or HMSA. According to HMSA, the other third party payors of note are United Concordia, the CHAMPUS plan for military dependents; HMAA (Health Management Alliance Association); the commercial carriers as a group; and HIDA (Hawaii Independent Dentist Association).

Hawaii Dental Services (HDS)

HDS is the oldest of the programs providing dental benefits to Hawai`i residents. It is a nonprofit insurance company founded in 1962 and a Delta Dental affiliate. It was originally run by dentists only. Today, twelve out of the twenty-five board members are dentists. Approximately 40% of the state population -- 470,000 people — are covered by HDS.[28] Statewide, 95% - 97% of all dentists are affiliated with HDS. HDS offers both a fee-for-service and a preferred provider plan: the preferred provider plans are by far the most popular option. HDS states that it does not offer a DMO as, unlike the medical field, where only a quarter of the doctors are generalists and three quarters are specialist, most of the dentists — 80% — are generalists. Dentistry therefore needs no gatekeeper — a common feature of managed care — to control its costs.[29]

HDS pays a lower reimbursement rate for non-pars. It does not accept patient assignment of benefits. HDS' position is that dentists would leave its PPO network if they could get the checks directly from HDS.[30]

Hawaii Medical Service Association (HMSA)

HMSA is not, contrary to popular opinion, an insurance company. HMSA is a mutual benefit society founded in 1938, which began offering dental benefits in the 1970s. Approximately 380,000 residents are covered by one of HMSA's four major types of dental benefit plans: fee-for-service, PPOs, DMOs, and QUEST. HMSA's PPO plans are by far the most popular.

HMSA pays a lower rate to its PPO non-pars. It does not support the ability of a patient to assign the patient's reimbursement directly to a non-par dentist.

Together, according to the Hawaii Dental Association, HDS and HMSA cover 96% of the people in Hawai`i with dental benefits: HDS covers 66%, and HMSA covers 30%.[31]

Endnotes

1. Malvin E. Ring, Dentistry: an Illustrated History (Harry N, Abrams, Inc. Publishers: New York 1985) at 193.

2. Id. at 188.

3. Id. at 53.

4. Id. at 81.

5. Id. at 47.

6. Vincenzo Guerini, A History of Dentistry: From the Most Ancient Times Until the End of the Eighteenth Century (1909, reprinted by Longwood Press: Boston, Massachusetts 1977) at 24.

7. Eric Bishop, Dental Insurance: the What, the Why, and the How of Dental Benefits (New York: McGraw-Hill 1983) (hereinafter Bishop) at 36.

8. Id. at 40.

9. Gordon J. Christensen, "Educating Americans About Dental Care Benefits," Journal of the American Dental Association, volume 128, February 1997, at 213.

10. See, *e.g*., M. Robin Dammed et al, "Public Attitudes Toward Dentists: a U.S. Household Survey," Journal of the American Dental Association, volume 126, November 1995 at 1563 ("Studies have suggested that patients' satisfaction with their dentists is a primary determinant of whether they seek preventative and treatment-related dental care.").

11. Bishop at 41.

12. Id. at 44.

13. Id. at 43.

14. Id. at 42, 44.

15. Id. at 43.

16. Id. at 45.

17. Id. at 45.

18. Id. at 45.

19. Id. at 46, 48.

20. Stephen A. Eklund et al, "Trends in Dental Care Among Insured Americans: 1980 to 1995," in the Journal of the American Dental Association, vol. 128, February 1997 at 171, 173.

21. Donald S. Mayes, Managed Dental Care: a Guide to Dental HMOs (International Foundation of Employee Benefit Plans) at 30.

22. "Insurance, that complex third-party arrangement that characterizes America's health care financing, insulates both providers and consumers from a concern about prices and costs and from normal market forces ... Prices have not been particularly important for millions of Americans whose health care was paid for in full or in large part by a third party." Rashi Fein, Medical Care, Medical Costs: the Search for a Health Insurance Policy (Cambridge MA: Harvard University Press 1986) at 168

23. Albert H. Guay, D.M.D., "Understanding Managed Care," in the Journal of the American Dental Association, vol. 126 at 425 (April 1995) (hereinafter Guay).

24. The only one that could be identified by the researcher is Royal State Group, which offers "a very small dental service business for accommodation of long-standing customer purposes only. The service structure ... does not lend itself to anything but a totally closed panel provider system[.]" Letter from Melvin M. Higa, Royal State Group, to Wesley T. Park, President and CEO, Hawaii Dental Services, dated July 8, 1997 (copy on file with the researcher).

25. For a succinct distinction between PPOs and HMOs, see Note, "ERISA Preemption of "Any Willing Provider" Laws — an Essential Step Toward National Health Care Reform," Washington University Law Quarterly, vol. 73, no. 1 1995 at 229, fn. 8.

26. Guay at 430.

27. Firm data on these figures is not easy to come by. However, the State Data Book states that the resident population of Hawai`i is approximately 1,184,000. Of this number, according to HDS, it services 470,000. According to HMSA, it services 380,000 and CHAMPUS/Concordia services 75,000, HMAA services 25,000, the commercial insurers service 10,000, and HIDA services 5000. This gives an approximate total of 81.5% of the resident population with dental benefits, of which 88% is either HDS or HMSA. Sources: DBEDT, The State Data Book, Table 1.04: "Resident and De Facto Population by Residence Status: 1980 to 1996", http://www.hawaii.gov/debedt/db96/index.html; Memo, HMSA, "Sources of Dental Coverage in Hawai`i" (undated) on file with the researcher; Memo, HMSA, "Issues for Discussion with Ms. Jaworowski (LRB)," (undated) on file with the researcher.

28. Interview with Wesley T. Park, President and CEO; Raleigh Awaya, Executive Vice President; Mark Fukuhara, Senior Vice President of Marketing and Product Development; and Patrick Crowe, D.D.S., Dental Consultant of HDS on July 24, 1997 (hereinafter HDS meeting).

29. Id.

30. Id.

31. Interview with Stephen Miyagi and Norman Chun, Hawaii Dental Association, on July 17, 1997.

Chapter 3

EQUAL REIMBURSEMENT AND ASSIGNMENT OF PAYMENT: OTHER STATES' EXPERIENCES

Comparison of Hawai`i to Similar States

The Bureau was asked to provide:

> Descriptions and comparisons of the quality, accessibility, costs, and choices of dentists' services in other states utilizing a system similar to the current system in Hawai`i.

The current system in Hawai`i has three salient features: a population with a high percentage of dental benefit coverage; dental coverage predominantly through preferred provider plans; and two major third party payors, HDS and HMSA, that have contracted with most of the dentists in the State. The Bureau solicited HDS, HMSA, the Hawaii Dental Association (HDA), and the American Dental Association (ADA) for suggestions as to which states would be similar to Hawai`i. The Bureau also contacted a number of state dental associations for information. The states that were discovered to be similar to Hawai`i were Pennsylvania, Virginia, Nebraska, and Michigan.

Pennsylvania has two primary dental health care payors -- a local Delta plan, and a local Blue Cross Blue Shield, both of whom offer preferred provider plans .[1] Virginia also has local Delta and Blue Cross Blue Shield as major dental care payors, utilizing preferred provider networks.[2] Michigan has two dominant providers who are affiliated with almost all the dentists in the state: Delta, whose plan is a high-end preferred provider plan, and Blue Cross Blue Shield.[3] The executive director of the Nebraska Dental Association also describes his state's dental benefits provider situation as very similar to that in Hawai`i.[4]

Unfortunately, the Bureau was unable to obtain information on the quality, accessibility, costs, and choices of dentists' services in these states. The dental associations of these states have never studied these issues. To the best of their knowledge, no such studies have been done, except in Virginia, where a study of accessibility to medical and dental care is planned but not yet underway at the time of contact.[5] The Bureau also contacted the ADA to determine whether a nationwide comparative study might have been done. According to the ADA, it has not.[6]

It is thus impossible for the Bureau to ascertain, with the limits on its time and budget, from thousands of miles away, what the conditions are in these states when even their own dental organizations do not have this data.

Equal Reimbursement Statutes in Other States

The resolution asks for a description and comparison of "'freedom of choice,' 'equal reimbursement,' or other similar statutes that mandate equality of payments ... to any dental patients." It must first be noted that this term is far broader than the specific issues mentioned in the resolution. "Freedom of choice" encompasses a spectrum of legislation, including the "any willing provider" laws, point of service laws, elimination or modification of closed panels, allowing patients to select the dentist of their choice, and restrictions on gag clauses. The equal reimbursement issue which, along with the direct payment issue, are the primary issues discussed in the resolution, are only a part of "freedom of choice" issue. Most of the other types of freedom of choice laws are not relevant to Hawai`i. Therefore, this study will focus on the "equal reimbursement" and "assignment of payment" laws only.

The American Dental Association (ADA) list of state statutes indicates that only six states have "equal reimbursement" statutes and eight states have "assignment of payment" statutes, and of these fourteen states, three overlap. Thus it is more correct to say, for the purposes of guidance from other states, only eleven states have relevant legislation to the specific issues posed by this resolution.

The six states with equal reimbursement statutes are Alabama, Georgia, Louisiana, Mississippi, Oklahoma, and Utah.[7]

Alabama. Alabama's law regarding dental care expenses provides: "Said payment of reimbursement for a noncontracting provider dentist shall be the same as the payment of reimbursement for a contracting provider dentist"; provided that the policy or plan shall not be required to pay an amount greater than the amount specified, or greater than the actual fee.[8]

Georgia. Georgia's law reads, in pertinent part: "Health benefit plans providing incentives for covered person to use ... dental services of preferred providers shall contain a provision which clearly identifies that the payment or reimbursement for a noncontracting provider of covered ... dental services shall be the same as the payment or reimbursement for a preferred provider"; provided that the plan shall not be required to pay an amount higher than the dentist's actual fee.[9]

Louisiana. Louisiana states: "The payment or reimbursement for a noncontracting provider dentist shall be the same as the payment or reimbursement for a contracting provider dentist"; provided that the plan shall not be required to pay more than the amount specified in the plan or more than the dentist's actual charge.[10]

Mississippi. Mississippi's law reads: "Payment or reimbursement for a non-contracting provider dentist shall be the same as the payment or reimbursement for a contracting provider dentist"; provided that the plan is not required to pay an amount greater than the amount specified or than the dentist's actual fee.[11] Mississippi excludes this provision from applying to their nonprofit dental service corporation law or employee benefit plans paid completely by the employer.[12]

Missouri. Missouri states: "No health services corporation may discriminate in its coverage or reimbursement amounts for covered services among persons duly licensed to provide such covered services." The section applies to dentists but does not apply to federally qualified HMOs.[13]

Oklahoma. Oklahoma's statute reads: "Any member in a prepaid dental plan shall be free to select any licensed dental practitioner to provide dental services and prepayment or reimbursement determinations shall be made without regard to whether the provider is a participating or nonparticipating member of the plan."[14]

Utah. Utah's plan, which just went into effect on July 1, 1997, reads: "Except when operating under Section 312A-22-617, an insurer shall reimburse a health care provider, health care facility, or insured for services rendered under Subsection (2) a like amount as paid by the insurer for comparable services to health care providers and health care facilities who are ... under contract with or employed by the health insurance plan ... and ... in the same class of health care providers."[15]

The operative language of these statutes is virtually identical, except for Utah's, which is substantially similar. Most of the statutes have an added clause that restricts the payment to non-pars so that it does not exceed either the amount specified in the plan and/or the dentist's actual fee. The restriction to paying no more than the dentist's actual fee is reasonable: the plans reviewed by the Bureau contain similar language for participating dentists, who receive the lower of either the amount established by the plan or their actual fee. The reason for adding the specific restriction on limiting payment to the amount specified in the plan is unclear, as that restriction also applies to pars and thus there seems to be no need to emphasize that concept in the statutes.[16]

The Impact of Equal Reimbursement Statutes in Other States

The resolution further asks for an analysis of the effect of the equal reimbursement legislation on quality, accessibility, costs, availability of dental services, and dental coverage in states with this legislation. Few states have even attempted to perform an analysis of dental health and insurance issues, and none of the states contacted has done either a formal or informal analysis of the impact of their equal reimbursement law. The Bureau contacted these states' dental associations about the law's impact, and obtained their opinions; however, it must be emphasized that these are opinions only and that no formal analysis exists. In addition, these laws were not adopted in a vacuum; three of them, Alabama, Georgia, and Oklahoma, also adopted an "assignment of payment" law, as discussed further in this chapter. Even if a formal analysis were available, it might be impossible to discern the exact impact of just this legislation, as opposed to this legislation in conjunction with the assignment law.

Alabama. While Alabama adopted a law in 1984 requiring equal reimbursement on the books, the law has been struck down by a federal district court. The Alabama Dental Association[17] indicated that soon after the law passed, Blue Cross Blue Shield (BCBS) filed suit against the law in federal court. The federal district court ruled in favor of BCBS on the ground that the Alabama law was preempted by the federal ERISA.[18] An appeal was filed with the Eleventh Circuit Court of Appeals. Arguments were heard in June 1997, with the court indicating orally that it would probably uphold striking down the law for plans covered by ERISA on the ground of preemption, but that it

would probably send the non-ERISA issues back to the state supreme court, where it presumably would be upheld. (ERISA will be discussed more fully in chapter 5, but basically ERISA (the Employees Retirement Income Security Act of 1974) is a federal law covering the areas of retirement benefits and health and other welfare type of benefits. It preempts most state laws. The Hawai`i Prepaid Health Care Act, chapter 393, *Hawaii Revised Statutes*, has been specifically exempted from much of ERISA, but the Hawai`i act does not include dental benefits.)

The association stated that if the court were to rule this way, it would be a hollow victory for dentists, as, in Alabama, seventy-five percent of all persons with dental/health insurance belong to BCBS, and ninety percent of BCBS's business would fall into the category preempted by ERISA. As the law has been challenged almost since its inception, the association did not indicate that there had been any significant impact on dental care in that state.

Georgia. The dental association stated that due to the large number of dental plans exempted by ERISA from the state law, only a "very small number of people" are affected by the legislation.[19] They have seen very little impact from the law. Apparently the law was adopted in the expectation of ERISA reform, so that Georgia would have a law on the books as soon as that would be accomplished.

Louisiana. Tracing the initial impact of Louisiana's 1985 law is difficult. According to the Louisiana Dental Association, depending on whom is consulted, there are two points of view about its effect. One is that dental care quality increased as fewer health plans included dentists and quality of care remained high, and that dental care costs did not increase appreciably. The other is that it had virtually no impact.[20] While the positive impact of this law is unclear, it does appear that the actual impact, whatever it might be, was at least not a negative one.

When asked about the impact of the law on the dental insurance industry, the association stated that the insurance lobby has such clout in Louisiana that if it had perceived a negative impact from the law, the lobby would have killed it or defused it. As no such effort was made, the association infers that the health insurance industry foresaw no problems with the legislation. The association did state that there "is no evidence suggesting any increase in dental fees related to this law."[21] The association stated that the law did not have a significant impact on dental coverage or on competitiveness between health care insurers, apparently because the health insurers also covered the medical area, and dental care comprises only about 1% of the medical care costs in the state.

Today the law has little impact. Over the ensuing twelve years, the dental industry in Louisiana has changed significantly. At the time the legislation was passed, approximately five percent of the dental insurance plans were dental maintenance organizations (DMOs). This type of managed care entity is not considered "insurance" and is not covered by the statute. Over the years, managed care in the form of DMOs has displaced many PPOs due to the former's comparatively lower costs. DMOs now account for about half the market. Of the remaining dental plans, a large number are self-funded plans which are exempt from state regulation under ERISA. When these two large categories of dental health care are excluded, few plans are subject to the law.

The association added that the circumstances in Louisiana are so unique that their experience may not prove helpful in assessing the impact of a similar law in Hawai`i.

Mississippi. Mississippi's law has been in effect since 1985. Neither the legislative chair of the Mississippi Dental Association nor the State Commissioner of Insurance is aware of any negative impact of the law.[22]

Oklahoma. Oklahoma's law has been effective since 1983. No noticeable impact on dental services or dental insurance has been noted: the opinion of the dental association is that it has not been a particularly effective law as there are no penalties for non-compliance.[23] The association does not know how the law has been utilized and cannot state whether it has had a positive or negative effect.

Utah. As Utah's statute became effective on July 1, 1997, insufficient data exist to determine its impact on dental care in that state.

Assignment of Payment Statutes in Other States and Their Impact

Seven states have statutes that allow a dental patient to assign payment of benefits to a non-participating provider. These statutes are referred to as "assignment of payment," "assignment of benefit" or "direct payment" statutes. It is important not to confuse these statutes with "direct reimbursement" statutes, which refer to an entirely different type of law that removes third party payors from the third party dental benefits arena by setting up systems in which employers reimburse employees directly for their dental care. As the terms "direct payment" and "direct reimbursement" are easily confused, this study will refer to "direct payment" types of statutes as "assignment of payment" statutes.

The seven states that are alleged by the ADA to have "assignment of payment" legislation are Alabama, Alaska, Georgia, Idaho, Nevada, Oklahoma, and Tennessee.[24] Their laws are quite similar.

Alabama. Alabama provides that the dental plan beneficiary may assign reimbursement directly to the provider of services, and the company or agency shall pay the claim directly to the dentist.[25] This law, like its equal reimbursement law discussed above, has been struck down by the federal district court and is pending federal circuit court review.

Alaska. The Alaska statute has some teeth in it: it requires an insurer to pay the provider of dental services directly upon written request of the insured and, if the insurer pays the insured after the insured has elected direct payment, the insurer must also pay the dental provider.[26] The statute has been "very successful" and worked "very well" for medical, dental, and hospital service providers.[27]

Georgia. According to the ADA, Georgia is supposed to have this type of statute, but the only one that could be located allows assignment at the *insurer's* option.[28]. This is the same situation as currently exists in Hawai`i: HDS and HMSA could allow assignment, but will not. Georgia's experience, therefore, does not advance this discussion.

Idaho. Idaho's law[29] was opposed by its Delta and Blue Cross/Blue Shield organizations, but once the law was passed in 1992, an assignment form was agreed on and there have been no problems in the implementation, according to the Idaho Dental Association.[30] The impact has apparently been small: Blue Cross reorganized itself so that it no longer falls under the category of organizations that are mandated to accept assignment, yet to date it still accepts and processes the assignment forms.

Nevada. Nevada has two relevant statutes: one simply states that persons insured under a health insurance policy may assign benefits to the provider, which includes dentists, while the second requires group health policies, upon written request of the insured, to make payments directly to the provider. Both laws provide that payments so made discharge the insurer's obligation, but if the insurer pays the insured instead, the insurer must pay the assignee as well.[31] There was no response from Nevada as to its impact.

Oklahoma. While the ADA has Oklahoma listed as an assignment of payment state, any statute so authorizing that is not readily ascertainable. The Oklahoma Dental Association was contacted by the researcher but that entity was unable to provide any assistance.

Tennessee. Tennessee's law as originally drafted was flawed: while the assignment of payment law states that it is to apply to health care provided by a provider covered under title 63 — which includes dentists — a later enumeration of the term "health care provider" excluded dentists. However, that statute was amended in the 1997 legislative session to specifically include dentists.[32] This provision became effective July 1, 1997, and so no data on its implementation was available at the time this study was prepared.

Summary

Six other states have laws requiring equal payment for non-participating dentists. The statutes are straightforward and quite similar. It is difficult to gauge the impact that these statutes have had on dental care in their respective states. Of the six, Utah's just became effective July 1997, and thus has no data as of the time this study was prepared. Alabama has had its statute on the books since 1984, but the statute has been under attack in federal court and apparently has had no impact as yet. Louisiana reports very little impact from its statute at this time as many of the dentists have moved into DMOs, or participate in plans that fall under ERISA, which preempts state statutes. However, when the law was originally enacted, no negative impact on quality, coverage, or the insurance industry was noted.

Georgia's state dental association notes very little impact from the law. Mississippi has noted no negative impact from the law by either the state dental association or the insurance commissioner. There has been no noticeable impact from the law in Oklahoma.

Seven states are alleged to have laws that permit the patient to assign payment of benefits to a non-participating dentist. The Alabama law is awaiting federal court review. Tennessee's law became effective as to dentists only as of July 1, 1997, so that the state has no information yet on its impact. Georgia, as noted in the equal reimbursement discussion, has noted very little impact from the law. The Oklahoma Dental Association was unable to verify even whether such a law exists in

their state. Nevada was unable to isolate the impact of this legislation from its other Freedom of Choice legislation.[33] Idaho has noted no problems in its implementation. Alaska has stated that their law had been "very successful."

In short, in those states that have had equal reimbursement and/or assignment of payment laws for any appreciable time, these laws appear to have had no known negative impact.

Endnotes

1. Phone interview with Joe Sullivan, Pennsylvania Dental Association Dental Care Programs Coordinator, on June 30, 1997.

2. E-mail from Connie Jungmann, Assistant Executive Director, Virginia Dental Association, June 25, 1997.

3. Michigan's Blue Cross Blue Shield has the unique arrangement of permitting dentists to elect to participate as either a par or a non-par on a per procedure, per claim basis. However, even given this freedom, ninety-six percent of all claims in this situation are done as a preferred provider. Phone interview with Bill Burke, Michigan Dental Association, August 12, 1997.

4. E-mail from Tom Bassett, Executive Director, Nebraska Dental Association, June 16, 1997.

5. Phone interview with Bill Zepp, Virginia Dental Association, on August 12, 1997.

6. A representative of the Michigan Dental Association was of the opinion that no one in this country has done a proper study of dental quality, as that would require significant time and money in order to make a factual, longitudinal study of patient dental health, rather than merely querying patients about how they felt about their treatment.

7. Source, American Dental Association, Patient Provider Options, August 5, 1997.

8. Code of Alabama 1975 sec. 27-19A-4 (1986 Supp.). This section has been challenged in federal court. The federal district court held that it was preempted by ERISA. The case is on appeal to the federal court of appeals.

9. Official Code of Georgia Annotated, section 33-30-23 (c)(1).

10. West's Louisiana Statutes Annotated, section 1513(C)(2)(b).

11. Mississippi Code 1972 Annotated, section 83-51-5 (b).

12. Id., section 83-51-13.

13. Vernon's Annotated Missouri Statutes, section 354.027.

14. Oklahoma States Annotated, section 6148 (D).

15. Utah Code Annotated, section 31A-22-617.5 (3).

16. Some participating dentists have indicated, anecdotally, that upon occasion they will receive more than the amount specified in a plan for dental work that is far more complicated than average. Perhaps this language is intended to exclude non-pars from these apparently rare occurrences.

17. Phone interview with Wayne McMahan, Alabama Dental Association, July 11, 1997.

18. *Blue Cross & Blue Shield v. Neilsen*, 917 F. Supp. 1532 (N.D. Ala. 1996).

19. Phone interview with Nelda Greene, Director of Public Relations, Georgia Dental Association, on August 21, 1997.

20. Phone interview with Ward Blackwell, Director of Communications and Regulatory Affairs, Louisiana Dental Association, on July 8, 1997, and E-mail from Blackwell to researcher on August 7 and 8, 1997.

21. Id.

22. Phone interview with Dr. James Russell Dumas on August 18, 1997; phone interview with George Dale, Commissioner of Insurance, State of Mississippi, on August 19, 1997.

23. Phone interviews with Susan Hillman, Oklahoma Dental Association, in July and August, 1997.

24. Source: American Dental Association paper, Patient-Provider Options, dated August 5, 1997. The ADA also lists Colorado as a state with an assignment of payment law, but Jim Towle of the Colorado Dental Association indicated that their assignment of payment statute, Colorado Revised Statutes, section 10-16-317.5, does not mandate that plans permit assignment; rather, that law states that if the plan permits assignment, and the patient does assign, the insurance company must honor that assignment. Phone interview with Jim Towle, Colorado Dental Association, on August 18, 1997.

25. Alabama Revised Statutes, section 27-1-19 (d).

26. Alaska Statutes, section. 21.54.020(a).

27. Phone interview with Frank Thomas-Meers, President, Multiple Risk Managers, and Insurance Administrator for the Alaska Dental Society, on October 22, 1997.

28. Georgia Code, section 33-30-5 : "Any group accident and sickness policy may provide that all or any portion of any indemnities provided by any policy on account of hospital, nursing, or medical or surgical services may, *at the insurer's option,* be paid directly to the hospital or person rendering such services[.]"

29. Idaho Code, section 41-3417 (3).

30. Phone interview with Jerry Davis, Idaho Dental Association, on August 18, 1997.

31. Nevada Revised Statutes, sections 629.031 (definition of health care provider), 689A.135 (1), and 689B.040).

32. Phone interview with David Horvap, Executive Director, Tennessee Dental Association, on August 18, 1997.

33. Phone interview with Gary Mouden, Executive Director, Nevada Dental Association, on October 24, 1997.

Chapter 4

THE DENTISTS' PERSPECTIVE

The Hawaii Dental Association (HDA) is a nonprofit association incorporated in 1976, representing approximately 90% of Hawai`i's dentists. The HDA positions itself as the advocate of the patient. It supports both "equal reimbursement" and "assignment of payment" legislation. While it acknowledges the benefits of third party payor plans in making dental care affordable, it wants to communicate the fact that:

- Dentistry did not have the rapidly escalating prices that medical care experienced in the past decades, which prices were the primary impetus for managed care plans.

- Dentistry, unlike medicine, focuses on the preventative, which is generally cheaper than medicine's primary focus on the corrective.

- Dental overhead is extremely high, often running approximately 75% of the prices charged. When plans restrict payment to the 75th percentile, some dentists may not make enough on treatment to meet their overhead, much less make a profit.

- Plans that restrict payment, ostensibly for the patient's benefit, may backfire if the dentist is forced to substitute cheaper materials and less painstaking procedures so that the quality of care suffers.

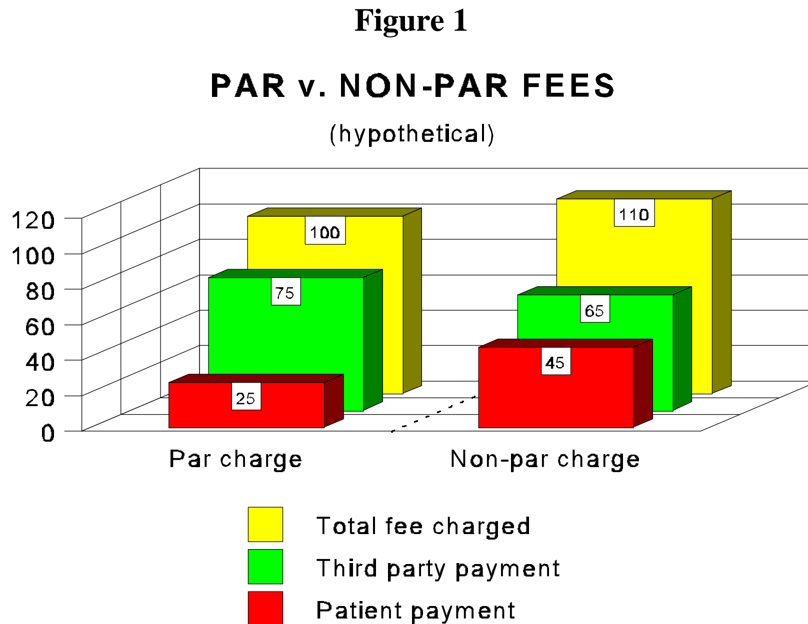
The HDA is particularly concerned with the managed care environment in Hawai`i to the extent it may be creating a breakdown in quality of care. Hawai`i dentists pride themselves on being professionals with the goal of providing the best in dental care to their patients. They claim that two tactics are commonly done that have a negative impact on quality: setting low UCR fees for dentists, and paying only for the cheapest possible alternative.

In participating provider organization (PPO) plans, a participating (par) dentist's fee is capped at a specified rate for each procedure. The patient often has a set co-payment to make, but the par dentist is not allowed to "balance bill" for the actual costs of the procedure over the set fee. For example, a dentist may regularly charge $110 for a silver amalgam filling. The PPO plan may say that the UCR fee for this procedure is $100, and that it will cap payment for the filling at the 90th percentile or $90. The plan will only pay 75% of this fee, which is $67.50, leaving the patient to pay the balance — $90 minus $67.50, or $22.50. The dentist must accept the patient's $22.50 as the patient's share in full, and cannot "balance bill" the patient the difference between the dentist's regular $100 fee and the plan's $67.50 payment, which would be $42.50.

A non-participating (non-par) dentist, on the other hand, is under no such restrictions. The non-par can charge the usual fee, without a cap or a percentile discount. However, most third party payors (including HDS and HSMA) will pay the non-par less than they would pay a par. Continuing the example started above, if the non-par dentist charges the dentist's usual $110 fee for a silver amalgam filling, a third party payor may pay only 65% of its UCR, instead of the 75% which it would pay had the work been done by a par dentist. The patient pays the difference.

The following chart, while simplified, illustrates the difference between par and non-par payments:

Figure 1



While this arrangement is certainly advantageous for the patient, consider the negative impact on the dentist's bottom line. If the dentist's overhead is 75% of the dentist's charge, for a $110 procedure, the dentist must make $82.50 just to pay overhead, much less make a profit. If the plan and the patient both pay their share of $90, that leaves just $7.50 for the dentist as profit — not a rate that most professionals would envy. However, the dentist could lower the cost of the procedure by using a cheaper material or by spending less time with the patient so that the dentist could see more patients per day. Both of these compensating tactics can have a negative impact on the patient, who will receive a lower quality of care.

The other tactic deplored by dentists is the practice of having the third party payor pay only for the least costly treatment alternative. Some dental problems can be handled in more than one way. A badly decayed tooth can be restored with a large filling or by a crown. A missing tooth can be replaced by a denture or a bridge. A deep cavity can be filled with or without a pulp cap. The dentists see it as their duty to their patients to provide the best and most appropriate treatment. However, the third party payors will often make the decision that the condition could be treated in another, less optimum but less expensive way, and will only agree to reimburse for that cheaper alternative. The third party payor does not tell the patient what to do, but the patient often interprets

the payor's decision to pay only for the cheaper alternative to mean that the cheaper alternative is as good as the optimum approach suggested by the dentist. The dentists have very strong negative feelings about the way in which their patients are swayed toward selecting these sub-optimal procedures, considering it an infringement on and an interference with the practice of dentistry.

Survey Results

Allegations were made in the resolution concerning how a change in the dental benefits law would affect the provision of dental services. The Bureau sent out surveys to 899 dentists in the State to determine their position on the allegations, as well as their position on PPO plans in general and the ones in Hawai`i in particular.[1] Of these, 44 were returned as undeliverable, leaving a universe of 855. The response rate was 57%.[2]

The Bureau considers it important to present the survey results at length, both to set forth the dentists' own position, and because the dentists speak, to a great extent, on behalf of the patients. The patients do not have an organized lobby, and it was not feasible to poll a representative sample for their opinions. While the interests of the dentists and the patients are not identical, they do overlap considerably, especially in the area of quality of care.

The vast majority, 87% of the surveys respondents, were general dentists; only 13% were specialists. The majority, 76%, were from Honolulu, but returns were received from all counties.[3] Dental benefit plans impact them greatly: 73% of them reported significant numbers[4] of patients with these plans. The vast majority — 91% — of the respondents are participating providers with HDS; 62% are participating providers with HMSA. The next two highest groups were HMAA, with 22% participating providers responding, and United Concordia Companies, Inc., a mainland plan that is the official dental plan for federal uniformed service military dependents, with 20%. Only a few participated with MetLife and PGMA, just under 4% each. The rest of the groups[5] had a mere handful of providers.

When asked all the reasons why they had become participating providers, the overwhelming response was "as a service to my patients" (78%). Other reasons that ranked highly were "guaranteed reimbursements from the third-party payor" (53%), and "to maintain a competitive advantage with other dentists" (35%). Less important were "the reputation of the plan" and "the plan's quality assurance programs are good for the public and the profession" (25% each) and "the plan serves as a good marketing and referral source for my practice" (23%). Of comparatively little importance were "mandatory lower prices attract patients" (8%) and "the other dentists in my office belong to a dental plan" (6%). Fifty respondents wrote in answers. Of those, the three themes repeated most often were loyalty to HDS, the first dental benefits plan in Hawai`i; accommodation by specialists who joined the plan because their referring dentists were participants; and bankruptcy and/or starvation if the respondent did not belong.

Patient Payment

The section on patient payment was enlightening. The Bureau included these questions to determine the impact of the non-assignment of payments to non-pars. As stated in chapter 2, neither HDS nor HMSA allow their subscribers to assign payment to non-participating dentists. They will only send the check to the patient. HDA complains that this practice is a hardship to the patients, as it compels them to pay their charges up front. The Bureau asked how the non-pars handle payment for patients with dental insurance. The options presented on the survey were:

- Pay only the patient's estimated share (the amount the patient alone would owe) up front
- Pay only the patient's estimated share as services are rendered
- Wait until services are completed before asking patient to pay the estimated share
- Wait until services are completed before asking patient to pay the whole fee (including the amount that the third party payor will reimburse the patient)
- Pay the whole fee up front

Most if not all patients would prefer to pay only the patient's estimated share and then forward the payment by the third party payor for the balance. The least desirable alternative would be to have to pay the entire fee up front.

While a few dentists protested that the questions were skewed to try to show that dentists were money-grubbers without their patients' best interest at heart, the majority of survey respondents — 59% — flatly stated that in this situation, they would require the patient to pay the entire fee up front. Of this majority, another majority — 57% — said that they do this all the time, with 15% saying they do this over half the time and 11% stating they do this about half the time. The response for the other alternatives was far smaller: 20% said they allow the patient to pay the estimated share upon delivery; 15% said they wait until after the services have been rendered to ask the patient to pay the total charges; 8% request the patient to pay only the estimated share up front; and 5% allow the patient to wait until after services have been rendered to pay the patient's estimated share. Some dentists wrote in to state that they work out payment plans with their patients.

The number one reason given by the dentists who ask for the whole fee up front for doing so is past experience with the patient. The second was the fact that the patient was episodic and not likely to continue treatment with the office. The third was lack of previous contact with the patient. A few dentists commented that they were more likely to arrange for payment plans for their regular patients who have paid reliably in the past.

The tone of the written comments varied: a few stated that they asked for all fees up front "just like any other business," but the majority seemed either apologetic or defensive in explaining their choices. Some dentists reported that a high number of non-paying patients led them into

adopting this policy. One stated that over the years he has sent "hundreds" of unpaid patient bills to a collection agency.

What these answers reveal is that the third party payor's refusal to allow assignment of benefits has a considerable negative impact on the patients, who are frequently required to pay all of the bill, including the part that will be reimbursed by the third party payor, up front.

Dentists' Willingness to Drop Out of PPO Plans

One reason cited by third party payors in not changing their assignment of payment policies and their par/non-par rate differentials is that if they did, their network would collapse as all the providers would leave. To test this assertion, the Bureau tendered two hypotheses to the dentists. The first was, assuming that the dentist belongs to a PPO plan, if the plan were to be required to allow assignment of payment, how likely would the dentist be to drop out of the plan?

Of the 460 responses received, this is the order of the responses:

Strongly agree:	23%	Agree:	15%
No impact:	21%	Disagree:	15%
Strongly disagree:	18%	Not sure:	8%

Thirty-eight percent either agreed or strongly agreed that they would be likely to drop the affiliation; 54% would be likely to remain affiliated (including those who selected "no impact"), and 8% are unsure.

The second hypothetical was also based on belonging to a PPO plan, and asked dentists to determine whether they would be most likely to drop their affiliation if the non-par providers received the same amount of reimbursement as the pars. Answers ranked in order, of the 467 who replied, are:

Strongly agree:	34%	No impact:	16%
Agree:	18%	Disagree:	9%
Strongly disagree:	16%	Not sure:	6%

So 52% reported that they were most likely to change, while 41% reported that they would stay the same (including "no impact"). The larger number of dentists who are willing to change based on this hypothetical, as opposed to the first, reflects the priority of these issues to the dental community. In neither case, however, would all or even close to all the dentists leave the plans. One respondent dentist theorized that in the long run, requiring assignment of benefits and equal par/non-par payments would have no impact on the number of providers in a plan:

> In the beginning you may have a higher rate of dentists dropping out or threatening to drop out (i.e., mainly to use this position as leverage), but rightfully so. At this point everything is skewed so

> heavily in favor of the insurance companies. Over a period of time as eligibles increase and dental benefits improve, providers will come back or drop out rate will level off. HMSA and other insurance companies are mainly trying to create a state of paranoia.

In addition to the statistical data requested, the dentists submitted considerable comments about HMSA, HDS, preferred provider plans in general, the assignment of payment issue, and the par/non-par pay differential issue. These comments are synopsized below.

HMSA

The dentists have an extremely negative view of HMSA. Only two had a positive comment about HMSA without a negative rider. The few others that were positive focused on the monetary benefit to the patient — makes dentistry more affordable, convenience for the patient — and the benefit to the dentist of receiving payment directly. However, those comments were by far outweighed by the multiple categories of complaints. All quotations in this section are taken from the surveys. The main areas of complaint which can be broken down into five main categories:

1. Fees are Too Low (UCRs Too Low and Percentile Paid is Too Low)

"Low fee schedule compared to mainland insurance compan[ies], even though we have higher overhead expenses." [6]

These are two separate but related issues. The UCR is the price that HMSA sets as the maximum fee for each service covered. The percentile is how much of the UCR that HMSA will allow the dentist to collect. The dentists allege that HMSA has a double whammy here: it has low UCRs, and sets a low percentile — 75% — of an already too low fee, leaving the dentists with fees that in some cases do not even allow them to meet their overhead. HMSA does not base its UCRs on a statistical profile of actual dentist charges; rather, they set their assessment based on how their existing fees compare with their major competitor, and try to create an internally consistent fee schedule based on the relative value of the services.[7] The decisions are made within the confines of a budget, and the statistics and underwriting departments make recommendations on the fee schedules. The more frequently used services are priced more competitively. While HMSA is, of course, free to set its pricing schedule as it wants, the fact that it is not based on actual dental fees and does not take into consideration a dentist's high fixed overhead costs can lead to a severe impact on the dentists, who are constrained by their fixed costs.

The dentists allege that their overhead costs are high due to fixed costs for staff, sterilization procedures, and office space, and that overhead can be 75% or more of the dentists' usual fee. When the dentist's overhead is 75% of the dentist's usual fee, and the dentist only receives, from HMSA, 75% of a UCR that may be lower than the dentist's usual fee, the dentist skates on the fiscal thin edge.

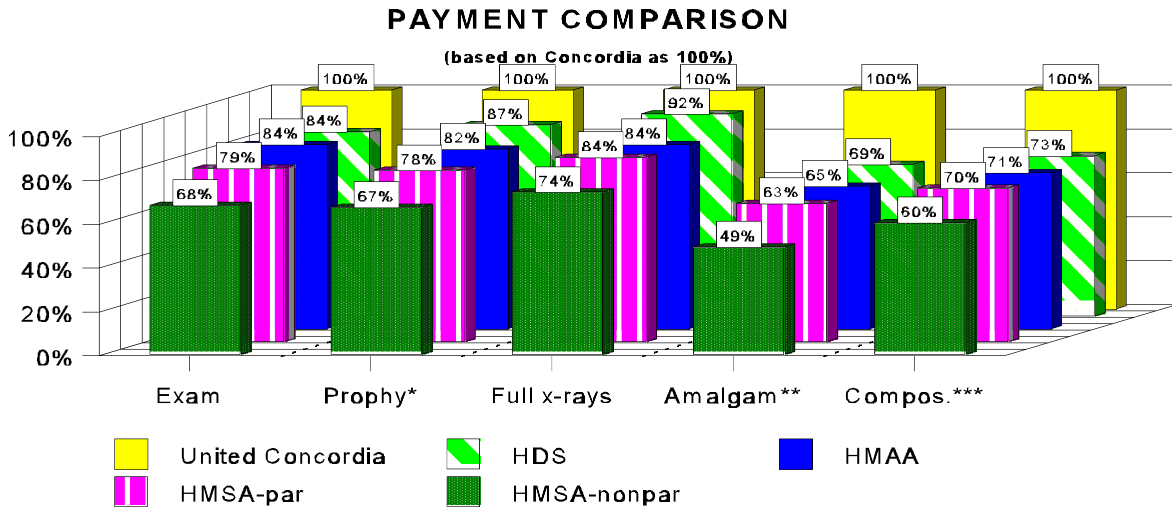
The low fees do not only affect the dentists: they also affect the patient. A dentist can lower the cost per procedure by using cheaper materials, taking less time, or substituting a cheaper procedure in place of one that the dentist thinks is better for the patient. These economies are

difficult for the patient to detect: when the crown breaks five years down the line instead of lasting for twenty years, is it due to the cheaper material, the less painstaking procedure, the patient's mediocre oral hygiene, or some other factor?

Sometimes patients collaborate in the use of less than optimum dental treatment: if HMSA will only pay for the cheaper procedure — the partial denture instead of the bridge, the filling instead of the crown — the patient, unwilling to pay more out of pocket, and uneducated in the nuances of dental treatment, will select the cheaper treatment as the patient thinks that because the third party payor will pay for the cheaper alternative that it is the equivalent in quality, comfort, and longevity of the more expensive procedure.

HMSA's low fees are a particularly sore point for Hawai`i's dental community as they appear to be far below the most popular mainland-based plan, United Concordia. HDS reportedly pays around the 90 percentile, and the mainland plans mentioned by the dentists — in particular, United Concordia, which is the administrator for the federal military dependent plan — is applauded for their high UCRs and high percentiles. HMSA and HDS would not release a copy of their UCRs to the Bureau. However, HDA was able to prepare a simple chart of common procedures, and compare the rates of HMSA (both par and non-par), HDS, HMAA, and United Concordia. In all instances, United Concordia was substantially higher, sometimes more than twice one of the others. Without listing specific numbers, and using United Concordia as having one hundred percent payment per procedure, here is a chart demonstrating what the respective percentages are compared to United Concordia, for payment on five common procedures:

Figure 2



* = prophylaxis (cleaning)
** = amalgam filling, one surface, permanent
*** = composite filling, one surface, permanent

Given the low HMSA reimbursements, it is initially puzzling that approximately 60% of dentists in the State belong to the plan. But according to the survey, so many residents have dental benefit

plans, and seek out participating providers with the plans, that they would lose patients and "risk bankruptcy" if they did not belong to a plan.

One reason that HMSA does not approach, with the dentists, the acceptance level of HDS — which has signed up approximately 96% of all the dentists in the State — is that HDS exercises what it calls its "most favored nations" clause with providers who belong to both. An HDS provider who also is a par with HMSA will be paid — by HDS — at HMSA's lower rates. This discourages participation with HMSA by HDS preferred providers.

The dentists say (all emphases in all quotes in the original):

> *"A participating provider has an agreement not to charge the claimant more than "eligible" fees. These fees are in most cases 20% less than comparable "mainland" insurance companies. In a state which costs 30% more to live this is absurd!"*
>
> *"Just look at dental insurance companies from the mainland: Aetna, Travelers, Concordia, MetLife (just some of which I deal with). All of these have higher eligibles or UCR, all reimburse me directly even though I am non-par."*
>
> "*Our [HMSA] insurance fees are well below our counterparts in other places in the country who even have much lower overhead costs. No fair procedure in determining fees [here].*"
>
> *"Just to stay in business doctors have to cut corners in every possible way because fees are held artificially low. Patients ultimately suffer. Nebraska, Kansas, and Oklahoma fees are higher than here and the cost of rent, salaries, supplies are lower so individual patients can get more personal attention because the dentist isn't rushing to do more "procedures" in a day to make a living."*
>
> *"I did not want to join [HMSA] due to the low reimbursement, but we had problems with patients taking the HMSA check and spending it. It is very, very depressing and frustrating that whenever I talk to a mainland dentist his fees for the same procedure is much higher than mine. Our cost of living is high and we get less. Nuts!"*
>
> *"[I am not a preferred provider as] I will not have my fees regulated and limited by any carrier, especially when both HMSA and HDS have usual and customary fees far below any of the fees recognized in the west coast states."*
>
> *"[HMSA is] too dictatorial on fee matters — such as not allowing fee to reflect the added cost of OSHA requirements a few years ago. Not realistic to expect all costs to be borne by the practitioner. The more the patient and dentist are responsible to each other the more healthy the relationship. Minimize third party participation in the health process."*

"By participating with both HMSA and HDS, fees for most dentists in Hawaii are, in essence, controlled by HMSA. This has serious effects for the dentists as well as for patients. Learning and improving to better serve your patients should be a part of every dentist's lifestyle. There has been a significant drop in attendance at seminars. Why improve when your reimbursement stays the same? New development and materials cost more in time and money. If there is no proportional increase in fees, you lose money. There is no financial incentive to be a better dentist in Hawaii if you participate with HMSA."

"Fee structure makes quality not a possibility over the long haul. Would you work and not get paid?"

2. HMSA's Restrictions Are Not in the Patient's Best Interest/HMSA Dictates Treatment

"Patients tend not to want procedures not covered by the insurance plan."

This was the second largest category of complaints against HMSA. Dentists feel that their professional judgment is being challenged when third party payors restrict the treatment that the dentists believes is the best for each patient. In many cases, the patient will follow what HMSA will pay for rather than what the dentist suggests because (1) the patient is led to believe that HMSA is as knowledgeable about the patient's dental health and appropriate treatment as is the dentist, and (2) the patient, faced with a far bigger co-payment as HMSA will only pay for the cheaper treatment, cannot afford that co-payment and is forced to select the cheaper treatment. The dentists allege that the consultants who approve and disapprove their treatment plans are not themselves licensed dentists, yet are in effect "practicing dentistry" through their decision on treatment for which they will pay, often with only the dentist's written description or at most some x-rays to go on. As one dentist commented, "If I diagnosed based on x-rays alone, I'd be guilty of malpractice." Yet the dentist feels that these consultants are non-dentists who are practicing dentistry by diagnosing and then undercutting the dentist's more informed and more skilled diagnosis and treatment plan.

No incidents were reported in which the consultant suggested a more expensive treatment in lieu of the dentist's cheaper solution: all reported incidents involved the substitution of cheaper services. Examples included paying for a filling for a badly decayed tooth instead of a crown and paying for partial dentures rather than a fixed bridge in certain instances.

"Prevents us from doing needed procedures because of "rules" the insurance company has. For example: If patient has severely broken down tooth, we must do a large silver filling instead of building the tooth up and crowning."

"*Consultants are unrealistic with treatment recommendations."*

"[HMSA] has many problems with approval process: altering treatment proposed; limiting or denying treatment; requiring us to request consultations with their dental consultants."

"They don't consider all people have special needs for special services. The regulations imposed by insurance companies result in "compromised care" for the claimants."

"HMSA is constantly trying to change my treatment plans to eliminate crowns!"

"Management at HMSA more than usual dictates what treatment can be done on patient. If they feel certain treatment is not worth it for the patient they will deny treatment coverage."

"Poor coverage of benefits [is a drawback to HMSA] (i.e., their plans state that they cover bridges or partials, yet if a patient is missing several teeth, HMSA will sometimes only pay for a partial. If a patient wants the bridge, they must pay the difference. HMSA does this because a partial is a cheaper procedure.)"

"[I] have become an employee of HMSA with limited self-employment power: they control my practice."

"They dictate treatment way too much. The reimbursement rates are way too low for quality work. Most of my fellow dentists send work to <u>cheaper</u> labs and use cheaper materials for their HDS and HMSA patients versus their Mainland insurance and private pay patients."

"No coverage for sterilization fees, oral hygiene instruction."

"[Drawback] to HMSA is a greatly reduced reimbursement rate; patients tend to choose only the procedures covered by the insurance irrespective of what is best."

"Insurance companies interfere with choices of treatment. Patients feel [that] if treatment is not covered, it is not essential."

"Drawbacks [to HMSA] are unfavorable benefit/coverage decisions, with simultaneous wording/marketing that the provider is overcharging."

"HMSA WILL NOT REIMBURSE PATIENTS FOR DRAINAGE OF AN ORAL ABSCESS BY A DENTIST. They claim this to be a medical procedure and thus have been denying payment." (emphasis in original)

"[Drawback to HMSA]: Inability to charge for certain procedures, such as pulp capping, office visits, temporary or interim partial denture."

These allegations are tied into the third major area of complaint:

3. HMSA is Decreasing the Quality of Dentistry in Hawai`i

> ***"HMSA has continued to lower their limits on plans and exclude procedures, thereby jeopardizing the quality of care. Dentists are coerced into providing lower standards of care. They must cut corners on materials, equipment, and time spent with the patient."***

The dentists perceive themselves as the champions of their patients. They see the patient as the unrecognized element in the equation running between the employer, the third party payor, and the dentist. The dentist acts as the ombudsman when the third party payor denies a claim, downgrades the treatment, or mispays a claim. The dentist sees the goal of dentistry as providing the most appropriate care for each patient. They see HMSA's goal as providing reimbursement for the minimum care possible necessary. To the extent that HMSA's behavior puts a road block between the dentist and patient, the dentist sees the quality of dentistry as being negatively affected.

> *"If [I were a PPO with HMSA and my] reimbursement is reduced, I would have to use low cost dental labs (mainland) and use lower cost restorative materials. I will not compromise [on] the quality[.]"*

> *"These plans used to be an advantage before (10-15 years ago). But now they have gotten to a point that they are controlling the way the profession must run — to a point that it's cheaper for the patients — but not better."*

> *"Disadvantage is low reimbursement schedule and their contract controlling the type of procedures you can bill the patient for, i.e., they package many procedures into one fee so if there are extra procedures that would be beneficial to the patient, the dentist is forced to do it all for free or not at all. This influences the type and quality of the procedures I offer my patients."*

> *"[They] question my diagnosis too often."*

> *"The table of allowances is low in some areas which pressures the dentists to try to do more in less time and this can lead to lower quality treatment for the patient."*

> *"HMSA forces you to do lower quality work. Even if a patient needs a crown as the best and strongest treatment, I would prefer to do a patch amalgam, even if the tooth already had 2-3 old fillings. HMSA pays so low on crowns and other major work that it is economically better for me to keep patching the tooth. I cannot pay my staff, pay for the gold, pay the lab, and still make less than patching the tooth."*

> *"I have on a couple of occasions had the HMSA consultant admit that the care that they were authorizing was <u>below</u> the standard of care, but it was all they would cover."*

> "<u>Never</u> *does HMSA do a check on the* <u>quality</u> *of care rendered."*

"[For both HDS and HMSA]: we are taught in dental school to be idealistic and offer the best treatment. In the real world insurance has us do the least costly by giving mediocre to poor care. It is enormously difficult to educate patients that quality fee for service care is a good investment."

4. HMSA Administration Difficulties

"Patients are told not to consider recommended alternative non-covered therapies."

A number of complaints were also received concerning difficulties with the HMSA administration and its dental consultants. Allegations included statements that the administration was hard to work with, had an excessive amount of red tape, was manipulative, acted in bad faith, was unscrupulous, dishonest, and unethical.

At least one dentist reported an instance in which the HMSA consultant allegedly told the patient to select the cheaper alternative, and a couple reported being told by their patients that HMSA advised them that the dentist was too expensive and to seek a cheaper one. If true, this type of comment is clearly outside the appropriate context of a third party payor: they should not be giving dental advice or steering subscribers away from dentists due to cost factors.

Other comments from the dentists were:

"HMSA is unethical. A customer service representative actually told one of our patients to switch to an HMSA participating dentist."

"HMSA is very belligerent and uncooperative in their relationship with non-par dentists. They will not provide us with their table of allowances, or provide us with information regarding my patient's dental coverage, or provide us with information regarding the amount of dental costs which will be reimbursed[.] My patients are angry at HMSA."

"When my patients call either HMSA or HDS they are often told I am too expensive and they should go to a participating provider. This ... is not ethical."

"I do not agree with [HMSA's] philosophies and management of their dental insurance coverage. A patient is entitled to their insurance benefits, yet my staff often seems to be fighting to obtain payment. Their attitude is to withhold payment in ways like asking for additional information that is irrelevant to the procedures being performed. Also, their telephone representatives are uncooperative and do not pass on information willingly."

"HMSA does not notify the patients when their benefits have changed. We, as providers, are left with this job which is not our responsibility. For example, HMSA

sent us a memo to tell us not to bill for office visits because they would no longer be covered. HMSA failed to inform its members directly."

Dentists are also concerned about direct competition from HMSA:

5. HMSA Runs Competing Dental Maintenance Organization

"Why are there so many HMSA-run dental clinics — are they insurers or providers?"

As discussed in chapter 2, there are three primary types of dental insurance: the fee-for-service, the preferred provider organization, and the dental maintenance organization (DMO). The DMO is modeled after the more familiar HMO, in which a dentist/doctor is given a monthly fee (capitation) for each patient signed up with that dentist/doctor. All of the patient's dental/medical needs would be serviced by that health care provider. If the patient does not come into the office, the dentist/doctor still keeps the money; if the patient comes in but the cost of treatment is less than the capitation fee, the dentist/doctor takes home a profit from that patient; but if the patient needs and is provided care that costs more than the capitation fee, the dentist/doctor loses money on that patient for that month.

HMSA offers a few small DMOs, including the Hawaii Family Dental Center (HFDC). The dentists fear the potential for encroachment of HFDC and the other DMOs upon their practices. However, they have another, more personal reason for their dislike of HFDC: some dentists claim that HMSA representatives try to talk their patients into switching to HFDC. They claim that HMSA blurs the distinction between functioning as a provider of dental plans that contract with dentists and actually providing the services through its hired dentists.

"You must compete with HMSA clinics. HMSA is playing both sides by selling dental insurance and as providers with their own dental clinics. HMSA HMO clinics provide the least amount of dentistry at the lowest cost. The patient is the loser."

Allegations are made that HFDC operates at a loss, propped up by HMSA medical.

"[HMSA's DMOs] are in direct competition with their <u>own</u> providers."

"HMSA should not have their own clinics that compete with their own PPS. I've had a lot of patients say HMSA pushes their own HMO plan and tries to steer employers away from traditional plans."

However, it should be noted that the national Delta Dental organization advertises a Delta DMO, DeltaCare USA, on its web site[8], and United Concordia, a plan that in general receives high marks from dentists, also offers its own DMO plans along with its PPO plans.[9] It appears to be within industry standards to offer both.

To summarize, a substantial majority of dentists in Hawai`i dislike HMSA, even those who are their own participating providers.

HDS

HDS received mixed reviews from the dentists. Some were quite pleased with the reimbursement levels, the competency of the consultants, the timeliness of the payments, and the generally more cooperative nature of HDS.

> *"Best plan in the state — fair coverage and reimbursement."*
>
> *"(1) Positive attitude toward dentistry by clinical standards. (2) Higher reimbursement. (3) Cooperative corporate mind set set to higher dental standards."*
>
> *"HDS at least stands with dentistry even though they have to make some decisions based on financial success."*

However, many were not impressed with HDS:

> *"Some of the same problems [as HMSA] but to a lesser extent.*"
>
> *"Not innovative and do not cover for procedures even after they have become accepted and established."*
>
> *"Slow payment to provider. Slow to update new plans."*
>
> *"HDS sees me accepting low HMSA fees and makes me accept the exact same fees HMSA [is] paying me. They are punishing me [for] being an HMSA provider."*
>
> *"[HDS drawbacks are] low eligible fees, bundling codes, slow payments, most favored nations clause."*

However, in general, there is considerably more regard for HDS and a far lower level of rancor against it. The dearth of specific comments in this section is a function of that attitude.

The two main categories of complaints were HDS's "most favored nations" clause, and the slowness of the payments.

Most Favored Nations Clause

> ***"Why should those [HDS pars also] participating with HMSA get paid less for the same service than those who do not?"***

As mentioned above, HDS pays approximately in the 90th percentile of its UCRs, while HMSA pays approximately in the 75th. However, if HDS discovers that one of its pars is also a participating provider with HMSA, it will drop that provider's reimbursement rate to that of HMSA's. HDS's rationale for this is that by accepting HMSA's payment, the dentist is dropping the dentist's own fees to HMSA's level, and since the HDS contract pays at the 90th percentile of HDS's UCRs or the dentist's own fee, if lower, HDS is justified in basing its fees on HMSA's. It is curious that HMSA appears to accept this situation: it is clearly aimed at discouraging dentists from becoming HMSA providers, and it apparently uses HMSA's own proprietary data to set fees. This data is considered so confidential that HMSA would not share its fee schedule with the Bureau for this study. Yet an HMSA spokesman said that HMSA does not really have a position on the most favored nations clause, and that it is up to each plan to do what that plan believes is in that plan's own best interest.[10]

This is even more interesting when the fate of the most favored nations clause in other jurisdictions is considered: in Rhode Island, the federal Department of Justice has brought suit against the local Delta Dental affiliate to strike down the clause, and in the settlement that was reached, Delta Dental agreed to stop using it.[11] There have apparently been similar settlements in Arizona and Oregon.[12] It is unclear what the result would be in Hawai`i.

> *"At first if you were a provider with two plans and you received a lower fee from one plan than the other, no problem. Now your lowest reimbursement must be your highest reimbursement with HDS, which is entirely illegal."*

> *"HDS discriminates against HMSA providers by paying the lesser HMSA fee[.] Dentists who participate only with them and not with HMSA receive a higher fee — this is discriminatory and has been judged illegal in other states when Delta Dental groups have attempted this."*

> *"With other mainland plans, it doesn't matter who you participate with. They pay everyone equally."*

Slow Reimbursements

> ***"Slow payment to provider."***

The second most-mentioned problem with HDS is its slow reimbursement time. While a few dentists commented on HDS's "timely payments," many more complained about slow reimbursements, although a few said that the situation is improving.

> *"[HDS] drawbacks: payment for work 1 - 3 months after work completed."*

HDS v. HMSA

Although HDS and HMSA have some similarities, especially in their two-tier payment schedule for pars/non-pars and their joint refusal to allow assignment of payment, some Hawai`i dentists perceive a clear distinction between them. HDS, the plan originated by dentists, is perceived by many of the survey respondents to still have a generally dentist-oriented philosophy. Twelve out of its twenty-five board members are dentists, and all of its phone consultants are dentists. It is perceived by some of the survey respondents to be more reasonable and more patient- and dentist-oriented. However, a fair number of respondents indicated that they saw very little difference between HDS and HMSA, and that both had fees that were too low and a bureaucratic, cost control-oriented attitude that puts profits before patients.

HMSA, in contrast to HDS, has only one dentist on its board[13] and no phone consultants, who make the front line decisions on paying for treatment, with dental degrees. HMSA is viewed as an entity for whom the bottom line is all. It is hard to overestimate the rancor felt by some dentists toward HMSA. HMSA does not view the dentists' allegations with particular sympathy: it takes the position that dentists want higher prices so that they can maintain a certain type of lifestyle.[14] However, it is not necessarily the case that HMSA is the evil empire that some dentists claim it to be. HMSA is a business entity. Its focus is its fiscal bottom line and, one hopes, the good of its subscribers. If it sees the basic benefit to its subscribers as being the lowest possible prices and not the optimum level of care, perhaps, without further name-calling, some kind of detente could be reached in which it could be recognized that quality of care is as much an element to be concerned with — for the sake of the patient — as is cost.

Preferred Provider Plans in General

"[I am] often placed in the middle of insurance versus patient needs."

Some dentists seem to indicate that they would not have trouble belonging to a PPO plan that was more generous in its payment structure and sought less to second-guess dental recommendations. The most popular plan cited was that of United Concordia, which handles the military contract in Hawai`i. United Concordia was praised for its high fees, generous reimbursement, and assignment of payment policy for non-pars. However, other dentists indicated that the general concept of PPO plans is incompatible with what they consider good dental practice:

> *"Providers are put into the position of being agents of the insurance company, agree to accept discounted reimbursements and payments, do most (if not all) of the paperwork on behalf of the patients but become the scapegoats for both patients and insurance company when patients are dissatisfied. (Note: providers have absolutely no say in any contract negotiations between the insurance company and employer/subscribers.)"*

"I would like dental treatment to be a mutual agreement between the doctor and the patient <u>without</u> third party controls which are not medically sound and [are] financially motivated."

> *"The law says that the doctor ... is the trained professional in his field to be the best qualified individual to define the standard of care for his patient. Insurance companies are solely responsible for simply supplying a benefit package to help make that standard of care more affordable. Yet by establishing a benefit or not recognizing a benefit they are sending a message to the patient which says this is what we deem appropriate, and patients question us* continuously *about this ... you the professional must be wrong in requiring a different standard."*

The dentists are correct: their professional code of ethics requires that they hold the well-being of their patients as the primary determinant of the care they provide.[15] The quality of that care "should not be driven by financial incentives or reimbursement schemes."[16] In fact, PPOs even require their dentists to assess the given co-payment: they are not allowed to waive it, as non-par dentists can.

Given these issues and the generally low PPO fees in Hawai`i, why are so many dentists participating providers? As one authority puts it:

> The current dental market is highly competitive.... [P]urchasers control blocks of patients and can steer them toward selected providers. Providers operating well below capacity may be willing to accept the terms of a managed care agreement as a way to boost their practice. What's more, if most of a dentist's patients sign on to a managed care plan, the dentist may feel compelled to get on board or risk losing his or her patients. So the provider accepts discounted fees ... in exchange for the promise of a steady flow of patients[.][17]

This is particularly true in Hawai`i, as we have the lowest ratio of dentists to patients in the United States, 1:1215. (The United States average is 1:1714, and Nevada, the state with the highest ratio, is 1:2689.[18]) A significant number of dentists in the survey complained that their choices boiled down to joining a PPO or filing for bankruptcy. However, to a certain extent, the dentists have created their own problem by joining a PPO. If some drop out, then they will more likely than not lose some patients for whom cost is a factor. But if all the dentists dropped out, there could be no PPO plans. Some other dental benefits mechanism, such as fee-for-service, would most probably be offered in its place, although the extent of its acceptance with employers is impossible, at this point, to gauge.

A side issue that the dentists noted is that, as non-pars, they have been cut off from receiving report to member statements from the third party payors. These statements list the type of service, the dentist's charge, any provider adjustment, the eligible charge, what the third party will pay, and the balance owed to the dentist. Par providers get these, but when a patient goes to a non-par, the reports go to the patient only, who cannot elect to have these reports sent directly to the non-par. Yet it is the dentist who is often expected to explain the benefits to the patient, who will spot any errors in the report, and who will be the one to pursue corrective action with the third party payor. Sending a copy of the report is not a benefit to the non-par as much as it is a benefit to the patient, the third party payor's own subscriber. Yet often this point is lost in the third party payors' determination to deprive the non-par of any possible benefit arising from the PPO.

A situation in which costs rise too high could possibly lead to dental benefits being dropped by some employers: as both HMSA and HDS point out, Hawai`i law mandates medical care, but not dental care. A balance between giving the dentists enough compensation to do quality work yet not discouraging the provision of dental benefits by employers must be achieved.

Par/Non-par Payment

> ***"It is unfair to patients who pay the same premiums to get unequal reimbursement."***

The biggest drawback mentioned in regard to PPO plans in general is the difference some plans have in payment schedules for participating (par) and non-participating (non-par) dentists. Most plans, including HDS and HMSA, pay a smaller reimbursement for the same procedure when done by a non-par than when done by a par. The justification for this is that it is an incentive to induce dentists to join the plan. But the dentists' position is that the par/non-par payment differential hurts the patient, who is paying all or part of the premium, and who should get full benefit from his or her premium dollar:

> *"HMSA has gone further by financially penalizing patients who seek care from [non par] dentists[.] Monetary reimbursements are drastically reduced. These patients are not getting a fair deal. Their employers are paying identical premiums for patients (their employees)[.] Employers assume that all employees are receiving equal reimbursement. I don't think they realize that some of their employees are discriminated against if they choose to see care form a non-par[.]" (emphasis in original)*

> *"Please remember, regardless of type of plan ... dental insurance is paid for by the patient and for the benefit of the patient. Variable reimbursement according to provider participation is unfair to the patient and negates freedom of choice." (emphasis in original)*

> *"I would think members of the legislature would be critical of HMSA paying lower benefits to some subscribers than to others, even though they pay equal premiums. If HMSA can negotiate with doctors to provide discount services to their patients, so be it. It would provide a financial incentive for patients to see HMSA participating doctors. But to penalize a paying subscriber by paying a lower co-payment if they choose a non-HMSA doctor and retain the difference as their own profits, is unconscionable. The public deserves better."*

Indeed, the rationale for the payment differential appears very weak: the so-called benefits that the subscriber gets from the par relationship are minimal. While HMSA has a rigorous, two-step quality assurance program for HFDC, involving both on-site and records checking, and has a one-step quality assurance program for its QUEST dentists involving records checking, it has no quality assurance program for its preferred provider plan. It does not do an office assessment or primary source verification for those plans, while it does a primary source verification for its QUEST program

and both a verification and office assessment for its DMO.[19] Its participating dentist contract contains a provision requiring the dentist to permit HMSA's medical or dental directors and representatives to examine and audit records on claims submitted to HMSA, but apparently this is not done.

HDS's provider quality assurance program consists of an audit of:

(1) Approximately 200 claims per year selected at random by the computer;

(2) Claims referred by an HDS dental consultant that "may warrant the more comprehensive review process" (approximate number per year unknown); and

(3) Claims pursuant to a letter or request of complaint from a subscriber (approximate number per year unknown).[20]

It is instructive to note what this does not include: it does not include at all an on-site evaluation of the dentists' offices for facilities, environment, clinical records assessment, or administrative assessment. If dental consultants note conditions that "may warrant" a more comprehensive review, that may be done — but what those conditions are and what a more comprehensive review consists of is not stated. Given the fact that HDS has 470,000 subscribers, a review of only 200 random records per year seems totally inadequate.

HDS's claim that it is not cost-effective to add non-par dentists to the database so that their reimbursement checks can be sent to them directly is similarly weak, especially as HDS has approximately 96% of all Hawai`i dentists as its pars. It cannot be more cost-efficient to send checks to all of the HDS subscribers who use non-par dentists (and HDS subscribers number in the hundred of thousands) rather than add the handful of dentists who are not pars.

Finally, one issue not adequately addressed by HMSA is the hardship on patients on neighbor islands or rural areas who may not have any par providers nearby. This is not so much an issue with HDS, with 96% of the dentists in the State on contract, but HMSA has only 60% of the State's dentists overall, with most on O`ahu. Penetration on neighbor islands can be as low as 50%.[21] According to HDA, some areas, particularly on the Big Island, are underserved by par dentists. Unless patients are willing and able to travel significant distances to a par dentist's office, they must use the non-par dentists in the area, which effectively deprives them of par benefits.

Assignment of Payment

Many other third party payors send checks directly to non-pars as a matter of course. In Hawai`i, United Concordia, Traveler's, and MetLife do. The Bureau contacted a number of Delta Dental and Blue Cross Blue Shield plans on the mainland, and found that about half do and half do not.[22] Given the fact that the sending of checks is a routine practice by over half the Delta and BCBS plans contacted, as well as by some of the other third party payors in the State, it is difficult to conceive how this practice is a crucial factor in the continued economic health of HDS and HMSA, as opposed to being a business tool used by them to punish the non-par dentists for not participating with them. These dentists note that sometimes patients will keep the reimbursement checks that come

to the patients, instead of forwarding the check to the dentist. One dentist alleged that he has sent hundreds of patients to collection agencies.

> *"When patients receive dental insurance reimbursement checks made out to them, the normally spend the money. The dentists don't normally receive this reimbursement." (emphasis in original)*

> *"Insurance companies, especially HMSA, have not allowed payments to go [directly] to nonpars, with lower reimbursements to nonpars, as a way to "bully" and coerce dentists into participating with low-quality plans they would otherwise not participate with. HMSA knows very well that many times the patients will take the check and cash it and not pay the dentists. It does not increase HMSA's cost to mail the check directly to the dentist rather than the patient. Dental insurance plans should be competitive based on the quality of the plan rather by coercion."*

The state of Washington has used a novel technique to combat misappropriation by the patient of payment intended to reimburse the dentist: their law requires that insurance reimbursement check be issued either jointly to both patient and provider, or just to the provider. While this would still mean more work for the subscriber in that he or she would still need to forward the check to the dentist, at least the check cannot be cashed and used by the subscriber.

Summary

HDA is a nonprofit association representing approximately 90% of Hawai`i's dentists. HDA and its members support the concepts of equal reimbursement and assignment of payment. The dentists were surveyed to obtain their impression of the effectiveness of the current third party payor system and to ascertain whether certain allegations concerning the future of dental benefits in Hawai`i should the law be changed were true. The dentists criticized HMSA the most, although HDS also came in for a portion of critical remarks. It appears that the two sides are polarized, with HDS and HMSA taking the tack that the most important thing that a dental benefits plan can provide is low costs to make care affordable for patients, while dentists take the position that quality of care must be paramount.

Endnotes

1. Addresses for the surveys were supplied by Dr. Mark Greer, Chief, State Dental Health Division, Department of Health, State of Hawai`i.

2. Each of the Bureau's surveys contains an official, postage paid Bureau envelope. In an excess of enthusiasm for the survey, the Hawaii Dental Association copied the Bureau's survey and circulated it to its members. Due to concerns about possible duplication of responses, the Bureau divided the responses it received into three categories: those received in an official Bureau response envelope (457), those received in an envelope with a return address (43), and those returned in unmarked envelopes (36). Those in the unmarked envelopes were not used in any of the statistical compilation of data, as it was impossible to determine whether these were duplicated surveys. However, the comments on the surveys

were read and a few of them incorporated into this chapter.

Those received in envelopes with addresses were retained and the sender, if the name could be ascertained from the envelope, was called to determine whether this was the sender's only response. Those that were duplicates or for whom no reliable answer could be obtained were discarded, leaving a total of 34. These surveys were compiled separately. As their data tracks that of the 457 valid surveys, those 34 were added into the statistical information described in this chapter, and comments, where appropriate, were also incorporated. Therefore, the statistical data in this chapter was taken from 491 surveys out of a universe of 855, for a response rate of 57%.

3. The breakdown is as follows: Honolulu (all O`ahu): 373 (76%); Hawai`i county: 49 (10%); Maui county: 37 (8%), and Kaua`i county: 24 (5%) (percentages rounded). No response was listed for 8 surveys.

4. In this context, "significant numbers" means that between 71% and 100% of their patients have a dental benefits plan.

5. Including CIGNA, Aetna, Denticare, QUEST, Dawson, Prudential, Travelers, Guardian, HIDA, GEHA, Connecticut General, John Hancock, Aloha Care, and HMSA's HMO plan.

6. All quotes in this chapter, unless otherwise attributed, came from the responses to the Bureau's dentist survey.

7. Phone interview with Stephen Lung, Controller, HMSA, on September 30, 1997.

8. Delta Dental, "Dental, Dentala USA," http:www.deltadental.com/deltadat/care.htm (November 3, 1997).

9. Telephone interview with Steve Murdock, Vice President, Contract Administration Division, United Concordia, on September 26, 1997.

10. Phone interview with Stacy Sugimura, Legislative Analyst, HMSA, on September 22, 1997.

11. Phone interview with Anthony DiGioia, Assistant United States Attorney, District of Rhode Island, August 1, 1997.

12. E-mail from Daniel J. Creed, the American Dental Association, to researcher, dated July 30, 1997.

13. Hawaii Medical Services Association, 1996 Annual Report and Financial Highlights, at 14.

14. Interview with Stacy Evensen, Director, Community and Government Relations; Stacy Sugimura, Legislative Analyst; and Michael Stollar, Director, Dental Products, HMSA, on July 22, 1997 (hereafter HMSA interview).

15. Albert H. Guay, "Understanding Managed Care," Journal of the American Dental Association, April 1995 at 425.

16. Id.

17. Id.; see also Mel M. Tekavec and Carol D. Tekavec, "Managed Care: Trends in the Transfer of Financial Risk," Dental Economics (October 1994) at 63.

18. American Dental Association, Survey Center, 1995, "Distribution of Dentists in the United States by Region and State."

19. Interview with William F. Bourne, Dental Cost Management Director; Manuel Pinto, Operations Manager; and Stacy Sugimura, Legislative Analyst, HMSA on August 28, 1997.

20. Letter from Raleigh S. Awaya, Executive Vice President, HDS, on September 25, 1997.

21. HMSA interview.

22. The seven plans that do permit assignment of payment are Delta Dental of Massachusetts, Blue Cross of Washington & Alaska; Blue Shield in North Central Washington; Blue Cross Blue Shield of Alaska, Blue Cross of California, Blue Cross Blue Shield of Michigan, and Washington Dental Service (a Delta plan). The five that do not are Delta Dental of California (will only allow assignment to non-pars that are out of state), Northeast Delta Dental, Blue Shield California, Blue Cross Blue Shield of Maine, and Alliance Blue Cross Blue Shield of St. Louis, Missouri. Three of the plans stated that they will permit assignment of payment, but only if the group (employer) so requests. Those plans are Delta Dental of Virginia (no assignment unless the group requests and it is put into the contract. One or two of the groups have done so — typically the "huge" groups.), Blue Cross Blue Shield of New Jersey, and Blue Cross Blue Shield of Arizona.

Chapter 5

ANTITRUST AND ERISA ISSUES

Senate Resolution No. 118, S.D. 1, asked the Bureau for:

> An assessment of whether passage of legislation in Hawaii, in which health insurers, health/dental plans, HMOs, mutual benefit societies, dentist sponsored plans, IPAs, government, and employer plans are compelled to pay directly to nonparticipating dentists, the amount of a claim under the same payment schedule and criteria that would have been paid to participating dentists, under a preferred provider contract, would conflict with federal or state statutes or regulations concerning competition[.]

The Bureau requested the assistance of the Department of the Attorney General in making this assessment, as that department is the official source of legal opinions in state government.

The full text of the opinion will be found in Appendix B. The Attorney General examined federal antitrust law as Hawai`i law is to be construed in accordance with it. The Attorney General did not examine the laws of other states "since any conflict between a law enacted by the Hawai`i State Legislature and a law of another state would not be of critical concern."[1]

The Attorney General opinion reports that "we were unable to find an antitrust statute which specifically addressed the legality of the proposed law."[2] After some discussion of case law, the opinion states, "we can only report that at this time we have nothing to indicate that a law which incorporates the concept of compelling dental health insurers to provide direct and equal payments to all dentists, whether classified as participating or non-participating, and does not involve a price-fixing agreement among competitors, is contrary to the antitrust laws."[3] The opinion does qualify that statement, however, by adding: "If the Legislature found it appropriate to enact the proposed law, and if the law were challenged on the basis of a conflict with the antitrust laws, the proposed law could possibly survive a challenge under the "state action" doctrine. Caution is advised, however, when applying the doctrine."[4]

The Attorney General opinion did not address the ERISA issue. ERISA — the Employees Retirement Income Security Act of 1974 — is a federal law covering the areas of retirement benefits and health and other welfare types of benefits. According to one source, Congress enacted ERISA to counter a dramatic increase in mismanagement in employee health, welfare, and pension plans.[5] ERISA preempts state laws that could potentially come into conflict with its provisions;[6] however, certain state laws concerning insurance, banking, or securities are preserved from ERISA's effects.[7] There is a small category of plans that are exempt from ERISA, including plans established by government for their public employees, and plans for church employees for certain churches, and plans maintained outside the country for nonresident aliens.[8]

Hawai`i developed its own comprehensive employment-based health insurance law in the early 1970s, the Hawaii Prepaid Health Care Act.[9] This plan covered different types of medical benefits, but not dental benefits. Standard Oil Co. of California sued the State in federal court, through the Director of Labor and Industrial Relations, when the State attempted to enforce the Act. The district court and court of appeals found that ERISA preempted the state law, and the United States Supreme Court affirmed the decisions by memorandum opinion.[10] Hawai`i's congressional delegation introduced legislation to specifically exempt the Hawai`i prepaid health care law from ERISA preemption, which passed in 1983, but which exempted Hawai`i's law only as it was in effect on September 2, 1974.[11] So the law that preserved Hawai`i's prepaid health care also effectively froze it in time. It cannot be modified and still withstand an ERISA challenge. The Act does not include dental benefits, nor can they be added to the prepaid health care law at this point in time. Dental benefits could conceivably be added, however, through changes to the State's general insurance laws, in much the same manner as certain specific medical coverages, such as in-vitro fertilization, have been added. It is not clear, since the Attorney General's opinion does not address it, whether the proposed changes in the law would run into problems with ERISA. It can be noted that Alabama's law is presently in federal court over the issue, but that the other states with this type of legislation have reported no ERISA-related issues.

The Legislature should note that federal legislation, the Patient Access to Responsible Care Act of 1997, has been introduced and was undergoing hearings as this report was being prepared. This proposed Act, which would apply to all health professionals and providers, and would require that "health insurance coverage shall provide for reimbursement rates for covered services offered [by non-pars] that are not less than the reimbursement rate ... [for pars]."[12] The bill had 193 co-sponsors and had two subcommittee hearings in October 1997.[13] Further action was pending at the time this report was finalized.

Endnotes

1. Letter from Rodney I. Kimura, Deputy Attorney General, to Wendell K. Kimura, Acting Director, Legislative Reference Bureau, dated November 12, 1997, at 3 (attached as Appendix B).

2. Id. at 3.

3. Id. at 5.

4. Id. at 7.

5. Michael G. Pfefferkorn, "Federal Preemption of State Mandated Health Insurance Programs Under ERISA — the Hawaii Prepaid Health Care Act in Perspective," Saint Louis University Public Law Review, Volume III, no. 2 (1989) at 340.

6. Id. at 341.

7. Id. at 344.

8. Id. at 341.

9. Id. at 348.

10. Id. at 354-358.

11. Id. at 358.

12. H.R. 1415, 105th Congress, 1997.

13. According to THOMAS, the House of Representatives Subcommittee on Employer-Employee Relations heard H.R. 1415 on October 23, 1997, and the Subcommittee on Health and Environment heard it on October 28, 1997. THOMAS:

    http://thomas .loc.gov/cgi.bin/bdquery/z?d105:HR01415:@@@L

Chapter 6

THIRD PARTY PAYORS: AN ANALYSIS OF THEIR POSITIONS

Senate Resolution No. 118, S.D. 1, asked for input from the primary parties involved, HDS, HMSA, and HDA, as well as various state and private entities. This chapter will present their positions and analyze the issues.

Hawaii Medical Service Association (HMSA)

Hawaii Medical Service Association (HMSA) commenced business in 1938 offering medical benefit plans. It did not offer dental plans until the 1970s. HMSA is a mutual benefit society that develops plans, based on input from the marketplace, to provide dental health benefits, and sells and administers them. It is not an insurance company. A mutual benefit society is a nonprofit business entity organized and carried on for the primary benefit of its members and their beneficiaries, that provides benefits to its members, including payment of benefits in the case of illness or disability.[1] A mutual benefit society can serve the same purpose as an insurance company, but the two are regulated differently. Mutual benefit societies are basically subject to chapter 432, *Hawaii Revised Statutes*, while insurance companies are regulated under chapter 431, *Hawaii Revised Statutes*. This distinction is not widely understood; many of the dentists who responded to this Bureau survey, for example, referred to HMSA as an "insurance company." The error in terminology does not affect their points, but it is incorrect.

For the year ending December 31, 1996, HMSA had $1,090,942,921 in earned premiums and net assets of $709,552,488.[2] The dental aspect of HMSA's business is relatively small, with premiums earned for the same period of only $43,637,717.[3] Thus, HMSA's earned premiums for its dental business is only 4% of its total business. HMSA is an independent Blue Cross Blue Shield Association.

HMSA's dental business offers fee-for-service plans, participating provider plans, and DMOs (Hawaii Family Dental Center, Island Dental Professional Group, and twenty-three individual affiliates).[4] The most popular plans are the participating provider plans. HMSA also participates in the QUEST dental program. Approximately 70% of the dentists in Hawai`i participate with HMSA's preferred and traditional dental plans; however, HMSA has the highest concentration on O`ahu. Distribution of HMSA par dentists on the neighbor islands is only about 50%.[5] As of September 1997, approximately 364,482 residents are members of one of HMSA's dental plans.[6]

In general, HMSA's rates to the employers for its participating provider plans are 5% - 10% less than the comparable HDS rate.[7] Its average overall reimbursement rate differential for these plans, is 18%, with some differentials being as great as 50% and some being identical.[8] According to HMSA, it reimburses its participating (par) dentists 7.8% to 10% less than HDS reimburses its par dentists, depending on HDS's withholding.[9]

HMSA opposes both of the proposed changes — equal payments to non-pars and assignment of payment. With respect to equal payments to non-pars, HMSA takes the position that its rates are set by its actuaries, based on the knowledge that some of its subscribers will seek care from non-pars and receive a lower rate of reimbursement. It notes that its PPO plans are 8 - 10% cheaper than its fee-for-service plans because it allows for the par/non-par reimbursement differential.[10] If it is forced to pay non-pars the same, it will be forced to raise the rates that employers are charged, by almost 4%.[11] HMSA states that it is concerned that if rates go up, employers will stop offering dental benefits, since dental benefits (unlike medical benefits) are not mandated under Hawai`i's Prepaid Health Care law.

HMSA also opposes an assignment of payment law. HMSA stresses the cost-containment value of non-assignment of payment on the basis that disallowing them gives dentists more incentive to become participating providers.[12] HMSA states that if legislation passed that required both types of changes, there would be no incentive for dentists to join a PPO, many fewer dentists would retain their affiliation with a PPO, and a major cost-containment strategy would be eliminated.[13]

Additionally, HMSA expresses a concern for patients who may be forced to use non-par dentists. HMSA paints a scenario in which, under the proposed legislation, all HMSA par dentists relinquish their par arrangement with HMSA. It dramatically states that out-of-pocket costs to members who use a "former par dentist" would increase by at least $3.5 million.[14] However, HMSA has 270,000 people enrolled in its PPO. Assuming that all of them are now forced to use non-pars because the pars have all quit, the average increase per patient would only be $12.96. Even assuming that half of them use non-pars already, the average increase per patient would only be $25 — and that increase to that group would have to be offset by the other 140,000 HMSA patients whose out of pocket expenses just <u>decreased</u> because their non-par dentists are receiving a higher reimbursement.

HMSA also talks about a potential impact on the medical arena, but, as discussed in a previous chapter, the fields of dentistry and medicine differ significantly and there are substantive reasons to treat them differently so that this concern does not seem particularly realistic.

HMSA also takes the position that this legislation "raises serious concerns regarding the merit of the government interfering in private business contracting."[15]

Hawaii Dental Services (HDS)

Hawaii Dental Services (HDS) was organized in 1962 as a nonprofit dental service corporation providing dental benefit plans.[16] HDS offers two basic kinds of plans, as discussed in chapter 2: the traditional fee-for-service, and a large preferred provider network of dentists. In brief, in a fee-for-service plan, the patient and dentist decide on the treatment, the dentist performs the treatment, and the third party payor pays the established percentage or amount for that treatment. In a preferred provider plan, the patient and dentist decide on treatment. If the dentist is a participating provider, the dentist informs the patient of the total fee for the procedure, which has been established by the third party payor, which in most cases is lower than the dentist's usual fee for that procedure. The patient pays for the patient's predetermined portion of that fee, and the third party payor pays the dentist the balance. If the dentist is not a participating provider, the dentist is

free to charge the patient the dentist's usual fee, but the payment proffered by the third party payor is usually less than that offered the participating dentist. Further, HDS will send the check only to the patient, and not the dentist. HDS will also not permit the patient to assign the payment directly to the dentist.

HDS is a Delta Dental affiliate. Approximately 96% of the dentists in the State are participating providers with HDS, and about 470,000 residents are covered by one of HDS's dental plans. HDS determines its UCR fees for its par dentists by looking at a variety of factors, including the dentists' own fee schedules, the Consumer Price Index for Hawaii, market trends, and the competition. HDS pays its par dentists the lower of the UCR or the dentist's own fee, but, for the most part, the dentists' fees are higher than the UCRs and so reimbursement is generally based on HDS's UCR fees. However, not all HDS par dentists receive this rate as par dentists can charge lower rates. In the 1980s, HDS instituted a policy, nicknamed the "most favored nation" policy, by which it lowers the reimbursement to its own par dentists if the dentists are also a participating provider with another third party payor.[17] HDS's reimbursement rate is generally higher than HMSA's. HDS states that a dentist's UCR is based on not only the fees for the service as generally charged in the community, but also on the dentist's own fees. HDS takes the position that by accepting the lower HMSA par fee, the dentist has established the dentist's own normal fee at the low HMSA level. HDS alleges that a dentist who is par with HMSA has lowered that dentist's usual fees to HMSA's level, and thus should have his or her payment lowered to the HMSA level.

As far as the proposed changes in the dental benefits law, HDS has stated that it is "caught in the middle on this one," as it wishes to emphasize quality dental care with fair prices for both dentist and patient.[18] However, ultimately, HDS opposes an assignment of payment law.

HDS also opposes paying non-pars the same as pars, on the grounds that that would cause premiums to rise, although HDS said that it was impossible to estimate the amount of the increase without performing a formal analysis with assumption. HDS is concerned that a rise in premiums would lead the employer to re-evaluate dental benefits, and that the employer might do anything from not offering the dental benefit at all to moving more of the cost of the benefit to the employees.

Hawaii Dental Association (HDA) and the Dentists

The position of HDA and the dentists has been presented in chapter 4. In short, they support a change in legislation that would both permit the patient to assign payment directly to a non-par dentist, as well as require non-pars to be paid the same as par providers.

QUEST

The Hawaii QUEST program was established under a federal medicaid waiver program to provide health care to public assistance clients.[19] As originally established, the QUEST program provided dental care to children and adults. However, due to cost constraints, regular dental care for adults was dropped and at this point, and for the foreseeable future, QUEST will provide only emergency care to adults, although it has retained its general dental care program for children.[20] The

QUEST program, at the time this study was researched, had three contractors to handle its dental patients: DentiCARE, HMSA, and AlohaCare. QUEST pays a capitated rate — a flat fee for each person enrolled — to all three. The programs can in turn either pay a capitated rate to their dentists, or pay them on a fee for service basis. Usually the choice of payment method depends on the number of QUEST patients the dentist sees. The dentists in the QUEST component of these three plans form, essentially, an exclusive provider, or closed panel, network.

The resolution does not specifically exclude QUEST from its scope, so the Bureau contacted QUEST administrators in both the Department of Human Services and the Department of Health to ascertain what the impact would be on QUEST if the QUEST program had to reimburse dentists outside the QUEST network for eligible work done for QUEST participants. Both departments had firm, negative responses about the impact on QUEST, based on the lack of control over utilization and quality of services rendered. The Med-QUEST Division Medical Director stated that neither of the issues applied to the Medicaid fee-for-service program for the aged, blind, and disabled as, under the federal and state Medicaid statutes, payments can only be made to providers who participate in the program and accept the Medicaid payment as payment in full.[21]

The Med-QUEST division administrator warned:

> [E]xperience has shown us that dentists not working under the contractual guidelines of a program like QUEST vary widely in clinical services delivery and patient management practices. I feel that if we had to pay non-QUEST dentists (those not obligated by contract to conform to our stated performance standards) the same as QUEST dentists, our influence over utilization, access, and quality would be lost. Given this, I would expect program costs to increase somewhat. However, aside from program costs, my greater concern would be the loss of our ability to assure the public a consistent, high quality service.[22]

State Agencies

The Bureau was asked to contact the Department of Commerce and Consumer Affairs (DCCA), the Office of Consumer Protection (a division of the DCCA), the Insurance Commissioner (a division of the DCCA), the Department of Labor and Industrial Relations, the Chief of the Dental Health Division of the Department of Health, and other relevant public agencies. The Bureau also contacted the Department of Human Services and the Department of the Attorney General. The Insurance Commissioner's office provided the Bureau with background information. The Dental Division Chief and the Department of Human Services provided information on the QUEST program. The Department of the Attorney General provided information on the antitrust aspects of this study. The Department of Labor and Industrial Relations indicated that that department had no comments on this study.

The only state agencies that took a position on the substantive issues were the QUEST components of the Department of Health and the Department of Human Services. Their comments are contained in the QUEST section.

Private Agencies

The Bureau was asked to contact the Hawaii Dental Association (HDA), the Hawaii Medical Services Association (HMSA), the Hawaii Dental Service (HDS), and "other relevant private health insurers, health dental plans, HMOs, mutual benefit societies, dentist sponsored plans, IPAs, government, and employer plans, and other relevant private sector organizations." The Bureau contacted the three named entities and met with their representatives. The Bureau requested the assistance of HMSA in obtaining information about whom to contact in the other categories, as that language had been added to the resolution at HMSA's request. HMSA supplied the names of Dr. Gary Kondo of the Hawaiian Independent Dental Alliance, and Dr. Eugene Azuma with the IPA Island Dental Professionals. Both parties were contacted and their input solicited. In addition, the Bureau contacted the administrator of the Hawaii Public Employees Health Fund, the Chamber of Commerce of Hawaii, Dawson Dental Services, DentiCARE in Hawaii, Senior Dental Service Inc. in Hawaii, as well as United Concordia, Aetna, and Traveler's dental insurance offices, and numerous state dental associations, local Delta plans, local Blue Cross and Blue Shield plans, and state insurance agencies.

United Concordia, one of, if not the largest Mainland dental benefits plan operating in Hawai`i, also takes the position that the payments should not be equalized for non-par providers. However, Concordia's position is somewhat different in that it is only present in Hawai`i to serve military dependents through a contract with the federal government. According to the contract administration director, this Concordia contract is supposed to be exempt from state and local laws that would amend its terms.[23] If Hawai`i law were to change and were to be held to apply to Concordia's contract, Concordia would have to go back to the federal government and request an adjustment to the contract. This echoes HMSA's concern that the contracts are actuarially determined based on a percentage of subscribers using non-par dentists paid at a lower rate.

The Hawaiian Independent Dental Alliance (HIDA) is a nonprofit IPA[24] which contracts with insurers and third party payors to provide dental services. It is not an insurance company. It has approximately 170 member dentists on all islands, who serve as preferred providers for various dental benefit plans. HIDA's position is that the proposed changes would have the ultimate effect of decreasing the number of par providers. However, HIDA's concern is not so much the impact of these changes but, as it says, the "real threat" of having a large HMO in Hawai`i with no point of service or out of network option (which would permit payment to non-pars).[25]

Hawai`i's Royal State Group submitted a letter requesting HDS to submit its input on the study, as Royal State group is, in its own words, a very insignificant player in the dental plan market.[26] Royal State's position is that it maintains a very small dental service business to accommodate its long-standing clients. The service structure is alleged to be unique. Royal State initially took the position that this system "does not lend itself to anything but a totally closed panel provider system[.]"[27] Royal State later amended its position to say that "the concept" would be

workable for its system if all its members were allowed to select the dental provider of their choice, and that these dental providers were forced to participate in Royal State's plan and comply with its terms.[28] These requirements are too stringent to be realistic.

Capitation

As mentioned previously in this study, a small percentage of plans in Hawai`i are DMOs. In these DMOs, for the most part, dentists are not paid for each incident of treatment; instead, the dentist gets a set fee, called a capitated rate, for each patient who is assigned to that dentist by the DMO. For this very low monthly fee, the dentist is supposed to provide all the services that the patients will need. Obviously, the only way in which this will work for the dentist is if some of the patients never come in, or come in sporadically for the cheapest of services, which will balance the patients who come in frequently and who need extensive work. For this reason, most dentists do not accept belonging to a DMO unless the dentist can get a sizeable pool of DMO patients, in order to ensure that, statistically speaking, the no-shows will balance out those who are more costly. Another difference between DMOs and PPOs is that, at least for the majority in Hawai`i, a patient may go to a PPO non-par and receive some type of reimbursement. For DMOs, the patient must go to the assigned (or chosen) dentist: going to any other dentist will mean forfeiting the payment of any dental benefits.

How would the proposed legislation apply to capitated plans? Although assignment of payment is not an issue, equal reimbursement clearly is an issue. The issue in equal reimbursement is premised on the disparity between pars and non-pars. The Legislature could require that the DMOs begin to pay non-pars — but how would that payment be measured? If a DMO par gets, say, $10 per month, how would that be equated to a non-par who sees a DMO patient and fills a cavity at a usual cost of, say, $50. Would the non-par get the patient's entire $10 for the month? What if the DMO patient went to non-par dentist A for a cleaning the first week of the month and non-par dentist B the last week? Would both get paid, and if so, how much? Should a non-par get only one-thirtieth of that amount (splitting up the $10 fee by the day)? Wouldn't that essentially be useless? Would the non-par be able to force the DMO to pay the non-par's usual fee, even if the DMO is not set up financially to be able to handle that kind of expense? These questions highlight the difficulty of shoehorning DMOs into the proposed equal reimbursement legislation. It is a classic apples/oranges discordance. While some DMOs are set up to handle small amounts of fee-for-service work, the DMO paradigm is premised around capitation, and large-scale violation of that system will simply thwart the DMO system. The Insurance Commissioner agrees with this assessment:

> These [DMOs] attempt to reduce costs by contracting with certain providers to provide care on a capitated basis. The capitation is the major cost-saving measure. If the dental plans must pay nonparticipating providers ... on a fee-for-service basis ... [t]he plan would have to set aside a part of its reserves for the projected fee-for-service payments and the capitation system is compromised. [29]

In addition to the compensation aspect, some of the DMOs themselves object to allowing non-pars to service their customers, claiming that non-pars do not meet their standards. This is the basic reason behind QUEST's opposition to involving non-pars in its program.[30]

Effect of Requiring Assignment of Payment and Equal Payment to Non-pars

Both HMSA and HDS oppose a change in the law that would require them to pay non-pars directly. Despite an attempt by HDS to cloak the issue as one of administrative convenience, and attempts by both HDS and HMSA to characterize assignment of payment as primarily an integral part of their cost-containment efforts, it seems clear that the dominant reason that they prohibit the right of a non-par to receive a check directly is to apply economic pressure to the dentist to influence the dentist to join their respective participating provider networks. The fact that half the Delta and Blue Cross Blue Shield plans contacted in other states routinely permit the assignment of payment to non-pars, and that the few states that require this practice have not noted any negative impact from it enhances the argument that this is not an administrative decision necessary to the business operations of the plan but just a recruiting tactic to enhance the plan's competitive edge.

The dentists do agree that the ability to receive their checks directly is important to them as patients often do fail to transmit the checks to the dentists. The dental survey revealed that approximately a third of par dentists would be likely to drop out of the plans if they could otherwise receive their checks directly. Would that number of network dropouts be sufficient to close down the plans? Probably not. First, other economic pressures may force the dentists to stay with the networks. Hawai`i has the lowest ratio of patients to dentists in the nation, which in itself provides heavy competitive pressure. If a dentist leaves the network and loses too many par patients to the remaining par dentists, the dentist may have to rejoin the network to keep the dentist's practice open.

Second, even if some dentists did leave permanently, it has not been demonstrated that their loss would shut down the PP plans. The remaining par dentists would probably benefit handsomely by the addition to their clientele of patients for whom the lower cost they offer is the primary factor. Patients unable or unwilling to use a par dentist would still be able to receive dental services and receive some dental benefits through a non-par dentist. Given this, it is not clear that there would be any negative impact at all on an employer's willingness to offer a dental benefits plan. It would be quite different if the employer's employees could not access any benefits at all outside the network, as would happen in a DMO. However, since HDS and HMSA do not use closed panel systems in their PP plans, the impact on the availability of dental services should not be significant. Costs might go up for some patients, but the patient would still be able to receive some dental benefits.

HDS and HMSA also disagree that non-pars should receive the same level of compensation as non-pars. Both third party providers take the position that their plans are actuarially established based on a lower non-par payment, and that requiring equal payment would cause premiums to rise, which may have negative side effects ranging from causing employers to select plans with a lower benefits ceiling, passing more of the more premium onto the employee, or even dropping the benefit entirely. He notes that for the Hawai`i public employees, the fund pays 60% of the plan with the largest enrollment for active employees, and the employee pays the remaining 40%, while the

employer pays 100% of the cost for children and retirees. The Bureau contacted The Chamber of Commerce for the employer's perspective, but no response was received.

The fact that the few states that have adopted this type of law have not noted any negative repercussions is an indicator that this type of law does not pose an automatic death knell to preferred provider plans.

This is a bigger issue to the dentists than assignment of payment. While only a little over a third of the par dentists said that they would be likely to leave the plans if that law were changed, more than half — 52% — said that they would be likely to leave the plan if equal payment for non-pars was mandated. The issues surrounding whether they would actually leave and, if they did, whether economic circumstances would force them to come back, have been discussed above.

Emotional debate aside, the issue has both an ostensible and a less obvious component. On the surface, the third party payors are concerned that their plans, as currently structured, cannot fiscally support paying pars and non-pars the same rate. United Concordia agrees with HDS and HMSA on this issue: it states that if the state law were to be changed and if it were to apply to United Concordia,[31] that it would have to go back and renegotiate its federal contract to obtain more payment from the employer. That the third party payors have structured their plans to include paying lower reimbursement to non-pars cannot be denied, and that they may be in a fiscal bind if equal reimbursement legislation is enacted without giving them a chance to restructure their charges is evident. However, the second — and less obvious agenda — is that non-pars are paid less in order to reward the pars and to induce the non-pars to join the plan. The third party payors see this as a basic business tactic, while the dentists see it as an infringement on their ability to practice their occupation.

But to limit the discussion of this issue to just these parties ignores the most important factor: the patient. Why should the patient pay — literally — for efforts of HDS and HMSA to corner the market on dentists? As one commentator puts it:

> The [third party payor] defends this arrangment [non-assignment of payment and unequal fees for non-pars] on the basis that it is not in a position to enter into fee verification ... with a non-participating dentist as it can ... with a participating dentist. Further, the participating dentist ... voluntarily assumes some corporate responsibilities that the nonparticipant does not and in return is entitled to the benefits of membership as well as the risks.

The difficulty with [this] position is that the patient sits outside the quarrel, cannot do much about it except change dentists but suffers the adverse results. **The patient is, in effect, held hostage in order to force the dentist to accept membership.**[32] (*Emphasis added*)

The commentator notes that this problem does not arise often as in most states with these types of plans, the "overwhelming majority" of dentists are participating members. However, in cases where they are not — like HMSA, which has only about 60% of all dentists as participating providers

-- "**the equity to the patient poses a vexing problem that the [third party payor] defense does not address satisfactorily**."[33] (*Emphasis added*)

This is a key issue. The purpose — the very existence — of the dental benefits plans is not to put money in the coffers of the third party payors or line the dentists' pockets. It is to provide dental care for the patients. Because the patients are not organized and do not lobby, they are effectively voiceless. The dentists are the major entity most closely aligned with the patients, but even their advocacy on the patients' behalf can be misinterpreted and ignored as being merely an adjunct to their own agenda. It is easy for the third party payors to downplay the quality of care issue, for instance, as merely the dentists' desire to maximize their income, and to allege that they are the ones truly interested in the patient as they seek to keep the patient's out-of-pocket costs down. It may be true that low costs are attractive to patients, but it is not at all clear that quality of care is not an equal, or even superior, consideration, to patients.

To the extent, then, that third party payors paint the assignment of payment as a benefit-to-non-par-dentists issue, they likewise distract from the fact that these are issues of importance to the patient. In those plans where the employer pays all of the premium, perhaps it is not unreasonable to the patient to have to abide by a system in which the patient receives varying amounts of compensation depending on the dentist's par/non-par status.

If the employer is paying fully for a benefits package in which it is acknowledged that some of the patient/employees will go to a non-par and receive a lower benefit, the employer will be getting the full benefit of the employer's bargain, no matter how unfair it might feel to the employee. But in a system where the patient pays part, or especially all, of the benefit premium, the patient may well feel that he or she should receive an equal benefit, no matter which dentist the patient visits, for the employee's premium dollar. It is not, after all, the dentists who pay the premiums, or who pay the third party payor for belonging to the network. If the third party payor wants to develop a participating provider package with a range of benefits, including set fees and some kind of quality assurance control, the patient/employee who declines this package may not unreasonably think that he or she should not have to suffer — through a lower reimbursement — for this choice. Through wording this issue as a dentist-only issue, the third party payors obscure the true interest of the patients.

Given this situation, it is not possible to give a simple answer to the Legislature's question as to whether passage of equal reimbursement and assignment of payment legislation would "eliminate the incentive for a dentist to participate with a plan, thereby reducing access and quality while raising costs." A simple answer would have to be "no," as the dentists' survey reveals that even with this legislation, many dentists would continue with the plans. However, this answer would not do justice to the complexity of the situation. The legislation would reduce the incentive to belong, in the case of assignment of payment, by 38% of the dentists, and in the case of equal reimbursement, by 52%. If these dentists do in fact carry through and initially drop their affiliations with the plan, whether they can all do so and be economically viable is not clear. And even if they do, it is not clear that "access" will be reduced. Access to dental care will remain the same. Access to the former par provider will be the same — in fact, the former par dentist may be easier to obtain access to if some patients leave in favor of other par dentists. Access to a par dentist may be more limited if patients

insist on using only a par dentist — but if the market for par dentists becomes too limited, it may encourage non-pars to switch to take advantage of the overflow of patients.

The resolution further asked if this legislation would "reduce quality." Only in this area can a clear answer be found: no. The dentists are virtually unanimous in faulting the PP plans themselves for reducing quality due to the dentists being forced to use cheaper, inferior materials and not being able to take their time to do quality work. The legislation would seem to have the consequence of increasing the quality of dentistry in Hawai`i.

Last, the resolution implies that this legislation would raise costs. As far as the assignment of payment legislation goes, that is an incorrect assumption. Assignment of payment should have no effect on premium rates. In fact, there probably would be a cost savings to HDS and HMSA as they could consolidate the paperwork and postage of sending out individual reimbursement checks to the thousands of patients utilizing the service of non-par dentists in favor of sending them to the few hundred, in HMSA's case, or few dozen, in HDS's, non-par dentists themselves. There would be a rise in costs if the equal reimbursement legislation passed, but it would be comparatively minor — HMSA estimated their differential to be 8 - 10%. HMSA declined to speculate what theirs might be. It should be noted that, compared to medical costs, dental costs are very modest. HDS's monthly premium, in the public employee's fund, for a self dental plan, is only $20.16, as compared to HMSA's monthly premium, in the same fund, for a self medical package of $131.80.[34] Even a 10% increase on a $20.16 premium would only be $2 per employee. This increased cost might be absorbed by the employer, passed on to the employee, or eliminated through use of lower plan caps or imposing a deductible. It is difficult to conclude that this relatively modest price increase would cause the widespread dropping of dental plans by employers.

The patient's interest, which are largely ignored by this question, should also be given some weight in the Legislature's decision on implementing these laws. Quality of care, and the ability to obtain the same value for one's premium dollar whether one goes to a par or non-par dentist, have not been successfully addressed by the third party payors.

Endnotes

1. Section 432:1-104, *Hawaii Revised Statutes*.

2. 1996 Annual Statement of the HMSA for the year ending December 31, 1996, at page 2, on file with the Insurance Commissioner, Division of Financial Institutions, Department of Commerce and Consumer Affairs, State of Hawai`i.

3. Id. at 6.

4. Interview with Stacy Evensen, Assistant Vice President, Community and Government Relations; Michael Stollar, Director, Dental Products/Hawaii Family Dental Centers; and Stacy Sugimura, Legislative Analyst, HMSA, on July 22, 1997 (hereafter HMSA meeting, July 22, 1997).

5. HMSA meeting, July 22, 1997.

6. Letter from Stacy Evensen, Assistant Vice President, HMSA, to researcher, dated December 4, 1997.

7. HMSA meeting, July 22, 1997.

8. HMSA letter dated December 4, 1997 (see Endnote 6).

9. Letter from Stacy Evensen, Director, Community and Government Relations, HMSA, to researcher, dated August 5, 1997.

10. HMSA meeting, July 22, 1997.

11. Memo, HMSA, "Issues for Discussion with Ms. Jaworowski (LRB)," (undated), on file with the researcher.

12. Letter of Stacy Evensen, Director, Community and Government Relations, to researcher on August 5, 1997.

13. Memo, HMSA, "Issues for Discussion with Ms. Jaworowski (LRB)," (undated) on file with the researcher.

14. Memo, HMSA, "Summary of Findings: Direct and Equal Reimbursement to Non-Pars," (undated), on file with the researcher.

15. Id.

16. HDS later began to offer a medical benefits plan, HDS Medical, but the majority of its business is still on the dental side.

17. Id.

18. Interview with Wesley T. Park, President and CEO; Raleigh Awaya, Executive Vice President; Mark Fukuhara, Senior Vice President of Marketing and Product Development; and Patrick Crowe, D.D.S., Dental Consultant, HDS on July 24, 1997.

19. Letter from Charles C. Duarte, Administrator, Med-QUEST Division, Department of Human Services, to researcher on August 7, 1997.

20. Interview with Dr. Mark Greer, Chief, Dental Health Division, Department of Health, and Dr. Karen Hu, Board of Dental Examiners, State of Hawai`i, on June 20, 1997.

21. Letter from Lynette Honbo, M.D., Medical Director, Med-QUEST Division, Department of Human Services, to researcher, dated November 6, 1997.

22. Duarte letter at 2.

23. Phone interview with Steve Murdock, Vice President, Contract Administration Director, United Concordia, to researcher, on September 26, 1997.

24. An IPA is an independent physicians' association, a panel of independent doctors who provide services at a predetermined fee to the subscribers on a fee-for-service basis. Rashi Fein, Medical Care, Medical Costs: the Search for a Health Insurance Policy (Harvard University Press: Cambridge, MA 1986) at 139-40.

25. Id.

26. Letter from Melvin M. Higa, Royal State Group, to Wesley T. Park, President and CEO, HDS, on July 8, 1997.

27. Id.

28. Memorandum from Melvin, Royal State Group, to Wesley Park, HDS, on July 14, 1997.

29. Letter from Rey Graulty, Insurance Commissioner, to researcher, dated August 5, 1997.

30. This point was also raised by DentiCARE, another DMO plan. Phone interview with Wes Mun, DentiCARE, November 11, 1997.

31. Which is debatable: according to United Concordia, its contract with the federal government exempts it from state regulation of its activities. Phone interview with Steve Murdock, Vice President, Contract Administration Division, United Concordia, on September 26, 1997.

32. Eric Bishop, Dental Insurance: the What, the Why, and the How of Dental Benefits (McGraw-Hill: New York 1983) at 101.

33. Id.

34. Pamphlet, Hawaii Public Employees Health Fund, Benefit Plans for Employees: July 1997 - June 1999 at 87. Sixty percent of the premium is paid by the employer, forty percent by the employee.

Chapter 7

THE TAKE ALL COMERS PROVISION

The resolution also asks for:

> An assessment of the following additional mechanism to increase access to quality dental care for privately and publicly funded dental plan consumers, should direct and equal reimbursement become law: A licensed dentist may not exclude from their practice any patient requesting care who provides existence of coverage from a health insurer, health/dental plan, IPA, government, or employer plan, regardless as to the dentist's participating status with that plan[.]

The point of this paragraph is unclear, which hampers its assessment. On its face, it appears to force every dentist in the State to accept any patient who wants to use that dentist's services as long as the patient has any type of insurance at all. In a state where approximately 80% of the population has dental insurance, this is absurd. Each dentist has a finite number of patients that he or she can serve, and this could force them to have to provide service to many times over that number of patients. As a practical matter, this language makes no sense, for it appears to impose a duty on dentists to provide service without question, even if the patient, for example, is notoriously delinquent in paying the patient's own portion of the dental bill. Public policy does not usually force businesses to accept all comers to their own detriment. As a dental consultant at HDS asked, "is a dental practice a place of private business or a public establishment?"[1]

The resolution asks for an assessment as to whether this proposed change would increase access to quality dental care for privately and publicly funded dental plan consumers. While it seems as though this would increase access in the technical sense that it appears to force dentists to accept all comers, it would not necessarily lead to quality dental care if dentists are forced to take on more work than they can handle competently.

It has been suggested that this issue is really about the QUEST program, and that this language is designed to force dentists to participate in that program. However, if that is the case, there are further problems. One is that the QUEST reimbursement rate is quite low. A number of dentists who responded to the survey described in chapter 4 indicated that their QUEST patients were basically charity cases. It is unclear, under this scenario, whether dentists would be forced to provide services and receive only the extremely low QUEST fee as their only recompense, or whether they would, as a non-par usually would, be allowed to "balance bill" the patient for the difference. If they can balance bill, then QUEST becomes meaningless. If they cannot, the State would be forcing professionals to provide their services at a basically pro bono rate — something other professionals — *e.g.* lawyers, doctors — are not required to do. Such a choice should trigger considerable discussion about the public policy aspects of such a requirement.

Perhaps more to the point, though, the QUEST program does not seem to want to make this type of change. According to the plan administrator, he feels that "if we had to pay non-QUEST dentists (those not obligated by contract to conform to our stated performance standards) the same as QUEST dentists, our influence over utilization, access, and quality would be lost."[2] He fears both an increase in costs and a decrease in control and quality.

Given these concerns, and the potential burden that would be placed on dentists if this additional change were to be made to the law, it seems as though there would not be increased access to quality dental care under this mechanism, either for privately or publicly funded dental plan consumers.

Endnotes

1. Meeting with Patrick Crowe, D.D.S., and others, HDS, on July 24, 1997.

2. Letter from Charles C. Duarte, Administrator, Med-QUEST Division, Department of Human Services, to researcher on August 7, 1997.

Chapter 8

FINDINGS AND RECOMMENDATIONS

Preliminary Observation: A Discussion of Factual Allegations Contained in S.R. No. 118, S.D. 1

The resolution discusses a number of issues relating to dentistry in its Whereas clauses, but the scope of the tasks assigned to the Bureau is actually much less expansive. The facts alleged in the resolution are not always entirely accurate, and to the degree that they are not, they obscure the debate. Accordingly, before the findings and recommendations are made, a review of the allegations needs to be done to clarify the true issues involved.

Allegation 1: A number of third party payors - mutual benefit societies, health insurers, independent physicians associations, and others — have participating provider plans that cover patients' dental services.

True. Participating or preferred provider organizations (PPOs: the terminology used in the literature is generally "preferred" provider, while the term most prevalent in the dental community in Hawai`i appears to be "participating" provider) are by far the most widespread form of dental plan in the State. There are three primary types of dental plans available: fee for service, preferred provider, and dental maintenance organization.

A fee for service plan is one in which (1) the patient and the dentist are free to decide on a treatment plan, (2) the dentist charges the dentist's usual fee for the treatment selected, and (3) the third party payor pays a predetermined percentage of the fee. This plan gives the patient the largest array of choices. This type of plan is also the most expensive.

A preferred provider plan is more complicated: dentists are solicited to join a network. The network places a cap on all services to be provided, based on the UCR (usual, customary, and reasonable) fee for each service, and sets up a percentage of the fee that it will reimburse the patient. The patient will then be responsible for the balance, and the participating (par) dentist cannot charge any fee in excess of the balance. For example, if the service is a silver amalgam filling, the plan may determine that the UCR fee is $100, and that it will pay participating dentists $80. The dentist will bill the patient for only the remaining $20.

A par dentist and the patient can decide on a treatment plan, but unlike the fee-for-service plan, the third party payor has the ability to refuse to accept pay for that treatment if the third party payor believes that a cheaper treatment would suffice. In that case, the third party payor will still pay if the more expensive treatment is performed, but only the amount that it would pay for the cheaper choice.

Some PPO plans on the Mainland will not pay for services performed by non-participating dentists ("non-pars"), but the major plans in Hawai`i will pay, with two differences: first, they use a lower percentage of reimbursement (for example, reimbursing fillings at 70% for non-pars but 80%

for pars), and second, they will reimburse the patient only, and will not, even at a patient's request, pay the non-par dentist directly.

The third type of plan is a dental maintenance organization (DMO), similar to the HMOs in the medical field. In these plans, the cheapest of the three, a dentist who signs up for the plan receives a set fee each month per DMO patient. The dentist keeps the fee regardless of whether the patient ever comes, and is required to treat all DMO patients who do come in. The sole advantage to this plan is its low cost. Its disadvantages can be numerous, depending on how the plan is run. Typical complaints include, from the dentists' side, having too many patients and too little time to give them proper treatment. From the patients' side, the complaints are similar to those heard about HMOs: rushed treatment, the least expensive treatment offered and/or performed even if it is not what the patient wants, and assembly-line care. Perhaps the biggest drawback is the capitated system itself: it can pit the doctor between the patient's good and the doctor's own bottom line as the doctor must treat all his or her patients, and the only funding the dentist receives is the capitated payment. In a month with a very high utilization rate, the doctor could conceivably go into the red performing all necessary services for each DMO patient. At present, the DMO presence in Hawai`i is very limited.

Allegation 2: A significant percentage of Hawai`i's dentists are participating providers with at least one of these plans.

Yes. Significant is too weak a word. There are two primary dental plans in Hawai`i: HMSA, which has approximately sixty percent of all dentists in the State as participating providers, and HDS, which has approximately ninety-six percent, together covering ninety percent of the patients in Hawai`i that have dental benefits coverage.

Allegation 3: In some cases, patients who go to non-participating providers (non-pars) are not able to assign their benefit checks to be paid directly to the non-par dentist, which requires the patients to pay their services in advance, and that this situation may cause them to postpone, neglect, or delay dental treatments to their detriment.

Yes. "In some cases" is too mild. The two major players, HMSA and HDS account for ninety percent of all patients who are covered by dental insurance. Both HDS and HMSA have fee-for-service plans, and HMSA also has a small DMO, but the great majority of their plans are preferred provider plans, and neither plan allows assignment of benefits checks from patients to non-pars. United Concordia, which holds the nationwide federal plan for military dependents and thus has a presence here in Hawai`i, does routinely permit assignment to non-pars.

The second part of the sentence above implies that non-pars require patients to pay for services in advance, and that an inability to pay for all dental care costs up front prevents patients from receiving needed dental care. This implication is not necessarily accurate. First, if a patient cannot afford to pay for services up front, the patient may be much more likely to "vote with his feet" and simply choose a participating provider for the required services. Second, in recognition of the fact that requiring full, up-front payment will cause them to lose patients in a very competitive job market, many non-pars offer a variety of payment options, including making payments over time, and paying only the patient's unreimbursed expenses and waiting for the patient to turn over the third

party payor's check. Comments on the Bureau survey discussed in chapter 4 indicated a real concern on behalf of some non-par dentists to make their services affordable.

Allegation 4: A new type of dental plan, direct reimbursement, always requires advance payment.

Preliminary, but not exhaustive, research indicates that this is the case. However, even if so, it is not particularly relevant to the issues assigned to the Bureau by this resolution, which concern PPO plans, not direct reimbursement.

Allegation 5: In some cases, non-pars are paid less, and under different criteria, than are participating providers.

Yes. The Bureau has found this to be true of every PPO plan in Hawai`i that it has reviewed. Non-pars are paid a lesser percentage than pars. Some representatives from the Hawaii Dental Association (HDA) have stated that HMSA also pays non-pars based on an older, lower fee schedule, so that HMSA non-pars are receiving a lesser percentage of a smaller fee than pars are receiving.

Allegation 6: The methods and criteria for dentist reimbursement, as dictated by the third party payors, may play a critical role in patients' financial interests and determination of which dentist to use.

Yes. To the extent that this is true**,** this is where the State's interest in protecting the health, safety, and welfare of its residents comes into play. If the way in which dental plans are structured in this State are preventing access to dental services, placing roadblocks to dental services, or imposing substandard care on patients, the State has the ability and the duty to regulate.

Allegation 7: Proponents of proposed legislation that would require third party payors to pay non-pars the same as participating dentists, and to allow patients to assign payment of their reimbursement directly to non-pars, make the following points:

- Twenty-six other states have adopted "freedom of choice" or "equal reimbursement" statutes that provide for equality of payments to all dentists.

This statement is misleading. The term "freedom of choice" is much broader than the rest of the subject matter of the resolution. "Freedom of choice" encompasses a spectrum of legislation, including eliminating or modifying closed panels of dentists, allowing patients to select the dentist of their choice, any willing provider laws, and a restriction on gag clauses. Thus the equal reimbursement issue which, along with the direct payment issue, are the primary issues discussed in the resolution, is only a part of "freedom of choice" issue. Most of the other elements are not relevant to Hawai`i.

The American Dental Association (ADA) list of state statutes indicates that only six states have "equal reimbursement" statutes and seven have "direct payment statutes," and of these three overlap.

Thus it is more correct to say, for the purposes of guidance from other states, only eleven states have relevant legislation to the specific issues posed by this resolution.

- Current preferred provider plans in Hawai`i may prevent patients from using the dentist of their choice as patients of non-par dentists:

    - incur the burden of pre-paying for services;

Overbroad. In some cases, this is true: some non-par dentists do require their patients to pay in advance. However, others do not.

- pay higher costs;

True but somewhat misleading. This is true but the basis for the truth must be explored: part of the reason costs are higher is that the dentist is able to charge a market price for the dental services, but part is also because the third party payors pay patients a smaller reimbursement, leaving them with more out of pockets costs to cover themselves. So to some extent, the third party payors are the cause of this extra cost.

- may modify the type and quality of services performed;

True but misleading. This situation is not limited to patients of non-par dentists: patients of par dentists also modify the type and quality of service performed based on the third party payor's low reimbursement rates for some dental procedures.

- may result in hardship for patients whose local dentists are non-pars and thus must travel to utilize a par.

This may be true, although the only evidence shown is anecdotal: while HDS has 96% of all dentists in Hawai`i in its plans, HMSA has only about 60%, with less penetration on the neighbor islands. It is possible that some neighbor island PP patients must travel out of their way to be treated by a par.

Allegation 8: Opponents of proposed legislation that would require third party payors to pay non-pars the same as participating dentists (pars), and to allow patients to assign payment of their reimbursement directly to non-pars, make the following points:

- Participating dentists agree to accept the third party payors' schedule as full payment and thus their fees are overall less than those charged by non-pars.

True. It is true that the UCR fees that the pars are allowed to charge are generally below market rate.

- The legislation would lessen or remove the incentive for dentists to be part of the preferred provider network, which would result in higher dental costs and a modification or the type and quality of the services performed**.**

This allegation makes assumptions that may not be accurate. First, it appears to be the case that the legislation would encourage some dentists to drop their preferred plan affiliations, especially with HMSA as (1) HMSA has generally lower reimbursements than HDS, and (2) HDS has a "most favored nations" clause in its contract that provides that if its pars also participate with another dental plan, payment **to its own pars** will be reduced to the other plan's schedule, if it is lower than HDS'. These factors, plus the cap on services and bundling of services, are the factors most likely to lead to dentists' dropping their affiliation. A survey of dentists found that on the assignment of payment issue, the majority — 54% — would be likely to stay with the network if the legislation were to pass, and only 38% would drop out. On the equal payment issue, 41% said that they would stay, and 52% said that they would be likely to drop out.

However, the allegation makes two further assumptions: first, that if dentists drop out of plans, higher dental costs would result, and second, that there would also be a modification of the type and quality of dental services performed. But unless the plans collapse entirely, which does not appear to be the case from the large number of dentists who have indicated that they would not drop out, "higher dental costs" would only result for patients who choose to go to non-pars. If those patients are willing to pay a higher price to go to the non-par of their choice, are "higher dental costs" really an issue? In fact, the marketplace — *i .e.*, the patients -- may cause dentists to rejoin PP plans if patients insist on using par dentists. The higher dental costs issue appears to be a red herring.

The additional assumption that there would be a modification of the type and quality of dental services performed is questionable. It does appear to be correct that non-pars tend to charge more than pars. However, if the non-pars receive a higher reimbursement rate — equal to the pars — then a non-par patient's share of the costs will actually <u>decrease</u> compared to what the non-par patient pays now. In this case, it is unlikely that a modification in dental services would occur, or that it would be detrimental if it did. A former par patient who switches to a non-par may experience some higher costs — but lower than what a current non-par patient pays. The third-party payors are not currently concerned about the fact that their subscribers who go to non-pars may have to modify their services if they are unable to afford the higher payments. It seems more than a little hypocritical for them to care deeply about the fate of non-par patients now. In any event, it should be up to the patient to decide whether to stay with the cheaper par or pay more for the non-par.

- The legislation would lessen or remove the incentive for dentists to be part of the preferred provider network, which would result in higher dental costs and a modification or the type and quality of the services performed.

This statement is misleading as it lumps together true allegations with speculation, giving an overall incorrect impression. Yes, it is true that the proposed legislation would lessen the incentive for dentists to belong to PPOs. But this would not lead to increased costs for those patients who still choose to utilize par dentists. It would actually lead to decreased costs for those who are already seeing non-par dentists, as, since the non-par would be reimbursed at the higher par rate, the patient would have less out-of-pocket costs to pay. This would only lead to increased costs for patients who want to use par dentists but are forced to use non-pars if not enough par dentists are available. However, as discussed in chapter 4, it is not clear whether economic factors, including Hawai`i's very

competitive dental market, will permit enough dentists to become non-par to cause this scenario to occur.

- Higher rates for dental care services would result in less access and utilization of dental services and be detrimental to the patient's dental health.

This statement is too general. A one hundred percent increase probably would result in less utilization, while a few percent increase might not even be noticeable. Some people who have free dental services never use them, while others who have no dental insurance and pay the full market cost out of pocket themselves go religiously. Without more specific information on how this legislation would change fees, it is impossible to state whether this statement will be true in this context.

- Preferred provider plans are contractual agreements occurring in a competitive private section health care marketplace, and legislation that would restrict this market may be unwarranted and detrimental in providing a choice of services to patients.

This statement does not really address the issue raised by the proposed legislation. That legislation would not "restrict the market": it would merely (1) allow non-pars to receive the same reimbursement as pars, and (2) allow patients to assign their benefits directly to non-pars. It does not restrict dentists from contracting with a plan; it does not restrict employers from negotiating plans; and it does not prevent third-party payors from setting up plans. To the extent that some of the PPO plans might become a little more expensive, it is possible for employers to revamp their plans, such as using a lower cap, or passing more costs onto the employee — to keep the employer's out of pocket costs the same. It is also not clear that the proposed legislation is "unwarranted"; if the current system is unfair to consumers, or has a detrimental impact on their receipt of dental services, the State is empowered to examine the issue. It is also not clear that the legislation would be detrimental in providing a choice of services to patients.

- Consumers in Hawai`i have a strong interest in determining whether adoption of "freedom of choice," "equal reimbursement," or similar statutes would enhance the quality, availability, and cost-effectiveness of dental care in Hawai`i.

True.

Findings

The Bureau finds that:

1. There are three primary types of third party payor dental benefit plans: fee-for-service, preferred (or participating) provider organizations (PPOs), and dental maintenance organizations (DMOs). Of these, the most popular plan type by far in Hawai`i is the PPO. In a PPO plan, dentists contract with a third party payor to provide dental services at a specified rate to patients who subscribe to the plan, which is usually cheaper than the dentist's own normal rate. The plan will reimburse the participating (par) dentist directly.

A patient may obtain services from a non-participating (non-par) provider, who may charge a higher overall fee. However, the patient will be reimbursed a lesser amount if the patient uses a non-par provider, and the reimbursement check will be sent to the patient instead of to the non-par.

2. There are two major players in the dental benefits arena in Hawai`i: Hawaii Dental Service (HDS) and Hawaii Medical Service Association (HMSA). HDS dental benefits plans cover approximately 470,000 state residents; HMSA dental benefits plans cover approximately 380,000 state residents. The remaining fraction is spread between numerous smaller entities, such as HMAA, United Concordia, Royal State, Aetna, MetLife, and Travelers.

3. Ninety percent of the dentists in the State belong to the Hawaii Dental Association (HDA). HDA supports both assignment of payment and equal reimbursement legislation. Assignment of payment legislation would permit patients to assign payment of their benefit checks from third party payors such as HDS and HMSA so that it would go directly to the non-par provider. Equal reimbursement legislation would permit patients who use non-pars to receive the same level of reimbursement as those who use pars.

4. While the resolution states that twenty-six states have adopted freedom of choice laws in the context of this study request, that figure is not accurate. Freedom of choice is the umbrella term for a number of laws revolving around the dentist-patient relationship. Equal reimbursement and assignment of payment are only two of those laws. Only six states have passed laws requiring equal reimbursement, and only eight have enacted laws calling for assignment of payment at the patient's option. Of these states, three overlap, so only eleven states have relevant laws. The Bureau contacted these states to determine what the state's experience had been with the law, but received very little helpful information. At the time this report was prepared, none of these states had done a formal evaluation of the impact of the law or laws on the practice of dentistry. The response was either that no change had been detected or that there had not been sufficient time for the law to be in force and assessed. There were, however, no reported incidents of problems related to the laws, with the exception of Alabama, where the laws were preempted based on ERISA concerns.

5. Half of the Delta Dental and Blue Cross-Blue Shield affiliates who responded to the Bureau routinely permit assignment of payment.

6. HDS and HMSA oppose assignment of payment laws. HMSA stresses the cost-containment value of non-assignment of payment on the basis that disallowing it gives dentists more incentive to become participating providers. HDS has stated that direct payment is that "carrot" HDS uses to get dentists to sign up with their plans, stating that "conformity is the price [dentists] pay for getting their checks directly."

7. HDS and HMSA oppose equal reimbursement laws. HMSA takes the position that its rates are set by its actuaries, based on the knowledge that some of its subscribers will seek care from non-pars and receive a lower rate of reimbursement. Its PPO plans are 8% -

10% cheaper than their fee-for-service plans because they allow for the par/non-par reimbursement differential. If HMSA is forced to pay non-pars the same, it will be forced to raise the rates that employers are charged, and HMSA states that it is concerned that if rates go up, employers will stop offering dental benefits, as those benefits, unlike medical benefits, are not mandated under Hawai`i's Prepaid Health Care law. HDS also opposes paying non-pars the same as pars, on the grounds that that would cause premiums to rise, although HDS said that it was impossible to estimate the amount of the increase. HDS is concerned that a rise in premiums would lead the employer to modify or eliminate dental benefits. Both HDS and HMSA also allege that they provide other services as part of their PPO package, such as quality assurance, that make it equitable for them to reimburse their pars more, and the non-pars less. However, the quality assurance programs were either nonexistent or inadequate to justify the differential.

8. In a survey of the dentists in this State, 38% of the dentists indicated a likelihood of their leaving their PPO plan if assignment of payment became law, while 52% indicated a likelihood of leaving if equal reimbursement became law. It is not clear that, given the extremely competitive dental market in Hawai`i, whether that number of dentists would actually leave or, if having left, whether economic pressures would force them to return.

9. The Bureau finds that third party payors tend to couch the debate on these laws as an "us versus the non-pars" issue, and attempt to justify their opposition to both laws on the ground that the non-pars, by the fact of their non-participation, do not deserve the same benefits as the pars. What the third party payors do not address is how this has an impact on the patients, their plan subscribers. The patient is held hostage to the third party payor's desire to expand their business by signing up more dentists. The "equity to the patient," as one commentator puts it, of the patient getting less of a benefit for the same premium when the patient uses a non-par, poses a vexing problem that the third party payor does not address satisfactorily.

10. Dental benefit plans are supposed to be for the benefit of the patient, not schemes to be manipulated to allow greater market leverage by the third party payors or greater reimbursement to the dentists. The interests of the patients themselves have been largely obscured by the debate on these issues.

11. DMOs base their payment on a capitation system, which is a low monthly payment to the dentist for each patient assigned to that dentist, for which the dentist will provide all the patient's dental needs. This system does not easily lend itself to payment to non-pars, as the payment is not generally based on a per-service basis.

Recommendations

1. The Bureau would recommend passage of an assignment of payment law for all dental benefit plans.

Discussion: The law would merely permit, not require, the patient to decide whether to assign the patient's dental benefits to a non-par provider. This law would benefit the patient as, through the assignment, the patient will not have to provide the money for all of the services to non-pars in advance. Over half the nonpars do require the patient to pay all the fees in advance due to the inability to have the benefits assigned to them, which is an unnecessary burden on the patient. Almost 60% of the non-par dentists say that they require this advance payment, the majority of them all of the time. The states that have assignment of payment legislation report no problems with it, and half the Blue Cross/Blue Shield and Delta Dental entities contacted routinely allow assignment of payment. The Attorney General appears to conclude that there would probably not be an ERISA preemption problem with the law.

By not allowing assignment, the patients are being "held hostage," as one commentator puts it, to the third party payors' desire to build their PPO empires by inducing dentists to join with the "carrot" of direct payment. This is not appropriate: the needs of the patient should drive the structure of the payment, not the business interests of the third party payors.

2. The Bureau makes no recommendation at this time concerning equal reimbursement.

Discussion: The Bureau recognizes that as currently structured, the PPOs are actuarially premised on the expectation that a certain percentage of patients will see non-par dentists and receive a lower reimbursement. Equal reimbursement would require the third party payor contracts with the employers to be renegotiated, and it is not possible to ascertain what impact that may have on the offering of dental benefits. Although it should be noted that HMSA states that premiums for an equal reimbursement PPO would rise not even four percent above current PPO rates, which is a relatively minor amount, given the generally low cost of dental benefits.

The Bureau has concerns about the State taking action that might have the effect of substantially affecting the existence of the major PPO plans in the State. The Bureau notes that, unlike the assignment of payment law, which would provide a benefit to the patients, an equal reimbursement law would be both a benefit and a possible detriment: patients using non-pars would have less out-of-pocket expenses, but all patients may have their premiums increased or benefits trimmed to provide money for the additional payment.

The Bureau also notes that more than half the dentists surveyed state that they would be likely to leave a PPO plan if equal reimbursement became the law. To the extent that such a large number might leave, there may be a significant impact on the ability of PPOs to operate in the State,

although the numbers of those dentists who would remain are considerable. It should be remembered, though, that as a practical matter, the dentists hold the key to the survival of the PPO plans in their own united hands: if they disaffiliated en masse from the plans due to problems with the reimbursement levels, the plans would have to fold.

3. If the Legislature passes an equal reimbursement law, QUEST and the other DMOs should be exempted for the reasons stated in chapter 6.

Discussion: As a practical matter, plans using capitation must be exempted from an equal reimbursement law. Requiring capitation plans to pay any outside dentist a regular fee-for-service would ruin the plan, and forcing dentists to accept only a low capitation rate — assuming that it could be decided what that amount is — would be tantamount to forcing dentists to work virtually pro bono for any member of a capitated plan. It should also be noted that two of the capitated plans who responded to the Bureau, QUEST and DentiCARE, indicated that they did not want to have non-affiliated dentists treating their patients, for quality assurance reasons.

4. A "take all comers" law should not be adopted.

Discussion: The reasons discussed above also point out the drawbacks of a "take all comers" law. While it may work in a PPO environment, it is not needed in one: there are no reports of dentists turning away patients because they participate with a plan that the dentist does not. The dentist would undoubtedly be happy to be able to charge the dentist's full fee, rather than receive the scaled-down PPO par fee.

The concept would not work in a capitated environment. Capitated plans, especially QUEST, which this law is arguably supposed to benefit, oppose the idea of non-pars treating their patients. They have reservations about the quality of care that would be rendered to their patients. There is also a serious problem with calculating reimbursement for a one-time service for one patient for a plan that is based on monthly rates for many patients.

Appendix A

THE SENATE
NINETEENTH LEGISLATURE, 1997
STATE OF HAWAII

S.R. NO. 118 S.D. 1

SENATE RESOLUTION

REQUESTING A STUDY OF THE IMPACT OF PROVIDER REIMBURSEMENT ASSIGNMENT PRACTICES OF HEALTH INSURERS, HEALTH/DENTAL PLANS, AND HEALTH MAINTENANCE ORGANIZATIONS ON DENTAL COSTS AND COMPETITION AMONG DENTAL CARE PROVIDERS.

1 WHEREAS, the State of Hawaii has a vital interest in
2 ensuring that its people have adequate access to options in
3 choosing affordable and quality dental health care services
4 from licensed dentists; and
5
6 WHEREAS, health insurers, health/dental plans, health
7 maintenance organizations (HMOs), mutual benefit societies,
8 dentist sponsored plans, independent physicians associations
9 (IPAs), government, and employer plans operating within the
10 State may cover a patient for dental services through contracts
11 with dentists which establish the participating provider
12 system; and
13
14 WHEREAS, a significant percentage of Hawaii's dentists,
15 under the incentive of receiving direct reimbursement for fees,
16 are participating providers with at least one health insurer,
17 health/dental plan, HMO, mutual benefit society, dentist
18 sponsored plan, IPA, government, or employer plan; and
19
20 WHEREAS, in some cases, people who select dentists who are
21 nonparticipating providers do not have the freedom to assign
22 their pre-paid benefits directly to the dentist of their
23 choice, and this therefore requires them to pay for dental
24 services up front and then in turn seek reimbursement from the
25 health insurers, HMOs, mutual benefit societies, dentist
26 sponsored plans, IPAs, government, and employer plans for the
27 fees that they have prepaid, and whose financial situation may
28 cause them to postpone, delay, or neglect necessary dental
29 treatments that are prepaid benefits they are entitle to,
30 resulting in detrimental effects on their health; and
31
32 WHEREAS, a new dental plan, direct reimbursement, always
33 requires up front payment; and
34
35 WHEREAS, in some cases, the health insurer, health/dental
36 plan, HMO, mutual benefit society, dentist sponsored plan IPA,
37 government, or employer plan reimburses the patients of
38 nonparticipating providers less, and under different criteria,

than is otherwise paid directly to participating providers; and

WHEREAS, the methods and criteria for reimbursement as dictated by the health insurers, health/dental plans,HMOs, mutual benefit societies, dentist sponsored'plans, IPAs,* government, and employer plans may play a critical role in the patients' financial interest and determination of which dentist they receive dental care services from; and

WHEREAS, in past years legislation has been introduced in the Legislature that would allow patients to authorize, health/dental plans, HMOs, mutual benefit societies, dentist sponsored plans, IPAs, government, and employer plans to pay directly to nonparticipating dentists, the amount of a claim under the same payment schedule that would have been paid to participating dentists under a preferred provider contract; and

WHEREAS, proponents of the aforementioned legislation have presented the following key points in arguing that the proposed legislation would be beneficial to consumers:

(1) Precedent has been set by twenty-six other states that have adopted, in various forms, legislation oftentimes referred to as "freedom of choice" or "equal reimbursement" statutes, that provide for equality of payments to all dentists, whether they are participating in a plan or not, from a health insurer, health/dental plan, HMO, mutual benefit society, dentist sponsored plan,IPA, government, or employer plan;

(2) The current preferred provider plans in Hawaii may exclude a patient's choice of dentist, by financially inducing the patient to utilize a participating provider, because patients of nonparticipating providers must incur the burden of pre-paying for services;

(3) The existing preferred provider plans may exclude a patient's dentist of choice because the lower payments by a health insurer, health/dental plan, HMO, mutual benefit society, dentist sponsored plan, IPA, government, or employer plan for nonparticipating provider services, may result in higher additional costs to the patient (copayments), and may result in a modification of the type and

quality of services performed by the participating dentist; and

(4) In some cases, under current preferred provider plans, patients may incur a hardship in travelling to a participating dentist's office location, as there may not be any participating providers practicing in the patients' neighborhood;

and

WHEREAS, on the other hand, supporters of the current system of preferred provider plans have presented the following key points in arguing that the proposed legislation would be detrimental to consumers:

(1) Preferred provider plan dentists agree to accept eligible charges as payment in full and to provide a specified type and quality of services, thus the total charges for services are, overall, less than those charged by nonparticipating dentists;

(2) The proposed legislation would lessen or remove the incentive for dentists to contract as preferred providers, and the resulting reduction in preferred provider dentists would result in higher dental costs and a modification of the type and quality of the services to be performed;

(3) Higher rates for dental care services would result in less access/utilization of dental care services and be detrimental to the dental health of the patients; and

(4) Preferred payment plans are contractual agreements occurring in a competitive private sector health care industry marketplace, and legislation that would restrict this market may be unwarranted and detrimental in providing a choice of services to patients;

and

WHEREAS, consumers in Hawaii have a strong interest in determining whether the adoption of "freedom of choice", "equal reimbursement" or other similar statutes would enhance the

quality, availability, and cost effectiveness of dental care in Hawaii; and

WHEREAS, S.B. No. 1816 was introduced in the 1997 Regular Session to guarantee patients' freedom to choose the dentist of their choice under chapter 431:10A, Hawaii Revised Statutes; now, therefore,

BE IT RESOLVED by the Senate of the Nineteenth Legislature of the State of Hawaii, Regular Session of 1997, that the Legislative Reference Bureau (LRB) is requested to conduct a study of the impact of provider reimbursement assignment practices of health insurers, health/dental plans, HMOs, mutual benefit societies, dentist sponsored plans, IPAs, government, and employer plans, and other organizations providing dental health care coverage in Hawaii, on dental care benefits, costs, billing practices, competition, and quality of care; and

BE IT FURTHER RESOLVED that the study include but not be limited to:

(1) Descriptions and comparisons of the quality, accessibility, costs, and choices of dentists' services in other states utilizing a system similar to the current system in Hawaii;

(2) Descriptions and comparisons of "freedom of choice", "equal reimbursement", or other similar statutes that have been adopted in other states that mandate equality of payments by health insurers, health/dental plans, HMOs, mutual benefit societies, dentist sponsored plans, IPAs, government, and employer plans to any dental patients;

(3) Analysis of the effect in other states of the adoption of "freedom of choice", "equal reimbursement", or other similar statutes, upon the quality, accessibility, costs, and availability of dentists' services, and the dental coverage provided by health insurers, health/dental plans, HMOs, mutual benefit societies, dentist sponsored plans, IPAs, government, and employer plans;

(4) A determination of the expected impact in Hawaii on the cost, utilization, and scope of dentists' services and coverages provided by health insurers,

health/dental plans, HMOs, mutual benefit societies, dentist sponsored plans, IPAs, government, and employer plans in the event health insurers, health/dental plans, HMOs, mutual benefit societies, dentist sponsored plans, IPAs, government, and employer plans are authorized by the patient to pay directly to nonparticipating dentists, the amount of a claim under the same payment schedule and criteria that would have been paid to participating dentists, under a preferred provider contract; and

(5) An assessment of whether passage of legislation in Hawaii, in which health insurers, health/dental plans, HMOs, mutual benefit societies, dentist sponsored plans, IPAs, government, and employer plans are compelled to pay directly to nonparticipating dentists, the amount of a claim under the same payment schedule and criteria that would have been paid to participating dentists, under a preferred provider contract, would conflict with federal or state statutes or regulations concerning competition;

(6) An assessment of whether passage of legislation in Hawaii, in which health insurers, health/dental plans, HMOs, mutual benefit societies, dentist sponsored plans, IPAs, government, and employer plans are compelled to pay directly to nonparticipating dentists, the amount of a claim under the same payment schedule and criteria that would have been paid to participating dentists under a preferred provider contract, would reduce the competition between companies, or cause existing companies to go out of business, by the examination of states that have enacted "freedom of choice" legislation;

(7) An assessment of whether passage of legislation in Hawaii, in which health insurers, health/dental plans, HMOs, mutual benefit societies, dentist sponsored plans, IPAs, government, and employer plans are compelled to pay directly to nonparticipating dentists, the amount of a claim under the same payment schedule and criteria that would have been paid to participating dentists under a preferred provider contract, would cause dental fees to rise significantly, by the examination of states that have enacted "freedom of choice" legislation;

(8) An assessment of whether passage of legislation in Hawaii, in which health insurers, health/dental plans, HMOs, mutual benefit societies, dentist sponsored plans, IPAs, government, and employer plans are compelled to pay directly to nonparticipating dentists, the amount of a claim under the.same payment schedule and criteria that would have been paid to participating dentists under a preferred provider contract, would eliminate the incentive for a dentist to participate with a plan, thereby reducing access and quality while raising costs; and

(9) An assessment of the following additional mechanism to increase access to quality dental care for privately and publicly funded dental plans consumers, should direct and equal reimbursement become law: A licensed dentist may not exclude from their practice any patient requesting care who provides existence of coverage from a health insurer, health/dental plan, HMO, mutual benefit society, dentist sponsored plan, IPA, government, or employer plan, regardless as to the dentist's participating status with that plan:

and

BE IT FURTHER RESOLVED that the LRB conduct this study in consultation with: the Office of Consumer Protection; the Department of Commerce and Consumer Affairs; the Insurance Commissioner; the Department of Labor and Industrial Relations; the Chief of the Dental Health Division, Department of Health;. other relevant and public agencies; the Hawaii Dental Association; the Hawaii Medical Service Association; Hawaii Dental Service other relevant private health insurers, health/dental plans, HMOs, mutual benefit societies, dentist sponsored plans, IPAs, government, and employer plans, and other relevant private sector organizations providing dental care coverage or information thereof; and

BE IT FURTHER RBSOLVED that the LRB conduct this study using to the extent available, valid standards of measure, state experience, and other data sets; and

BE IT FURTHER RESOLVED that responses to specific findings and conclusions of the study by the primary parties involved be included in the study report; and

1
2 BE IT FURTHER RESOLVED that the LRB submit a report of its
3 findings and recommendations to the Legislature no less than
4 twenty days before the convening of the Regular Session of
5 1998; and
6
7 BE IT FURTHER RESOLVED that certified copies of this
8 Resolution be transmitted to the Director of the Legislative
9 Reference Bureau, Director of Commerce and Consumer Affairs,
10 the Executive Director of the Office of Consumer Protection,
11 the Insurance Commissioner, the Director of Labor and
12 Industrial Relations, the Director of Health and the Chief of
13 the Dental Health Division, the Director of Human Services and
14 the Quest Dental Division, Hawaii Dental Service, the Hawaii
15 Dental Association, the Hawaii Medical Services Association,
16 the Chamber of Commerce Hawaii, and Small Business Hawaii.

Appendix B

REFERENCE BUREAU

BENJAMIN J. CAYETANO
GOVERNOR

MARGERY S. BRONSTER
ATTORNEY GENERAL

JOHN W. ANDERSON
FIRST DEPUTY ATTORNEY GENERAL

STATE OF HAWAII
DEPARTMENT OF THE ATTORNEY GENERAL
425 QUEEN STREET
HONOLULU, HAWAII 96813
(808) 586-1500

November 12, 1997

Mr. Wendell K. Kimura
Acting Director
Legislative Reference Bureau
State of Hawaii
State Capitol
Honolulu, Hawaii 96813

Dear Mr. Kimura:

RE: Your Request for Legal Assistance Relating to S.R. No. 118, S.D. 1

During the past legislative session, the Senate passed Senate Resolution No. 118, S.D. 1, which directed the Legislative Reference Bureau to conduct a study on payment and reimbursement practices for services provided by dentists.

In a letter dated June 13, 1997, you requested our assistance on a particular aspect of the study relating to the following assessment:

> An assessment of whether passage of legislation in Hawaii, in which health insurers [and other third party payors of dental benefits] are compelled to pay directly to nonparticipating dentists, the amount of a claim under the same payment schedule and criteria that would have been paid to participating dentists, under a preferred provider contract, would conflict with federal or state statutes or regulations concerning competition. ...

You requested that the following two issues be analyzed:

1. Whether compelling dental health insurers to pay the claims of nonparticipating providers directly conflicts with [federal or state statutes or regulations concerning competition;] and

2. Whether compelling dental health insurers to pay nonparticipating providers at the same rate as they pay their participating providers conflicts with [federal or state statutes or regulations concerning competition].

By way of background, your letter indicated that it is a rather common practice for a dental health insurer ("insurer") to establish arelationship with a dentist whereby the dentist agrees to provide dental services according to the insurer's restrictions and standards, including an agreement by the dentist to accept the amount paid by the insurer as payment in full for services rendered to the insured patient ("insured").

A dentist who establishes a relationship with the insurer is called a participating provider. Your letter mentioned that a dentist who is outside of the insured's plan is a "so-called nonparticipating provider." We assumed that a dentist will be labeled as a nonparticipating provider where the dentist does not agree to provide dental services per the insurer's restrictions and standards.

Both the Resolution and your letter indicated that insurers treat participating providers and nonparticipating providers differently. First, participating providers receive payments directly from the insurer. In the case of a nonparticipating provider, however, the insurer pays the insured directly, and it is the insured who is responsible for paying the nonparticipating provider. Second, the amounts paid by the insurer for services rendered by a participating provider may be more than the amounts paid for services rendered by a nonparticipating provider.

We initially had difficulty defining the scope of the requested opinion because of the breadth of the phrase "federal or state statutes or regulations concerning competition" in the Resolution.[1] We subsequently confirmed with your office that your concern was as to a conflict between the antitrust laws and a law requiring that an insurer provide direct and equal payment treatment to both participating providers and nonparticipating providers.

Having confirmed that the focus of our attention should be the antitrust laws, we further refined our attention. First, although the Hawaii State Legislature has enacted antitrust laws, (see Chapter 480, Hawaii Rev. Stat.), we felt it was appropriate to focus on the federal antitrust laws (primarily the Sherman Act, 15 U.S.C. sections 1 and 2), because section 480-3, Hawaii Rev. Stat. provides that the provisions in chapter 480,

1 Statutes and regulations could be deemed to be "concerning competition" where the statute or regulation promotes/protects competition, displaces competition, acts as a surrogate for competition, or simply touches upon matters relating to competition, but does not directly work in favor of or against competition.

Hawaii Rev. Stat "shall be construed in accordance with similar federal antitrust statutes ...." and because the Legislature has not made chapter 480, Hawaii Rev. Stat' explicitly applicable to the State. Big Island Small Ranchers Ass n. v. State 60 Hawaii 228 236 (1978).[2] Second, we eliminated an examination of regulations since regulations implement statutes. Finally, we opted not to examine the statutes of other states since any conflict between a law enacted by the Hawaii State Legislature and a law of another state would not be of critical concern.

For the remainder of this opinion, our use of the term "proposed law" means a law which incorporates the concept of compelling dental health insurers to provide direct and equal payments to all dentists, whether classified as nonparticipating or participating.

Turning now to our research on the issues, we were unable to find an antitrust statute which specifically addressed the legality of the proposed law. We found a number of cases where the practice of insurers treating nonparticipating and participating providers differently was challenged under the antitrust laws. Many of these cases held in favor of the insurers' disparate treatment practices.[3] Significantly, however, we did not find cases

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[2] We are aware that in the case of section 480-2, Hawaii Rev. Stat', the Hawaii counterpart to section 5(a)(1) of the Federal Trade Commission Act, the Legislature has indicated that this section may be interpreted in light of trends or conditions in Hawaii and federal authority. See, e.g. Sen. Stand. Corn. Rep. No. 2635 in 1988 Senate Journal 1118. See also Island Tobacco Co. V. R.J. Reynolds Tobacco. Co., 63 Hawaii 289, 300 (1981). But given the holding in Big Island Small Ranchers Ass'n. v. State, supra, we did not see a need for a separate analysis of section 480-2, Hawaii Rev. Stat., at this time.

[3] See, e.g., Barry v. Blue Cross of California, 805 F.2d 866, 873 (9th Cir. 1986) (citing the negative impact on physician participation in a Blue Cross plan, the court disagreed with a contention raised by the nonparticipating physicians that Blue Cross should reimburse policyholders for the services of nonparticipating physicians at the same rate as for participating physicians); and Brillhart v. Mutual Medical Insurance, Inc. 768 F.2d 196 (7th Cir. 1985) (a provider agreement program calling for the insurer to make direct payments only to participating physicians was not a violation of section 1 of the Sherman Act since the agreement was not between competitors in the medical services industry or between competitors in the insurance industry, nor was the arrangement between Blue Shield and the participating physicians a vertical restraint of trade -- the arrangement was a legitimate contract between a buyer of medical services and sellers of such services).

(continued...)

challenging or discussing the extent to which a direct and equal payment practice mandated by statute may conflict with the antitrust laws, despite the existence of statutes in some states which attempt to address these issues.'

4(...continued)

But note that the presence or absence of facts and circumstances may call for a different conclusion about the legality of disparate treatment arrangements. For example, in Arizona v. Maricopa Countv Medical Societ , 457 U.S. 332 (1982), the Court held that a plan setting maximum physician fees was a per se violation of section 1 of the Sherman Act. In that case, the objectionable conduct was the fact that the physicians themselves were setting the maximum fees, thereby presenting a situation where competing health care providers engaged in price-fixing activity. See, also, Virginia Academy of Clinical Psy. v. Blue Shield of Va., 624 F.2d 476 (4th Cir. 1980) (evidence showing sufficient physician control of Blue Shield brought Blue Shield's actions within the purview of section 1 of the Sherman Act); and Tom v. Hawaii Dental Service 606 F.Supp. 584 (D. Hawaii 1985) (court expressed an assumption that a plan which established maximum price schedules was a per se violation of section 1 of the Sherman Act where the plan was run by managers responsible to a board of directors, where the board of directors were mostly drawn from dentists who were members of the plan, where the plan called for the member dentists to file annual disclosures of their usual, customary, and reasonable fee for each dental procedure, and where the plan required each member dentist to agree to charge not more than a fee equal to the 90th percentile of all fee schedules filed with the plan by the member dentists).

We do not offer the control issue as being the only circumstance where disparate treatment of participating vis-a-vis non-participating providers may be a violation of the antitrust laws, nor do we speculate on other circumstances which might pose a violation of the antitrust laws. We also note that depending on the attendant circumstances, physician control over prices may not warrant per se condemnation under the antitrust laws. In one of the health care policy statements jointly issued by the Federal Trade Commission and the United States Department of Justice, these agencies have indicated that under certain circumstances, agreements on prices by physicians participating in a physician-controlled venture will not be treated as per se illegal. Rather the pricing agreements will instead be examined under the "rule of reason" analysis to determine whether the anticompetitive effects outweigh any procompetitive benefits. See, Statement of Department of Justice and Federal Trade Commission Enforcement Policy on Physician Network Joint Ventures, reprinted in 4 Trade Regulation Reporter ¶13,153, pp. 20,814 - 20,825.

[5] This is not to say that statutes enacted by other states have not been subject to (continued...)

Therefore, we can only report that at this time we have nothing to indicate that a law which incorporates the concept of compelling dental health insurers to provide direct and equal payments to all dentists, whether classified as nonparticipating or participating, and does not involve a price-fixing agreement among competitors, is contrary to the antitrust laws.

We caution that the results of our research may be a function of the fact that we performed our analysis without the benefit of particular statutory language, and without myriad facts. As such, if the Legislature deemed it appropriate to enact the proposed law, it is possible that the actual text of the proposed law may foment a court challenge, perhaps where a party perceives that the conduct contemplated by the law conflicts with the antitrust laws.[5]

At the outset, the challenge may raise an issue of whether such conduct might be protected from antitrust scrutiny under the McCarran-Ferguson Act. The Act provides that conduct that is the "business of insurance" which is regulated by a state, and is not in the form of coercion, intimidation, or a boycott, is exempt from antitrust scrutiny. 15 U.S.C. sections 1012(b) and 1013.

We note that courts have held that participating provider arrangements between an insurer and third-party providers are subject to antitrust scrutiny because the arrangement is not the "business of insurance," Thus, the exemption may not be available if the

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[4](...continued)
challenge. We note, for example, that one court has held that the Employment Retirement Income Security Act of 1974, 29 U.S.C. § 1001, et seq. ("ERISA") preempts a state statute requiring that an assignment of benefits to nonparticipating providers be honored notwithstanding contrary provisions **in a health benefit contract**. Blue Cross and Blue Shield of Alabama v. Nielsen 917 F.Supp. 1532 (N.D. Ala. 1996), questions certified 116 F.3d 1406 (11 th Cir. 1997). 'We do not address the effect of ERISA in light of the scope of the requested opinion.

[5] It is also possible that the proposed law may be challenged as abridging any existing contractual relationship between an insurer and a participating provider. We note that the Resolution refers to the arrangement between the insurer and the participating provider as a "preferred provider contract," although the Resolution does not provide any details on the contract nor otherwise substantiate that the arrangement is a contractual one. We raise this point but do not address it given the scope of the opinion request.

[6] See, e.g. Ratino v. Medical Service of Dist. of Columbia, 718 F.2d 1260, 1267
(continued...)

proposed law is characterized as a cost-savings arrangement between an insurer and third-party providers. Due to the absence of facts of, among other matters, particular statutory language, we will refrain from opining on the applicability of the McCarran-Ferguson exemption to conduct contemplated by the proposed law.

Assuming, therefore, that the conduct contemplated by the proposed law would be subject to antitrust scrutiny, the law may survive such scrutiny. In Parker v. Brown, 317 U.S. 341 (1943), in reliance upon principles of federalism and state sovereignty, the United States Supreme Court held that the Sherman Act did not apply to anti-competitive restraints imposed by a state "as an act of government." 317 U.S. at 352. Based on this rationale which is commonly referred to as the state action doctrine, the United States Supreme Court has held that legislation adopted by a legislature is exempt from the operation of the antitrust laws:

> . . . [U]nder the Courts rationale in *Parker*, when a state legislature adopts legislation, its actions constitute those of the State, (citation omitted), and *ipso facto* are exempt from the operation of the antitrust laws.

Hoover v. Ronwin, 466 U.S. 558, 567-568, reh'g. denied, 467 U.S. 1268 (1984). Stated another way, the Sherman Act does not apply "to the anticompetitive conduct of a State acting through its legislature." Town of Hallie v. City of Eau Claire, 471 U.S. 34, 38 (1985).[7]

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[6](...continued)
(4th Cir. 1983); and Hoffman v. De eltDental Plan of Minnesota, 517 F.Supp. 564, 568-569 (D. Minn. 1981). Both cases cited to Group Life & Health Ins. v. Royal Drug Co., 440 U.S. 205, 214 (1979), which held that arrangements between Blue Shield and participating pharmacies were not the business of insurance, but "... merely [cost-savings) arrangements for the purchase of goods and services by Blue Shield."

[7] The state action doctrine may also accord antitrust immunity to state executives and executive agencies where their actions are "taken pursuant to their constitutional or statutory authority, regardless of whether these particular actions or their anticompetitive effects were contemplated by the legislature." Charley's Taxi Radio Dispatch v. Sida of Seevaii, also, F.2Deak-Perera (9th Cir. 1987). a i i . Inc. v. Department of Transp., 745 F.2d 1281 (9th Cir. 1984), cert. denied, 470 U.S. 1053 (1985). The activity of private parties may also be covered by the state action doctrine where such activity is: (1) pursuant to a clearly articulated and affirmatively expressed state policy; and (2) the activity is actively supervised by the state. California Retail Liquor Dealers Ass'n. v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980).

Mr. Wendell K. Kimura
November 12, 1997
Page 7

But the mere fact that a legislature has acted does not mean that the conduct or action directed by the statute will be outside the purview of the Sherman Act in all instances. For example, the United States Supreme Court has held that a statutory scheme establishing a hybrid restraint violates the Sherman Act. See, e.g. California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., supra; Schwegmann Bros. v. Calvert Distillers Corp., 341 U.S. 384, reh'g. denied, 341 U.S. 956 (1951).[8]

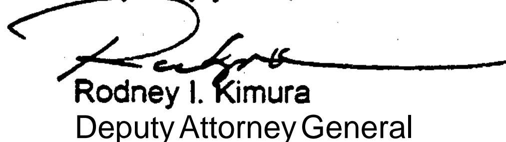
The application of the state action doctrine requires that various factors be analyzed, including the nature of the restraint. Accordingly, caution is not only advised but is imperative when applying the "state action" doctrine.

In summary, based on our research, we have not found an antitrust statute or any case law indicating that a law which incorporates the concept of compelling dental health insurers to provide direct and equal payments to all dentists, whether classified as participating or nonparticipating, and does not involve a price-fixing agreement among competitors, is contrary to the antitrust laws.

If the Legislature found it appropriate to enact the proposed law, and if the law were challenged on the basis of a conflict with the antitrust laws, the proposed law could possibly survive a challenge under the "state action" doctrine. Caution is advised, however, when applying the doctrine.

Thank you for allowing this office to contribute to your study. Should you have any questions, please do not hesitate to contact this office immediately.

Very truly yours,



Rodney I. Kimura
Deputy Attorney General

Approved:

Margery S. Bronster
Attorney General

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[8] A hybrid restraint is one in which private actors are granted a degree of private regulatory power in the context of a statutory scheme.