HB 1048
Opposed
Daniel Doherty

The Maryland State Dental Association Opposes HB 1148 – Health Insurance Two-Sided Arrangements and Capitated Payments – Authorization

HB 1148 establishes a complex regulatory scheme governing arrangements between an insurer and providers that departs from the norm of providing services to beneficiaries of the insurer pursuant to a set fee schedule arrangement. It also extends the ability to capitate to self-funded plans. This extends the risk assumed by providers since a provider's acceptance of capitated payments for the services to be provided is the acceptance of risk. This deviates from statutory prohibitions against this practice, prohibitions that are of the utmost importance in the coverage for dental services.

The Maryland State Dental Association strongly opposes HB 1148 being applicable to dentists and dental insurance, and its authorizing insurers to employ capitation as a method of payment to dental providers. There are three factors that give rise to this opposition:

1. When HB 1021 (the forerunner legislation of HB 1148) was introduced last Session, it was the first MSDA had any knowledge of this insurer backed legislation. At no time since then has there been any effort on the part of the proponents to contact, discuss or negotiate the provisions of HB 1148 with dental providers. Further, before any discussion was initiated with the proponents last session, HB 1021 and SB 758, were withdrawn. MSDA was then apprised that the issue was to be limited in scope to MDs and Osteopaths, and that MedChi had agreed to negotiate with CareFirst. This narrowing of the legislation's scope was reaffirmed by persons involved in the negotiations with CareFirst as late as December 2021. However, the legislation is drafted to include dentists, and other health care providers. It also appears that dentistry is not the only health care profession affected by HB 1148 that has not been contacted.

2. Dental insurance is unique and not truly analogous to traditional medical insurance. Initially, everyone needs dental care. Most people have dental disease. Virtually all experience decay, gum disease, trauma and/or other dental maladies. All of us need periodic prophylactic treatments and examinations, usually twice a year, to hopefully avoid, or at least arrest, dental disease. Dental insurance has been designed to provide insureds limited benefits with caps on annual benefits, $2,000/year or usually less. The cost of dental care can sky-rocket if the patient puts off dental care for long periods of time, with resulting treatment costs sometimes in the 5-figure range. Since the pandemic this is exactly what has occurred, our patients have more serious and more costly dental needs. During the pandemic insurers continued to receive full premiums, while paying for minimal dental treatment.

   Major medical insurance is dramatically different. It provides coverage for the cost of treatment for a variety of illnesses and diseases, many, if not most, of which, insureds do not contract. Not everyone gets cancer, MS, diabetes, heart disease etc. Actuaries make analyses

of these facts, as well as other considerations, to determine premiums. However, virtually everyone gets or has dental disease, and everyone annually needs at the very least prophylactic dental care.

3. Due to the nature of dental disease and dental insurance's limited benefits, capitation exposes a dentist to great financial risk. Frequently patients who have deferred needed dental care, and thereafter receive capitated dental coverage, suddenly return to the dentist seeking treatment that is more extensive and more costly. Health insurers employ capitation as a means to transfer this adverse selection risk downstream to a dental practice. The dentist is forced to absorb the resulting negative financial impact. While an insurer's liability under the non-capitated plan is capped at a set amount, under capitation there is no cap on the cost of services a dentist must provide. Dentists will be forced to **"bite the bullet"** and treat the patient to the financial detriment of the dental practice.

   Insurers argue that the dentists don't have to enter into one of these 2-sided arrangements and can refuse to accept capitation payments. First, the protections in the bill to protect a dentist from being penalized for refusing to enter into one of these arrangements are insufficient. Second, even if a dentist is astute enough, and lucky enough, to retain knowledgeable legal counsel the costs can be daunting. Finally, organizations such as the MSDA cannot advise their members against entering into such contracts because to do so would violate anti-trust laws. MSDA remembers the 1980s and early 1990s when dentists were drowning financially due to capitation contracts. Now HB 1148 will authorize 2-sided contracts and allow capitation under the guise of promises of health equity, improvement of health outcomes, and financial incentives. In dentistry it is more likely it will lead to no improvement of health outcomes, and the financial consequences will be the unjust enrichment of health insurers on the backs of dental practitioners.

Conclusion: MSDA opposes HB 1148 because: 1. dentistry was not included or invited to the table to negotiate the provisions of the bill; 2. dental coverage is unlike major medical insurance, and should not be subject to a comprehensive regulatory proposal establishing broad guidelines for the arrangements, authorizing capitation payments, and offering broad and easily circumvented protections to dentists that refuse to participate; 3. capitation shifts too much risk to the dentists, risk that should be borne by the insurer; and 4. capitation will place dentists in financial jeopardy, and will threatened the dental health of the insureds/dental patients.

For these reasons MSDA requests that HB 1148 receive an unfavorable report.

Submitted by:
Daniel T. Doherty, Jr
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