

MetLife

MetLife Opposes Section 5 from Senate Bill 16.

Good Afternoon, Chairman Crisco, Chairman Megna and members of the Committee – I'm Joy Chairusmi, Government Relations Counsel at MetLife.

I am testifying here today in opposition to Section 5 of Senate Bill 16. This section will cost your constituents money out of pocket, takes away a benefit our policyholders have been entitled to for decades, and interferes with the private right to contract.

MetLife opposes Section 5 since it would permit dentists to disregard fee discounts for certain services that are part of their contractual relationship with dental plans. This proposal, if enacted, would lead to higher costs for dental patients and interfere with a dental plan's ability to enter into contracts with dentists.

The Proposal – The proposal to be considered by this Committee, states that no contract between a dentist and an insurer may set a fee for a dental service unless it is a “covered service.” It would seem to affect only those instances where an insurance policy would not pay for the service that is being provided. Actually, the effect is more far-reaching, resulting in higher costs to the patient.

The Reality – In fact, dental insurance provides a meaningful benefit to insureds even when specific services may not be covered. MetLife network dentists agree to a fee schedule (typically at discounted rates) in order to be part of the network. A feature that insureds count on is that they are charged these discounted rates when they visit a network dentist, *whether or not the policy pays a benefit*. By entering an insurer's network, a dentist typically increases the number of patients in his or her practice – contributing to the growth of the practice. This proposal would permit dentists who accepted the discounted fee arrangement and grow their practice to now increase patient out-of-pocket costs by eliminating network discounts.

It is now common knowledge that good dental health is critical to overall health. The increase in consumers choosing dental insurance coverage is contributing to better dental and overall health – and, increased visits to dentists. This proposal could reverse that trend.

To maintain affordability, dental insurance typically has an annual maximum benefit of \$1,000 or so, which covers the typical annual dental bills of most insureds. There are, however, many reasons why an insured may need access to a particular service that may not be “covered.” These include:

- Services provided to a patient who has exceeded the annual maximum benefit for that calendar year. (Extensive dental care may easily exceed the \$1,000 annual maximum.)
- Services in excess of the frequency limit in the plan. (For example, most dental plans cover two cleanings in a year. If a patient wanted a third cleaning, that would not be covered and on that third cleaning, the patient would not be entitled to the negotiated rates that are in their plan and would be charged whatever the dentists chooses to charge them.)
- Cosmetic procedures, which are not medically or dentally necessary, and thus not covered by a dental insurance policy.
- Services that may be performed by a dentist, but are specifically excluded from the plan of coverage.

The Impact – In each of these examples, the patient should *still* be charged the discounted rate. The discounted rate is a benefit that consumers purchase with dental insurance – and the arrangement that dentists enter when choosing to grow their practice and accept dental insurance as a form of payment. This proposal would eliminate these discounts, causing consumers to pay more out of their pockets.

* * * * *

Given the harmful and costly impact this proposal would have on consumers if adopted, we urge the members of the Committee to reject Section 5 of Senate Bill 16. Thank you and I would be happy to take any questions.