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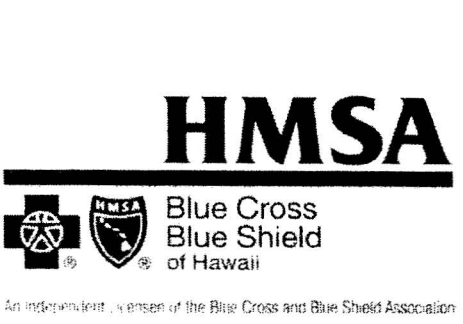

February 13, 2009

The Honorable Ryan Yamane, Chair
The Honorable Scott Nishimoto, Vice Chair
House Committee on Health

Re: HB 1208 – Relating to Dental Care

Dear Chair Yamane, Vice Chair Nishimoto and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on HB 1208. We believe that HB 1208 is unnecessary at this time and have concerns with some of the language included in the measure.

HMSA already provides notification on the coordination of benefits to our members who have dental coverage through HMSA. When an individual initially joins HMSA as a member, they receive a document that outlines all the coordination rules which we follow to ensure that members are receiving appropriate coverage. Any changes to this language are mailed directly to the member as an update. Also, HMSA, like the majority of plans in the state, follow the National Association of Insurance Commissioners (NAIC) guidelines relative to establishing the order of benefits between two or more plans as well as fundamental coordination rules.

HMSA is already complying with the language included in HB 1208 regarding payment of benefits. When a coordination of dental benefits issue comes into play HMSA's dental plan ensures that the total payment for a single claim from all dental plans does not exceed the total charged by the dentist for the services provided and does not exceed the total maximum of the member's plan. This is meant to ensure that providers are not receiving duplicate payments between plans for services rendered.

Additionally, we believe that the existing language in section (e) could have unintended consequences. There is a statement which could end up forcing a secondary dental plan to pay a non-participating provider an amount above the plans' eligible charge. The language in HB 1208 could award a provider the benefits of participating without having them comply with a plan's contractual requirements.

We would respectfully request some amendments to the measure to ensure that all dental plans are included and to afford consumer protection to individuals visiting a non-participating provider.

- Concerning subsection (c), Sections 1-3, on the information to be provided by the plan on the coordination of dental benefits, we would request that language be changed from being required to being "prominently" declared to allowing plans to make the information available. Currently the coordination of benefits language is quite lengthy and does not apply to the vast majority of our members so rather than include it in our Guide to Benefits (GTB), the GTB contains language stating that the entire policy is available to members upon request. This cuts down on the administrative cost of producing our GTB

which is already quite lengthy. These changes take place throughout the bill on Page 2, Line 14-16, Page 5, Lines 5-8, Page 7, Lines 17-20 and in the new section on Page 10, Lines 7-10.

- Lastly, we believe that there could be a potential problem with the language contained in Sections 1-3 (e). The concern with the original language in the bill was that plans considered the secondary plan could end up having to pay more than the eligible charge to non-participating providers than the plan would typically pay since it required the plan to pay the member's total out of pocket cost. In addition we believe that under this, providers could potentially increase out of pocket charges in order to obtain increased payments from the plan. We would request adding the NAIC definition of "allowable expense" throughout the measure to help ensure that plans providing dental benefits would not be forced to pay charges above the eligible benefit of the member. This definition was added throughout the bill on Page 1, Lines 9-14, Page 4, Lines 5-10, Page 6, Lines 17-22 and the new section on Page 9, Lines 6-11. Additionally, we would also request the language in section (e) be replaced with language incorporating the definition of "allowable expense" on Page 3, Lines 1-10, Page 5, Lines 13-21 through Page 6, Lines 1-2, Page 8, Lines 3-13 and in the new section on Page 10, Lines 15-22 through Page 11, Lines 1-3.

- HDS is by far the largest provider of dental services in the state. Requiring health plans comply with HB 1208 but not HDS would create a regulatory unlevel playing field in favor of HDS. We would respectfully request that if it is the Committees will to pass this measure that HDS be included in its scope. This would be accomplished by adding a new section (Section 4) with language mirroring that included in the previous three sections but pertaining to HRS 423. HRS 423 is the statute which allows for the formation of dental service corporations, which according to HDS' website is how they are organized.

We believe that the requested changes will meet the intent of the measure. Thank you for the opportunity to provide comments today.

Sincerely,

Jennifer Diesman
Assistant Vice President
Government Relations