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January 5, 2016

Nancy Grodin
Deputy Insurance Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202-2272

Dear Deputy Commissioner Grodin:

The Maryland Dental Action Coalition (MDAC) is an organization comprised of consumer advocates, public health professionals, dental health professionals, and other stakeholders who are committed to the mission of improving oral health outcomes in Maryland.

During the stakeholder discussions on House Bill 1318/Senate Bill 929 during the 2016 session, MDAC strongly advocated for the Maryland Insurance Administration to adopt network adequacy requirements for dental plans. We are pleased that this requirement was incorporated into the final bill. We appreciate the opportunity to submit written comments and testify at the Network Adequacy Workgroup meeting on January 5th and would be happy to provide additional written testimony to answer any follow-up questions that arise.

Network Adequacy Standards are Meaningful to the Dental Consumer

MDAC is a strong proponent for network adequacy standards for dental plans in Maryland for the following reasons:

- **Consumers Need a Sufficient Number of Dental Providers:** In order for consumers to access care, there needs to be a sufficient number of dental providers in a network. For this reason, there are standard time and distance criteria for dental plans in the federally facilitated marketplace (FFM) and other network adequacy standards isome state-based exchange markets such as Arkansas and Minnesota; and in the off-exchange insurance market in New York. In addition, the Center for Medicare & Medicaid Services (CMS) just finalized a Medicaid rule that requires states implement time and distance standards for certain provider types, including pediatric dental providers, by July 1, 2018;

- **Dental Consumers Face Barriers to Access Care Out-of-Network:** If a provider network is insufficient, consumers in need of dental care may face even more barriers to care than consumers of health care services:

- **High Upfront Costs of Dental Care:** When a consumer goes to an out-of-network dental provider, the consumer is typically required to pay for services at the time of the appointment; and then the consumer or provider submits the claim to the dental plan for reimbursement. Because the out of pocket cost of a dental visit may be high, consumers may be less able to afford the upfront costs and may forgo services if they cannot identify an in-network provider. In a 2014 study[1], the Health Policy Institute found that cost is the top barrier, as identified by 35% of respondents, to obtaining dental care for adults with insurance. The Agency for Healthcare Research and Quality also found that cost creates a barrier for insured individuals seeking dental care. Using 2014 data[2], the Agency for Healthcare Research and Quality found that 60.9% of individuals with private insurance delayed or were unable to obtain dental care because of cost. This compares to 34.3% of privately insured individuals who delayed or were unable to obtain medical care because of cost[3].

  In addition, we also believe it is common for consumers to pay with a credit card if they do go to an out-of-network dental provider. This means some consumers may be facing high interest rates if they do not obtain reimbursement promptly.

  Dental care can be expensive. This is because dental care, beyond screenings and cleanings, is procedure-based; and thus it requires expensive equipment, materials, the administration of anesthesia or sedation, and more time from the dental provider. It is generally more expensive than office-based medical care, so consumers have to pay more up-front costs than for medical care.

- **High Cost of Out-of-Network Care:** Most Marylanders with private dental insurance are in PPO plans.[4] Consumers pay higher prices for services out-of-network, as market prices are higher than negotiated prices under plans.[5] If networks are inadequate, then consumers will be more likely to pay higher market rates.

Recommendations

MDAC considered the statutory charge to the Maryland Insurance Administration (MIA) when developing our recommendations. Maryland statute requires that the Insurance Commissioner adopt regulations to:

- Ensure that all enrollees, including adults and children, have access to providers and covered services without unreasonable delay and travel;
- Ensure access to providers, including essential community providers, that serve predominately low-income, medically-underserved individuals; and

- Require the carrier to specify how the carrier will monitor, on an ongoing basis, the ability of its providers to provide covered services to its enrollees.

1. *Provider Ratios*

Provider ratios are one of the most common tools to measure the adequacy of a network. This tool is most typically used in Medicaid network standards. In Maryland, regulations governing HealthChoice MCOs require a dentist-to-enrollee ratio that is no higher than 1:2,000 for each MCO.

We recognize that the population covered by commercial plans is different than Medicaid plans. We turned to information published by the National Association of Dental Plans for statistics for commercial plans. In Maryland, the average number of dentists per 10,000 is 1.62 for DHMOs, 8.25 for DPPOs, and 5.07 for Discount plans.[4] We are not recommending a specific ratio, rather we are noting this data because it appears as though most PPOs would meet the standard used by Maryland Medicaid.

MDAC recommends that the MIA consider adopting a provider ratio requirement for general dentists and pediatric dentists. However, we recommend that such a ratio requirement be adopted only in conjunction with time and distance standards. As we will discuss in the next recommendation, only distance standards can ensure an appropriate geographic distribution of providers.

2. *Time and Distance Standards*

CMS uses time and distance standards for dental plans in the 28 states to evaluate network adequacy under the FFM since the 2017 plan year. CMS has proposed the same criteria for 2018. On the Medicaid side, CMS will require all state Medicaid programs to set time and distance standards for pediatric dental benefit programs for plan year 2018 (CMS does not mandate that Medicaid programs cover adult benefits).

MDAC strongly recommends that the MIA adopt the time and distance standards used by CMS to evaluate network adequacy for FFM plans since 2017: 1) Time and distance standards are the most meaningful measure of access to consumers; 2) Maryland law already recognizes that plans have a responsibility for ensuring consumers have access to out-of-network providers if the consumer faces "unreasonable delay or travel" to access an in-network provider (Health General 15-830 (d) (ii) (2)); 3) Some plans, particularly major plans, already operate in the FFM and are evaluated by the CMS criteria in those states; and 4) it benefits the industry and consumers to create consistency across markets.

In addition, MDAC also recommends that the MIA study the issue of creating separate time and distance standards for general and pediatric dentists. MIA's statutory charge is to ensure access for both adults and children. However, we recognize that there is not sufficient information at this time to develop separate time and distance standards.

CMS time and distance standards for the FFM in 2017 and Proposed for 2018 are detailed below:

Table: Specialties and Standards for Marketplace PY17 Certification and Proposed PY 18

Specialty Area	Maximum Time and Distance Standards (Minutes/Miles)				
	Large	Metro	Micro	Rural	Counties with Extreme Access Considerations (CEAC)*
Primary Care	10/5	15/10	30/20	40/30	70/60
Dental	**30/15**	**45/30**	**80/60**	**90/75**	**125/110**
Endocrinology	30/15	60/40	100/75	110/90	145/130
Infectious Diseases	30/15	60/40	100/75	110/90	145/130
Oncology–Medical/Surgical	20/10	45/30	60/45	75/60	110/100
Oncology–Radiation/Radiology	30/15	60/40	100/75	110/90	145/130
Mental Health (Including Substance Use Disorder Treatment	20/10	45/30	60/45	75/60	110/100
Rheumatology	30/15	60/40	100/75	110/90	145/130
Hospitals	20/10	45/30	80/60	75/60	110/100
Outpatient Dialysis	30/15	45/30	80/60	90/75	125/110

*There are no counties in Maryland that meet the federal criteria for a CEAC (<10/mi)[1]

3. Essential Community Provider Standards

CMS has required dental plans to contract with 30% of Essential Community Providers (ECPs) since 2015 in the FFM. The Maryland Health Benefit Exchange adopted this FFM requirement for 2017 plans. In Maryland, the types of ECPs relevant for dental plans include: federally qualified health centers, any willing local health department that meets credentialing requirements, and any school-based health center that meets credentialing requirements. [3]

MDAC strongly recommends that the MIA adopt the current FFM and MHBE requirement that dental plans contract with 30% of ECPs for the following reason: 1) Maryland law requires the MIA to adopt regulations to "ensure access to providers, including essential community providers, that serve predominately low-income medically underserved individuals"; 2) Requiring plans to include ECPs will assist more previously uninsured Marylanders retain their dental homes. With the high cost of dental care, individuals in a wide income range utilize ECPs because of their sliding fee scale; 3) In 2017, all Maryland dental plans have to comply with the 30% ECP standard in the Exchange market. Many plans have also had to comply with the 30% ECP standard in the FFM and other state-based exchange markets.

Conclusion

We thank the Maryland Insurance Administration (MIA) for the opportunity to work with the agency on establishing network adequacy standards for dental plans services for Marylanders in all regions of the state. If MDAC be of further assistance, please contact me at relliott@policypartners.net or (443) 926-3443.

Sincerely,

Robyn Elliott
Public Policy and Governmental Affairs Consultant

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[1]Why Adults Forgo Dental Care: Evidence from a New National Survey. Health Policy Institute, 2014.
[2] Medical Expenditure Panel Survey, Table 4.3. Center for Financing, Access and Cost Trends, Agency for Healthcare Research and Quality, 2014.
[3] Medical Expenditure Panel Survey, Table 4.2. Center for Financing, Access and Cost Trends, Agency for Healthcare Research and Quality, 2014.
[4]Maryland Dental Benefits Fact Sheet. National Association of Dental Plans, 2016.
[5]An Analysis of Dental Spending Among Adults with Private Insurance. Health Policy Institute, May 2016.
[6]Final Letter to Issuers. Maryland Health Benefit Exchange, 2017.