Colorado Dental Political Action Committee (CODPAC)
Colorado Dental Small Donor Committee (CDSDC)
2016 Briefing Document for Candidates Seeking State Legislative Seats

To receive an endorsement or financial support from CODPAC or CDSDC, a candidate must participate in CODPAC's and CDSDC's candidate questionnaire and/or interview process.

CODPAC and CDSDC are the Colorado Dental Association's bipartisan political action committees. They represent more than 3,000 dentists across Colorado (more than 70% of the dentists in Colorado). CODPAC and CDSDC's goal is to support state legislators who understand dentistry's importance, relevance and impact on overall health and are committed to the oral health of Coloradans.

CODPAC and CDSDC are governed by Boards composed of seven dentists appointed by the leadership of the Colorado Dental Association. Current members are:

Dr. Jason Ehtessabian (General Dentist, Castle Rock)
Dr. Jeff Hurst (General Dentist, Lakewood)
Dr. Jeff Kahl (Pediatric Dentist, Colorado Springs)
Dr. David Lurye (General Dentist, Ridgway)
Dr. Carol Morrow (General Dentist, Walsh)
Dr. Rhett Murray (General Dentist, Aurora)
Dr. Steven Nelson (Oral and Maxillofacial Surgeon, Denver)

To determine the level and type of support for candidates, CODPAC and CDSDC will consider the following:

- A candidate's past voting record of support and leadership on dental issues, small business issues and general healthcare issues important to dentistry (if applicable);
- A candidate's philosophy and position on dental issues as indicated by responses to this questionnaire or a candidate interview;
- Demographics of the district and a candidate's ability to win; and
- Recommendations from local district dentists.

This document provides background information on key issues of concern to Colorado dentists. Please complete and return the candidate questionnaire to Jennifer Goodrum, Government Relations Director at the Colorado Dental Association (303-996-2847, fax 303-740-7989, jennifer@cdaonline.org or 8301 E. Prentice Ave. Ste. 400, Greenwood Village, CO 80111) no later than **June 20, 2016**.

Candidate interviews are available **June 27-30** and **July 11-15** from 6-9pm each night. Contact Jennifer Goodrum (303-996-2847, jennifer@cdaonline.org) or Katie Wolf (720-365-3990, katie@precisionpolicygroup.com) to schedule an interview time.

Candidate Name: _____

Access to Care: Dental Health Matters

Dental health is a critical component of a person's overall health, yet is so often overlooked in our current healthcare system. Ensuring patient access to dental services has been a primary focus for the Colorado Dental Association (CDA) over the last several years. Given the vital importance of dental health, the CDA and its member dentists are committed to doing our part to work with state and community leaders to help ensure that all Coloradans can access quality dental care. Colorado dentists have shown a long standing commitment to underserved communities through ongoing volunteer and charitable care. Each year, almost 90% of CDA's member dentists together provide millions of dollars of free and discounted care in their practices and through organized charitable events. But the CDA also recognizes that volunteerism is not a sustainable healthcare system and has worked to improve both infrastructure and the patient care system through a campaign called Dental Health Matters.

As part of these efforts, the CDA worked creatively with legislators and Colorado Medicaid in 2013 to extend dental coverage to underserved adults in Colorado. The CDA then engaged in a proactive provider network recruitment project, called "Take 5," to help ensure a sufficient pool of Medicaid providers to treat newly covered Medicaid adults. The legislature supported these provider recruitment efforts through innovative provider incentive programs and efforts to improve key dental rates to sustainable levels. While there is need for continued program improvements, the CDA has achieved great success with efforts to date and sincerely appreciates the legislative partnerships that have contributed to this progress. From 2014 to 2015, Medicaid reported a 50 percent increase in dental providers.[1] In total, nearly 50 percent of Colorado's actively practicing dentists now participate as Medicaid providers. Medicaid has also reported an increase of at least 28 percent in dentists who see more than 30 Medicaid patients in their practice. In the first complete year offering adult dental services in Medicaid, 33 percent of all eligible adult patients received dental services, a utilization rate on par with first year utilization in many private dental benefit plans. Early reports indicate a substantial reduction in emergency room visits related to dental conditions, with a state cost savings as high as $8 million the first year of the benefit alone. Additional study of patient health outcomes and cost savings related to concurrent medical conditions is being undertaken. These numbers and early outcomes demonstrate the amazing commitment of Colorado dentists to improving access and serving the at-need population in our state.

In addition to addressing dental coverage needs for at-risk populations, the CDA is committed to improving dental infrastructure in rural and underserved communities in our state. The CDA continues to seek to improve dental care throughout Colorado by helping dentists establish sustainable practices that will have a long-term presence in rural and underserved communities. The CDA has worked to match dentists with rural communities that currently lack direct dental services, coordinate mobile dental services for communities that may not be able to support a full-time dental practice, and develop infrastructure for new rural clinic sites.

The CDA has also been proactive in ensuring that Colorado can utilize existing dental team members to the full extent of their training, education and experience to expand access across the state. Colorado has historically been one of the more progressive states on dental workforce. Colorado has allowed the independent or unsupervised practice of dental hygiene for almost 40 years and is broad on the duties dental assistants can perform under a dentist's supervision. Colorado has some of the best dental workforce availability among U.S. states. These existing

[1] And dentist enrollment has continued to increase in 2016.

dental team members can be engaged to help provide important screenings and preventative services – reducing the need for costly restorative treatment and saving patients substantial expense. Adding to Colorado's already permissive baseline, the CDA collaborated on efforts to allow dental hygienists to prescribe limited preventive therapies and fluoride treatments as part of the sunset review of dental practice laws in 2014. In 2015, the CDA worked with partners to authorize dental hygienists to place interim therapeutic restorations, a temporary measure to stop decay, subject to appropriate training and supervision requirements. The CDA has also supported direct reimbursement to independent dental hygienists for the services they are qualified to provide. The CDA and partners are studying whether these additional allowances help improve the economic viability, sustainability and geographic reach of these alternative practice models to ultimately improve dental access in Colorado.

In addition, the CDA continues to work with partners who are engaged in complimentary initiatives to expand dental access. Some current initiatives include efforts to improve referrals to dentists for patients needing dental care to avoid more costly emergency-room visits, better integrate medical and dental care in pediatric medical practices, maximize dental care through telehealth services, and improve access to fluoridated water given its benefits in improving lifelong oral health.

Future efforts may include increasing partnerships between schools and local dental teams, working to develop infrastructure for additional co-location projects between dentists/dental hygienists and rural physicians, and exploring the possibility of a rural residency licensure model for recent graduates.

The CDA is committed to seeing these projects reach their full potential in expanding access to dental care in Colorado. We are excited about the positive impacts these initiatives are already having. In fact, a 2015 report on dental access found that 99% of Coloradans live in counties with access to a dentist and 97% of Colorado's dentist workforce needs are currently met. We recognize that there are still gaps, but these efforts are making a tangible difference.

Dental Health Matters has a presence on Facebook and Twitter (facebook.com/dentalhealthmatters, twitter.com/TeethMatterCO). We truly believe that Dental Health Matters for all Coloradans and hope you will partner with us as we work proactively to make Colorado the best state in the nation for oral health.

1. Which of the dental health and access initiatives outlined by the CDA do you view as top priorities?

2. Do you have additional concerns about dentistry and dental health in Colorado?

3. What do you think is the most important thing our state can do to address dental access gaps?

4. What policies would you advocate to ensure better oral health for Coloradans?

Access to Care: Dental Insurance Reform

Improving the environment for delivery of dental services to prioritize patient access is a key priority for the dental profession, including insurance reforms needed to address current systemic inequities. While Colorado dentists recognize that dental insurance can be an important catalyst in getting people to go to the dentist, a number of current practices by dental benefit plans do not benefit patients or providers, can aggravate access challenges, and are in need of reform.

There are ongoing conversations among the broad healthcare community about needed insurance reform, and the CDA is participating in those discussions. However, we also see a need for direct conversation and future action on elements unique to dental benefits. Current dental plan structures, coverage and plan limitations are not always in the best interest of patients. Of particular note are:

- **Benefit Design:** Current dental plan structures and coverage may not be sufficient to ensure needed care for patients. For example, dental benefits have remained capped at the same level for more than two decades, while the cost of care has continued to rise. Though gains are not always transparent, dental plans continue to profit while consumers face less and less access to dental care. Many efforts have been undertaken to ensure that patients receive patient-centered medical care and essential benefits. However, these efforts have not largely extended to dental care. Only pediatric dental benefits are universally available, though real barriers are posed by the current structure of plan deductibles. Other important populations, including pregnant women, elders and those with concurrent medical conditions, often lack coverage. Also, dental benefit plans are not comparable to medical insurance plans, though the differences are often not transparent to patients and the employers purchasing plans. Dental plans typically do not offer comprehensive or catastrophic coverage. Instead, they most often offer basic or preventative benefits only until a certain defined dollar amount (the annual maximum). After that cap has been reached, the plan ceases to offer a benefit, resulting in patients being responsible for substantial added out-of-pocket costs. Minimum standards ensuring transparency and benefit to consumers should be defined for dental plans offered in Colorado.
- **Out of Network Policies:** Many dental benefit plans penalize patients who choose to receive care from a dentist who is not a network provider for the patient's plan. Dental insurers often pay substantially less for service provided by an out-of-network provider than they would to an in-network provider, hurting the patient who is left liable for the balance of charges. Though the patient or their employer paid the same premiums for coverage, a patient who chooses to see an out-of-network provider receives far fewer or no benefits. This disparity can disproportionately impact patients who have a long-standing relationship with a particular provider, are comfortable with a specific provider, or have extremely limited choices for in-network provider in an area. If a patient is forced to find an in-network dentist instead of using a dentist of their choice, patients may be less likely to continue care or they may pay out-of-pocket to see a dentist they trust, essentially voiding the benefit the patient and employer pay for. Fair payment to an out-of-network provider should not be a financial hardship to a dental plan, as the patient has paid premiums and the plan would otherwise paid an in-network provider for the care. As such, patients should have freedom to choose the most appropriate provider, and dental plans should be required to contribute a reasonable payment for an identical service offered by both in-network and out-of-network providers.
- **Adhesion Contracts for Non Covered Services:** Some dental benefit plans use their market prominence to dictate payment rates for services that they do not cover. Because they have greater market share and negotiating leverage, larger plans use adhesion contracts to leverage

control over services in which they share no financial liability. Plans use these abusive contracting practices to their marketing advantage, incurring no cost but gaining competitive benefit over plans with less market control. In dentistry, non-covered services vary according to the type of plan that the patient or employer purchases; but plans often exclude services like implants, bone grafting, bite guards, night guards, or orthodontics (often procedures that are largely elective). In most plans, covered services include core procedures like cleanings and fillings. 39 U.S. states have banned dental plans from dictating fees for non-covered services[2] and have not reported increased consumer costs or patient concerns. The system works well without insurer interference, as there are ample market and consumer protections for patients that access non-covered services. The use of adhesion contract clauses to control fees for which the carrier assumes no financial liability results in inequitable and distorted markets. Inequitable contracting in business results in cost shifting and drives up costs for non-included parties – often the uninsured, who may be least able to access the care they need. Inequitable insurer practices related to fees for non-covered services can severely limit the ability of dentists to adjust fees, provide free care or help arrange payment options for patients in need. States that ban this practice simply eliminate this cost shifting. Studies have shown that dentists do not benefit financially from this change. Deeply discounted dental plans covering only a few basic preventative services are increasingly being offered to consumers, resulting in plans comprised almost exclusively of non-covered services. With the severe limitations of these new plans,[3] there is an even greater need to address this practice to ensure transparency and fairness to patient and providers. Colorado dentists support limiting the ability of dental plans to interfere with fees of services they do not cover, as these limitations would promote fairness and quality care. All patients should have the option to choose high quality, elective procedures, and pay the fair costs of a procedure when it is not paid for by an insurer.

Further, the use of adhesion contracts by dental benefit plans is of broad concern in the dental provider community. Interference with fees for non-covered services is only one example of harm that is done by inequitable contracting practices. Other practices like narrowing networks, renting networks without provider consent or transparency, utilizing unqualified personnel to review claims, and providing inadequate or no notice on contract changes are in need of reform. Anti-trust provisions skew the market in favor of large plans, and dentists have almost no ability to negotiate with insurers without running afoul of these anti-trust laws. These unfair practices ultimately hurt patient choice and continuity of care. Some states have attempted to address these concerns by allowing providers to band together to collectively negotiate with plans. Other states have defined fair contracting practices under state law. Given the numerous concerns identified for both patients and providers in the dental benefit market, comprehensive insurance reform efforts are needed.

1. Which of the potential insurance reforms outlined by the CDA do you view as top priorities?

[2] In addition, current federal legislation, H.R. 3323, seeks to align the practices of federally-regulated ERISA plans with state policies preventing plan interference in setting fees for services they do not cover.

[3] Which offer marketing benefits to plans and employers but are nearly devoid of any real care for patients.

2. The CDA sees a need to change contracting practices for non-covered dental services – preventing dental plans from setting fees for services they do not cover. Would you support a law that would end this practice as has been done in 39 U.S. states?

3. The CDA feels that penalizing patients who visit an out-of-network dental provider is an inequitable business practice that can impose excessive limits on patient choice and ultimately deter some patients from seeking dental care. Would you support a law to require reasonable equity in payments made to in- and out-of-network dental providers?

4. The Colorado Dental Association believes that comprehensive review of dental plan benefit design is needed. Would you support efforts to define minimum standards for dental plans offered in Colorado?

5. What policies would you advocate to ensure that dental benefit structures prioritize patient-centered dental care for Coloradans?