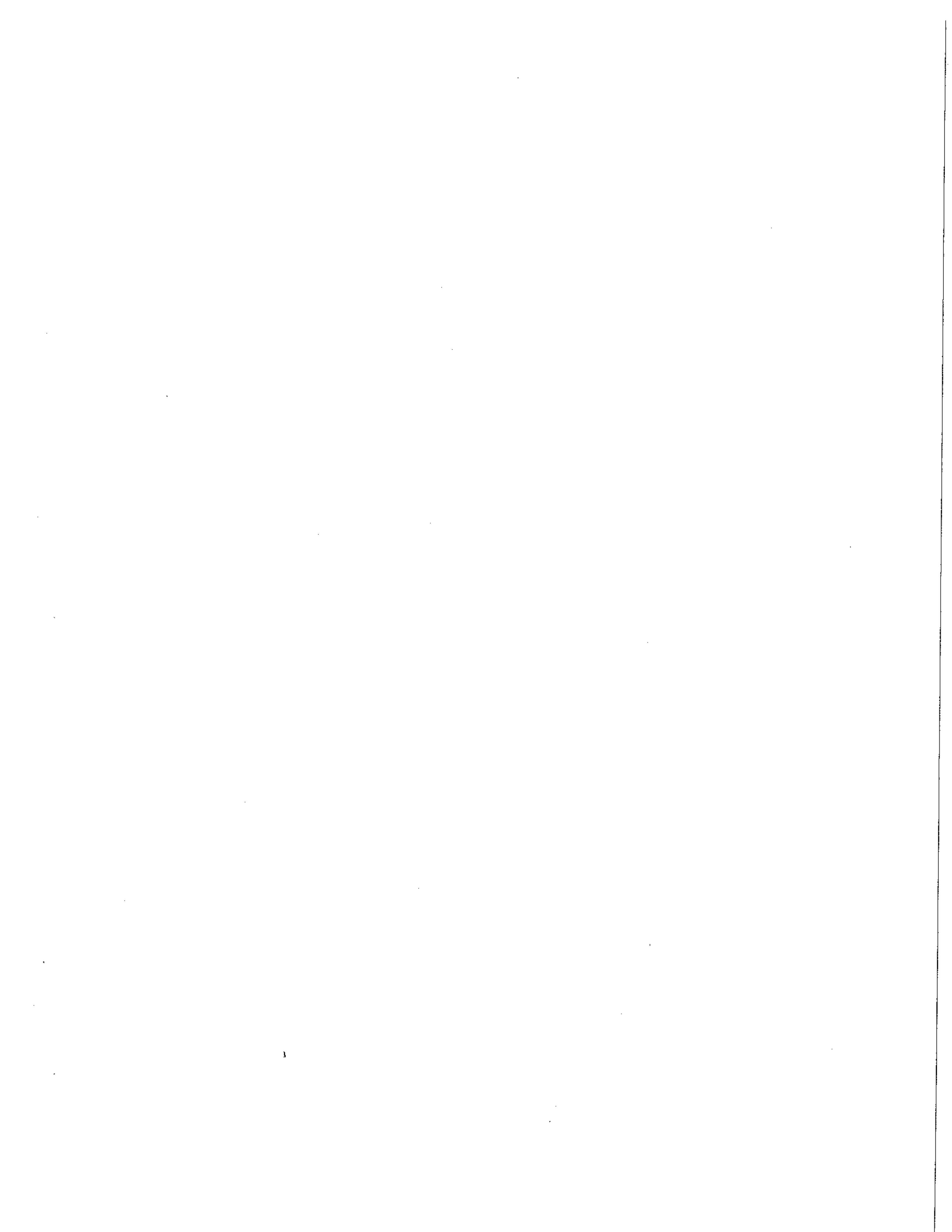
REPORT ON DENTAL EXTERNAL REVIEW

TO THE GOVERNOR AND GENERAL ASSEMBLY

Iowa Insurance Division
January 28, 2015



REPORT ON DENTAL EXTERNAL REVIEW

TO THE GOVERNOR AND GENERAL ASSEMBLY

2014 Iowa Acts, House File 2463, section 112 directs the Commissioner of Insurance to engage stakeholders and report findings and recommendations to the Governor and General Assembly regarding the differences in the bases used for external review of adverse determinations as applied to health care services relative to dental care services. This document has been developed for the purposes of the above-referenced Iowa Code section. A copy of the legislation is provided in Appendix A.

BACKGROUND

External review is a review by an independent third party of a plan's decision to deny coverage for or payment of a service. An external review can be requested if the plan denies a request for the provision of or payment for a health care service or course of treatment. External review is available when a plan denies treatment based on medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, when a plan determines that the care is experimental and/or investigational. An external review either upholds the plan's decision or overturns all or some of the plan's decision. An external review decision is binding on the health carrier.

Iowa's external review process is set out in Chapter 514J of the Iowa Code and 191-76 of the Iowa Administrative Code. The Iowa Insurance Division (IID) has been conducting external reviews since 2000 when 514J was codified. In 2013, for example, IID handled 89 external reviews on behalf of consumers with 22 of these reviews resulting in the decisions being overturned, 29 of the decisions being upheld (against the policyholders) and 38 of the decisions having been found not to be eligible for external review. From FY 2008 to FY 2014, IID has handled on average 56 external review claims per year.

External Review Year	# of External Review Cases	# of Reviews Upheld for Consumers
FY 2014	85	28
FY 2013	85	20
FY 2012	82	20
FY 2011	41	20
FY 2010	35	12
FY 2009	29	12
FY 2008	32	12

During a survey conducted by IID in 2011, the fees charged by independent review organizations varied from hourly rates to flat fees per review request beginning at $250.00 and upwards. Dating back to 1999, IID has handled roughly 372 dental complaints through the Division's Market Regulation Bureau. 80% of those involve self-funded dental plans or another state's dental plan that were referred on to that state's dental plan. Carriers have in place some form of initial internal appeal process that exists in addition to the state's external review requirements and typically must be exhausted prior to requesting an external review. The external review process offers resolution to disputes without costly litigation and serves as a consumer protection measure wherein an insurance company does not have a final say regarding benefits permitting patients and doctors to have a greater measure of control over health care decisions. Parameters exist in the external review process to ensure that the process does not become an overly burdensome, time-consuming, or expensive process for consumers, treating health professionals and insurance companies. Those parameters include filing deadlines and required response times to requests in addition to the reasons set out previously *(medical necessity, appropriateness, etc.)*

Common reasons for an insurance company denial include:

- The service is not covered under the policy.
- The service is covered by the policy but the provider was out-of-network.
- Pre-authorization was not obtained for the service.
- The service was experimental or investigational.
- The service was not medically necessary.

In an external review, medical records are sent to an independent third party known as an independent review organization (IRO). IID has certified organizations that can serve as IROs in Iowa and will select one that is appropriate for the particular claim. The IRO will then review the claim and determine if the denial was proper. The IRO will uphold, modify, or overturn the decision of the insurance company. The IRO is required pursuant to 514J to consider the following in reaching a decision:

a. The covered person's pertinent medical records.

b. The treating health care professional's recommendation.

c. Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, or the covered person's treating physician or other health care professional.

d. The terms of coverage under the covered person's health benefit plan with the health carrier, to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier.

e. The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations.

f. Any applicable clinical review criteria developed and used by the health carrier.

g. The opinion of the independent review organization's clinical reviewer after considering the information or documents described in paragraphs *"a"* through *"f"* to the extent the information or documents are available and the clinical reviewer considers them relevant.

Legislative History. Iowa's external review law, contained in Iowa Code chapter 514J, was originally enacted in 1999. The earlier version of the law was limited in that external review for dental insurance was completely excluded and external review of denials of coverage were based on medical necessity. In 2008, the law was amended to remove the exclusion for dental insurance, thereby, making dental insurance subject to external review. Beginning in July 2008, external review was available for dental insurance claims to the extent a dental insurance claim was denied based on medical necessity. In 2011, Iowa's external review law was completely rewritten as required by the Affordable Care Act. Section 2719 of the Affordable Care Act requires that states adopt an external review law that "at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners." Iowa's rewritten law essentially adopts the NAIC model and thus complies with the Affordable Care Act's external review requirements. The NAIC model completely excludes a number of limited scope insurance products, including dental insurance, from external review.

FINDINGS

IID engaged the stakeholders by sending an electronic notice of the meeting to interested parties on October 2, 2014 with an invitation to participate in a meeting scheduled for October 28, 2014 at the offices of the Iowa Insurance Division. IID reiterated for participants that the purpose of the meeting was to engage stakeholders to review the differences in the bases used for external review of adverse determinations under Chapter 514J as applied to health care services relative to dental care services. IID stated the desired outcomes of the meeting were to (1) gain an increased level of understanding of concerns involving dental claims and adverse determinations and (2) obtain data regarding the factors utilized to deny coverage of health care services and the factors utilized to deny coverage of dental care services. A transcript of the meeting was created and is provided in Appendix B. The meeting was attended by interested parties from the Iowa Dental Association and the dental insurance industry. Comments submitted by interested parties include The Federation of Iowa Insurers, the National Association of Dental Plans, Delta Dental of Iowa, Iowa Dental Association, Senator Matt McCoy, and Delta Dental Plans Association. Comments are provided in Appendix C.

The Commissioner asked the Iowa Dental Association (IDA) to provide examples of denials where the carrier had denied claims and from the dentist's point of view the denial was inappropriate and to provide information about the fiscal impact of any expanded external review for dental services. The insurance industry was permitted to offer a rebuttal/explanation of the examples provided by the IDA. The record was closed on November 17, 2014.

Summary of Comments

The Federation of Iowa Insurers	Supports the compromise set out in the legislation. Comments reflect opinion as to why the legislative language is appropriate. Position based on the scope of dental insurance is far narrower than major medical insurance, dental care is billed and reviewed differently than medical care, and the coverage amounts for dental insurance are far lower than major medical insurance.
Iowa Dental Association (IDA)	Holders of health benefit plans providing dental care services will be treated differently in external review proceedings than holders of health benefit plans providing other health care services; that appropriateness, health care setting, level of care, and effectiveness are all subcomponents of the definition of medical necessity; that limiting review to medical necessity only is contrary to the legislative intent and this issue is a matter of fundamental fairness for Iowans. IDA submitted examples of claim denials.
Delta Dental of Iowa	Clinical response to examples presented by IDA. From a clinical stand-point, dental benefits are a limited scope product. Treatment decisions are made between the dentist and the patient, but benefit decisions are based on industry criteria, frequencies, annual maximums, and whether a procedure is a covered benefit or not.
Delta Dental Plans Association	Both federal and state statutory frameworks support applying a separate standard for dental plans. The NAIC continues to exclude dental plans from its model law on external review.

	Limited-scope stand-alone dental plans are considered "excepted benefits" in the Public Health Services Act, and operate under a distinct set of rules from health carriers providing medical plans. Because of these distinctions, the Iowa Legislature intended external review for dental claims only when "medical necessity" is in question.
National Association of Dental Plans	Supporting arguments for the exclusion of dental plans from external review include: dental plans already have appeal procedures in place based on ERISA or state specific regulations; the costs of external review can reach $1000 to $2000; diagnostic codes are used to assist in medical external review, but currently are not utilized within the dental profession; and when such extreme costs are imposed upon dental plans, ultimately consumers will pay through increased premiums.
Senator Matt McCoy	Senate intended that Iowans with dental insurance must share the same benefit with those Iowans with health insurance. Intent was to provide uniform fairness for Iowans and allow for external review for adverse determinations. The legislation merely delineated "medical necessity" by including appropriateness, health care setting and level of care or effectiveness.

The profession of dentistry, and the mouth in general, were separated long ago from the body as part of the national health care movement. Dentistry became a subset or "other" health related profession outside primary care and the various sub-subspecialties of medicine. This has resulted in a disconnect between health care and dental delivery systems. The current national health care debate over affordable health care, Medical Home, Electronic Health Record (EHR and meaningful use), and Health Reform in general have essentially sidelined dental care as a critical component in the restructuring of the American health care system. This absence of attention on oral health is also true at the state and local level. ...This was mostly due to the different payment coding and tracking methods that evolved within medicine and the American hospital system. This coding method separates the health care system from the more procedure-driven coding system common to the dental delivery system. [The Impact of Unaddressed Dental Disease, Emergency Room Utilization, Bob Russell, DDS, MPH, Iowa Department of Public Health-Oral Health Bureau, October 1, 2010]

RECOMMENDATIONS

It is clear that parties on both sides come to this issue with their own perceptions, recollections and even potential biases. External review is an important step in reforming the health care system to make sure it works for consumers, not just insurance companies.

The treatment of dental coverage as an excepted benefit, as a limited benefit plan is duly accepted by IID. Existing Iowa insurance law and regulations permit different treatment for dental care. Noting the following:

Iowa Code §513B.2 the definition of health insurance does not include benefits provided under a separate policy as follows: (1) limited scope dental or vision benefits.

Iowa Code §513C.2 the definition of individual health benefit plan does not include...dental.

As part of prohibited policy provisions, the following appears in the Iowa insurance administrative Code:

> **191—36.5(514D) Prohibited policy provisions.**
>
> **36.5(6)** No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:
>
> ...
>
> *i.* Dental care or treatment;

Existing federal laws and regulations treat dental coverage as an excepted benefit, meaning that these benefits are generally not health insurance coverage. Sections 2722 and 2763 of the PHS Act, section 732 of ERISA, and section 9831 of the Internal Revenue Code (the Code) provide that the requirements of title XXVII of the PHS Act, part 7 of ERISA, and chapter

100 of the Code, respectively, generally do not apply to excepted benefits. Excepted benefits are described in section 2791 of the PHS Act, section 733 of ERISA, and section 9832 of the Code. One category of excepted benefits is limited excepted benefits, which may include limited-scope vision or dental benefits, and benefits for long-term care, nursing home care, or community-based care. To be excepted, the limited benefits must be either (1) provided under a separate policy, certificate, or contract of insurance; or (2) otherwise not be an integral part of a group health plan, whether insured or self-insured.

The Iowa Insurance Division recommends the following:

- No amendments to the statute to include additional processes beyond medical necessity given the lack of time to ascertain specific, unique issues that may arise to dental claims, recognizing that the law was effective July 1, 2014 and this report was prepared within six months of its effective date. Since the enactment of the statute, IID has received one inquiry about the dental external review process, but has not received any request for external review for denied dental services. Previously, when external review was available for dental claims under the law, neither dentists nor policyholders utilized the process. Consumers have availed themselves of the processes and remedies through IID but based on the historical numbers, only two requests have been conducted for dental external review. There are 13 IROs authorized by IID to conduct external reviews, 10 of which are authorized to review dental claims.

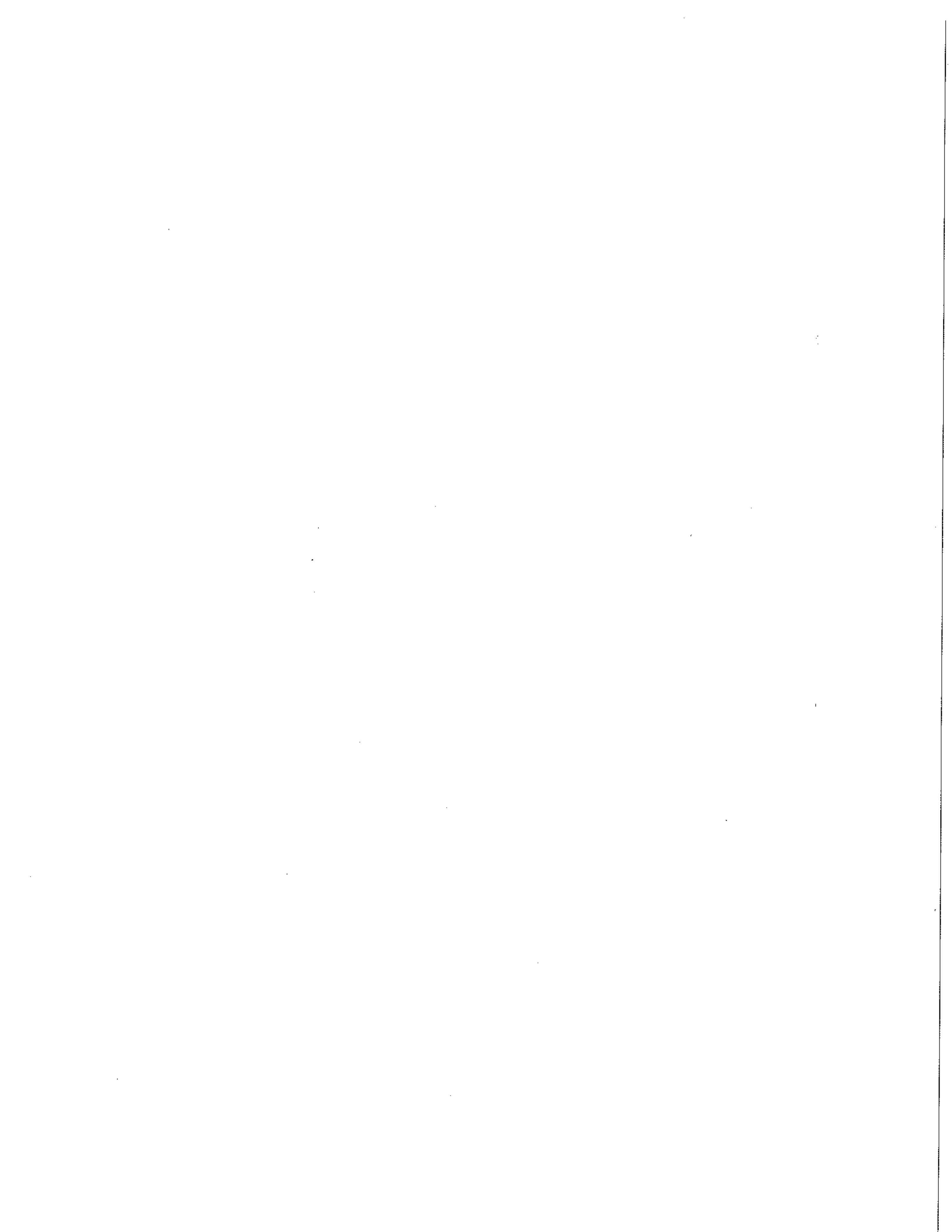
- Technical and clarifying amendments to the External Review Request Form set out in Iowa Administrative Code 191-76 to specifically accommodate dental external review claims.

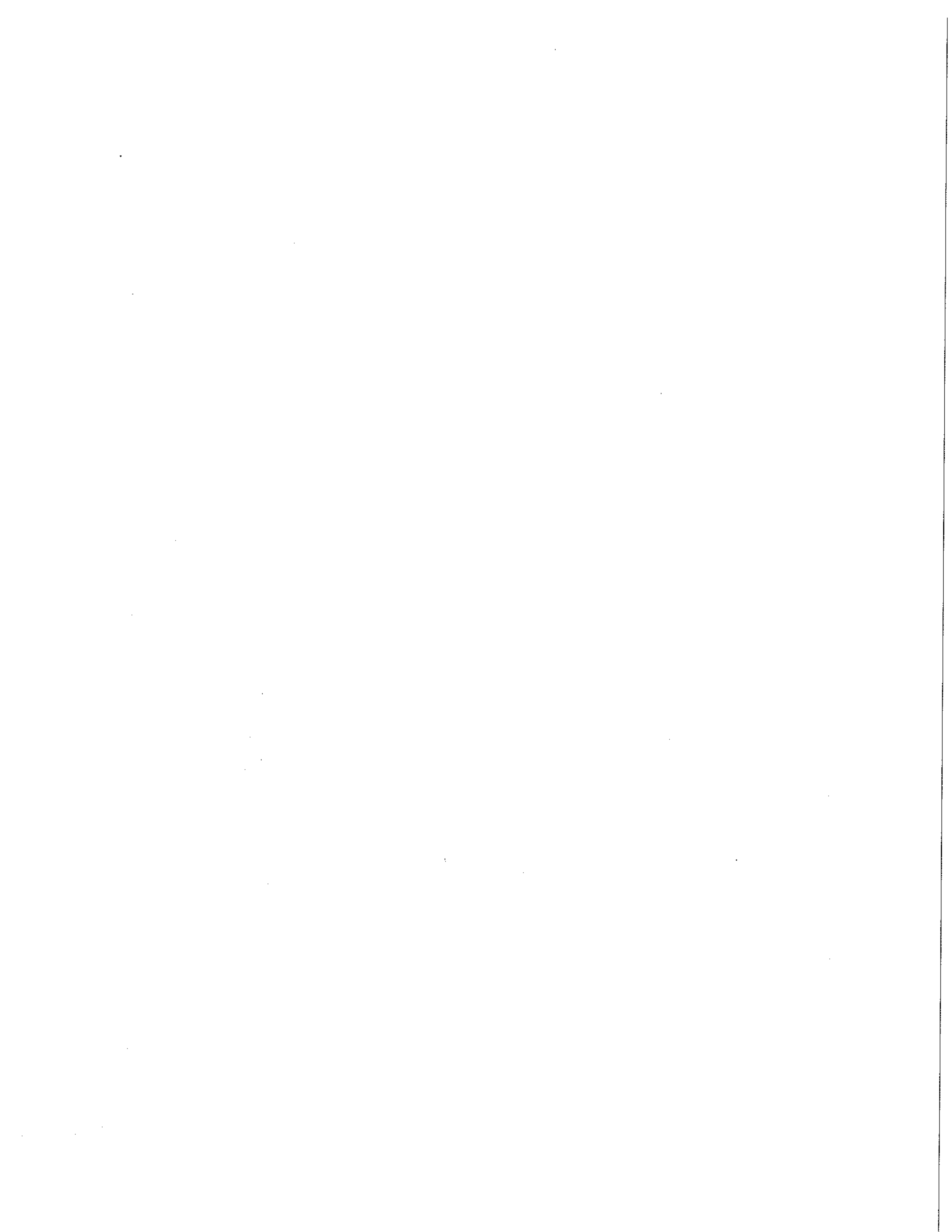
- Close consultation with IID on any further amendments to Iowa Code Chapter 514J as it may impact the federal government's designation of Iowa as having an effective external review program in compliance with the Affordable Care Act. In the absence of being designated as a state with an effective external review program, carriers doing business in Iowa would have to use a federally-administered external review process.

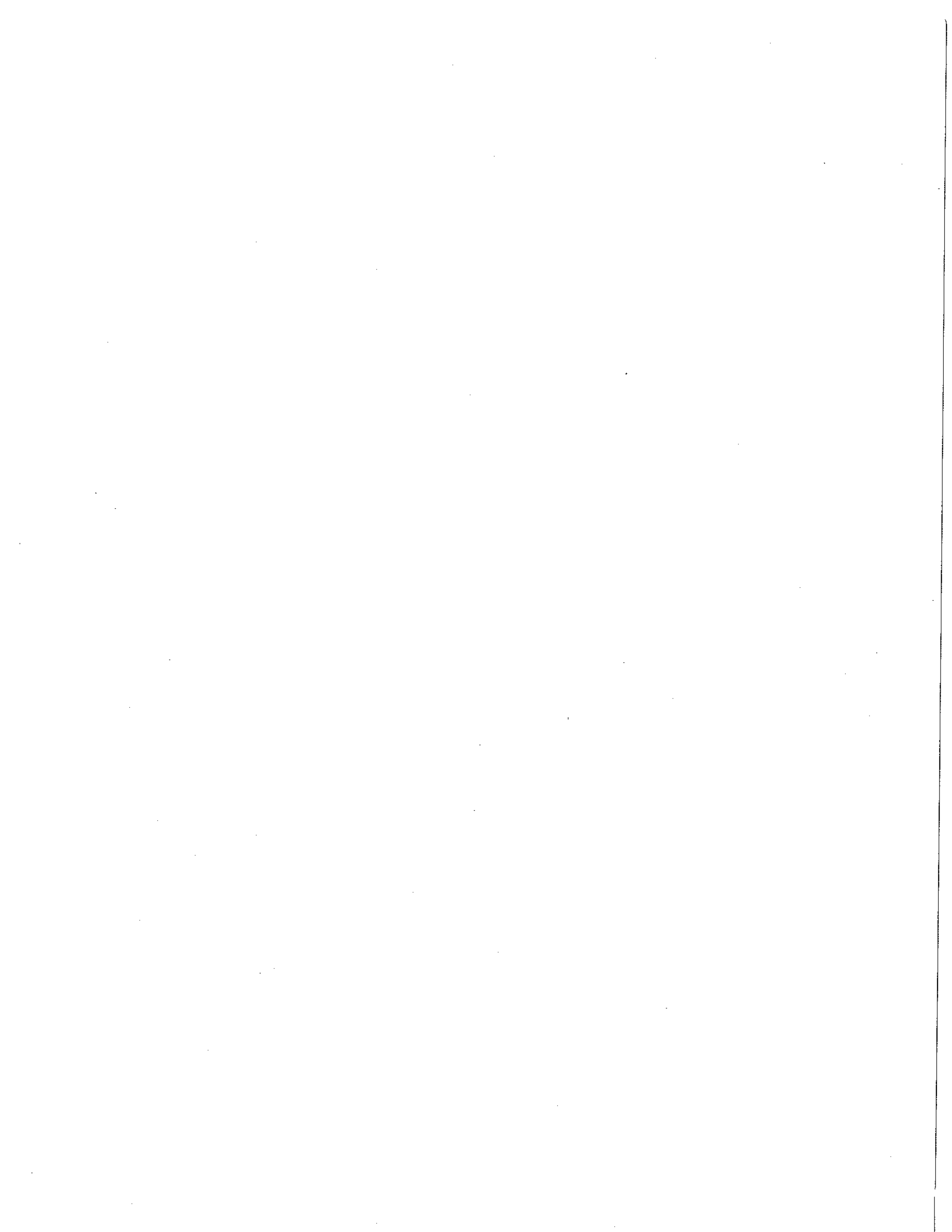
APPENDIX A- 2014 IOWA ACTS, HF 2463

APPENDIX B-TRANSCRIPT

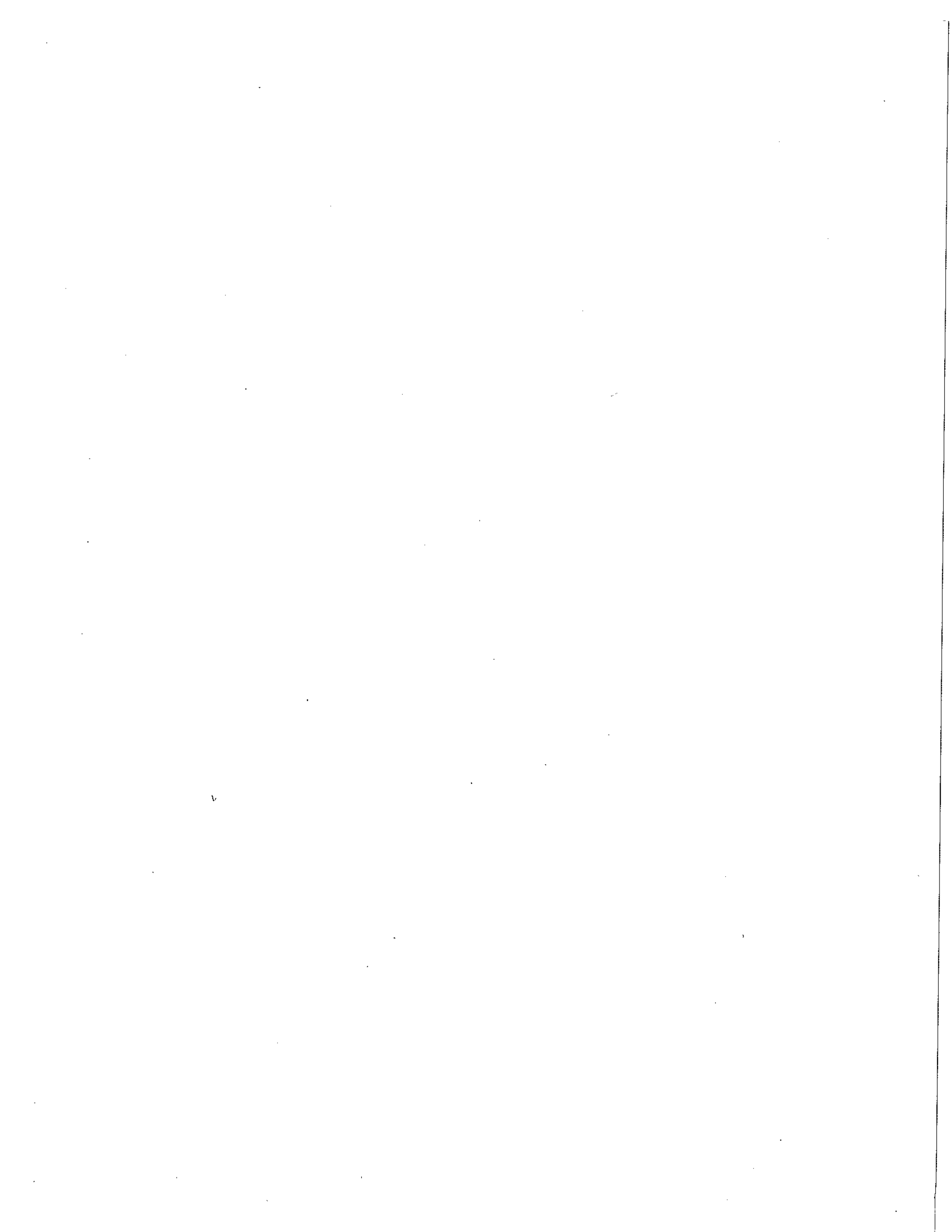
APPENDIX C-COMMENTS







APPENDIX A



6. The interim committee shall submit its findings and recommendations to the general assembly for consideration during the 2015 legislative session.

**DIVISION XIX*
HEALTHIEST CHILDREN INITIATIVE

Sec. 105. NEW SECTION. ***135.181 Iowa healthiest children initiative.***
1. The Iowa healthiest children initiative is established in the department. The purpose of the initiative is to develop and implement a plan for Iowa children to become the healthiest children in the nation by January 1, 2020. The areas of focus addressed by the initiative shall include improvement of physical, dental, emotional, behavioral, and mental health and wellness; access to basic needs such as food security, appropriate nutrition, safe and quality child care settings, and safe and stable housing, neighborhoods, and home environments; and promotion of healthy, active lifestyles by addressing adverse childhood events, reducing exposures to environmental toxins, decreasing exposures to violence, advancing tobacco-free and drug abuse-free living, increasing immunization rates, and improving family well-being.
2. The department shall create a task force, including members who are child health experts external to the department, to develop an implementation plan to achieve the purpose of the initiative. The implementation plan, including findings, recommendations, performance benchmarks, data collection provisions, budget needs, and other implementation provisions shall be submitted to the governor and general assembly on or before December 15, 2014.

*Sec. 106. EFFECTIVE UPON ENACTMENT. This division of this Act, being deemed of immediate importance, takes effect upon enactment.**

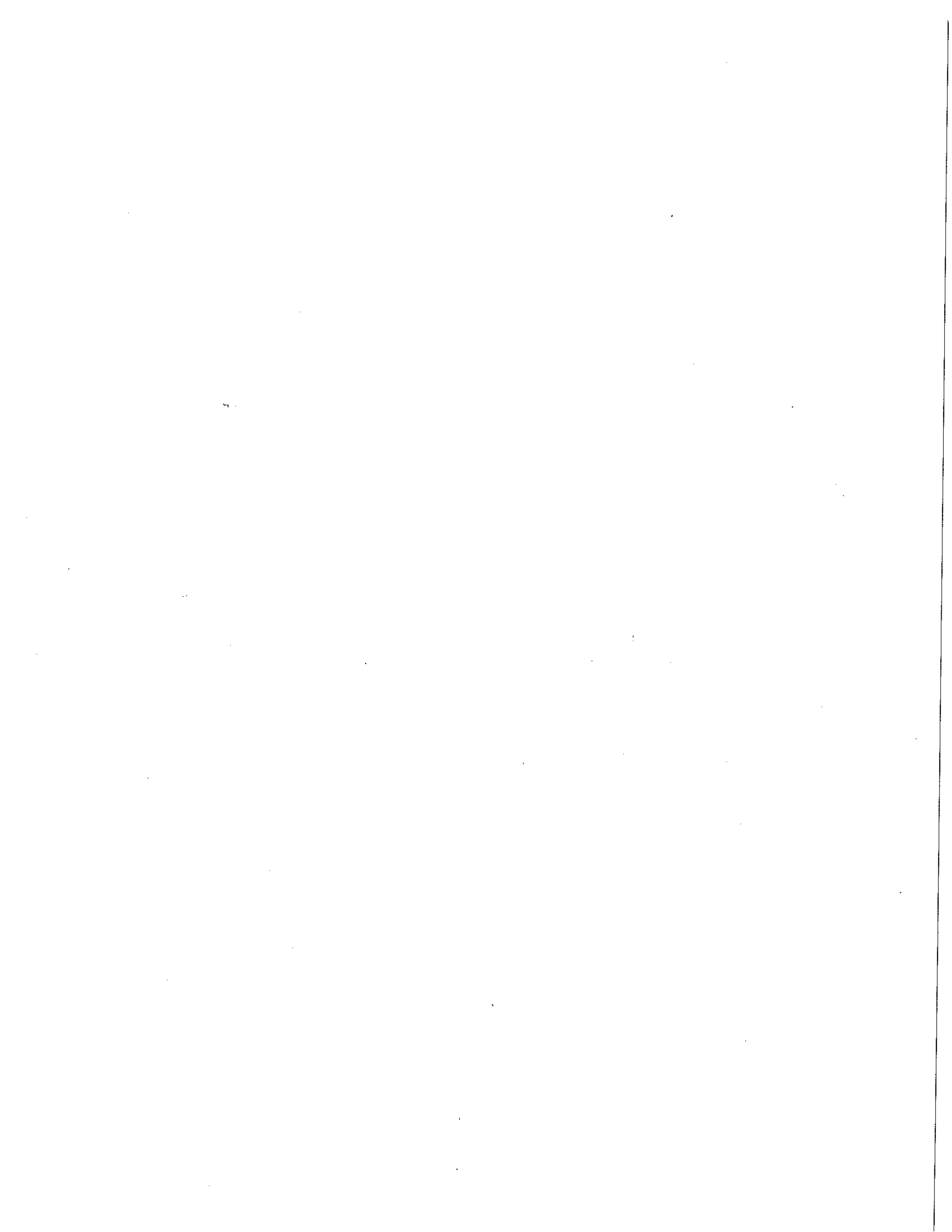
**DIVISION XX*
POTENTIAL MEDICAID STATE PLAN AMENDMENT — ELDERS

*Sec. 107. MEDICAID — POTENTIAL STATE PLAN AMENDMENT — HOME AND COMMUNITY-BASED SERVICES FOR ELDERS. The department of human services shall engage stakeholders with interest or expertise in issues relating to elders to review the potential for development and submission of a Medicaid program state plan amendment in accordance with section 2402 of the federal Patient Protection and Affordable Care Act to cover home and community-based services for eligible elders 65 years of age or older. The department shall make recommendations on or before December 15, 2014, to the governor and the general assembly, detailing provisions for incorporation into such a potential Medicaid program state plan amendment relating to financial eligibility; benefits, including whether individuals receiving such Medicaid services should be eligible for full Medicaid benefits; available services; and the needs-based level of care criteria for determination of eligibility under the state plan amendment.**

DIVISION XXI
DENTAL COVERAGE — EXTERNAL REVIEW

Sec. 108. Section 514J.102, subsection 1, Code 2014, is amended to read as follows:
1. *a.* *"Adverse determination"* means a determination by a health carrier that an admission, availability of care, continued stay, or other health care service, other than a dental care service, that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.
b. For the purposes of denial of a dental care service, *"adverse determination"* means a determination by a health carrier that a dental care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, and the requested service or payment for the service is therefore denied, reduced, or terminated in whole or in part.

* Item veto; see message at end of the Act



c. *"Adverse determination"* does not include a denial of coverage for a service or treatment specifically listed in plan or evidence of coverage documents as excluded from coverage.

Sec. 109. Section 514J.102, Code 2014, is amended by adding the following new subsection:

NEW SUBSECTION. 11A. *"Dental care services"* means diagnostic, preventive, maintenance, and therapeutic dental care that is provided in accordance with chapter 153.

Sec. 110. Section 514J.102, subsection 22, Code 2014, is amended to read as follows:

22. *"Health care services"* means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease. *"Health care services"* includes dental care services.

Sec. 111. Section 514J.103, subsection 2, paragraph a, Code 2014, is amended to read as follows:

a. A policy or certificate that provides coverage only for a specified disease, specified accident or accident-only, credit, disability income, hospital indemnity, long-term care, ~~dental care,~~ vision care, or any other limited supplemental benefit.

Sec. 112. REVIEW OF BASES USED FOR EXTERNAL REVIEW OF ADVERSE DETERMINATIONS. The commissioner of insurance shall engage stakeholders to review the differences in the bases used for external review of adverse determinations under chapter 514J as applied to health care services relative to dental care services. The commissioner of insurance shall report findings and recommendations to the governor and the general assembly by December 15, 2014.

Approved May 30, 2014, with exceptions noted.

TERRY E. BRANSTAD, *Governor*

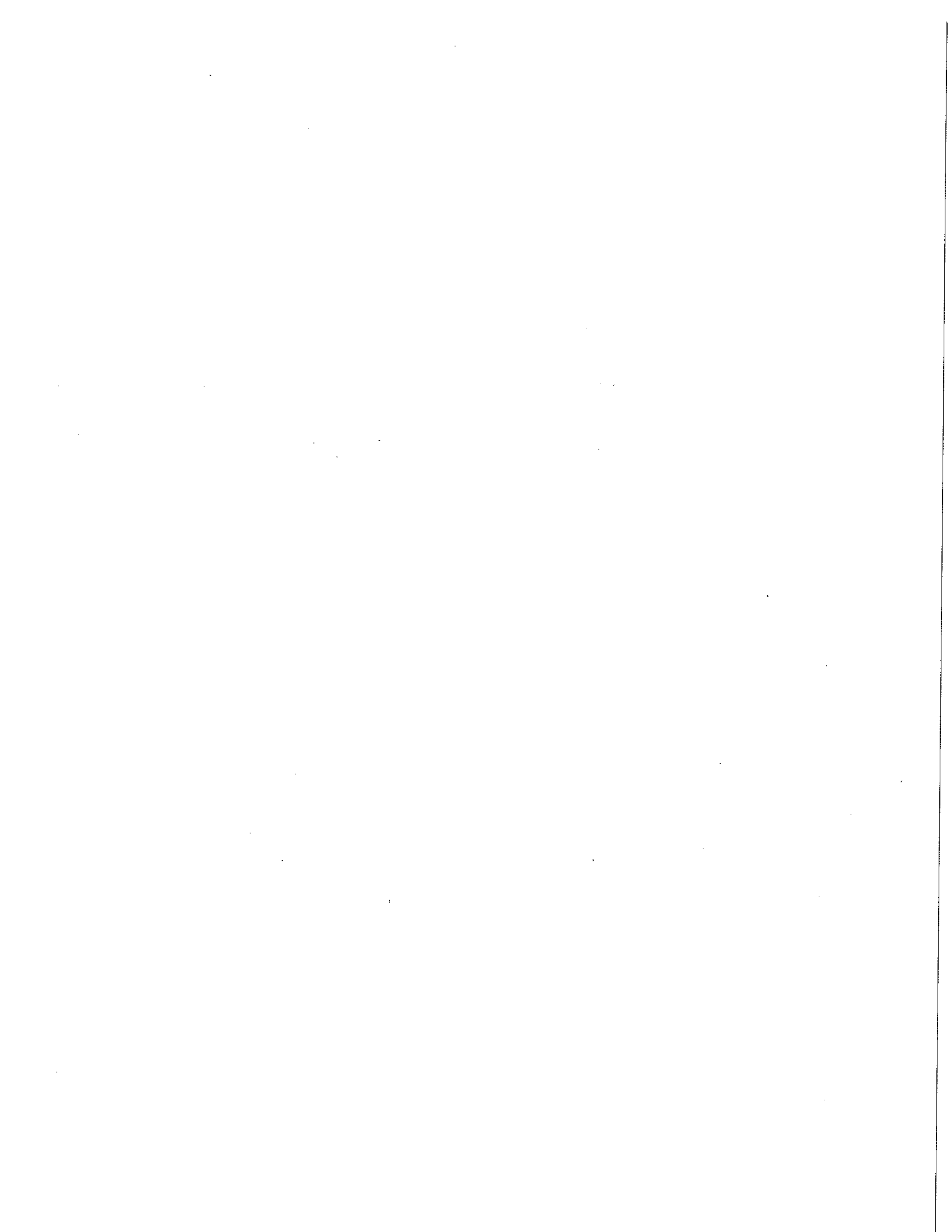
Dear Mr. Secretary:

I hereby transmit House File 2463, an Act relating to appropriations for health and human services and veterans and including other related provisions and appropriations, extending the duration of county mental health and disabilities services fund per capita levy provisions, and including effective date and retroactive and other applicability date provisions.

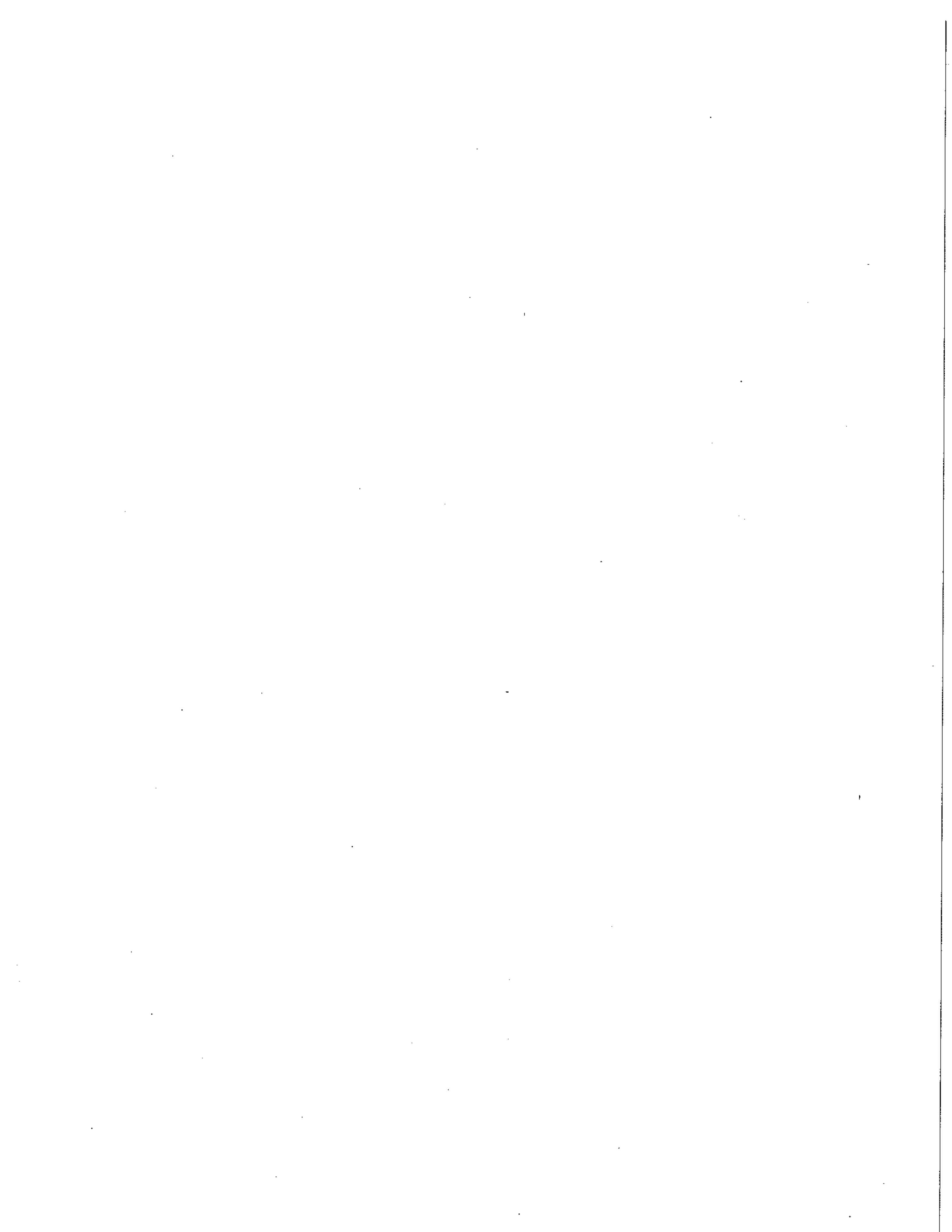
A stable, predictable health and human services budget is critically important to Iowa taxpayers who fund these programs and to Iowa's most vulnerable who rely upon these programs. This budget falls short of the high standard Iowans deserve and need, especially in two areas: compensatory education for former Iowa Juvenile Home residents and Medicaid. The budget I proposed in January 2014 included funding for compensatory education of children formerly served by the Iowa Juvenile Home. This bill fails to fund compensatory education; however, I am committed to ensuring the educational needs of the children are met. The Department of Human Services will fund any compensatory education required. Although sufficient funds will remain available to cover a potential Medicaid budget shortfall in fiscal year 2014, the failure to meet the projected needs for Medicaid leads to bad budgeting and is a practice that must be changed.

House File 2463 is approved on this date with the following exceptions, which I hereby disapprove.

I am unable to approve the designated portion of the item designated as Section 3, amending the 2013 Iowa Acts, chapter 138, section 133, subsection 4, lettered paragraph p by inserting subparagraph 2. This item requires the Department of Human Services to collaborate with the Iowa Collaborative Safety Net Provider Network and the Iowa Primary Care Association to develop a long-term place for the statewide regionally based network. This is unnecessary



APPENDIX B



BEFORE THE IOWA INSURANCE DIVISION

- -X

IN RE: :

DENTAL COVERAGE - EXTERNAL REVIEW :

HF 2463 :

- -X

ORIGINAL

Conference Room
Fourth Floor
Two Ruan Center
601 Locust Street
Des Moines, Iowa
Tuesday, October 28, 2014

The above-entitled matter came on for hearing at 10 a.m.

BEFORE: NICK GERHART, Insurance Commissioner
ANGELA BURKE BOSTON, Asst. Insurance Commissioner

APPEARANCES:

Federation of Insurers: SCOTT SUNDSTROM, ESQ.
PAULA DIERENFELD, ESQ.

Iowa Dental Association: JOHN HUNTER, ESQ.
HAROLD SCHNEEBECK, ESQ.
KATIE COWNIE, ESQ.
ADAM J. FREED, ESQ.
LARRY CARL
BARBARA BLOUGH

Delta Dental: SUZANNE HECKENLAIBLE
LYNN PATTERSON

KARLA FULTZ McHENRY
(Contract Lobbyist)

Principal Financial Group: GEORGIA VAN GUNDY

THERESA KENKEL - CERTIFIED SHORTHAND REPORTER

I N D E X

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Scott Sundstrom	10

E X H I B I T S

EXHIBITS

1 - Written Comments from Kris Hathaway, National Association of Dental Plans

2 - Written Comments from the Iowa Dental Association

3 - Written Comments from Scott Sundstrom, Federation of Iowa Insurers

1 P R O C E E D I N G S

2 COMMISSIONER GERHART: Good morning,
3 everybody. Nice to see you all today, and I think
4 everybody should have an agenda, right? Okay.
5 Excellent.
6 Well, I just--maybe before we get started,
7 it might make sense to just do introductions. I
8 think everybody probably knows everybody, but just
9 for my benefit and Angela's benefit and the court
10 reporter's, it might be good to do introductions.
11 I'm Nick Gerhart, the Insurance
12 Commissioner, State of Iowa.
13 ASSISTANT COMMISSIONER BURKE BOSTON: Angela
14 Burke Boston, Assistant Commissioner.
15 MS. COWNIE: I'm Katie Cownie with the Brown
16 Winick Law Firm.
17 MR. FREED: Adam Freed with the Brown Winick
18 Law Firm on behalf of the Dental Association.
19 MR. HUNTER: John Hunter, Brown Winick Law
20 Firm, on behalf of the Dental Association.
21 MR. SCHNEEBECK: Harold Schneebeck, Brown
22 Winick, representing the Iowa Dental Association.
23 MR. CARL: Larry Carl. I work for the Iowa
24 Dental Association.
25 MS. BLOUGH: Barb Blough with the Iowa

1 Dental Association.
2 MS. HECKENLAIBLE: Suzanne Heckenlaible,
3 Delta Dental.
4 MS. FULTZ McHENRY: Karla Fultz McHenry,
5 Delta Dental contract lobbyist.
6 MS. PATTERSON: Lynn Patterson with Delta
7 Dental.
8 MS. VAN GUNDY: Georgia Van Gundy with
9 Principal.
10 MR. SUNDSTROM: Scott Sundstrom with the
11 Nyemaster Law Firm representing the Federation of
12 Iowa Insurers.
13 MS. DIERENFELD: Paula Dierenfeld of the
14 Nyemaster Law Firm, the executive director of the
15 Federation of Iowa Insurers.
16 COMMISSIONER GERHART: Thank you, everybody,
17 for that.
18 As you can see on the agenda we have the
19 purpose, but I guess before we really go to the
20 agenda, my goal today is we, under the Code, have
21 this obligation to include a stakeholders meeting and
22 receive comments, and I guess I just wanted to hear
23 from the parties how things are working, or not
24 working. It's going to help us in our report to the
25 Governor's Office and the legislative policymakers.

1 As you can see, we do have a court reporter
2 here, so there will be a transcript from today's
3 meeting.
4 So with that, Angela, why don't you kind of
5 just go through really what our desired outcomes are.
6 ASSISTANT COMMISSIONER BURKE BOSTON:
7 Certainly. We are here regarding House File 2463,
8 the Dental External Review provision that the
9 legislature and the Governor signed this past
10 session.
11 As the Commissioner stated, we are here to
12 engage you, as stakeholders, regarding the bases for
13 external review of the adverse determinations. And
14 our obligation as regulators is to prepare a report
15 for the Governor and the General Assembly based on
16 what you provide to us today.
17 House File 2463 outlines--redefines "adverse
18 determination" regarding dental care services, and
19 adjusts our existing external review, Chapter 514J,
20 to accommodate dental care services, as well as
21 obligating the Division to prepare this report, which
22 is due December 15th.
23 COMMISSIONER GERHART: Good. So I guess
24 with the housekeeping matters and the summary done, I
25 guess right now it's your turn to offer comments. I

1 know we had some comment letters received, at least
2 one. I saw that this morning.
3 ASSISTANT COMMISSIONER BURKE BOSTON: Right.
4 The National Association of Dental Care--Dental Plans
5 provided comments.
6 COMMISSIONER GERHART: And we'll probably
7 put all these online when we get them--the file done,
8 so to speak, but it's really your time to offer
9 comments, so...
10 ASSISTANT COMMISSIONER BURKE BOSTON: I
11 understand that the Iowa Dental Association wishes to
12 make a presentation, as well as the Federation.
13 COMMISSIONER GERHART: Sure.
14 ASSISTANT COMMISSIONER BURKE BOSTON: And
15 there's also been a request that after our
16 proceedings today, that we leave the record open for,
17 perhaps, a week to accommodate or address--
18 COMMISSIONER GERHART: Further comments?
19 ASSISTANT COMMISSIONER BURKE BOSTON: Uh-huh.
20 COMMISSIONER GERHART: We'll do that. We'll
21 leave the record open for a week from today. So
22 close of business, I guess, next Tuesday will be the
23 final time to put in a comment letter so that we can
24 do our report.
25 With that, why don't we go ahead and listen

1 to you folks.

2 MR. HUNTER: That sounds great.

3 I'm John Hunter on behalf of the--

4 representing the Iowa Dental Association and its

5 members. With me today is Larry Carl and Barb

6 Blough, executive director and assistant executive

7 director of the association. Also with me is Harold

8 Schneebeck, Katie Cownie, and Adam Freed.

9 We're here today, as you said, to discuss

10 the external review provisions as they apply to

11 dental services under Iowa Code Chapter 514J.

12 Iowa 514J applies to covered persons or

13 participants in plans and Iowa citizens. The purpose

14 of 514J is to allow them to have an external review

15 by a third party of an adverse decision made by their

16 health carriers. The external review provisions

17 generally are to provide uniform standards for that

18 review, consistency, and fairness. I think it's a

19 matter of just fundamental fairness in the issuance

20 of a policy that you have an external review

21 provision.

22 Prior to 2011, both dental and traditional

23 medical services were both subject to the external

24 review procedures when an adverse determination was

25 made based upon the carrier's requirements for

1 medical necessity. As part of that review it
2 required looking into the carrier--the contract
3 between the carrier and the participant, and it was
4 based upon that review that medical necessity was
5 defined.
6 In 2014 external review is now available
7 again for dental services. Today all participants,
8 whether they're in traditional medical plans or
9 dental services, are entitled to the external review
10 procedures.
11 At this time I'd like to focus on the
12 statute, particularly Section 514J.102(1)(a) and (b).
13 Those are the provisions that define "adverse
14 determination" for--that trigger the external review.
15 514J.102(1)(a) defines external--or an
16 "adverse determination" for all benefits other than
17 dental benefits. And those--external review is
18 triggered when it's either a medical necessity,
19 appropriateness, health care setting, level of care,
20 or effectiveness.
21 Subdivision (b) defines an "adverse
22 determination" for dental services and limits that to
23 medical necessity. It eliminates the terms
24 appropriateness, health care setting, level of care,
25 or effectiveness.

1 On its face the statute appears to make
2 substantial differences between the review processes.
3 However, in practice, I believe it's a distinction
4 without a difference based upon the reading of the
5 policies that are in place today.
6 Under 514J, as I said before, you have to
7 look at the policy to determine whether there's an
8 adverse determination in the definition of medical
9 necessity. Under most policies today, both
10 traditional health care services and dental services,
11 appropriateness, health care setting, level of care,
12 and effectiveness are all subcomponents of the
13 definition of medical necessity.
14 Stated another way, in order to determine
15 whether a procedure is medically necessary, you have
16 to look and determine whether that procedure is
17 appropriate, the health care setting is appropriate,
18 the level of care, and whether that procedure is
19 effective.
20 The addition of these terms to the health
21 care provisions, the traditional health cares, I
22 would view as actually redundant with the term
23 "medical necessity." The problem we face today with
24 the statute is it creates an ambiguity between the
25 review procedures that are allowed for traditional

1 medical services and dental services. It gives the
2 appearance that dental services are not entitled to
3 the same review or the same heightened level of
4 review. It can create misconceptions with the
5 public, and potentially the review panels that are
6 hearing the external review procedures.
7 The principal purpose of 514J is to provide
8 consistency and fairness, and I think this ambiguity
9 in the statute defeats those purposes.
10 In closing, external review for dental
11 services is necessary, it's in the statute today.
12 However, Section 102(1)(a) and(b) have internal
13 inconsistencies and an ambiguity that should be
14 corrected.
15 External review of dental services is needed
16 both for--and should be included for both medical
17 necessity, and should include the additional terms
18 appropriateness, health care setting, level of care,
19 and effectiveness. We ask that you request this
20 clarification in your report to the legislature.
21 Thank you for your time.
22 COMMISSIONER GERHART: Thanks.
23 For the Federation?
24 MR. SUNDSTROM: Scott Sundstrom for the
25 Federation of Iowa Insurers. I do have some written

1 comments, which I will submit. I don't have enough
2 for everyone in the room. I'll hand out what I've
3 got, and we can provide more, if need be.
4 MR. HUNTER: I'm sorry. I also have some
5 written comments. I'll just pass them out.
6 COMMISSIONER GERHART: Pass them out.
7 MR. SUNDSTROM: I will also be very brief.
8 I'll try not to replow the same ground, but--and I'll
9 just summarize the written comments that I've
10 offered. I think we heard some summary of the
11 background of how we got to where we are now, and
12 I'll just expand on that slightly.
13 Iowa has had an external review law since
14 1999, and the original version of Iowa's external
15 review law in 1999 was fairly limited in two
16 respects. One, it excluded dental insurance
17 completely; and, two, it was limited to only external
18 review of denials of claims based on a determination
19 by the carrier that the claim was not medically
20 necessary.
21 In 2008, after intense lobbying by the Iowa
22 Dental Association, Iowa's prior external review law
23 was amended to remove the exclusion for dental
24 insurance. And, therefore, starting in July of 2008,
25 Iowa's external review law allowed external review of

1 claims under dental insurance policies, but only for
2 claims denied based on medical necessity, consistent
3 with the rest of the statute.
4 So that was the status quo for about three
5 years. Then under the Affordable Care Act, States
6 were required to take a look at their external review
7 laws and, if necessary, to update them so that they
8 were--provided consumer protections consistent with
9 at least the consumer protections and the processes
10 in the NAIC Model External Review Law.
11 So Iowa, being a leader in many areas, acted
12 quite promptly, and in 2011 Iowa completely rewrote
13 its external review law. And in doing so,
14 essentially adopted the NAIC Model External Review
15 Law. It's very, very similar.
16 The NAIC Model External Review Law excludes
17 a number of types of limited-scope insurance
18 policies, vision, accident, disability, long-term
19 care, and dental insurance. At the time that Iowa's
20 external review law was rewritten in 2011, there was
21 no opposition stated at the Statehouse, and the bill
22 passed with--relatively uneventfully. It went
23 through with very little drama, a rare and blessed
24 event in the world of insurance legislation. It took
25 effect.

1 And then starting in 2012, and continuing
2 for the next couple of years, there was concern
3 expressed by the Iowa Dental Association that Iowa's
4 external review law now excluded external review for
5 dental insurance. And the Iowa Dental Association
6 then had introduced legislation that did a number of
7 things, but one of the things was to remove the
8 exclusion for dental insurance in Iowa's rewritten
9 external review law. That was kind of a simmering
10 issue for two or three sessions at the Iowa
11 legislative sessions.
12 In an attempt at a compromise, and I know
13 that the Dental Association didn't view it as a
14 compromise, but the legislature did take action near
15 the end of this legislative session, in 2014, and the
16 result was House File 2463, or Division XXI of House
17 File 2463, which the ultimate purpose of that was to
18 restore the status quo for external review of dental
19 insurance as it existed from 2008 until 2011; and
20 that is there is now external review for dental
21 insurance because that exclusion has been removed,
22 but the external review is limited to claims that are
23 denied based on medical necessity. So the intent was
24 to restore, again, the status quo as it had been
25 before.

1 And we at the Federation of Iowa Insurers
2 believe that that's an appropriate compromise, and
3 there are a few reasons that I've outlined in the
4 written comments, and I'll just very briefly touch on
5 them. And the reasons for those turn on differences
6 between dental care and dental insurance, and major
7 medical insurance and medical care, broadly speaking.
8 First of all, the scope of dental insurance
9 policies is far narrower than major medical
10 insurance. Dental insurance policies, like most
11 other limited-scope insurance policies, vision,
12 disability, long-term care, et cetera, provide a much
13 narrower scope of benefits than major medical
14 insurance, which is generally quite broad, especially
15 under the Affordable Care Act reforms is very broad.
16 And dental insurance policies generally have
17 specific lists of procedures that are covered, and
18 sometimes they'll have some lists of things that are
19 not covered, but it's a pretty narrow universe of
20 coverage, and it's set forth in the policy, quite
21 different from major medical insurance.
22 The external review law, both the old one
23 and the current one, state that any coverage that's
24 specifically excluded in a policy cannot be the
25 subject of external review. In other words, external

1 review cannot create coverage. And so when you have
2 a very limited scope of coverage, there are much more
3 limited circumstances when external review is
4 appropriate, and that's the case with all limited-
5 scope products, in particular dental insurance.
6 Secondly, dental care generally is billed
7 and reviewed differently than medical care is.
8 Medical care claims are billed using detailed
9 diagnostic codes. There are literally thousands and
10 thousands of diagnostic codes for medical care. That
11 then provides the payer, the insurance company, a
12 very detailed understanding of what the nature of the
13 care was, not just the procedure, but the diagnosis
14 of the patient and the type of care so that it's very
15 easy for a carrier to understand what the treating
16 physician or provider believes is wrong, and then
17 what care they are billing to treat that problem.
18 Dental is different. Dental codes are much
19 simpler. They're generally just procedure codes, and
20 again a narrower scope of types of claims, and that
21 then provides the insurance carrier with much less
22 detailed information about the nature of the
23 diagnosis. It's just a billing procedure, which
24 works with a limited-scope product. And, again,
25 that's the regime it's in.

1 And, finally, the coverage amounts. The
2 amounts at issue in a typical claim can be much less
3 in dental insurance than major medical insurance.
4 Dental insurance, again, is a limited-scope product.
5 In addition to limited scope of coverage, there's
6 often limited benefits. Most dental insurance
7 products contain a limitation on annual benefits, a
8 fairly small dollar figure amount. Major medical
9 insurance, on the other hand, can have no annual or
10 lifetime limits under the Affordable Care Act.
11 And the typical dental claim is generally
12 much smaller than medical insurance claims. And
13 certainly at the top end of the more complex things,
14 medical insurance claims can be hugely expensive.
15 The size of those claims and the typical amount at
16 issue is relevant because when there is an external
17 review claim, under the external review law, the
18 insurance carrier is responsible for paying for all
19 of the costs of the claim.
20 And the concern is that if there's overly
21 broad review of dental insurance--or dental claims,
22 that the amount of the claim at issue could reach or
23 exceed--or the costs of the external review could
24 reach or exceed the amount of the claim at issue,
25 meaning the carrier spends more on the administrative

1 costs of reviewing the claim than they would on just
2 paying the claim. That seems to be a misallocation
3 of administrative costs, which will just raise the
4 cost of insurance for everyone.
5 And for those reasons we think that having a
6 limited scope of external review, limited to medical
7 necessity for dental care claims, is appropriate.
8 It's an appropriate compromise between no external
9 review, which is what we've had before this session,
10 and full-blown external review that also includes
11 appropriateness, health care setting, et cetera. We
12 think the compromise or the middle ground that the
13 legislature struck in House File 2463 makes sense
14 given the nature of the insurance products in the
15 market, and the nature of the way this care is billed
16 and delivered.
17 Thank you.
18 COMMISSIONER GERHART: Thank you.
19 Are there any other further comments before
20 we-- Well, I think at this point--oh, yeah. That's
21 true. There are two points that we do want to cover.
22 The fiscal impact of expanding, we're going to need
23 to have some level of understanding of what that
24 fiscal impact could be. So I haven't read these
25 comment letters fully, but to the extent that we can

1 have information on what the fiscal impact could be,
2 that would be very helpful. Whenever we bring
3 something before the legislature, we always have to
4 mention that.
5 And then for the Dental Association, one of
6 the questions that I would have are reasons for
7 denials. If you--I don't know if it's in your
8 comment letter here, but maybe a comment letter in
9 the next week that talks about some general reasons
10 that the dentists have for denials.
11 MR. HUNTER: Okay. Get you some examples?
12 COMMISSIONER GERHART: Yeah, some examples.
13 And then from there--
14 MR. CARL: Nick, could I ask a question to
15 clarify? You're talking about providing examples
16 where the carrier has denied a claim, and the view of
17 the dentist and the patient as to how that's
18 inappropriate? Is that--
19 COMMISSIONER GERHART: Yes. That would be
20 helpful. Yes.
21 MR. CARL: Okay. I just want to make sure.
22 Thank you.
23 COMMISSIONER GERHART: And then from there,
24 as I said, we'll close the record next Tuesday after
25 close of business, we'll take all the information,

1 and then we're going to start working on our report,
2 and December 15th is our--hopefully we'll have it
3 done before then, but we have until December 15th to
4 get it done, and our goal is to probably have it done
5 sooner than that.
6 Am I missing anything, Angela?
7 ASSISTANT COMMISSIONER BURKE BOSTON: No.
8 COMMISSIONER GERHART: Okay. Well--go
9 ahead.
10 MS. HECKENLAIBLE: Can I respond to the
11 denials? Would there be an opportunity for us to
12 review those examples so that if, in fact--we could
13 respond in regard to those as well? I mean, if
14 there's a denial and they deem it as inappropriate,
15 where is the justification from our side?
16 COMMISSIONER GERHART: I think that seems
17 reasonable. So why don't we do this--when can you
18 give me that kind of example list, Larry? In a week?
19 MR. CARL: Well, because I've got a number
20 of things going on, can I have until the middle of
21 November?
22 COMMISSIONER GERHART: Okay. Let me think
23 here. So that would put us--okay. Well, can we do
24 it maybe--
25 ASSISTANT COMMISSIONER BURKE BOSTON: What's

1 that first Monday after--
2 COMMISSIONER: After--what would that be?
3 That would be the 10th?
4 ASSISTANT COMMISSIONER BURKE BOSTON: The
5 10th.
6 COMMISSIONER GERHART: Can we do it by the
7 10th?
8 MR. CARL: Yes. I'll do my best.
9 COMMISSIONER GERHART: How about if I give
10 you until the 17th--
11 MS. HECKENLAIBLE: Okay.
12 COMMISSIONER GERHART: --if that's fair. So
13 I guess our record is going to be open until the 17th
14 of November.
15 MR. HUNTER: And those are just examples of
16 denials that could have had--
17 COMMISSIONER GERHART: Yes.
18 MR. HUNTER: --medical review--or external
19 review? Sorry.
20 COMMISSIONER GERHART: Yeah. Then that
21 gives you folks a week.
22 MS. HECKENLAIBLE: Sure, based on this
23 adverse determination of those other components.
24 MR. CARL: More clarification. We're not
25 going to be able to give patient detail. You

1 understand that?

2 COMMISSIONER GERHART: No. I don't want

3 patient--yeah. Yeah. No, I don't--I can't do that.

4 MR. CARL: Not only would the dentist not

5 give it to me--

6 COMMISSIONER GERHART: I don't want it.

7 ASSISTANT COMMISSIONER BURKE BOSTON: Yeah,

8 we don't want it.

9 COMMISSIONER GERHART: So we're going to

10 have the record open a bit longer, but--November

11 17th. That will probably--we'll have to have a quick

12 turn there, Angela--

13 ASSISTANT COMMISSIONER BURKE BOSTON: Right.

14 COMMISSIONER GERHART: --but we'll get it

15 done. So...

16 MS. DIERENFELD: You just thought you were

17 going to have the family over for Thanksgiving.

18 COMMISSIONER GERHART: We'll have a good

19 Thanksgiving Day conversation.

20 ASSISTANT COMMISSIONER BURKE BOSTON: So if

21 others had examples, too--I mean to share with us,

22 where there are denials that you deemed appropriate

23 or not appropriate, what you're seeing, because this

24 is your opportunity to educate us so that we can

25 provide a complete report to the legislature.

1 MR. SUNDSTROM: This is Scott Sundstrom
2 again. I will just say, obviously we'll get more
3 detailed submissions. I know one of the issues that
4 was discussed sometimes by lobbyists at the Capitol
5 during the discussions about this issue was that
6 sometimes there are denials when a dentist requests
7 anesthesia for a procedure, you know. The
8 circumstances might be the patient has some
9 particular sensitivity or underlying condition, or
10 something. And I think the response we would have
11 is, as far as I'm aware, virtually all dental
12 insurance policies exclude coverage for anesthesia,
13 exclude it. So it wouldn't be subject to external
14 review under any version because another section of
15 the statute specifically states that if a coverage is
16 excluded, it's not eligible for external review
17 because, again, external review does not create
18 coverage.
19 So I know that's one example that was talked
20 about. There may be other situations. We can,
21 obviously, take a look at that.
22 COMMISSIONER GERHART: Okay.
23 ASSISTANT COMMISSIONER BURKE BOSTON: But in
24 the real world, that situation--so the anesthesia was
25 run through the medical coverage?

1 MR. SUNDSTROM: It potentially could.
2 ASSISTANT COMMISSIONER BURKE BOSTON: Or not
3 be covered at all?
4 MR. SUNDSTROM: Right.
5 ASSISTANT COMMISSIONER BURKE BOSTON: Okay.
6 MS. VAN GUNDY: Well, I'll just give an
7 example where speech therapy for a child wasn't
8 covered, because their teeth weren't formed correctly
9 and they have poor speech. Well, speech therapy
10 would never be covered under a dental policy. That's
11 just an example.
12 COMMISSIONER GERHART: I think now we can
13 close this meeting, not close the record, but close
14 this meeting. And, again, send us any comments you
15 have, but by the 10th we hope to get that, and then
16 have a week for you folks to respond.
17 All right. Thanks, everybody.
18 (Proceedings concluded at 10:28 a.m.)
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25

1 CERTIFICATE

2 I, the undersigned, a Certified Shorthand
3 Reporter of the State of Iowa, do hereby certify that
4 I acted as the official court reporter at the hearing
5 in the above-entitled matter at the time and place
6 indicated;

7 That I took in shorthand all of the
8 proceedings had at the said time and place and that
9 said shorthand notes were reduced to typewriting
10 under my direction and supervision, and that the
11 foregoing typewritten pages are a full and complete
12 transcript of the shorthand notes so taken.

13 Dated at Des Moines, Iowa, this 30th day of
14 October, 2014.

15

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18 CERTIFIED SHORTHAND REPORTER

19

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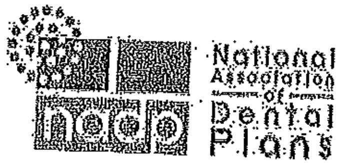

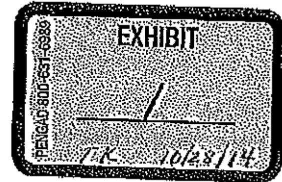

October 27, 2014

The Honorable Nick Gerhart
Iowa Insurance Division
601 Locust St., 4th Floor
Des Moines IA 50309-3738

Re: Dental External Appeals

Dear Commissioner Gerhart;

The National Association of Dental Plans (NADP) is providing comments to the Iowa Insurance Division (IID) in relation to the external review meeting being held on October 28, 2014.

This spring, the Iowa Legislature passed and the Governor signed IA HF 2463 / Chapter 1140, which focuses on health appropriations. The bill also includes a small section on dental external review. Division XXI, Sec 112 of the bill requires the insurance commissioner to engage stakeholders and review the differences in the bases used for external review of adverse determinations under chapter 514J as applied to health care services relative to dental care services. While on the surface this would seem an appropriate requirement to place on dental plans, the costs associated with additional adverse determinations beyond medical necessity will increase premiums without correlated consumer benefits.

The National Association of Insurance Commissioners did not apply their Health Carrier External Review Model Act to dental insurance; specifically, Section 4(C) of the Model Act exempts most supplemental insurance products, including dental insurance, from the mandated external review process. This exclusion recognizes that dental coverage is a supplemental policy with a limited scope of benefits and services and an average claim cost of $150 - a small fraction of medical claims that typically trigger external reviews. The differences between medical and supplemental products like dental resulted in the ACA's exemption of supplemental products from its market reforms, including external review.

In short, supporting arguments for the exclusion of dental plans from external review include:

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Alexandria, VA

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National Association of Dental Plans
Dallas, TX

National Association of Dental Plans
12700 Park Central Drive • Suite 400 • Dallas, Texas 75251
972.458.6998 • 972.458.2258 (fax)

- Dental plans already have appeal procedures in place based on ERISA or state specific regulations. These procedures utilize different dental professionals and are approved by the IID as part of a dental plan's coverage materials. The IID has the authority to review, audit and modify the existing appeals procedures and processes submitted for their approval.

- The costs for external review can reach $1000 to $2000. About 50% of the dental benefit plans that are in place today have annual maximums in the $1000 to $1500 range; over 95% are less than $2,500. Dental benefit companies offer higher maximums to purchasers, but because 93% of Americans with dental benefits never exceed their annual limit, it is not cost effective for employers to select plans with higher maximums. The costs for external review would exceed the typical annual maximum of most dental benefit plans, and even the total annual premium charged for many dental programs. Such costs are out of proportion with the value of the actual benefit being contested and the average premiums collected, which range from $13.73 to $29.07 monthly.
  - The median claim value submitted by a dentist to a carrier is $147.80. When compared to the charge of an external review, the cost analysis is unjustified for dental policies.

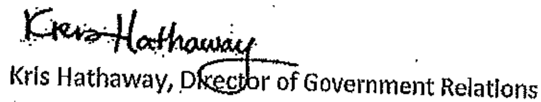
- Diagnostic codes are used to assist in medical external review, but currently are not utilized within the dental profession. While there a few specific dental diagnostic codes within ICD-9 and ICD-10 related to medical conditions, the dental diagnostic codes, also known as SNODENT, are not widely utilized by dentists or carriers at this time.
  - Dental decisions on payment are related to contractual provisions. In some limited instances there may be a determination based on dental necessity but medical necessity was only recently introduced for orthodontia for children, and in those instances, plans have included definitions of what constitutes medical necessity under their policies.

When such extreme costs are imposed upon dental plans, ultimately consumers will pay though increased premiums. As dental benefits are an ancillary benefit and a discretionary purchase by the employer and by the consumer, access to benefits and care may be thus reduced.

➢ **Recommendation**: Dental is different from medical in both design and operations, and as such external review is a costly, inefficient and unnecessary approach for resolving adverse dental claim decisions. Our recommendation to the Iowa Insurance Division is not to include any further external review processes for the adverse determination of dental claims beyond medical necessity, as already approved by the Iowa legislature.

Thank you for your review and consideration of NADP's comments. If you have questions on these comments or would like additional background information, please contact me at khathaway@nadp.org or (972)458-6998x111. Again, thank you for your consideration.

Sincerely,



Kris Hathaway, Director of Government Relations

National Association of Dental Plans

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NADP Description

NADP is the largest non-profit trade association focused exclusively on the dental benefits industry, i.e. dental PPOs, dental HMOs, discount dental plans and dental indemnity products. NADP's members provide dental benefits to approximately 90 percent of the 187 million Americans with dental benefits. Our members include the entire spectrum of dental carriers; companies that provide both medical and dental coverage, companies that provide only dental coverage, major national carriers, regional, and single state companies, as well as companies organized as non-profit plans.

National Association of Dental Plans

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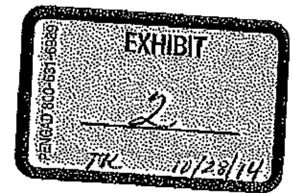


STATEMENT OF THE IOWA DENTAL ASSOCIATION

PREPARED FOR THE IOWA COMMISSIONER OF INSURANCE

OCTOBER 28, 2014

The intent of the Iowa legislature in enacting Iowa Code chapter 514J is clearly stated in section 101 of that chapter. In enacting that statute the legislature intended "to provide uniform standards for the establishment and maintenance of external review procedures to assure that ***covered persons*** have the opportunity for an independent review of an adverse determination . . . made by a health carrier." *Iowa Code* § 514J.101 (emphasis supplied).

By definition, the "covered persons" for whom the legislature intended to provide uniform standards include Iowa policyholders, subscribers, enrollees or other participants in health benefit plans that include dental care services. See *Iowa Code* §§ 514J.102(19), (22), & (23). Thus, it was the stated intent of the Iowa legislature that Iowa participants in health benefit plans should have the benefit of external review standards that are uniform whether they have plans that include dental care services or health benefit plans that include other health care services. In other words, Iowans with health benefit plans that include dental care services and Iowans with health benefit plans that include other health care services should receive equal treatment under the law. That was the stated intent of the legislature and that is a matter of fundamental fairness for Iowans.

Under Iowa Code chapter 514J, only those persons who receive "adverse determinations" as defined by the statute are entitled to external review of a determination by a health carrier denying, reducing, or terminating payment for a health care service. Thus, the definition of an

"adverse determination" is the key to determining which Iowans will receive external review when their health benefits are denied or reduced and what standards will be employed by the external reviewer if and when the external review takes place.

It is, thus, perplexing that the legislature appears at first glance to have chosen to define "adverse determination" differently for purposes of the denial of a dental care service, than it did for purposes of denials of other health care services. This variance in the definition of "adverse determination" potentially defeats the legislative intent to provide uniform standards for external review procedures. At the very least it creates an ambiguity in the statute which may lead external reviewers to apply different standards when denials of dental care services are involved than they do in the external review of the denials of other health care services.

On the one hand, *Iowa Code* § 514J.102(1)(a) defines an adverse determination involving a denial of health care services other than dental care services as one that is based on the carrier's determination that a covered benefit does not meet the carrier's requirements for "medical necessity, appropriateness, health care setting, level of care or effectiveness." But on the other, *Iowa Code* § 514J.102(1)(b) defines an adverse determination involving a denial of dental care services as one that is based on the carrier's determination that a covered benefit does not meet the carrier's requirements for "medical necessity" alone, omitting the terms appropriateness, health care setting, level of care or effectiveness. Those additional terms appear facially to provide additional bases for external review of denials of health care benefits that are not available when a denial of dental care services is involved.

On a closer review of the statute, however, it is clear that no fundamental difference is involved. First, chapter 514J does not provide a definition of "medical necessity." Rather, it

leaves that definition to be provided by the health carrier in the underlying contract. The meaning of "medical necessity" under chapter 514J is the same for purposes of the definition of an "adverse determination," whether the denial of a dental care service or the denial of another health care service is involved. The statute requires one to look in both cases at the health carrier's definition of medical necessity, which is determinative. Thus, under *Iowa Code* § 514J.102(1)(a), "adverse determination" means that the health carrier has denied that some health care service, other than a dental care service, on the basis that it "does not meet **the health carrier's requirements for medical necessity**." *Iowa Code* § 514J.102(1)(a) (emphasis supplied). Likewise, for purposes of determining whether there has been an adverse determination of dental care service, "adverse determination" means that a health carrier has denied a dental care service on the grounds that it "does not meet **the health carrier's requirements for medical necessity**. *Iowa Code* § 514J.102(1)(b) (emphasis supplied). By adding the additional terms "appropriateness, health care setting, level of care or effectiveness," subsection 102(1)(a) adds no additional substantive criteria for the definition of adverse determination that are not already present in the term "medical necessity," but rather simply spells out the traditional elements of medical necessity itself.

In standard policy forms for health benefit plans providing for reimbursement of the costs of health care services other than dental care services, appropriateness, health care setting, level of care, and effectiveness are elements of the definition of medical necessity. Thus when it adds those terms, *Iowa Code* § 514J.102(1)(a) is not in fact enumerating additional bases for adverse determination apart from medical necessity, but is simply setting out discrete elements of medical necessity.

Nevertheless, this approach leads to two fundamental problems. First, it is confusing and potentially suggests to an external reviewer that different standards should be applied for purposes of the review of dental care services on one hand and other health care services on the other. This ambiguity threatens the legislative goal of providing uniform standards for external review for all covered persons under the Act. Second, by looking to the health carriers for the definition of medical necessity, the statute as currently written permits differential standards, not only between carriers, but also with the same carrier over time. Because the definition of medical necessity set forth in the policies of health carriers may change over time, the meaning of that term for purposes of Iowa Code chapter 514J is inherently unclear and ambiguous.

Thus, the current definition of "adverse determination" set forth in Iowa Code section 514J.102(1) introduces an element of ambiguity into the external review process. This ambiguity threatens the uniformity of standards for the establishment and maintenance of external review procedures in external review that the legislature intended to provide. It creates the very real potential that holders of health benefit plans providing dental care services will be treated differently in external review proceedings than holders of health benefit plans providing other health care services.

This is not only contrary to the intent of the legislature in the enactment of the statute, but denies fundamental fairness to those Iowans with coverage under health benefit plans providing dental care services. This is harmful to those Iowans with health benefit plans that provide dental care services. The need for external review among Iowa dental patients can best be illustrated through several real-life patient examples. To protect the patients' identities, we refer to these patients as Jane, John, and Jill.

Jane visited an Iowa dentist with severe pain in one of her molars. The dentist completed an examination and determined that Jane's molar was splitting in half. The standard of care for this condition among the dental profession is to place a crown on the tooth as soon as possible. Jane's dentist informed her that without a crown, her tooth will continue to split each time she chews. If the split continues untreated and reaches the root, the tooth will not survive. Jane initially declined treatment because her dental insurance carrier had previously refused to cover crowns, even though her dental insurance policy explicitly provided coverage for crowns. Once the pain became unbearable, however, Jane returned to her dentist and obtained a crown. The dentist submitted the claim to Jane's dental insurance carrier, but the carrier denied coverage on the grounds that a crown was not "medically necessary." Jane had no opportunity to have this denial reviewed by a third party, and as a result, Jane had to pay the full $1,000 cost of the crown out of her own pocket even though crowns were a covered service under her dental insurance plan. Unfortunately for Jane, about ten months after receiving the crown, she had to have the tooth extracted when an abscess developed. The dentist informed Jane that the delay in treatment likely caused the abscess to form. If Jane had been able to obtain an external review of the denial, the crown would have likely been covered and she would have received the necessary treatment in a timely manner. In fact, if external review had been an option for dental patients in this situation, the carrier likely would not have denied coverage in the first place.

Like Jane, John visited his dentist with severe pain in one of his molars. John's dentist completed an examination and determined that John needed a crown. John's dentist informed him that his molar was nearly covered with filling material, and that a new cavity was eating away the small amount of tooth that remained. There was simply not enough tooth left to hold a

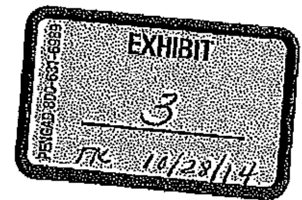
new and bigger filling, so a crown was the only option. Over the years, John's dentist had experienced numerous problems with John's dental insurance carrier denying coverage for necessary crowns, so she had enacted a policy requiring preauthorization before treatment. Although John was in severe pain, he agreed to wait for treatment to allow his dentist and her staff to obtain the preauthorization from the dental insurance carrier. Although crowns were a covered service under John's dental insurance plan, his dental insurance carrier denied coverage. Despite the financial burden it would place on John and his family as a single parent, John elected to move forward with treatment. John had to set up a payment plan with the dentist to allow him to pay for the treatment over time. John's dentist informed him that any licensed dentist would have concluded that a crown was necessary for a patient with John's condition. Unfortunately, John had no opportunity for external review of the denial, so he had no option but to pay for the treatment himself. Once again, if external review had been an option for John, the dental insurance carrier likely would have never denied coverage in the first place.

Jill visited her dentist for the placement of two crowns in 2011. At her recall appointment, one of the crowns was painful and one was moving. The dentist had to send Jane to an endodontist for treatment of the painful crown. The dentist removed the moving (mobile) crown and discovered the molar was fractured. The dentist did crown lengthening and placed a post and core to preserve the tooth. Following treatment by the endodontist, the patient returned to the first dentist. Ultimately, the dentist determined that the best course of treatment would be to replace both of the crowns and seat them as a single unit to provide strength and cemented them together. The dentist then filed a claim with Jill's insurance company for the placement of the second two crowns. The claim was denied because the insurance company determined that

the new crowns had been placed too close in time to the first ones. The medical necessity of Jill's second set of crowns was completely ignored.

These examples highlight the reason external review is critical for Iowans with health care plans that provide dental care benefits. The Association is pleased that the legislature restored external review for dental patients, but remains concerned that ambiguity in the statute could frustrate this critical protection. The Association respectfully requests that the Commissioner inform the legislature about this issue and support steps to ensure uniform and fair treatment for Iowans with health benefit plans that provide dental care services.

700 Walnut Street, Suite 1600
Des Moines, Iowa 50309



October 28, 2014

Angela Burke Boston
Assistant Commissioner
Iowa Insurance Division
601 Locust St., 4th Floor
Des Moines, IA 50309-3738

RE: Meeting on Dental External Review and House File 2463

Dear Angela:

The Federation of Iowa Insurers submits the following comments concerning the amendments to Iowa Code chapter 514J made in Division XXI of 2014 Iowa Acts, House File 2463 relating to external review of dental care coverage decisions.

I. Background

To place the new statutory changes to Iowa Code chapter 514J in perspective, it bears briefly reviewing the history of Iowa's external review law and its treatment of dental insurance.

Iowa's external review law, contained in Iowa Code chapter 514J, was originally enacted in 1999. *See* 1999 Iowa Acts, ch. 41, §§ 7-20. That prior law was limited in two ways: first, it completely excluded external review for dental insurance, *see* Iowa Code § 514J.3 (2007); and second, it only authorized external review of denials of coverage based on medical necessity, *see* Iowa Code § 514J.2(2) (2007). After lobbying from the Iowa Dental Association, the prior law was amended in 2008 to remove the exclusion for dental insurance, thus making dental insurance subject to the law. *See* 2008 Iowa Acts, ch. 1030, § 1. Consequently, beginning in July 2008, external review was available for dental insurance claims, but only to the extent a dental insurance claim was denied based on medical necessity.

In 2011, Iowa's external review law was completely rewritten as required by the Affordable Care Act. *See* 2011 Iowa Acts, ch. 101. Section 2719 of the Affordable Care Act requires that states adopt an external review law that "at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners." Iowa's rewritten law is essentially the NAIC model and thus complies with the Affordable Care Act's external review requirements. The current, rewritten law allows external review of a much broader class of claim denials in addition to medical necessity. *See* Iowa Code § 514J.102 (2014) (defining an "adverse determination" that is subject to external review to include "medical necessity, appropriateness, health care setting, level of care, or effectiveness").

Notably, the NAIC model completely excludes a number of limited scope insurance products, including dental insurance, from external review. Consistent with the NAIC model, Iowa's rewritten law also excluded these limited scope insurance products when it was adopted in 2011.

The Iowa Dental Association was unhappy that Iowa's rewritten external review law excluded dental insurance, and advocated for legislation to remove the exclusion. *See, e.g.*, Senate File 286, §§ 4-5 (introduced Feb. 28, 2013). After extensive discussions, the legislature reached a compromise embodied in Division XXI of House File 2463. The compromise simply restores the pre-2011 status quo for external review of dental insurance; i.e., dental claims are subject to external review, but only when a claim is denied based on medical necessity. As a result of this compromise, Iowa's external review law is now broader than the NAIC model.

II. The Compromise Legislation Is Appropriate

The Federation of Iowa Insurers supports the compromise in Division XXI of House File 2463. There are a number of reasons why it is entirely appropriate to limit external review of denied dental insurance claims only to those denials based on medical necessity:

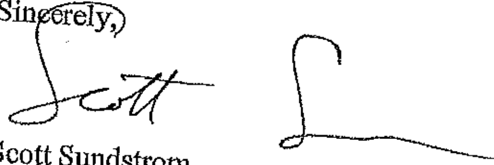
- **The scope of dental insurance is far narrower than major medical insurance.** Like the other excluded limited scope insurance products (e.g., vision, disability, long-term care), the coverage of a dental insurance policy is much narrower than major medical insurance. Dental insurance policies specifically list covered procedures and specifically exclude other procedures. The external review law specifically states that it does not apply to services or treatments excluded from coverage under a policy. Iowa Code § 514J.102(1). In other words, external review cannot create coverage that is not present in the policy.

- **Dental care is billed and reviewed differently than medical care.** Medical care claims are billed by using detailed diagnostic codes. These codes – of which there are literally many thousands – provide insurance carriers with a detailed understanding of the nature of the medical care being provided and allow for detailed review of the providers' bills. Dental care, by contrast, is not reviewed and reimbursed using clinical diagnostic codes and instead is billed using a simple code based only on the procedure. This difference in the coding systems makes external review of dental claims inappropriate.

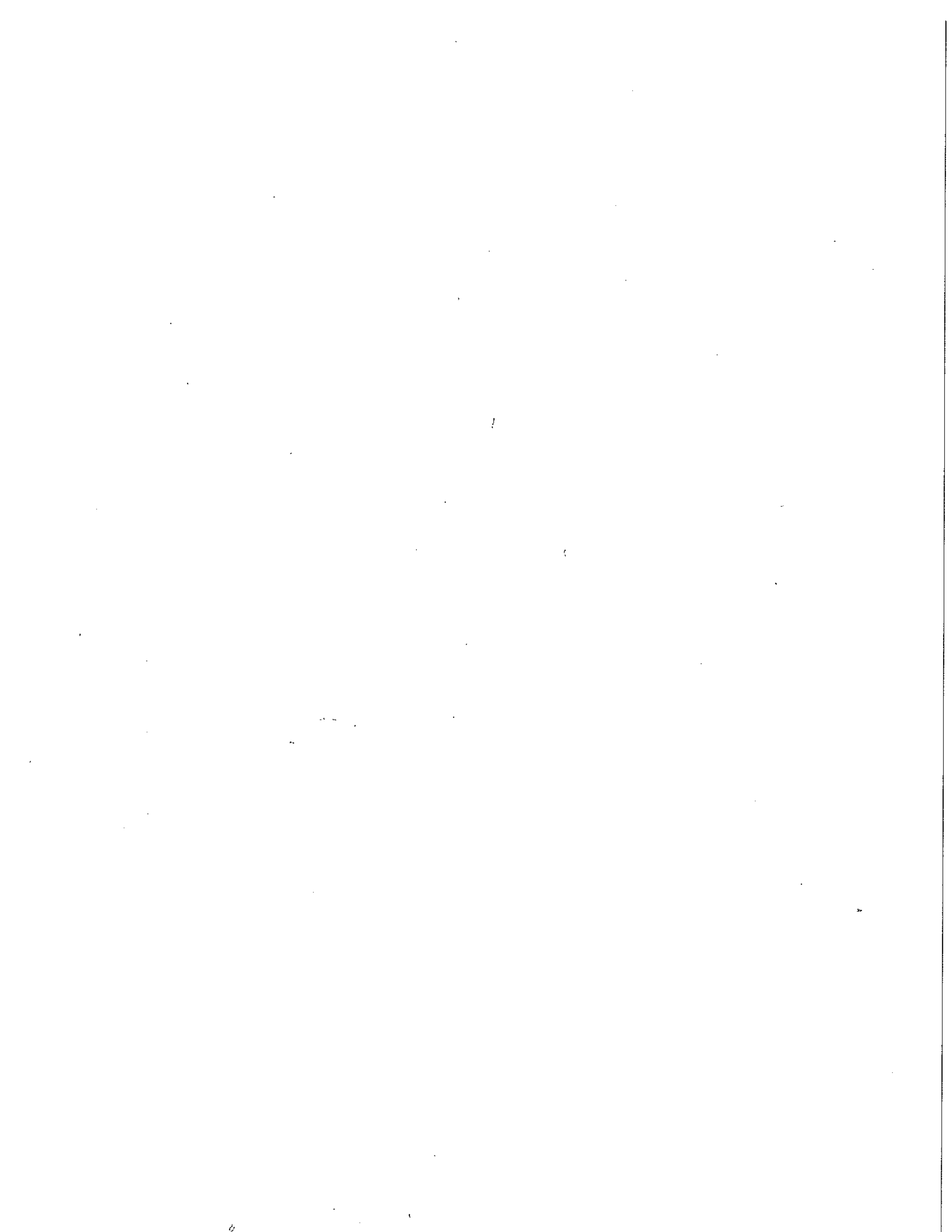
- **The coverage amounts for dental insurance are far lower than major medical insurance.** Because dental insurance is a limited scope product, dental insurance plans generally contain maximum annual coverage amounts that are relatively small. This makes sense given that most dental procedures involve relatively small dollar amounts (at least in comparison to medical procedures). Under the Affordable Care Act, major medical insurance is prohibited from containing annual or lifetime dollar coverage limits. The costs of external review can be considerable – and every cent is paid for by the insurance carrier. Iowa Code § 514J.115. For the small dollar amounts at issue in dental insurance claims, the costs of external review can potentially exceed the amount at issue.

Thank you for your consideration and the opportunity to comment. Please contact Paula Dierenfeld or me if you have any questions or would like to discuss these comments further.

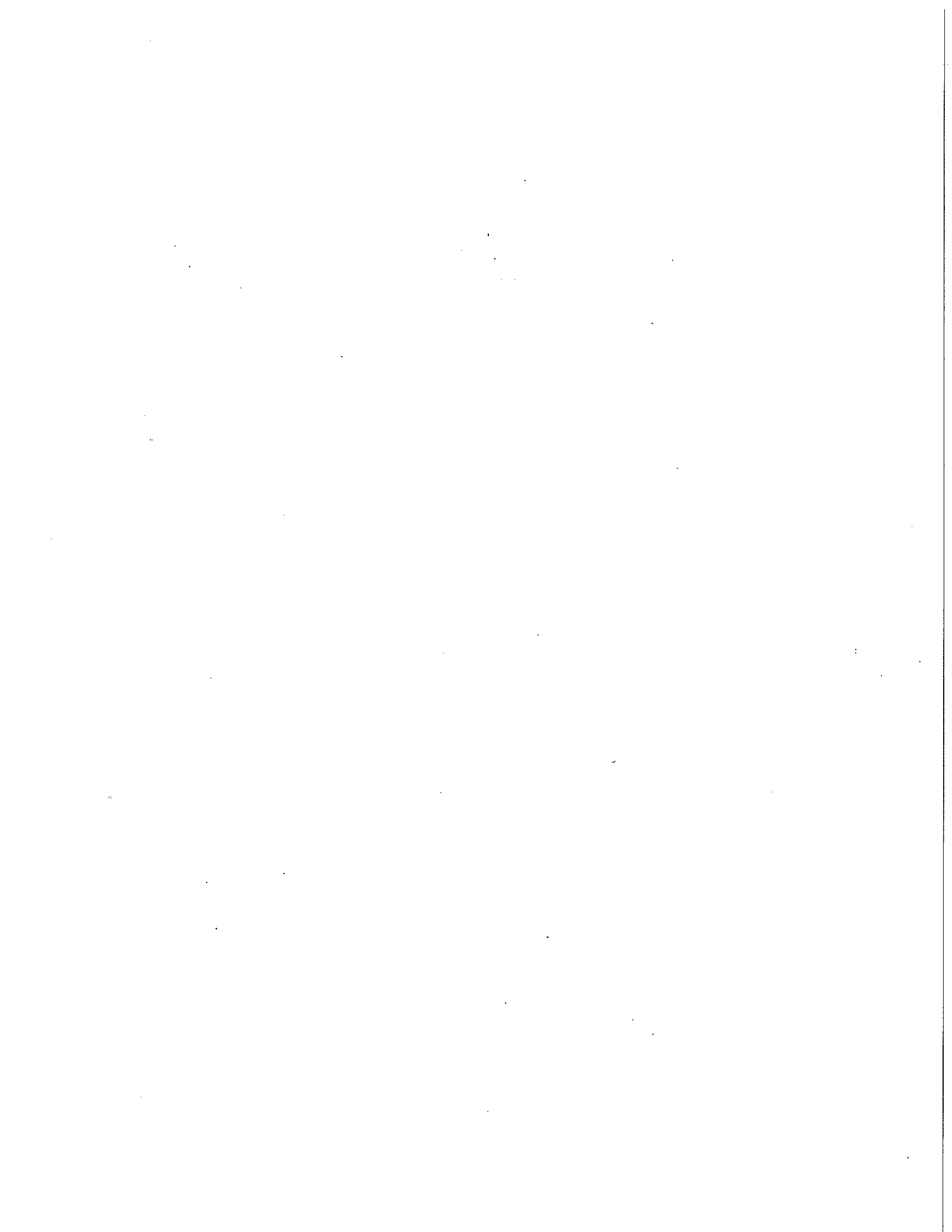
Sincerely,



Scott Sundstrom
Legislative Counsel
Federation of Iowa Insurers



APPENDIX C



SUPPLEMENTAL STATEMENT OF THE IOWA DENTAL ASSOCIATION

SUBMITTED TO THE IOWA COMMISSIONER OF INSURANCE

NOVEMBER 10, 2014

This is a supplement to the information provided to the Commissioner by the Iowa Dental Association on October 28, 2014. We want to thank the Commissioner for the time and attention that he has provided to these issues and consideration of these additional comments.

In response to the request at the hearing, attached in Schedule A are some examples of denials of claims where external review under *Iowa Code* chapter 514J (hereinafter "External Review") could have been beneficial to the participant. The purpose of including these examples is to show the potential benefit of External Review if it could have been sought by the participant. It is not intended to show or imply that the external review process would have changed the determination made by the insurer. Those decisions and arguments are beyond the scope of the matters to be addressed by the Commissioner or these comments.

SUMMARY

The Federation of Iowa Insurers, the National Association of Dental Plans, and representatives of health carriers that provide dental care service (the "health carriers") who were present at the hearing held on October 28, 2014 pursuant to Section 112 of House File 2463, presented various arguments both in writing and in person. The arguments advanced by the health carriers are based on one fundamental premise which is fundamentally fallacious, namely that *Iowa Code* chapter 514J treats health benefit plans that provide dental care services as "limited scope insurance products" that are distinguishable from health benefit plans that provide

other health care services. No support can be found in the statute for this premise. In fact it is utterly without support aside from the unsworn testimony of one of the representatives of the health carriers, whose statements, sworn or unsworn, cannot form the basis for an interpretation of the statute.

In order to mask the fact that their arguments are without support in the statute, the health carriers advance various red herrings. Among these are: (i) the unfounded contention that the Iowa Dental Association seeks to expand external review to create coverage that is not included under the policy; (ii) that dental care is billed and reviewed differently than other health care services and this "coding" makes external review inappropriate; (iii) that small amounts are involved in dental insurance claims that do not justify the costs of external review; (iv) that dental plans already have appeal procedures in place based on ERISA or state specific regulations; and (v) that external review should be denied altogether because "dental necessity" is different from "medical necessity."

DISCUSSION

In both their written and oral comments the health carriers argue that *Iowa Code* chapter 514J provides more limited review to adverse determinations involving covered dental care services because insurance for dental care services is "a limited scope product." But the term "limited scope product" does not appear in the external review provisions of *Iowa Code* chapter 514J and the statute certainly does not use it to describe insurance for dental care services. Quite the contrary. The statute clearly provides that all "covered persons" should have the opportunity for an external review when a covered benefit is denied. *Iowa Code* § 514J.101. A covered person is any individual participating in a health benefit plan. *Iowa Code* § 514J.102(11). A

"health benefit plan" is a policy issued to provide health care services, *Iowa Code* § 514J.102(19), and health care services expressly includes "dental care services" as well as services for the diagnosis, prevention, treatment, cure, or relief of any health condition, illness, injury or disease. *Iowa Code* § 514J.102(22). The statute, thus, accords the status of a covered person entitled to external review equally to those Iowans with health benefit plans providing dental care services and other health care services.

Based upon the testimony of a representative of one of the health carriers the statute cannot be construed to change the plain meaning of the statute. To urge the Commissioner to do so flies in the face of established Iowa law. The goal of statutory construction is to determine the intent of the legislature. *State v. McCoy*, 618 N.W.2d 324, 325 (Iowa 2000). Legislative intent is determined from the words chosen by the legislature, not by what it should or might have said. *Painters & Allied Trades Local Union v. City of Des Moines*, 451 N.W.2d 825, 826 (Iowa 1990). Under the guise of construction, an interpreting body may not extend, enlarge, or otherwise change the plain meaning of the statute. *Auen v. Alcoholic Beverages Div., Iowa Department of Commerce*, 679 N.W.2d 586, 590 (Iowa 2004); *State v. Wedelstedt*, 213 N.W.2d 652, 656 (Iowa 1973).

In order to mask the fact that the statute in question refutes their position, the health carriers advance a series of irrelevant arguments which are red herrings that can only be intended to lead the inquiry off the track. First, the contention that the Iowa Dental Association seeks to expand external review to create coverage that is not included under the policy is false and unfounded. There is no dispute that external review is only available when a health carrier denies a claim when a "covered benefit" is involved. The Iowa Dental Association asserts only that when covered benefits that arise under a health benefit plan that provides dental care

services are denied, reduced or terminated, the "covered person" should be provided the opportunity for an independent review of the determination of the health carrier to deny the covered benefit.

Second, it is ludicrous to contend that because dental care services are coded, billed and reviewed differently than other health care services, the difference in the coding systems makes external review of dental claims inappropriate. When a citizen of the State of Iowa purchases a health benefit plan that includes dental care services, that Iowan does not buy a coding system. She pays her money for specified benefits. An example of how those benefits are spelled out is set forth at pages 14 - 17 in a Delta Dental PPO Plus Premier Individual Preferred Choice Plan Member Policy (Form Number: INDPC – 062013), attached hereto as Schedule B. A single glance shows that no codes are used to describe the covered benefits, which codes have no meaning to the insured. The procedures through which claims are coded, submitted and processed are established by the health insurance carriers for their own purposes. The right of a covered person to external review for the health carrier's denial of a covered benefit cannot be made contingent upon the health carrier's internal procedures without doing violence to basic concepts of fundamental fairness.

Next, the health carriers argue that because small amounts are involved in dental insurance claims, when the health carriers deny covered benefits, Iowans who are covered persons under the statute should be denied external review because the amounts involved do not justify the costs of external review. But, this is exactly the situation where Iowa consumers need protection and is one of the principal purposes for all consumer protection laws. One of the fundamental reasons consumer protection laws are necessary is to create a level playing field. Consumers have very limited rights to negotiate the provisions of any insurance policy.

Moreover, the history of external review of denials of dental services in Iowa indicates that the costs to the health carriers are not onerous. Iowa law has provided for external review of denials of covered benefits in the past. All indications are that no more than a handful of external review proceedings were conducted during the time when such procedures are available (2008 through 2011). Even assuming a cost of external review of $1,000 to $2,000 per case, as argued by the health carriers, given the small number of cases involved, external review hardly constitutes a financial hardship to the health insurance industry.

Moreover, effective external review procedures also provide a corollary benefit to the health carriers, potentially avoiding the potential for litigation. When benefits covered under these contracts of adhesion are denied by the carrier, the statute provides the insured with a mechanism for a review of the carrier's decision that avoids the necessity of litigation for both the insured and the carrier. An article recently published in the Iowa Law Review opines that the external review provisions of *Iowa Code* chapter 514J do not replace a covered person's common-law rights against an insurer. Thus to the extent the statute denies covered persons an effective tool for an external review of an insurer's denial of coverage, that "may motivate a covered person to pursue traditional litigation in some circumstances." Wade S. Hauser, *Does Iowa's Health Care External Review Process Replace Common-Law Rights?* 99 Iowa L.Rev. 1401 (March, 2014). Thus, although the external review process may involve some cost, that cost is not as great as the cost of litigation when external review is effectively denied when insurance carriers reduce, terminate or deny covered dental services.

The health carriers also argue that dental plans already have appeal procedures in place based on ERISA or state specific regulations. But appeal procedures relating to ERISA or

Medicare, Medicaid, federal employees health benefits, or military benefits are not available to "covered persons" under *Iowa Code* chapter 514J.

Finally, the National Association of Dental Plans argues that external review should be denied altogether because "dental necessity" is different from "medical necessity." Certainly the health carriers must acknowledge that the health benefit plans offered to participants in Iowa relate to Dental Services which are health care services under health benefit plans. Therefore the use of the term "Dental Necessity" within the policies themselves instead of "Medical Necessity" should not allow health carriers to avoid the external review procedures. To allow this would eviscerate the protections provided under the statute and thereby render the statute meaningless.

II. Analysis of existing Dental Insurance Policies in Iowa

Because *Iowa Code* chapter 514J does not provide a definition of "medical necessity" and leaves that definition to be defined in the policy of the health carrier, it is necessary to review briefly the provisions of certain dental policies in use in Iowa.

Principal Financial Groups (PFG).

A standard policy issued by PFG provides for a schedule of benefits and procedures that will be covered as part of the benefits available to the participant. Similar to most policies, the coverage issues center on the definitions. PFG's dental policy uses the following terms to describe the process to determine whether a covered benefit that appears in the "schedule of dental procedures" will be approved for payment:

> Covered Charges mean charges for the types of treatment or service listed in the SCHEDULE OF DENTAL PROCEDURES section to the extent the charges do not exceed prevailing charges. The treatment or service must be required for the treatment of

a sickness, injury, or certain routine care and must be considered by the claims administrator to be *necessary dental care*.

Therefore under the plan, in order for a participant to obtain the benefit under "Schedule of Dental Procedures" it must meet the administrator's definition of "necessary dental care". Necessary dental care is defined as:

> Necessary Dental Care means any treatment, service or materials prescribed by a dentist and considered by the plan administrator or its delegate to be:
>
> - Necessary and appropriate; and
> - Not experimental or investigational measures and not in conflict with accepted dental standards

Therefore, under the terms of the policy and under existing law, the participant would be entitled to external review that the procedure or treatment is "necessary and appropriate". We could find no further definition of "necessary and appropriate" contained in the policy. We would assert that in order to determine whether a procedure is "necessary and appropriate" you would be required to consider the other factors set forth in *Iowa Code* § 514J.102(1)(a) (i.e. "the health care setting, level of care and its effectiveness").

The Blue Dental Policy

The approved Blue Dental group policy provides that covered benefits will be paid under the policy if they are Dentally Necessary. The following sections from the Blue Dental Coverage Manual describe how Dentally Necessary is defined and applied.

> CONDITIONS OF COVERAGE
>
> Dentally Necessary and Appropriate. A Key general condition in order for you to receive benefits for any dental service is that it must be dentally necessary and dentally appropriate. Even a service listed as otherwise covered in *Details – Covered and Not Covered* may be excluded if it is not dentally necessary and appropriate in the circumstances. Unless otherwise required by law, Wellmark determines whether a service

is dentally necessary and appropriate, and that decision is final and conclusive. Even though a dentist may recommend a dental procedure or supply, it may not be dentally necessary and appropriate.

Dentally necessary means the service meets both of the following standards:

- The diagnosis is proper.

- The service is dentally appropriate for the symptoms, diagnosis, and direct treatment necessary to preserve or restore the form and function of the tooth or teeth and the health of the gums, bone, and other tissues supporting the teeth.

Dentally appropriate means the service meets all of the following standards:

- The treatment is consistent with and meets professionally recognized standards of dental care and complies with criteria adopted by Wellmark in terms of type, frequency, setting, timing, duration, and is considered effective for your symptoms and diagnosis.

- The treatment is not provided primarily for your convenience or the convenience of your dentist.

Based upon the express terms of the Blue Dental Group Policy, the consideration of Medical Necessity requires a consideration of each other factors set forth in *Iowa Code* § 514J.102(1)(a) (i.e. appropriateness, health care setting, level of care and its effectiveness) as these terms (or synonyms of these terms) are used in the policy to define whether a covered benefit is "dentally necessary".

Delta Dental

Delta Dental standard policies also provide that Covered Services are only available when the procedure is dentally necessary and appropriate. In its determination of Covered Services Delta Dental's policy states:

Is the Procedure Dentally Necessary?

All of the following must be true for a procedure to be considered dentally necessary:

- The diagnosis is proper; and

- The treatment is necessary to preserve or restore the basic form and function of the tooth or teeth and the health of the gums, bone, and other tissues supporting the teeth.

Is the Procedure Dentally Appropriate?

All of the following must be true for a procedure to be considered dentally appropriate:

- The treatment is the most appropriate procedure for your individual circumstances; and
- The treatment is consistent with and meets professionally recognized standards of dental care and complies with criteria adopted by us; and
- The treatment is not more costly than alternative procedures that would be equally effective for the treatment or maintenance of your teeth and their supporting structures. **If you receive services which are more costly than those equally effective for the treatment or maintenance of your teeth and supporting structures, you are responsible for paying the difference.**

Thus, Delta Dental's coverage provisions appear to attempt to distinguish between Dentally Necessary and Dentally Appropriate by separating the two definitions. Therefore, while participants under the Principal policy would be entitled to External Review for decisions regarding the "appropriateness" of the dental service, participants under the Delta Dental policy would not. There is no logical rationale to make this distinction between coverages. Furthermore, if this distinction is upheld by the agency or the external review panels, health insurers will be able to deny Iowa participants their right to external review merely by limiting the definition of Dental Necessity.

Schedule A
to the
Supplemental Response
by the
Iowa Dental Association

The ambiguity of the definition of the critical term "adverse determination" as the threshold requirement for an Iowa holder of health care services including dental care services to obtain external review of a health carrier's denial, reduction, or termination of a covered benefit can be illustrated through several examples drawn from Explanations of Benefits received from health carriers. To protect the patients' identities, we refer to these patients as Jane, John, and Jill.

Example 1

John took his son, Junior, to the dentist for dental care services. Junior was three years old and had fallen while playing in the backyard. Junior lost one of his front primary teeth in the fall. After evaluating Junior's condition, Junior's dentist determined that an implant was required to maintain adequate spacing for Junior's permanent teeth. Junior's dentist performed the procedure and submitted a claim to Junior's dental insurance company. The claim for Junior's implant was denied because the service would not correct the condition for a period of three years. Based on the denial received, no external review was available for Junior's claim. Junior's parents were left to pay out of pocket for the implant necessary to maintain the structure of Junior's mouth.

Example 2

Jill visited her dentist who recommended that Jill have two "crown" procedures performed. Just as was the case in example 1, Jill's claim was denied: "Based on the documentation received from the dentist the procedure does not meet the plan criteria to allow for a crown/onlay benefit". Again the EOB was ambiguous. Jill does not know if the health carrier contains that the "crown/onlay" procedure is not a covered benefit, or if it is a covered benefit that is being denied based upon medical or dental necessity. Jill does not know whether she has the right to challenge this determination through the external review process, or whether she must resort to litigation to secure her rights.

Example 3

Jill visited the dentist who recommended that she have an occlusal guard. Jill's dentist submitted the recommended procedure to Jill's health carrier which denied the health care service because: "[r]eview of claim doesn't support need for procedure." Although it is not as clear as might be hoped, the health carrier appears to acknowledge that the health care service recommended by the dentist is a covered benefit. But, once again, the EOB fails to provide a transparent explanation of the health carrier's basis for denying Jill health care services under her health benefit plan. Jill has no basis for determining whether she has the right to submit the health carrier's denial of dental care services to an external reviewer, or whether her only recourse is to hire a lawyer and pursue her common law remedies in court.

These examples highlight the fact that while the legislature provided external review procedures to Iowa citizens who have health benefit plans that provide dental care services and have received adverse determinations from their health carriers, the ambiguous definition of

"adverse determination" provided in *Iowa Code* § 514J.102(1) functions to deny them recourse to those beneficial procedures in many cases. The Association is pleased that the legislature restored external review for Iowans with health care plans that provide dental services, but remains concerned that ambiguity in the statute could frustrate this critical protection. The Association respectfully requests that the Commissioner support steps to ensure uniform and fair treatment for Iowans with health benefit plans that provide dental care services.

BENEFITS - Adult

CHECK-UPS AND TEETH CLEANING (DIAGNOSTIC AND PREVENTIVE SERVICES)

Dental Cleaning (Prophylaxis)

Removing plaque, tartar (calculus), and stain from teeth.
Limitation: Routine dental cleaning is a benefit only twice per Benefit Period.

Oral Evaluations

Limitation: This evaluation is a benefit only twice per Benefit Period.

X-Rays:

Bitewing X-Rays

Bitewing is an x-ray that shows the crowns of the upper and lower teeth simultaneously and that is held in place by a tab between the teeth.
Limitation: These x-rays are a benefit available only once every 12 consecutive months.

Full-Mouth X-Rays

Full-mouth x-rays include a combination of individual x-rays such as periapical, bitewing or occlusal taken by a dentist on the same service date. A panoramic x-ray is a benefit if full-mouth x-rays have not been performed within 5 consecutive years of the panoramic x-ray.
Limitation: Full-mouth x-rays are a benefit only once every 5 consecutive years.

Occlusal and Extraoral X-Rays

Occlusal x-rays capture all the upper and lower teeth in one image while the film rests on the biting surface of the teeth.
Limitation: These x-rays are a benefit only once every 12 consecutive months.

Periapical X-Rays

A radiographic image of a tooth, or limited number of teeth, that includes the crown and root portions.

Periodontal Maintenance Therapy

Includes various maintenance services such as pocket depth measurements, dental cleaning (oral prophylaxis), removal of stain, and root planing and scaling.
Limitation: To qualify as covered Periodontal Maintenance Services, maintenance services may immediately follow conservative or complex periodontal therapy. This benefit is available up to four times in the first Benefit Period following the initial periodontal therapy; this benefit also is available up to four times in the next Benefit Period; and is available twice per Benefit Period thereafter. *This procedure replaces the dental cleaning benefit (prophylaxis) described under Check-Ups and Teeth Cleaning earlier in this section.*

CAVITY REPAIR AND TOOTH EXTRACTIONS (ROUTINE AND RESTORATIVE SERVICES)

Emergency Treatment (Palliative Treatment)

Treatment to relieve pain or infection of dental origin.

General Anesthesia/Sedation

Limitation: General anesthesia, intravenous and non-intravenous conscious sedation are benefits only when provided in conjunction with covered oral surgery and when billed by the operating dentist.

Restoration of Decayed or Fractured Teeth

Pre-formed or stainless steel restorations and restorations such as silver (amalgam) fillings, and tooth-colored (composite) fillings.

Limited Occlusal Adjustment

Reshaping the biting surfaces of one or more teeth.
Limitation: Limited Occlusal Adjustment is a benefit only twice every 12 consecutive months.

Routine Oral Surgery

Including removal of teeth, and other surgical services to the teeth or immediate surrounding hard and soft tissues that are being performed due to disease, pathology, or dysfunction of dental origin.

ROOT CANALS (ENDODONTIC SERVICES)

Apicoectomy/Periradicular Surgery

Surgery to repair a damaged root as part of root canal therapy or to correct a previous root canal.

Direct Pulp Cap

Covering exposed pulp with a dressing or cement to protect it and promote healing and repair.

Pulpotomy

Removing the coronal portion of the pulp as part of root canal therapy. When performed on a baby (primary) tooth, pulpotomy is the only procedure required for root canal therapy.

Retrograde Fillings

Sealing the root canal by preparing and filling it from the root end of the tooth.

Root Canal Therapy

Treating an infected or injured pulp to retain tooth function. This procedure generally involves removal of the pulp and replacement with an inert filling material.

GUM AND BONE DISEASES (PERIODONTAL SERVICES)

Please note: Certain Procedures in this category should receive our review *before* they are performed. See the TREATMENT PLAN PRE-DETERMINATION section.

Full Mouth Debridement

Limitation: Full mouth debridement is a benefit only once in a lifetime after 36 months have elapsed since last dental cleaning (prophylaxis).

Guided Tissue Regeneration

Services and supplies for regeneration of lost periodontal structures.

Conservative Periodontal Procedures (Root Planing and Scaling)
Removing contaminants such as bacterial plaque and tartar (calculus) from a tooth root to prevent or treat disease of the gum tissues and bone which support it.
Limitation: Conservative periodontal procedures are a benefit only once every 24 consecutive months for each quadrant of the mouth.

Complex Periodontal Procedures
Various surgical interventions designed to repair and regenerate gum and bone tissues that support the teeth.
Limitation: Complex periodontal procedures are a benefit only once per Benefit Period for each quadrant of the mouth for natural teeth only.

Note: A quadrant is one of the four equal sections of the mouth into which the jaws can be divided and represents four or more contiguous teeth or bounded teeth spaces.

Localized Delivery of Chemotherapeutic Agents
Limitation: This benefit is for non-responding sites following periodontal therapy and is limited to one service per tooth with a maximum of two teeth in a 24 consecutive month period.

HIGH COST RESTORATIONS (CAST RESTORATIONS)

Please note: Certain Procedures in this category should receive our review *before* they are performed. See the TREATMENT PLAN PRE-DETERMINATION section.

Procedures in this category are only once every 5 consecutive years beginning from the date the cast restoration is cemented in place.

Cast Restorations for Complicated Tooth Decay or Fracture
Restoring a tooth with a cast filling when the tooth cannot be restored with a silver (amalgam) or tooth-colored (composite) filling.

Crowns

Restoring form and function by covering and replacing the visible part of the tooth with a precious metal, porcelain-fused-to-metal, or porcelain crown. *Crowns placed for the primary purpose of periodontal splinting, cosmetics, altering vertical dimension, restoring your bite (occlusion), or restoring a tooth due to attrition, abrasion, erosion, and abfraction are not a benefit. Limitation:* Crowns are a benefit only if the tooth cannot be restored with a routine filling.

Inlays
Restoring a tooth with a cast metallic or porcelain filling.
Limitation: Inlay benefits are limited to the amount paid for a silver (amalgam) filling.

Onlays
Replacing one or more missing or damaged biting cusps of a tooth with a cast restoration.

Posts and Cores
Preparing a tooth for a cast restoration after a root canal when there is insufficient strength and retention.

Recementation of Cast Restorations
Recementation of an inlay, onlay, or crown that has become loose.
Limitation: Benefits are available only once every 12 consecutive months after 6 months have elapsed since initial placement.

DENTURES AND BRIDGES (PROSTHETICS)

Please note: Certain Procedures in this category should receive our review *before* they are performed. See the TREATMENT PLAN PRE-DETERMINATION section.

Please note: Dentures, bridges, and dental implants (prosthetics) are a benefit once every 5 consecutive years.

Bridges
Replacing missing permanent teeth with a dental prosthesis that is cemented in place and can only be removed by a dentist. Also covered are bridge repairs.

Dentures (Complete and Partial)
Replacing missing permanent teeth with a dental prosthesis that is removable. Denture repair and relining are also covered.

Dental Implants
Dental implants which are surgically placed in the jaw bone, including attachment of devices to a surgically placed implant in the jaw.

Denture Adjustments
Limitation: Denture Adjustments will be limited to only than two per denture per Benefit Period after 6 months have elapsed since initial placement.

Tissue Conditioning
Limitation: Tissue conditioning will be limited to two per denture every 36 consecutive months.

BENEFITS – Child

CHECK-UPS AND TEETH CLEANING (DIAGNOSTIC AND PREVENTIVE SERVICES)

Dental Cleaning (Prophylaxis)
Removing plaque, tartar (calculus), and stain from teeth.
Limitation: Dental cleaning is a benefit only twice per Benefit Period.

Diagnostic Cast
Diagnostic cast is a replica of the teeth and tissues made from an impression; also called a study model.

Emergency Treatment (Palliative Treatment)
Treatment to relieve pain or infection of dental origin.

www.deltadental.com

November 17, 2014

The Honorable Nick Gerhart
Iowa Insurance Division
601 Locust Street, 4th Floor
Des Moines, IA 50309-3738

Re: **External Review of Dental Claims**

Dear Commissioner Gerhart:

Delta Dental Plans Association (DDPA) is providing comments regarding the Iowa Insurance Division's (IID) ongoing consideration of Iowa's external review statute and how it applies to dental plans.

In 2008, a bill was passed that applied external review for medical necessity to dental plans. In response to the Affordable Care Act, in 2011 Iowa's external review law was rewritten by adopting the model developed by the National Association of Insurance Commissioners (NAIC). This model specifically excludes dental plans. In order to apply external review once again to dental plans as it had been in 2008, Division XXI of House File 2463 (2463) was enacted in 2014. A plain reading of this statute demonstrates that the legislature sought to distinguish between "medical necessity" as a standard for external review for dental plans, and "appropriateness, health care setting, level of care or effectiveness" which, along with medical necessity, are applied as the five standards to a health carrier for external review.

Both federal and state statutory frameworks support applying a separate standard for dental plans. The NAIC continues to exclude dental plans from its model law on external review. Limited-scope stand-alone dental plans are considered "excepted benefits" in the Public Health Services Act, and operate under a distinct set of rules from health carriers providing major medical plans.

Because of these distinctions, the Iowa Legislature intended external review for dental claims only when "medical necessity" is in question. If the legislature had intended for all five standards given for health carriers to apply to dental care services, they would have used those precise words. The separate consideration of dental care services is important, and should be carried forward in IID's application of the statute.

The Iowa Dental Association (IDA) contends that the distinction the legislature drew between dental care services and health care services standards is, in effect, meaningless. The IDA argues that all five standards should be applied to dental care services because to do otherwise would deny external review for all "covered persons" and not reflect the uniformity the legislature sought to achieve. The IDA's analysis does not reflect a fair reading of the statute or take into account the practical impacts of applying this reading of the statute to dental care services.

Delta Dental Plans Association
1515 West 22nd Street, Suite 450
Oak Brook, Illinois 60523

Telephone 630-574-6001
Facsimile 630-574-6999

Despite the IDA's claims to the contrary, there are meaningful differences between dental care services and health care services. Conflating the two for the purpose of applying 2463 would add more costs to the system without any measureable benefit to consumers. For example, the "health care setting" standard has no meaningful application for dental care services, which occur almost exclusively in dental offices. Further, while the IDA asserts that the dental industry having a separate set of codes is irrelevant, dental's lack of diagnostic codes has a direct impact on whether the four additional standards could have any meaningful application in external review cases.

The IDA dismisses the high cost of external review for dental plans without any consideration of the implications that expanding the scope of external review might have on costs for employers, government and consumers. As other stakeholders have noted, the higher cost of medical claims makes the external review process affordable and appropriate for a health carrier. In the great majority of cases however, the cost of externally reviewing a dental claim would be more expensive than the actual dental care received.

Should you have any questions on this or would like to hear more about how the NAIC addressed dental issues and external review, please feel free to contact our representative Chris Petersen at 202-247-0316.

Sincerely,

Julia Grant
Vice President, Government Relations

November 17, 2014

The Honorable Nick Gerhart
Iowa Insurance Division
601 Locust St., 4th Floor
Des Moines, IA 50309-3738

Dear Commissioner Gerhart:

As the Vice-President and Dental Director of Delta Dental of Iowa, I wanted to provide you further information on the clinical cases provided by the Iowa Dental Association (IDA) in their October 28, 2014 brief and November 10, 2014 supplemental statement.

As a quick introduction, I am a 21-year veteran of the US Army and managed three multi-billion dollar dental insurance products for the Department of Defense. I am a board certified dental specialist in Dental Public Health and currently serve as the President of the American Board of Dental Public Health. Dental Public Health is one of the nine specialties of dentistry recognized by the American Dental Association.

I will provide an overview of each clinical case and then point out how a dental insurer would look at benefiting each scenario.

Clinical Scenario 1 – Jane

The scenario addressed a clinical situation where Jane's molar was splitting in half and IDA purports that the standard of care in the dental profession is the placement of a crown. The brief further details that the dentist informed the patient that tooth will continue to split each time she chews. The brief blames the insurer for the eventual extraction of the tooth.

There are some major gaps in the information provided. The clinical presentation suggests that the 'split tooth' may have been non-restorable when the patient presented to the dental office. This means that there may have been no way to 'save' this tooth based on the clinical symptoms described. There is a dental condition called cracked tooth syndrome that causes pain upon biting and would have minor cracks in a tooth. For patients with cracked tooth syndrome, a crown can save the tooth and mitigate the pain, but the scenario provided suggests that the crack was much larger and the tooth may have a questionable prognosis.

If the tooth was salvageable, there are other treatment options to alleviate pain and suffering for this patient in the short-term. A dentist can quickly place an orthodontic band on the painful molar. The orthodontic band does two things; (1) aids in diagnosis to see if the cracked tooth is minor and salvageable, and (2) alleviates the pain so the tooth no longer hurts until a time when the crown is placed. If the pain does not subside after the band is placed, the tooth is often not salvageable and extraction is the typical treatment.

This orthodontic band procedure can be benefitted under the dental procedure code D9110 (palliative treatment of dental pain) for most dental plans.

The IDA states that there is a standard of care for cracked tooth syndrome. I am unaware of any such printed standard of care that has been universally accepted and/or endorsed by the dental profession. The problem in dentistry, as opposed to medicine, is that dentistry lacks an evidence-based, universally accepted, standards of care for many procedures. Additionally there are no diagnostic codes used in dentistry to know why a provider is completing procedures. Since there are no accepted standards, the administrators of dental benefits must develop their own criteria. Those criteria are provided to dentists via provider manuals. The providers have access to the benefit criteria and the supporting documentation needed prior to initiating a procedure.

Delta Dental covers crowns for teeth that meet the benefit criteria of cracked tooth syndrome for posterior (back) teeth. A provider must provide a radiograph and narrative. The narrative should include the duration and type of symptoms experienced by the patient, the diagnostic tool used to determine cracked tooth syndrome, and identify the tooth cusp that is responsible for the pain. When these are provided, a crown can be benefitted. When providers fail to submit the required documentation and narrative to properly document the clinical symptoms, these benefits are normally denied.

Clinical Scenario 2 – John

The scenario detailed that John had severe pain in a molar tooth as a new cavity had developed around an older filling. John's dentist recommended a crown. The scenario suggests that the tooth was mostly covered with a filling.

This tooth may qualify for a crown. Crowns on posterior teeth (back) are covered in the following scenarios: a) there is a large area of decay on an additional tooth surface, b) there is extensive recurrent decay, c) the tooth has had a root canal and d) there is evidence of a cusp fracture. The dentist would need to submit the proper documentation and then the crown could be benefitted. If sufficient tooth structure remained after the additional cavity was removed, the insurance benefit would be limited to a direct filling. A direct filling is expected to be the treatment of benefit, until the tooth meets one of the four criteria listed above.

If the provider clearly documented that the clinical presentation of the tooth had little natural tooth left with a new cavity, a crown would most likely be benefitted.

Clinical Scenario 3 – Jill

Jill had two crowns placed in 2011. I infer from the narrative that the dental insurance company benefited (paid) their portion for the crowns in 2011. The patient had subsequent issues with those teeth which necessitated additional treatment and the replacement of those two crowns. The issue here is not a clinical issue, it is a frequency issue.

Dentistry is a limited scope benefit and benefit certificates document crown frequency. Delta Dental limits crown replacements to five years. It is the insurer's expectation that the quality of the dental work will last at least five years, and thus any costs associated with more frequent replacement would be borne by the patient or provider. All providers and patients are informed of this frequency limitation up front. If there were no frequency limitation, the cost of insurance would rise dramatically, and make dental insurance unaffordable to the masses.

There are varying reports on how long crowns last, but many reports cite an average of 10 years, with crowns lasting as long as 30 years. Factors that can affect longevity of crowns include, but are not limited to, the type of materials used and patient compliance with oral hygiene. The crown frequency limitation of 5 years for dental insurance does not place an undue burden on providers and patients. There must be some responsibility for the quality and lifespan of crowns by providers and patients. The insurer cannot bear the sole responsibility for the quality of a crown.

November 10, 2014 Supplemental Statement

The IDA provided a supplemental statement on November 10, 2014. One of the intents of the statement was to provide examples on how adverse determination affects providers and patients.

The additional clinical examples in the supplemental statement lack the necessary detail to be useful. For example, the third case involving Jill is far too vague to make any assessments. The case details that Jill's dentist recommended an occlusal guard. Many dental benefit programs cover occlusal guards for some conditions. Routinely, occlusal guards are an excluded benefit for the treatment of temporomandibular disorders (commonly referred to as TMD or TMJ). But, many insurances do cover the occlusal guards for bruxism (night time grinding). Thus if Jill's dentist filed a claim with a narrative of 'recommending an occlusal guard', most insurers would suspend the claim and request more information.

The IDA suggests that the consumers (patients) are confused. The patients do not understand dental science or dental benefits. If the dentist is a participating network provider, the dentist has a signed contract that details how dental benefits will be administered and is provided a detailed provider manual that clearly lists all covered services and the criteria used to assess those procedures.

It is the dentists' responsibility to understand covered services by using the provider manual, web services of the insurer, or the customer service staff of the insurer. If a particular service is not covered, but is the 'right' treatment for that patient, a patient and dentist should make the treatment decision and not expect reimbursement from a third party for a limited scope benefit.

Overall Impressions / Conclusions

The initial three patient scenarios of potentially needing crowns are typical in dentistry. Often a dentist states a tooth needs a crown, based on their clinical experience. But this clinical experience lacks both an evidence-base and a standardized protocol of when a tooth should have a crown. Based on the lack of diagnostic coding and evidence-based protocols, insurers have developed criteria for when procedures can be benefited. These criteria are publicly available to providers.

There is great variation in dentistry treatment planning as evidence by Bader and Shugars in the article titled Variation in Dentists' Clinical Decisions published in the Journal of Public Health Dentistry in 1995. Their conclusions are that 'even when differences in patients are controlled variation in dentists' clinical decisions is ubiquitous." Bader and Shugars are recognized as the dental quality subject matter experts in this country, and the findings of their 1995 seminal article still stand.

From a clinical stand-point, dental benefits are a limited scope product. Treatment decisions are made between the dentist and the patient, but benefit decisions are based on industry criteria, frequencies, annual maximums, and whether a procedure is a covered benefit or not.

When providers and consumers disagree with a benefit decision they have review and appeal rights. For an internal review, an independent dental consultant reviews the case and makes an autonomous decision of benefit coverage, consistent with the published provider manual criteria on whether to benefit the procedure or not. When there is still disagreement, the provider or consumer may request an internal appeal of the benefit decision and the case is reviewed by an internal appeal committee.

I hope that this sheds additional light on how dental benefits are applied.

Very Respectfully,

Jeffrey Chaffin, DDS, MPH, MBA, MHA

700 Walnut Street, Suite 1600
Des Moines, Iowa 50309

November 18, 2014

Angela Burke Boston
Assistant Commissioner
Iowa Insurance Division
601 Locust St., 4th Floor
Des Moines, IA 50309-3738

RE: Additional Comments on Dental External Review and House File 2463

Dear Angela:

The Federation of Iowa Insurers submits the following comments in response to comments from the Iowa Dental Association ("IDA") and to supplement the Federation's letter of October 28, 2014 concerning the amendments to Iowa Code chapter 514J made in Division XXI of 2014 Iowa Acts, House File 2463 ("HF 2463") relating to external review of dental care coverage decisions.

Section 112 of HF 2463 directed the Commissioner of Insurance to "review the differences in the bases used for external review of adverse determinations under chapter 514J as applied to health services relative to dental care services." In response to that directive, the Insurance Division solicited written comments and held a public hearing to allow stakeholders to submit their views. In its prior written submission and its oral testimony, the Federation presented information explaining the history of Iowa's external review statute, Iowa Code chapter 514J, discussed how dental insurance is treated differently than major medical insurance in both the NAIC model external review act and in chapter 514J, and provided numerous justifications for the statute providing different bases for external review of dental care services and other health care services.

In response, the IDA submitted additional comments that are most striking for their name calling. *See* Supplemental Statement of the Iowa Dental Association Submitted to the Iowa Commissioner of Insurance ("IDA Supplemental Statement") at 1, 2, 3, 4 (deeming the Federation's comments "fallacious," "utterly without support," "without support" (again), "red herrings," "unfounded," "irrelevant," "red herrings" (again), "false," "unfounded" (again), and "ludicrous" among other terms). Notably missing, however, is an explanation of why, exactly, the IDA is so upset that HF 2463 expanded Iowa's external review laws to apply to dental insurance for the first time since 2011.

I. Dental Insurance Is Regulated Differently than Major Medical Insurance

The IDA Supplemental Statement begins with a declaration of ignorance about what a "limited scope product" is or why the nature of the coverage provided is relevant to external review. Supplemental Statement at 2-3. As the Federation explained, dental insurance – along with a number of other limited scope insurance products – were intentionally excluded from both

the NAIC model external review law and the 2011 revisions to Iowa Code chapter 514J because dental insurance, like other limited scope products, truly is different and should be treated differently than major medical insurance. In the nearly 20 years since the enactment of the Health Insurance Portability and Accountability Act ("HIPAA") and up through the current implementation of the Affordable Care Act ("ACA"), Congress has recognized that limited scope insurance products, such as vision insurance, disability insurance, long-term care insurance, and dental insurance, are different from major medical insurance and should be subject to less regulation than major medical insurance. *See generally* 79 Fed. Reg. 59130 (October 1, 2014) (final ACA rule governing excepted benefits, including dental insurance), available at http://www.gpo.gov/fdsys/pkg/FR-2014-10-01/pdf/2014-23323.pdf.

Congress is not alone in treating these limited scope plans, such as dental insurance, differently. The Iowa legislature has for many years consistently treated limited scope insurance plans differently than major medical insurance. Iowa's laws regulating both individual and small group health insurance specifically exempt limited scope dental insurance from the definition of regulated health insurance. *See* Iowa Code §§ 513C.3(11) (dental not included in definition of "individual health benefit plan"), 513B.2(12)(c) (exempting limited scope dental insurance from the definition of "health insurance coverage"). Additionally, Iowa Code chapter 514C exempts dental plans (along with other limited scope insurance plans) from numerous mandates applicable to major medical insurance. *See, e.g.*, Iowa Code §§ 514C.13, 514C.18, 514C.19, 514C.20, 514C.22, 514C.23, 514C.24, 514C.25, 514C.26, 514C.27, 514C.28.

The point is that Iowa Code chapter 514J is entirely consistent with longstanding state and federal policy treating dental coverage differently than major medical coverage by exempting dental insurance or limiting the reach of regulations and requirements that apply to major medical insurance. Dental insurance truly is different. Congress knows this, the NAIC knows this, the Iowa General Assembly knows this. That the IDA does not know – or chooses to ignore – this long-standing regulatory scheme is, frankly, astonishing.

II. Dental Insurance Claims Are Billed and Reviewed Differently than Major Medical Insurance Claims

The IDA Supplemental Statement next dismisses the differences in coding and billing between dental and medical claims. But coding and billing is, of course, at the heart of a third-party payer system. And while such coding and billing may be largely transparent to insureds (which is a significant benefit of insurance), it is hardly a mystery to dentists. Every dentist who participates in a dental carrier's provider network has signed a provider agreement that specifies exactly how to bill and code dental procedures, and dentists know that following these requirements is essential for getting paid by insurers. Dentists know full well that dental billing systems are different and less complex than medical billing systems. These differences arise from the limited nature of dental insurance coverage the Federation discussed previously, and these differences make external review inappropriate for dental coverage in most circumstances.

It is also telling that the IDA tries to conflate the terms "medical necessity" and "dental necessity." *See* Supplemental Statement 6-9. The legislature specifically chose the words "medical necessity" when amending Iowa Code chapter 514J in 2014. In doing so, the Iowa legislature allowed external review of dental services when there is a dispute over medical necessity. External review is not allowed, however, when the denial is based on a lack of dental

necessity. The two terms are different and distinct, a point the IDA refuses to recognize. Nor does the IDA explain why limiting external review to medical necessity from 2008-2011 (which was the result of legislative changes specifically requested by the IDA) was sufficient then but is insufficient now.

III. The IDA's Examples Are Unhelpful

The IDA provides several examples of claim denials that purportedly demonstrate some sort of shortcoming with Iowa's external review law. These examples do not support that contention for a number of reasons.

Most significantly, the examples are provided with virtually no context and without crucial information. We have no idea what the relevant terms of the insurance coverage were. Consequently, we do not know if the requested services were covered at all or were subject to a plan exclusion such as a frequency limitation or an annual coverage maximum. Because we have so little information we don't even know whether these denials would actually be subject to external review under the changes made in HF 2463.

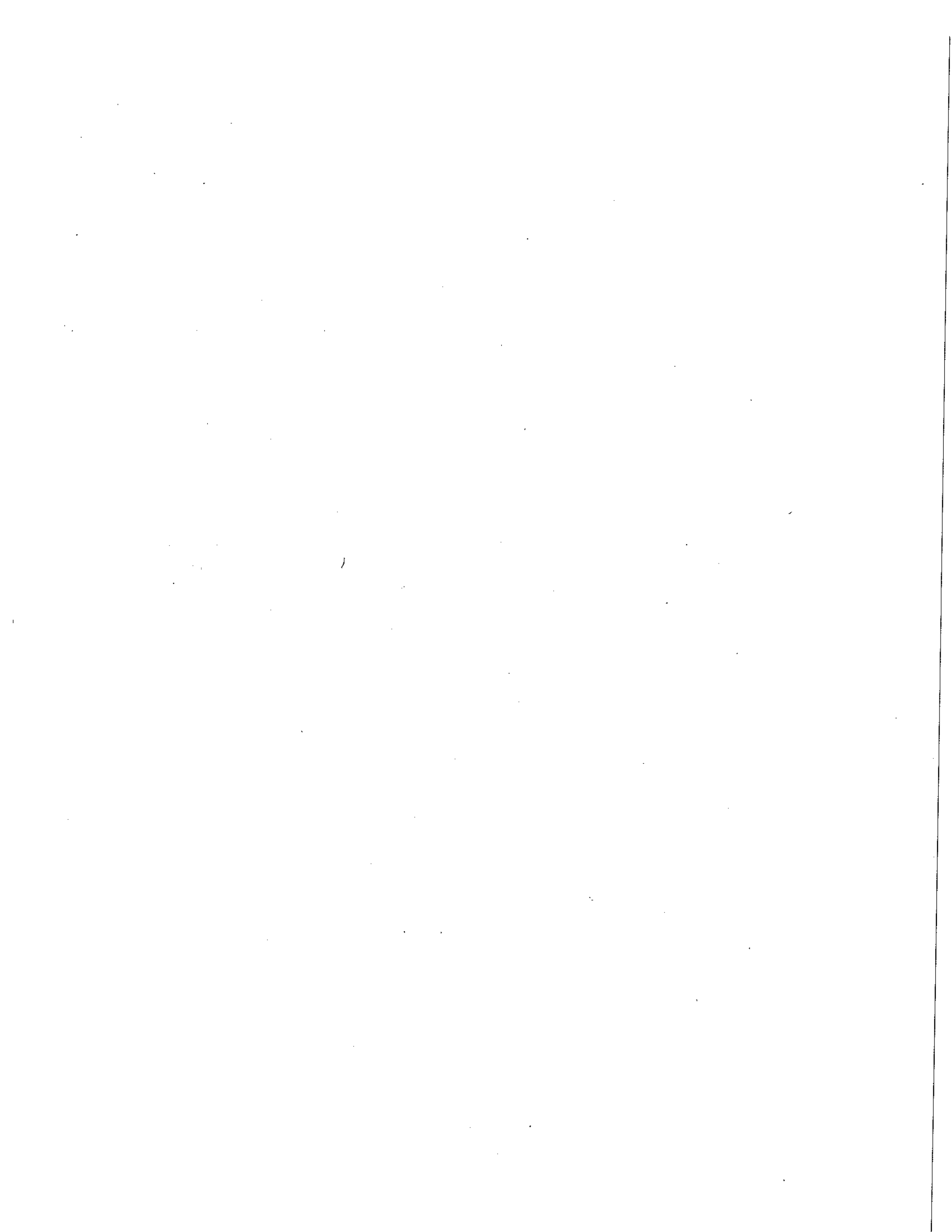
We also do not know what information the carrier provided to the dentist. We do not know if the dentist ever attempted to communicate with the carrier to ensure the carrier had a full understanding of the nature and reasons for the requested service. Did the dentist properly submit the claim as required by the dentist's provider agreement? Did the dentist attempt to discuss the claim before or after submitting it by taking advantage of the systems carriers have in place to help resolve billing queries?

Finally, we do not know whether any of the patients requested an internal review of their claim denial. Even in the absent of a statutorily required external review process, dental carriers generally provide robust internal review procedures for insureds. It appears that these procedures were never utilized or, if they were, what the outcome was.

Without any of this information, it is impossible to know what, if anything, altering Iowa's external review law would accomplish. Nor is it clear why the IDA believes that the expansion of Iowa's external review laws that were made in HF 2463 to cover dental insurance policies is so grossly insufficient.

Thank you for the opportunity to submit further comments. Please contact Paula Dierenfeld or me if you have any questions or would like to discuss these comments further.

Sincerely,
/s/Scott Sundstrom
Legislative Counsel
Federation of Iowa Insurers



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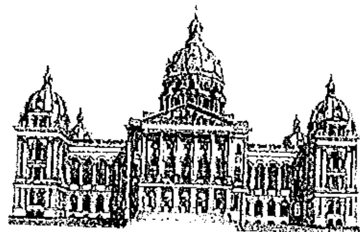

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State of Iowa
Eighty-fifth General Assembly
STATEHOUSE
Des Moines, IA 50319

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November 20, 2014

The Honorable Nick Gerhart
Iowa Insurance Division
601 Locust Street, 4th Floor
Des Moines, Iowa 50309-3738

Re: Dental External Review- HF 2463

Dear Commissioner Gerhart-

I am writing to share with you some background on the legislative intent of the legislation that was signed into law this past spring pertaining to dental external review. As the legislation's sponsor in the Iowa Senate, I was intimately involved with the drafting of the legislation and working with the stakeholders. The law clearly states that the legislature intends "to provide uniform standards for the establishment and maintenance of external review of an adverse determination ...made by a health carrier." *Iowa Code* § 514J.101.

Because of the concerns shared to us by those dental policy holders who were suffering severe medical issues, and yes, dental issues are medical issues, it was the Senate's intent that Iowans with dental insurance should be treated fairly and equitably under the law. Iowans with dental insurance must share the same benefit with those Iowans with health insurance. Dentists are in the best position to determine what is in the best interest for their dental patient. To begin to twist the intent of the legislature by trying to find differences in dental insurance versus health insurance is not only incorrect, it is wholly wrong. I was entirely aware of the differences in dental insurance versus health insurance. It was my intent to provide uniform fairness for Iowans and allow for external review for adverse determinations. The legislation merely delineated "medical necessity" by including appropriateness, health care setting, and level of care or effectiveness.

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There was no ambiguity in my minds or the minds of the Senators in the Committee who were clearly briefed on the intent of this legislation or its purpose. I hope that this provides some clarity to the Insurance Commissioner and his office to enforce the legislation as intended by its drafters in the state legislature.

Thank you.

Sincerely-

Senator Matt McCoy
District 21

Cc: Paula Feltner; Larry Carl