



**TESTIMONY TO THE
SUBCOMMITTEE ON STANDARDS AND SECURITY
NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS
ON
DENTAL STANDARDS ISSUES**

By

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NATIONAL ASSOCIATION OF DENTAL PLANS

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INTRODUCTION

Thank you, Dr. Cohn, and to the other members of the Subcommittee for the opportunity to address you today on behalf of the National Association of Dental Plans (NADP) regarding our present continued exclusion from the Code Revision Committee (CRC) and the licensing of CDT codes.

My name is Dr. Roger Adams and I am the immediate past-Chairman of the Board of NADP as well as the current chairman of the NADP Foundation. I am employed by Dental Select, a dental benefits company located in Draper, UT, where I serve as Vice President of Professional Relations. Prior to joining the dental benefits industry, I was a board certified oral and maxillofacial surgeon in Salt Lake City, Utah from 1983 – 1998. I received my surgical training during a 4 year residency at the Mayo Clinic in Rochester, MN. I completed my D.M.D, a 3 year residency in Oral Pathology, where I received a master's degree, a 1 year fellowship in Radiology from the Washington University School of Dental Medicine in St. Louis, MO

NADP represents member companies offering all lines of dental benefits including dental HMOs, dental PPOs, dental indemnity and discount dental plans. Our members include major commercial carriers as well as regional and single state companies. NADP members provide more than 70% of all network-based dental benefits and one third of all dental indemnity benefits in the U.S. This adds up to roughly 60% of the total dental benefits market. In fact, this means that NADP members provide dental benefits to approximately 95 million of the 155 million Americans with dental benefits. There is no other trade association, health or dental, that can claim this breadth of representation of the dental benefits industry¹.

NADP appeared before this Subcommittee in February 2002 on some of the issues before us today. Our Chairman at the time, Edward Murphy, testified that NADP strongly supported the move to electronic transactions and informed the Subcommittee of our industry's commitment to comply with HIPAA. Furthermore, Chairman Murphy reiterated our support for the use of a standardized code set as an essential tool for facilitating electronic transactions. Nevertheless, NADP also identified three (3) significant problems with the HIPAA non-medical code set development and maintenance:

1. NADP was concerned with the lack of an open and fair process for the maintenance of the CDT as recently outlined by the ADA;
2. NADP opposed the licensing requirement being imposed solely on dental benefits plans that severely limited the use of the CDT; and
3. NADP was concerned with the CDT usage fee and how such fees would be applied to the dental benefits industry.

¹ At the time of writing this testimony, we are still evaluating the impact of the merger of AAHP-HIAA on representation of the dental benefits industry.

At this time, I am here to report on the progress all interested parties have made in addressing the three concerns we listed. I am also here to report on the progress yet to be achieved. It is my sincere hope that my testimony today will facilitate the achievement of a positive resolution to these matters. Our primary objective during our initial testimony was to ensure that changes to the standardized code sets developed within a process that was fair, equitable and open to all interested parties. I want to reaffirm NADP's commitment to that goal.

IMPROVEMENT IN GAINING ACCESS

In the last year, there has been a significant shift in attitude towards allowance of NADP on the CRC. We believe this shift is a direct result of our insistence of inclusion as well as the improved relationship between the ADA and NADP.

During our initial hearing before this Subcommittee, we were deeply concerned about the process established to develop the HIPAA mandated code set. NADP was effectively shut out of the process because we did not receive proper notice of the time and/or location of the meetings. Further, observers at the first code-set meeting were not provided with copies of the agenda or materials relating to the proposed revisions or additions to the Code on site. Finally, no process was apparent to allow for comments from observers unless a comment was directly related to specific issues on the agenda and observers had to be recognized by a member of the Committee.

I am pleased to report that significant improvement has been achieved as it concerns NADP's access and participation in the code revision process. Not only has the ADA been more responsive in our requests for meeting notices and agendas, but they have been instrumental in facilitating changes that have dramatically improved our access to the code revision and maintenance process. Below are just a few examples of how the ADA has been helpful in this regard:

1. NADP participated in the work group that developed the current operational protocol for the CRC adopted in 2003;
2. NADP has been included in distribution of public materials related to the CRC meetings;
3. The ADA has circulated NADP's response to CRC submissions to the CRC members and interested parties; and
4. The Chair of the CRC has solicited NADP's comments as observers during the CRC meetings.

Moreover, through our internal CDT Technical Advisory Committee, NADP consistently monitors the development of the code set and offers commentary that is not currently represented by the CRC. The Subcommittee can be secure in knowing that the comments provided by our CDT TAC are truly representative of NADP members. CDT TAC was formed so that our members would have an open and predictable procedural mechanism by which they could comment on code-set development and maintenance. As a result, our CDT TAC holds monthly conference calls, develops comments through a tireless and

consensus building agenda, and distributes those comments to the membership to ensure that every NADP member has an ample opportunity to express their opinion. We believe this demonstrates the commitment and leadership we will bring to the CRC. While we do not have intimate knowledge of the comment procedures of other trade associations, we believe our involvement in the process has been beneficial to all involved.

Overall, we are pleased with the ADA's efforts to improve the access to the code set development and maintenance process, but it is far short of our preference to have a formal seat on the CRC.

BRIEF HISTORY OF CRC MEMBERSHIP

Again, while we are encouraged that the ADA has improved our access to the code set development and maintenance process, we still find it totally unacceptable that we, as the largest representative of the dental payor community, can still not have a seat on the CRC. During our last hearing, we documented that our efforts and requests for participation date back to 1993. Our participation has been rejected on grounds that the process was either bound by contracts or ongoing litigation. And when the contracts expired in 2000, we were told that we would not be considered due to a private legal settlement agreement between the ADA and the trade associations currently represented on the CRC. While the ADA and the trade associations certainly have a right to amicably resolve their legal differences, we do not believe it is appropriate for a settlement agreement – which no one including this Subcommittee has seen – to govern a process that HIPAA mandates be “fair, equitable and inclusive.”

As testified before, the CRC is currently comprised of five (5) dentists representing and appointed by the ADA. In addition, there are five payor representatives: Blue Cross Blue Shield Association (BCBSA) which has about 6% of the dental benefits market, Delta Dental Plan Association (DDPA) which has about 24% of the dental benefits market, Health Insurance Association of America (HIAA) which has about 9% of the dental benefits market, a representative of Centers for Medicare & Medicaid Services (CMS), and a representative of a “national group purchaser of significant dental services.” When we testified in two years ago, we suggested that the payor representative assigned to the CRC were not adequate because only DDPA solely focused on dental issues. The other two, BCBSA and HIAA, are primarily organizations of medical care plans with a component or committee focused on dental benefits. Moreover, we had concerns about the viability of the employer representative as a representative of “payor groups.”

RECENT DEVELOPMENTS OF NADP GAINING ADMISSION TO CRC

On October 21st of last year, AAHP and HIAA announced a merger of these two organizations. According to the press release, the new entity would be called “AAHP–HIAA” until a new name could be agreed upon. Prior to the merger, HIAA held a seat on the CRC. It was unclear whether AAHP–HIAA would remain involved in the dental arena and whether the new entity was entitled to assume the seat vacated by HIAA. If AAHP-HIAA did not continue representation of a portion of the dental benefits industry,

that vacancy would have been an avenue to NADP appointment to the CRC. However, our inquiries determined that the merged entity AAHP-HIAA planned to continue involvement in the dental benefits industry and had expressed interest in continued participation on the CRC. Since it is our position that all payor groups with unduplicated representation in the dental benefits industry should have a seat at the table, we continued our dialogue with both the ADA and DDPA regarding NADP appointment in some other manner.

Since our overture to both organizations, we have received assurances from the ADA and DDPA that they would support our inclusion on the CRC. However there has been no agreement between the two parties as to the best solution to resolve this issue. The ADA supports our inclusion by expanding the CRC, as evidenced by the following language taken from a letter written by Dr. James Bramson, the ADA's Executive Director, to Kim Volk, President and Chief Operating Officer of DDPA, on December 18, 2003:

“In summary, it is our recommendation that, in order to accommodate the interest of NADP in a seat at the CRC, we need to expand the CRC to add one additional member dentist and NADP. It also would make sense at this time to permit AAHP-HIAA to take the HIAA seat on the CRC.”

According to Dr. Bramson's letter, this expansion would occur by adding an additional dentist with the addition of NADP. Since the expansion would directly impact the majority requirement to add a code and the super-majority requirement necessary to delete or significantly revise a code, the ADA and DDPA would be required to sign a letter of agreement confirming not only the new composition of the CRC, but also the amendment of the super-majority voting requirement.

While supportive of our inclusion, DDPA does not support the solution of expanding the existing composition of the CRC. Instead, DDPA proposes that NADP replace the employer representative, as evidenced by the following language taken from a letter written by Ms. Volk dated December 22, 2003 in response to Dr. Bramson's letter:

“DDPA also agrees that NADP represents an aspect of the payer community and it would be advantageous to have its representation on the CRC. However, DDPA maintains that a better course of action is to replace the purchaser representative with NADP than expand the entire CRC.”

According to Ms. Volk, unlike NADP, the purchaser representative does not directly represent a defined constituency nor does it possess the unique combination of “clinical” and “buyer” knowledge in order to make meaningful contributions to the code set development and maintenance process.

While encouraged by these recent developments, we are here to state on the record that we will not wait indefinitely while the ADA and DDPA agree upon a solution. While we

agree with DDPA that replacing the purchaser representative creates the least amount of disruption to the CRC membership and process, we are not overtly opposed to expanding the current composition of the CRC. However, if expansion is adopted, we would not support any suggestion to change the current ratio necessary to meet the super-majority requirement.

We believe a rational and acceptable solution does exist. In fact, there has been considerable activity towards a solution in the last few weeks and it is very possible that this matter may be resolved before we testify. However, if the parties refuse to agree, we must challenge the private settlement agreement that presently blocks our access to the CRC in any way that we can be that legal or federal action. Our preference since it appears that all parties agree that NADP should be represented would be to avoid a waste of time and money on legal action or proposing a federal bill to codify the requirements for membership on the CRC.

LICENSING AGREEMENT

Finally, I would like to address the matter of the ADA's licensing of the CDT code sets. During our last hearing, we testified that the ADA required dental payors to pay \$1000 for the right to license the code sets.

When our companies first heard the proposal of \$1000, they assumed it would be applied by company, i.e. the parent or holding company. Indeed, the actual licensing agreement distributed by the ADA has no definition that would indicate otherwise. Thus, NADP has 60 members and our members would pay a total of \$60,000. While our members were not enthusiastic about the imposed costs, we at least felt we knew the absolute ceiling and we could then enter negotiations for a more appropriate cost for the full range of companies.

NADP's discussions with the ADA led to a proposal for an umbrella licensing agreement for NADP members. In the cover letter that accompanied the proposed umbrella licensing agreement, the ADA listed four "key components" of an umbrella agreement. The fourth component defined entity in a way that could require thousands of dollars per company rather than \$1000. Below, we have provided the relevant quote:

- "4. A NADP member would bear an annual license fee for each of its separately incorporated entities that has employees who use the *Code*."

While we agreed that the ADA has a legal right to license its copyrighted material, our members do object to paying thousands of dollars for one company on an annual basis. Thus, since the last hearing, we have engaged the ADA on the application of the \$1000 fee. We believe the impasse lies in the definition of "entity" and we have asked the ADA to reiterate their definition of the term.

The current definition, depending on interpretation, could result in either of the following as demonstrated in the scenarios below:

1. If our member, XYZ, is licensed in 12 states and its sister company, XYZ-2, is licensed in a single state, and its other sister company, XYZ3, is licensed in two states, theoretically, this member company could be liable for licensing each company and pay \$3000; or
2. If XYZ and its sister companies are required to attain a license for each state in which it's licensed, then XYZ would pay \$15,000.

Depending on how the ADA is interpreting the definition of "entity," some of our members could pay tens of thousands of dollars in annual licensing fees. Collectively, we could have approximately 7 companies, who are licensed in virtually every state, paying \$350,000 for licenses. We believe these companies would be unfairly penalized for complying with state regulations that require them to hold separate state licenses. Therefore, we believe it is absolutely essential to reevaluate to whom the \$1000 fee is being applied.

A tangential issue is the length of the agreement. Under the current licensing agreement, the license fee would be imposed annually. We do not find this consistent with the HIPAA preamble requiring "...efficient, low cost mechanisms for distribution (including electronic distribution) for the code sets and their updates." It would seem more appropriate for the agreement to be for the term of the version of the Code, i.e. currently two years.

NADP'S PROPOSAL

In September 2003, NADP submitted a counter-proposal to the ADA. Our counter-proposal gave a price break to the small companies, but produced about \$68,000 total over a two year period if all participated. This is in line with the fees paid to utilize CPT or ICD9. As we enter 2004, this figure would be higher as we had an influx of new members year-end who would pay at the top end of our proposed brackets.

Under our counter-proposal, which is detailed below, the number of licenses a company needs is related to their size and not to the number of "entities." For example, a plan with 10 subsidiaries, but only 300,000 members is still considered a small plan. Thus, as a small plan, they would only pay \$500.

1. Small plans would pay \$500 (0 - 499,999 members);
2. Medium plans would pay \$1000 (500,000 - 1,999,999); and
3. Large plans would be subjected to the following banding:
 - a. plans with 2 million - 2,999,999 members will pay \$2000;
 - b. plans with 3 million - 3,999,999 members will pay \$3000; and

- c. plans with 4 million members or greater will pay \$4000.

In concluding our counter-proposal, our membership numbers would be evidenced by the numbers submitted to NADP to complete NADP's annual statistical report. In order to comply with NADP's confidentiality policy, a separate permission line will be added on the data collection form so that NADP can release these numbers. Any participating member who doesn't sign the release will not receive the discount or will be charged the maximum cap of \$4000. Finally, in our proposal, the licensing fees would be renewed with each new version of the CDT Code. Currently, the CDT code is renewed every 2 years although there has been increasing discussion among payors and dentists that this frequency should be lengthened.

SNODENT

On July 17, 2003, NADP sent a letter to the Subcommittee Chairman describing our concerns about the designation of SNODENT in any manner as a standard under HIPAA. SNODENT is a privately developed, unreleased system of dental diagnostic codes. As such it is premature for it to be considered as the dental diagnostic coding system in the dental patient record or as the standard code set for dental diagnostic codes under HIPAA.

While ICD-9 is indeed limited with regard to dental diagnosis codes, SNODENT is totally unknown except for the fact that it includes some 6000 codes. Moreover, as the largest representative of the dental payor community, NADP believes that if SNODENT is designated a national code set under HIPAA, the maintenance of SNODENT must be accomplished in the "open" process established by HIPAA. Since the development process was not open to payor participation and there has been no payor evaluation of the system, significant time must be allowed for evaluation before any implementation could reasonably occur. As well, the maintenance process should be established so that there is a known method for input and feedback on the system prior to any adoption as a national standard.

NADP approached the ADA with these concerns and Drs. Bramson and Guay have communicated their preference that a separate process be established and that it would include payor participation. They indicated that since SNODENT has not been released, developing a process for its maintenance has not been a priority and that they would be open to receipt of payor recommendations in this regard. Thus, we will work with other willing payor groups to make such recommendations.

CONCLUSION

On behalf of the entire NADP membership, I want to convey our appreciation for the opportunity to address the Subcommittee and express our concerns. We believe that much of the improvement that has occurred in the last two years is directly attributable to

the Subcommittee's oversight of this process. Like the Subcommittee, NADP is dedicated to a fair and equitable process being developed to ensure the creation and maintenance of dental code sets.