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Proponent Testimony in Support of House Bill 344

Insurance Committee
Ohio House of Representatives
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Chairman Brinkman, Vice Chair Lampton, Ranking Member Miranda, and members of the House Insurance Committee-

Thank you for the opportunity to provide proponent testimony for House Bill 344 today. My name is Sharon Parsons. I am a general dentist practicing in Columbus. I have been doing this for 40 years. In that time, I have treated a large number of families, many of whom have been with me for over 20 years. I know their history, I know their teeth, in general, I know THEM.

I agreed to participate with a dental insurance company's PPO well over fifteen years ago. They showed me a sample of their fee schedule and, while it didn't pay my full fee, it seemed fair. Over the years, costs have risen, more and more families have been given this insurance by their employers, and I find myself in the position of having almost one third of my practice having this insurance. Another thing that has changed is the level at which I am reimbursed. Unlike medical practitioners, when I do a procedure, even though I have the cost of the room I use, the sterilization procedures needed to keep everyone safe, the staff and material costs incurred, I am only allowed to charge for the procedure itself. That in itself has not been raised in many years, despite the rising costs of doing business. The overhead in my business hovers between 65 and 70 percent. I am finding that this insurance company is only reimbursing me at 58 percent for some procedures. And in case you are wondering, my fees fall into the fiftieth to seventieth percentile in a survey of dentists in this region. My son, who has been practicing with me for two and a half years, and my new associate who just graduated from dental school are paid at an even lesser percent than me.

I am telling you all of this so that you understand my predicament. If the insurance company that I am contracted with employs the tactic of allowing me to charge what they say for a procedure that they do not cover instead of my normal fee, which falls into the average, then I will be forced to drop this insurance. The things not covered by insurance companies are deemed "elective" in most instances. Many of these are cosmetic procedures that the patient chooses to have, but are not considered essential by the insurance company, and thus are not covered. Most of these cosmetic procedures are very costly to perform because they take a lot of time, and many involve lab fees. If I am reimbursed at a level less than my costs, I am forced to cut corners or use a lesser quality lab in order to make ends meet. That in itself changes the relationship I have with my patients. I have spent my career giving my patients my best work. How can I now give them something less?

I have heard time and again that this tactic used by the insurance company is for the good of the patient. I refuse to perform to a lesser standard for my patients. Therefore, if this continues

to be allowed, I will be forced to drop the insurance of over five hundred families. They will have to pay more money out of pocket to continue their care with me or change to an office that does not know them and will be bound by these same restraints. How is this better for the patient?

I urge a passage of House Bill 344 so that patients can make their own choice on services that their insurance provider does not even cover.

Thank you again for the opportunity to testify in support of House Bill 344, and I would be happy to answer any questions.