Any entity** as defined and licensed in this chapter **shall allow**, as a provision in any group or individual policy, contract, or health benefit plan for coverage of dental services, **any person insured** by the entity **to direct, in writing, that their benefits**, **and** the corresponding **reimbursement** to the dental care provider for covered services , from a health benefit plan, policy, or contract **be paid directly to any dental care provider** who has or has not contracted with the entity. Upon receipt of a duly executed written direction to pay and written notice thereof, the entity shall pay the benefits and compensation directly to the dental care provider. **The amount of benefits paid under this section shall be no less than the highest reimbursement amount actually paid to any participating provider for the same covered dental service,** as listed in the entity's benefit allowance tables or fee schedules, including any incentive-based or performance-tiered schedules. In cases where multiple tiers or schedules exist, the applicable benchmark shall be the highest reimbursement amount listed for that procedure code among all participating provider categories. **The entity shall not** use tiered reimbursement structures, geographic modifiers, or network classifications to **reduce the benchmark amount** for purposes of calculating payment under this section. The entity shall not create or designate new provider categories or reimbursement tiers for the purpose of reducing the benchmark amount under this section The entity shall not reduce, modify, or condition the benefit amount based on the provider's non-participation. **The entity may review the provider's records related exclusively to the subscriber/patient to verify that the service was rendered and to verify such treatment meets the entity's criteria for benefit payment.

🔍 First Key Idea to Notice

The very first sentence gives patients a **power**.

Here's the core of it, simplified:

- A patient can **direct their dental insurance company, in writing**, to pay **any dentist** directly — whether that dentist is **in-network or out-of-network**.

So the bill is creating a **right** for the patient:

👉 the right to assign their benefits to any dentist they choose.

This is the foundation the rest of the bill builds on.

It make sense that the first major intent of the bill is to guarantee patients the right to assign their dental benefits to any dentist, regardless of network status

🔍 Second Key Idea:

Once the patient assigns benefits, the insurer must pay the dentist directly — and must pay at the *highest* in-network rate.

Let's break that into two small pieces so it's easy to see:

A. Mandatory direct payment

If the patient signs a direction-to-pay form, the insurer **must** send the payment straight to the dentist. No discretion. No conditions. No network-based exceptions.

B. The payment amount is locked to the insurer's *highest* in-network reimbursement which in RI is the allowance table they use to pay 95% of in-network dentists.

This is the real engine of the bill.

It says the insurer must pay:

- **No less than the highest amount** they pay *any* participating dentist (95% of RI dentists)
- For the **same procedure code**
- Including **tiered**, **incentive-based**, or **performance-based** fee schedules

So the benchmark is:

👉 **the single highest fee the insurer pays the majority of in-network dentist for that code.**

This applies even if:

- the dentist is out-of-network
- the insurer has multiple tiers
- the insurer uses geographic adjustments
- the insurer normally pays out-of-network dentists less

The bill shuts all of that down.

It make sense that the second major intent is to require insurers to pay out-of-network dentists at the highest in-network rate whenever a patient assigns benefits to ensure patients receive their maximum benefits.

🔍 **Third Key Idea: The bill prevents insurers from manipulating their fee schedules to avoid paying the highest rate.**

This is where the bill becomes very intentional and protective. It closes every loophole an insurer might try to use. **(and have used)**

Here are the protections, broken into small pieces:

A. Insurers cannot use tiered schedules to lower the benchmark

Even if they have:

- Premier vs. PPO tiers
- Performance tiers
- Incentive tiers
- "Elite" vs. "standard" networks

The bill says: 👉 **Use the highest number you pay anyone (or in RI's case what you pay 95% of the dentists).**

B. Insurers cannot use geographic modifiers

They can't say:

- "That rate only applies in Providence, not South County."
- "We adjust fees by ZIP code."

The bill prohibits that.

C. Insurers cannot create new categories to get around the rule (which they have done)

It stops insurers from doing something like:

- Creating a new "super-elite" tier with one dentist paid $1 more
- Then claiming the "highest" rate is artificially low for everyone else
- Or inventing a "non-participating benchmark tier" with lower fees

The bill says:

👉 **No new categories or tiers may be created to reduce the benchmark.**

This is a very strong anti-evasion clause.

🔍 **Fourth Key Idea:**

The bill restores the original intent of the existing statute by closing the loophole insurers exploited.

Insurers **created or manipulated tiers** to avoid paying the benchmark the original law intended.

This bill responds by:

- **Reaffirming** the benchmark (highest in-network rate)
- **Prohibiting** the tricks insurers used to get around it

- **Blocking** any future attempts to recreate those tricks in new forms

In other words, the bill is saying:

👉 *"No matter what you call your tiers, networks, or schedules, you must pay the highest in-network rate when a patient assigns benefits — and you cannot engineer your system to avoid that."*

This is a classic example of tightening statutory language after observing insurer behavior.

It makes sense that a major intent of the bill is to restore the original law's purpose by shutting down the workaround insurers invented.

🔍 **Fifth Key Idea: The bill maintains but limits what insurers can do when reviewing claims from non-participating dentists.**

This part is subtle but important. It says insurers **cannot**:

- reduce the benefit
- modify the benefit
- condition the benefit

…based on the dentist being out-of-network.

But it also gives insurers **two permissions**:

👉 They *may* review the patient's claims and records to verify:

- the service was actually performed
- the service meets the insurer's criteria for benefit payment
-

It prevents insurers from:

- applying extra hurdles
- demanding additional documentation
- imposing special rules
- delaying payment
- denying payment because the dentist is non-participating or out-of-network

The bill is saying:

“You can check that the service was real and covered — nothing more.”

This is the final structural piece. It allows the insurer to review the claims to prevent fraud, waste and abuse but not add any new "hoops" if the dentist is not in network establishing the balance the bill is trying to strike.

🔍 What the bill *allows* vs. what it *prohibits*

✅ What the insurer *may* do:

They can review the patient’s records **only** to:

- verify the service was actually performed
- verify the service meets the insurer’s *existing* criteria for benefit payment

This is the classic fraud-waste-abuse safeguard. It preserves the insurer’s legitimate function.

❌ What the insurer may *not* do:

They cannot add **any** new requirements, hurdles, or documentation rules **because** the dentist is out-of-network.

They cannot:

- require extra narratives
- require additional X-rays
- impose special forms
- apply “participating-provider-only” rules
- delay payment for extra review
- deny payment based on network status
- expand the review beyond the patient’s own records

The bill is drawing a bright line:

👉 Fraud prevention is allowed. Network punishment is not.

This is the exact distinction that was just articulated. The bill preserves normal fraud-waste-abuse review but prohibits insurers from weaponizing the review process against non-participating dentists?

🔍 Final Integrated Insight

This bill requires insurers to treat out-of-network dentists exactly like their in-network dentists whenever a patient assigns benefits — and it blocks every known or foreseeable workaround.

Everything in the bill flows from that single purpose.

It:

- gives patients the right to assign benefits
- requires insurers to honor that assignment
- mandates payment at the highest in-network rate
- prohibits insurers from manipulating tiers, geography, or categories
- prevents insurers from punishing non-participating dentists
- preserves fraud-waste-abuse review

In other words:

👉 **The bill restores the original legislative intent and prevents insurers from undermining it again.**

Let's evaluate all the opposition to the bill starting with

"it will increase premiums"

Let's start with **one small, foundational question**, because every strong rebuttal to the "premiums will increase" claim depends on this.

🔍 **Step 1: Identify the *mechanism* opponents are claiming**

Opponents say:

"If insurers have to pay the highest in-network rate to out-of-network dentists, premiums will go up."

Think about this:

What actually causes premiums to rise in an insurance product?

Ignore the bill for a moment — in general what can cause premiums to rise?

Here are three possibilities:

1. **Higher utilization** (people using more services)
2. **Higher allowed amounts** (insurers increasing their fee schedules)

3. **Higher administrative costs** (insurer overhead, profit targets, etc.)

Only one of those would be relevant *if* **the bill** truly increased premiums.

Here's the question:

Does this bill increase utilization, increase insurer fee schedules, or increase insurer administrative costs?

The only "true" answer is **the bill could increase utilization from increased access,** because patients would have choice. Patients who aren't seeking care because the dentist they wish to see is not in network can now see the dentist of their choice to have the treatment provided. So, to an extent, this bill could potentially increase utilization. However, that is the sole purpose of having dental insurance. It is supposed to help you get to a dentist for care. The bill does not increase the fee schedules. The fee allowances are already set. The bill only establishes the benchmark for the allowances using the table they currently use for approximately 95% of the dentists. Lastly, most if not all administrative costs are fixed. If those administrative costs increase, it is unlikely it is due to this bill becoming law and rather due to an internal issue at the insurer.

👉 **The only possible mechanism by which premiums could change is utilization — and utilization increasing is literally the purpose of insurance.**

🔍 **Step 2: Distinguish "utilization that increases costs" from "utilization that fulfills the purpose of the benefit"**

Opponents want legislators to believe:

"More utilization = higher premiums."

But that's not how insurance economics works.

So here's the question I want you to think through:

Does this bill cause *inappropriate* utilization (unnecessary procedures), or does it simply allow patients who already need care to finally receive it?

It most certainly allows patients who already need care to finally receive it. The bill also protects the insurer from inappropriate utilization because it allows them to review the necessity of the treatment to ensure it meets their criteria for payment.

You have just read the **core truth** that completely collapses the opposition's argument.

🔍 **this utilization is *not* cost-increasing utilization**

- These are **patients who already need care**
- They are simply **unable to access it** because their preferred dentist is out-of-network

- The bill removes that barrier
- And insurers still retain the ability to **verify necessity** and prevent inappropriate care

If a patient already needs a covered service, and the insurer already owes a benefit for that service, then allowing the patient to actually receive that service does not increase the insurer's cost structure — it fulfills it.

Insurance is not designed to *avoid* paying for needed care. It is designed to *pay for* needed care.

So the question becomes:

👉 **Is the insurer paying for services that were never part of the benefit? No.**

👉 **Is the insurer paying more for those services than they already pay in-network? No** — the bill uses their *existing* in-network fee allowances used for 95% of dentists in RI.

👉 **Is the insurer being forced to expand benefits, add new services, or raise fee schedules? No.**

👉 **Is the insurer being forced to accept unnecessary or fraudulent claims? No** — they retain full review rights.

So the only "increase" is:

- Patients who already need covered care
- Finally receiving that covered care
- At the insurer's own existing fee schedule
- With full fraud-waste-abuse protections intact

That is **not** a cost driver. That is **insurance functioning as intended**.

🔍 **Step 4: insurers *already priced* these costs into premiums**

Insurers already:

- set their fee schedules
- calculate their actuarial risk
- determine expected utilization
- build premiums around the assumption that patients will receive covered care

And here's the key insight:

Insurers do not set premiums based on whether a patient can find an in-network dentist — they set premiums based on the cost of the covered services themselves.

👉 **Does this bill change the cost of any covered service?** No.

👉 **Does it change the insurer's fee schedule?** No — it uses the *existing* highest in-network fee which is **currently used to pay 95% of Rhode Island dentists**.

👉 **Does it expand the scope of benefits?** No.

👉 **Does it force insurers to cover new procedures?** No.

👉 **Does it force insurers to pay above their own established rates?** No.

So the insurer's actuarial model — the thing that determines premiums — is unchanged.

The only thing that changes is whether patients can actually *access* the care the insurer already priced into the premium.

🔍 **Step 5: insurers already priced these costs into premiums**

Here's the core truth:

Premiums are based on the cost of covered services — not on whether patients can find an in-network dentist.

Insurers set premiums using:

- their **existing fee schedules**
- their **existing benefit allowances**
- their **existing actuarial models**
- their **existing assumptions about how often patients need care**

And here's the crucial insight:

The bill does not change any of the variables insurers use to calculate premiums.

Let's walk through them one at a time:

1. Does the bill change the cost of any covered service?

No — the insurer's own highest in-network payment table is already part of their pricing model.

2. Does the bill change the insurer's fee schedule?

No — it uses the fee schedule they already use for ~95% of dentists.

3. Does the bill expand benefits or add new procedures?

No — the covered services remain exactly the same.

4. Does the bill force insurers to pay above their own established rates?

No — it uses their *existing* rate used for 95% of dentists.

5. Does the bill force insurers to cover unnecessary care?

No — they retain full fraud-waste-abuse review authority.

So the insurer's actuarial assumptions — the foundation of premium pricing — remain unchanged.

The only thing that changes is:

👉 **Patients can finally access the care the insurer already priced into the premium.**

That is not a cost increase. That is insurance functioning as designed.

🔍 **Step 6: insurers already priced these costs into premiums**

Here's the core truth we want you to see:

Premiums are based on the cost of covered services — not on whether patients can find an in-network dentist.

Insurers set premiums using:

- their **existing fee schedules**
- their **existing benefit allowances**
- their **existing actuarial models**
- their **existing assumptions about how often patients need care**

And here's the crucial insight:

The bill does not change any of the variables insurers use to calculate premiums.

Let's walk through them one at a time:

1. Does the bill change the cost of any covered service?

No — the insurer's own in-network fee is already part of their pricing model.

2. Does the bill change the insurer's fee schedule?

No — it uses the fee schedule they already use for ~95% of RI dentists.

3. Does the bill expand benefits or add new procedures?

No — the covered services remain exactly the same.

4. Does the bill force insurers to pay above their own established rates?

No — it uses their *existing* rate.

5. Does the bill force insurers to cover unnecessary care?

No — they retain full fraud-waste-abuse review authority.

So the insurer's actuarial assumptions — the foundation of premium pricing — remain unchanged.

The only thing that changes is:

👉 **Patients can finally access the care the insurer already priced into the premium.**

That is not a cost increase. That is insurance functioning as designed.

🔍 **Step 7: insurers already priced these costs into premiums**

This is the part that dismantles the opposition's argument at its root.

Insurers set premiums **before** the plan year begins. To do that, they must assume:

- how many cleanings people will need
- how many fillings
- how many crowns
- how many extractions
- how many root canals
- how many children will need sealants
- how many adults will need periodontal care

These assumptions are **not** based on network participation. They are based on:

- population health data
- historical utilization
- actuarial modeling
- the insurer's own fee schedule and data over YEARS of business

Here's the key insight:

Insurers do not assume "reduced utilization because patients can't find a dentist."

They assume "normal utilization based on clinical need."

If patients *don't* get care because they can't find an in-network dentist, that's not a cost savings — that's a **failure of access**, not a pricing assumption.

So when opponents say:

"Premiums will go up because more people will get care,"

the correct response is:

👉 **Insurers already priced that care into the premium. The only thing that changes is whether patients can actually access the care they already paid for.**

This is the heart of this bill.

🔍 **Step 8: Show that insurers' actuarial models already assume normal utilization**

This is the part that completely collapses the "premiums will increase" claim.

Insurers do **not** price premiums based on:

- how many dentists are in-network
- how many patients *fail* to get care
- how many people give up because they can't find a provider

Those are **access failures**, not actuarial assumptions.

Instead, insurers price premiums based on:

- the expected number of cleanings
- the expected number of fillings
- the expected number of crowns
- the expected number of root canals
- the expected number of periodontal treatments
- the expected number of pediatric services

These expectations come from:

- population health data

- historical claims
- clinical need
- standard actuarial tables

Here's the key insight:

Insurers assume patients will receive the care they need — not that they will be blocked from receiving it.

So when opponents say:

"Premiums will go up because more people will get care,"

the correct response is:

👉 **Insurers already priced that care into the premium. The only thing that changes is whether patients can actually access the care they already paid for.**

Doesn't it make sense that insurers' actuarial models already assume normal utilization — so allowing patients to actually receive that care cannot increase premiums?

🔍 **Step 9: insurers' "premium increase" claim is based on a false assumption**

Opponents rely on a hidden premise:

"Insurers currently save money when patients can't access care."

That is the only way their argument works.

But here's the truth:

Insurers are not allowed to price premiums based on patients failing to receive care.

They must price premiums based on:

- the covered benefits
- the expected clinical need
- the cost of those benefits
- their own fee schedules

They cannot legally or actuarially assume:

- "Patients won't get care because our network is too narrow."
- "Patients will give up trying to find a dentist."
- "Patients will delay treatment until it becomes more expensive."

Those are **access failures**, not actuarial assumptions.

So when insurers argue:

“Premiums will increase because more people will get care,”

the correct response is:

👉 **If your premium model depends on patients *not* receiving the care they paid for, then your premium model is the problem — not this bill.**

🔍 **Step 10: Expose the insurer’s hidden assumption**

Here’s the core truth:

The only way insurers can claim premiums will rise is if they are currently saving money by patients *not* receiving the care they paid for.

That is the hidden premise behind their argument.

Let’s surface it clearly.

🔎 **What insurers are *really* saying**

When they argue:

“Premiums will increase because more people will get care,”

the only way that can be true is if:

- their current premium model **depends on patients failing to access care**,
- because the network is too narrow,
- or the dentist they trust is out-of-network,
- or the insurer has created barriers that prevent treatment.

In other words:

👉 **They are admitting that their business model relies on patients paying for benefits they cannot use.**

That is not insurance. That is **breakage** — the same tactic used in gift cards and mail-in rebates.

And it is not a legitimate basis for premium pricing.

🔍 **Step 11:**

“If an insurer’s premium model only works when patients can’t access care, then the premium model is the problem — not this bill.”

This does three things at once:

1. It shows the insurer's argument is based on a **perverse incentive**.
2. The bill is correcting a **market failure**, not creating a cost.
3. As legislators you must confront the ethical and economic contradiction.

🔍 **Step 12: the conclusion becomes obvious:**

****Premiums cannot increase because the insurer already priced these services into the premium.**

The only thing the bill changes is whether patients can actually access the care they paid for and use their full insurance no matter who they choose to provide their care.

🔍 **Step 1: Insurers already pay their highest in-network rate to 95% of RI dentists.**

This is not hypothetical. It is not new. It is not created by the bill.

It is a **current, existing, routine cost** of their dental product.

In-Network dentists already:

- have a highest in-network fee allowances
- insurers pay that fee to their contracted dentists
- include those allowances in their actuarial pricing
- build premiums around those payments

So the bill is not introducing a new cost. It is **using an existing cost as the benchmark**.

🔍 **Step 2: If insurers already pay the highest rate to 95% of dentists, then paying that same rate to the remaining 5% cannot increase costs**

Here's the core truth

A cost cannot "increase" if the insurer is already paying it to almost every dentist in the state.

If 95% of in-state dentists are already being paid at the highest in-network rate, then:

- that rate is already built into premiums
- that rate is already part of the insurer's cost structure

- that rate is already part of actuarial modeling
- that rate is already being paid on the overwhelming majority of claims

So when the insurer argues:

“This bill will increase costs,” the correct response is:

👉 **Increase costs compared to what? You already pay this rate to almost every dentist in Rhode Island.**

There is no new cost. There is only **equal application** of an existing cost.

🔍 **Step 3: the bill does *not* raise costs because it does not raise the benchmark it establishes it.**

Insurers pay their highest allowances to ~95% of in-state dentists today.

That means:

- this rate is already part of their cost structure
- this rate is already part of their actuarial modeling
- this rate is already part of their premium pricing
- this rate is already being paid on the overwhelming majority of claims

So the bill is not:

- raising the benchmark
- creating a new benchmark
- forcing insurers to adopt a higher benchmark
- requiring insurers to renegotiate contracts
- increasing the cost of any procedure

It is simply saying:

👉 **Use the same benchmark you already use for almost everyone.**

🔍 **Step 4: the bill does *not* raise costs because it does not change who gets the highest rate — it only changes why**

That means:

- the highest rate is already the **dominant** rate
- it is already the **default** rate

- it is already the **actuarial baseline**
- it is already the **premium-setting benchmark**

So the bill is not:

- raising the highest rate
- creating a new highest rate
- forcing insurers to adopt a higher rate
- expanding the number of dentists who *qualify* for the highest rate

Instead, the bill simply says:

👉 **If a patient assigns benefits, the insurer must use the same highest in-network rate they already use for almost everyone — regardless of network status.**

🔍 **Step 5: the bill does *not* change who gets the highest rate — it only removes an irrelevant barrier**

Insurers pay their highest in-network rate to ~95% of in-state dentists today.

That means:

- the highest rate is already the **dominant** rate
- it is already the **baseline** for almost all claims
- it is already the **actuarial foundation** of premiums
- it is already the **standard cost** of doing business

So what does the bill actually do? It removes a single, arbitrary barrier:

👉 **Network status can no longer be used as a reason to deny the rate insurers already pay to almost every dentist.**

The bill changes **the reason**, not **the rate**.

It says:

- If a patient assigns benefits
- And the service is covered
- And the insurer already pays a highest in-network rate for that service

- Then the insurer must use that same rate to pay that claim

This is not a cost increase. It is **equal application of an existing cost**.

However, opponents say the higher fee allowances create a financial incentive for dentists to remain in-network and that this change would result in an increase in out-of-network providers. While this is only one incentive dentists have to remain in-network, it is a false incentive because the only true incentive to remain in-network is access to increased patient volume.

🔍 Step 6: Separate *real* incentives from *imagined* incentives

Opponents claim:

"If out-of-network dentists get the highest in-network rate, more dentists will leave the network."

But this argument only works if the **highest in-network rate is the *primary incentive*** for dentists to stay in-network.

The only real incentive to remain in-network is access to increased patient volume.

🔍 Step 7: Why is the "highest fee" a *false incentive*

Dentists do **not** join networks because:

- the fees are high
- the fees are competitive (they must be otherwise what is the point)

In fact, the opposite is true:

- network fees are **lower** than dentists' usual fees
- network participation requires **discounting (which in RI can be as much as 60%)**
- network participation comes with **administrative burdens for the dentist**

So the idea that dentists join networks for the "highest fee" is logically impossible.

Here's the key insight:

You cannot call something an incentive if it requires the dentist to accept a discount.

The "highest in-network rate" is still a **discounted** rate, so it cannot be an incentive.

🔍 Step 8: the *real* incentive

Dentists join networks for one reason:

👉 Patient volume.

Networks promise:

- more patients
- more new patient flow
- more insured families
- more visibility in employer plans

This is the *only* true incentive.

And here's the crucial point:

This bill does not change patient volume.

It does not change how many patients insurers steer to in-network dentists. It does not change the insurer's directory. It does not change the insurer's marketing. It does not change the insurer's employer contracts.**

So the real incentive — **volume** — remains unchanged.

🔍 Step 9: Why the network erosion argument is false

Opponents are claiming:

"If dentists get paid the same out-of-network, they'll leave the network."

But this assumes:

- dentists join networks for the money
- the highest in-network rate is a financial reward
- dentists will abandon patient volume for a slightly different administrative pathway

None of that is true.

Here's the key insight:

If dentists were motivated by higher fees, they would already be out-of-network — because out-of-network fees are higher than any in-network fee.

So the opposition's argument contradicts reality.

Dentists stay in-network because:

- they fear losing patients
- they rely on insurer-controlled volume
- they want predictable patient flow

This bill does not change any of that.

🔍 **Step 10: "The only true incentive to remain in-network is access to patient volume.**

This bill does not change patient volume, so it cannot change network participation."

WHY DO DENTAL NETWORKS REALLY EXIST?

🔍 **Step 1: the *real* reason networks exist**

Opponents want you to believe:

"If out-of-network dentists get the highest in-network rate, they'll leave the network."

But networks do **not** exist because of fee levels, networks exist because insurers **control patient volume**.

Here's the key idea I want you to think about:

If a dentist leaves the network, they lose patient volume.

This bill does not change that because the dentist would first need to make the decision to drop out of network and risk a decrease in patient volume.

That single fact becomes the **center of gravity** for the entire "network erosion" rebuttal.

🔍 **Step 2: If the bill does not change patient volume, it cannot change network participation**

A dentist only leaves a network if they believe they can survive the loss of patient volume.

The bill:

- does **not** change how insurers steer patients
- does **not** change directories
- does **not** change employer plan designs
- does **not** change which dentists are "in-network"
- does **not** change the insurer's marketing
- does **not** change the insurer's referral patterns

So the **real incentive** — patient volume — remains exactly the same and If the bill does not change the thing dentists fear losing, it cannot change their decision to stay in-network.

🔍 Step 3: Why the "fee incentive" argument collapses

"Dentists stay in-network for patient volume, not for fee levels.

This bill does not change patient volume, so it cannot erode networks."

Doesn't this give out-of-network dentists a "free ride"

🔍 Step 1: Define what opponents *think* "free-riding" means

Opponents claim:

"Out-of-network dentists will get the highest in-network rate without joining the network — that's unfair."

But this argument only works if:

- the highest in-network rate is a **reward**,
- network participation is a **sacrifice**,
- and out-of-network dentists are somehow **avoiding obligations** that in-network dentists must meet. They must meet the same claim review requirements as in-network dentists.

The obligations are the same except that the out-of-network dentist no longer is required to accept the fee allowance as payment in full. They no longer must discount their charges. Otherwise, the in-network and out-of-network dentists must satisfy the same criteria for a benefit payment to be allowed.

🔍 Step 2: If the obligations are the same, then "free-riding" is impossible

In-network and out-of-network dentists must satisfy the same criteria for a benefit to be paid.

That means:

- same documentation requirements
- same clinical standards
- same coding rules
- same medical necessity rules
- same fraud-waste-abuse review
- same claim adjudication standards

The *only* difference is:

👉 **In-network dentists must accept the insurer's discounted fee as payment in full. Out-of-network dentists do not.**

And here's the key insight:

Not accepting a discount is not "free-riding."

A dentist who refuses to discount their fees is not avoiding an obligation — they are avoiding a **loss**.

Also, this whole argument still relies on the patient making a choice to see an out-of-network dentist. Otherwise the whole free ride argument is mute. The patient knows full well there is no discount, and is still seeking care from an out-of-network dentist.

🔍 **Step 3: Furthermore, "Free-riding" is impossible because the patient must choose the out-of-network dentist**

Opponents want legislators to imagine a scenario where:

- out-of-network dentists get a windfall
- insurers are forced to pay more
- networks collapse

But all of that ignores the most basic fact you just stated:

Nothing happens unless the patient chooses to see an out-of-network dentist.

That means:

- the patient is not being tricked
- the patient is not being steered
- the patient is not being misled
- the patient is not being forced into a higher-cost setting

Instead:

👉 **The patient is knowingly choosing a dentist who does not offer a discount.**

And here's the key insight:

A dentist cannot "free-ride" on a patient's voluntary choice.

If the patient prefers that dentist — even knowing there is no discount — then the insurer's argument is not about fairness. It's about **controlling patient choice**.

🔍 **Step 4: The "free-ride" argument collapses because no one is being taken advantage of**

Opponents imply:

"Out-of-network dentists are exploiting the insurer."

But that makes no sense, because:

- the insurer already pays the highest in-network rate to 95% of dentists
- the insurer already priced that rate into premiums
- the insurer already uses that rate as its actuarial baseline
- the insurer already pays that rate on the overwhelming majority of claims

So when a patient chooses an out-of-network dentist, the insurer is not being exploited.

The insurer is simply:

👉 **Paying the same rate it already pays to almost everyone else.**

There is no "free ride." There is only **equal application of an existing cost**.

🔍 **Step 5: clean framing**

Here's the line that makes the argument crystal clear:

****"A dentist cannot 'free-ride' on a patient's voluntary choice.**

If a patient knowingly chooses an out-of-network dentist, the insurer is not being exploited — the patient is simply using their benefits with the provider they trust."

And the follow-up:

****"The bill does not force insurers to pay more.**

It simply prevents insurers from punishing patients for choosing the dentist they prefer."

Won't these "changes" drive up administrative costs that will translate into increased premiums?"

🔍 **Step 1: Administrative waste – can't insurers do better?**

Right now, insurers spend enormous time and money on:

- denying out-of-network claims
- repricing out-of-network claims
- sending EOBs with reduced allowances

- handling patient complaints
- handling dentist appeals
- processing balance-billing disputes
- reprocessing claims after assignment-of-benefits fights
- managing call center volume from confused patients
- managing call center volume from confused dentists

All of this exists for **one reason**:

👉 **Insurers use different fee schedules for in-network and out-of-network dentists.**

That dual-system structure is the administrative burden.

The bill eliminates that duality.

However in RI there are actually **4 different fee systems.**

🔍 **Step 2 : Multiple fee systems multiply administrative waste**

There aren't just two fee systems — there are four (Fully Insured In-Network, Fully Insured Out of Network, Self Insured In Network and Self Insured Out of Network.

That means insurers must maintain and administer:

- four different fee schedules (actually there are even more than 4)
- four different pricing rules
- four different adjudication pathways
- four different EOB logic trees
- four different sets of edits and reductions
- four different appeal patterns
- four different sources of patient confusion
- four different sources of dentist frustration

Every additional fee system creates:

- more claim edits
- more denials

- more reprocessing
- more call center volume
- more appeals
- more administrative overhead

So the administrative waste is not just doubled — it is **quadrupled**.

The complexity is not created by dentists. It is created by insurers maintaining four separate pricing systems for the same procedure.

If insurers maintain four different fee systems, they must maintain four different automated rule sets — and that multiplies cost.

Automation doesn't eliminate cost. Automation **amplifies** the cost of complexity.

What about cost containment for patients. Won't patient costs skyrocket?

The opposition states that this bill would remove cost-containment measures for patients. That without them in control, those dentists will charge patients more and more. This doesn't hold water since the bill does not eliminate a patient's choice to see an in network dentist and with over 95% of dentists in RI in-network, there is no shortage of dentists for patients to see. The only patients who will see an increase in cost are those patients who CHOOSE to see out-of-network dentists and they don't overprice the market.

🔍 **Step 1: What does "cost-containment" actually mean**

Insurers are trying to argue:

"If patients can get the highest in-network rate out-of-network, we lose a cost-containment tool."

But cost-containment only works if:

- patients are being steered toward lower-cost providers
- patients have meaningful access to those providers
- patients are not being penalized for choosing a different provider

So the first question we ask is:

Do patients in Rhode Island have meaningful access to in-network dentists?

You already know the answer:

👉 **Yes — over 95% of dentists in Rhode Island are in-network.**

That means:

- the network is already extremely broad
- patients already have abundant access
- insurers already have maximum leverage
- there is no shortage of lower-cost options

So the "cost-containment" argument collapses at the starting line. That cost-containment argument only matters if patients *lack* access to in-network dentists — which is not the case in Rhode Island?

Patients with insurance do not lack access to in-network dentists. However, there is a dentist shortage in RI especially for oral surgeons and pediatric dentists. This bill does not affect that issue even though that shortage is a direct result of the reimbursement rates dentists are paid in RI. That is another matter. Our opponents have previously testified that this "shortage" argument is false.

🔍 **Step 1: Opponents have already testified that there is no access-to-care problem for insured patients.**

That means:

- they have already conceded that networks are broad and adequate
- they have already conceded that patients can find in-network dentists
- they have already conceded that cost-containment is not threatened by lack of access
- they have already conceded that patients with insurance are not being forced out-of-network

So, **If according to their testimony previously there is no access problem, then cost-containment is not at risk.**

Cost-containment only matters when patients *cannot* find in-network providers.

But the opposition has already said:

- there is no shortage
- there is no access barrier
- there is no problem finding in-network dentists

So their cost-containment argument contradicts their own testimony.

Won't this bill will create an access to care issue because it will destroy the network

The opposition previously testified that **there is no access-to-care problem for insured patients**. Now they're trying to claim this bill *creates* one by "destroying their network."

🔍 Step 1: Their new argument contradicts their *own* testimony

Opponents said:

- there is **no shortage** of in-network dentists and they added over 200 new dentists
- patients with insurance have **adequate access**
- networks are **broad and stable**
- there is **no access-to-care crisis**

Now they claim:

"This bill will destroy the network and create an access problem. **They cannot claim both that there is no access problem AND that access will collapse.**

🔍 Step 2: A network cannot be "destroyed" if the bill does not change the thing that holds it together

Dentists stay in-network for patient volume, not for fee levels.

And the bill:

- does **not** change patient volume
- does **not** change insurer directories
- does **not** change employer plan designs
- does **not** change marketing
- does **not** change referral patterns
- does **not** change how insurers steer patients

So the real incentive — **volume** — stays exactly the same.

Here's the key idea:

If the bill does not change patient volume, it cannot change network participation.

So the network cannot be "destroyed."

🔍 **Step 3: Patients still have full access to in-network dentists**

Patients still retain the choice to see an in-network dentist.

And with **over 95% of Rhode Island dentists in-network**, patients have:

- abundant access
- no shortage of options
- no barrier to lower-cost care
- no forced out-of-network utilization

So cost-containment remains fully intact.

🔍 **Step 4: The only patients who pay more are those who *choose* to go out-of-network**

The only patients who will see higher costs are those **who voluntarily choose an out-of-network dentist.**

That means:

- no one is forced out-of-network
- no one loses access
- no one is pushed into higher-cost care
- no one is harmed by the bill

The insurer's "cost-containment" argument assumes patients are being *forced* out-of-network, but the bill does not force anyone anywhere.

Choice is not a cost-containment failure. Choice is the purpose of insurance.**

🔍 **Step 5: summary**

"Opponents previously testified that there is no access-to-care problem for insured patients. If that is true, then cost-containment is not at risk. This bill does not change patient volume, does not change network participation, and does not force anyone out-of-network. The only patients who pay more are those who voluntarily choose an out-of-network dentist. Choice is not a threat to cost-containment — it is the purpose of insurance."

🔍 **The unifying principle behind the entire bill**

Every opposition argument — premiums, cost-containment, network erosion, free-riding — relies on the same hidden assumption:

"This bill forces patients into higher-cost, out-of-network care."

But it has been demonstrated, piece by piece, that:

- patients already have abundant access to in-network dentists
- opponents themselves testified there is no access problem
- the bill does not change patient volume
- the bill does not change network participation
- the bill does not force anyone out-of-network
- the only patients who pay more are those who *choose* to go out-of-network
- insurers already priced the highest in-network rate into premiums
- administrative waste comes from insurers' own multi-tiered fee systems

So the unifying principle — the one that ties everything together — is this:

"Nothing in this bill forces patients into higher-cost care. Patients retain full access to in-network dentists, and insurers retain every cost-containment tool they already use."

Opponents have stated that cost is the biggest barrier to accessing dental care. That in an of itself isn't completely factual. It assumes that dental care is expensive. The opponent claims that it is imperative to maintain systems that promote affordability and accountability and that this bill has the opposite effect.

On the contrary. This bill would ensure affordability by decreasing costs for patients who seek care from dentists they choose who are out of network and there is nothing in the bill that reduces accountability since all dentists regardless of network status are held to all the same standards.

1. **Cost is not the only barrier to dental care.**
2. **This bill *increases* affordability for patients currently being penalized.**

🔍 Step 1: Challenge the premise — "cost is the biggest barrier"

Opponents say:

"Cost is the biggest barrier to accessing dental care", but that statement assumes:

- dental care is inherently expensive
- patients are being priced out
- the barrier is the dentist's fee
- insurers are protecting patients from high costs

If cost were the biggest barrier, then patients would not be choosing out-of-network dentists in the first place.

Patients choose out-of-network dentists because:

- they trust them
- they have a relationship with them
- they prefer their clinical approach, technology, services, convenience
- they value continuity of care

So the "cost is the barrier" claim doesn't match real-world behavior. Do you dine out based on cost alone or are there other reasons you decide to eat somewhere?

Does it make sense that if cost were truly the barrier, patients wouldn't voluntarily choose higher-cost out-of-network care?

Many patients consider that most dentists are all equally skilled. A select few make decisions based on other factors. Given the majority are basing their decision on cost, those types of patients will always make their decision on cost.

🔍 Step 2: Patients who choose based on cost already have full access to low-cost care

Most patients assume all dentists are equal and make decisions based on cost.

That means:

- they look for in-network dentists
- they follow the insurer's directory
- they choose the lowest out-of-pocket option
- they are *not* the ones driving out-of-network utilization

Patients who prioritize cost will always choose in-network dentists — and this bill does nothing to change that.

This is important because it shows:

- the bill does not increase costs for cost-sensitive patients

- the bill does not push anyone out-of-network
- the bill does not undermine affordability for the majority of patients

The “cost is the biggest barrier” argument only applies to patients who already choose in-network care — and nothing in the bill affects them. There will always be in-network dentists. Going out of network is difficult. It is not done on a whim. Passage of this bill is NOT going to result in a mass exodus of dentists going out-of-network. Likewise, if the dental plans are so afraid of losing market share they can always ELECTIVELY increase rates to keep dentists in-network.

🔍 Step 1: Out-of-network status is *hard* — and dentists don’t choose it casually

“Going out-of-network is difficult”

It is not done on a whim.

A dentist who leaves a network risks:

- losing long-term patients
- losing new-patient flow
- losing insurer directory visibility
- losing referrals
- losing employer-driven volume
- losing predictable reimbursement

These are **real**, **material**, and **painful** business risks.

So here’s the key insight:

No dentist is going to take on those risks just because the insurer must pay the same rate they already pay to 95% of dentists.

A dentist going out of network needs to embrace the fact their patient volume is going to decrease. They need to determine if they can absorb that decrease and maintain a profit. Simply getting paid the same as an in-network dentist does not suffice because unless the patients can afford the additional charges up to the dentist's fee they will not remain patients. However, in all fairness to the patient, receiving their full benefit instead of a reduced benefit helps reduce their out of pocket costs and for some but not all makes it easier to remain with their dentist who is out of network.

🔍 Step 2: Out-of-network dentists face *real* financial risk

You said it exactly:

A dentist going out-of-network must accept that their patient volume will decrease.

That means:

- fewer hygiene visits
- fewer new patients
- fewer referrals
- fewer emergencies
- fewer treatment opportunities
- less predictable revenue

So the dentist must ask:

- *Can I absorb the drop in volume?*
- *Can I maintain profitability?*
- *Can my practice survive the transition?*

And here's the key insight:

Simply being paid the same as an in-network dentist does not compensate for the loss of patient volume.

This is why the "mass exodus" argument is not just wrong — it's economically impossible. Simply getting a small percentage increase does not offset the loss of volume or revenue as a 1:1 relationship. It helps to a small degree but does not completely solve the loss of revenue as a result of loss of volume. This needs to be determined before one goes out of network. What volume loss can the dentist sustain. Can that loss of volume be offset by the increase in collected charges to the patients who remain.

🔍 Step 3: Volume loss and revenue loss are not a 1:1 relationship

A dentist must calculate how much volume loss they can sustain.

That means they must ask:

- If I lose 20% of my patients, can I survive?
- If I lose 30%?
- If I lose 40%?
- How many of my patients will stay and pay my full fee?
- How many will leave because they cannot afford the difference?

This is not theoretical — it's math.

And here's the key insight:

A 5–10% increase in reimbursement does not compensate for a 20–40% drop in patient volume.

This is why:

- dentists do **not** leave networks casually
- dentists do **not** leave networks for small fee differences
- dentists do **not** leave networks because of this bill

The economics simply don't support it.