REPRESENTATIVE BILL THOMAS

ALASKA STATE LEGISLATURE DISTRICT 5

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HB 309 prohibits insurance companies from setting fee limits on noncovered procedures and also prevents them from setting age limitations for covered services.

A national trend has developed where dental managed care insurance plans are setting caps on dentist's fees for services that are not covered by the insurance plan. Dental managed care plans offer a service providing consumers with dental care at reduced rates. The insurance company sets a fee limit for a service and the consumer knows upfront how much will be covered and how much he or she will have to pay out of pocket. The problem arises when an insurance carrier tries to set fee limits on services that are ***not*** covered. Insurance companies have begun setting fee limits for certain noncovered services, forcing dentists to reevaluate their decision to participate in the insurance plan thus decreasing the number of dentists participating in the managed care plan. This leaves consumers with fewer dental care options, which usually ends up costing the consumer financially as well as in quality of care.

A second, more recent trend in dental managed care plans is minimum age restrictions. Before benefits are allowed, some insurance companies require that a child be at least four years old. This presents a huge problem in young children obtaining necessary dental care. Dental cavities in very young children continue to be a problem in Alaska and arbitrarily setting minimum age requirements will handicap efforts to restore dental health to this vulnerable population. Tooth decay is highly preventable through early and sustained home care and regular professional preventive services. In May 2003, the American Academy of Pediatrics issued a policy statement urging dental exams for very young children. The policy recommends that infants receive an oral health assessment from a health care professional by six months and be referred to a dental health professional by one year. This important statement recognizes that oral health problems can begin long before a child reaches the age of three.

HB 309 goes a long way towards preventing the above mentioned problems and will ensure that Alaskans continue to receive the dental care that they need. I strongly urge your support of HB 309.

HOUSE BILL NO. 309

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY REPRESENTATIVE THOMAS

Introduced: 1/19/10
Referred: Health and Social Services, Finance

A BILL

FOR AN ACT ENTITLED

1 **"An Act prohibiting health care insurers that provide dental care coverage from setting**
2 **a minimum age for receiving dental care coverage, allowing those insurers to set a**
3 **maximum age for receiving dental care coverage as a dependent, and prohibiting those**
4 **insurers from setting fees that a dentist may charge for dental services not covered**
5 **under the insurer's policy."**

6 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

7 * **Section 1.** AS 21.42.392(a) is amended to read:
8 (a) A health care insurer who provides coverage for dental care may not
9 include in the health care insurance plan or contract a provision that
10 (1) prohibits a covered person from obtaining dental care services from
11 a dentist of the person's choice, including a specialist;
12 (2) restricts a covered person's right to receive full information from
13 the person's dentist regarding the care or treatment options that the dentist believes are

New Text Underlined [DELETED TEXT BRACKETED]

1 in the best interests of the person**;**

2 **(3) sets a minimum age for receiving dental care coverage; or**

3 **(4) permits an insurer to limit a fee set by a dentist for a service**

4 **unless the service is covered under the insurer's plan or contract**.

5 * **Sec. 2.** AS 21.42.392(c) is amended to read:

6 (c) A health care insurer **that provides coverage for dental care** may

7 **(1)** reimburse a covered person at a different rate because of the

8 person's choice of a dentist if the dentist is not a part of the covered person's dental

9 network or preferred provider organization agreement**; the** [. THE] covered expense

10 for non-network providers may not be less than that allowed to a network provider,

11 although the covered expense may be reimbursed at a lower percentage or with higher

12 deductibles than if the service had been provided within the network**; and**

13 **(2) set the maximum age for a person to receive coverage for**

14 **dental care as a dependent**.

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List of Departments Affected by HB 309

1.) Department of Commerce, Community, and Economic Development – Division of Insurance
2.) Department of Health and Social Services

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB 309
() Publish Date:

Identifier (file name): HB309-CED-INS-2-5-10

Title	Dental Care Insurance	Dept. Affected:	DCCED
		RDU	Insurance
		Component	Insurance
Sponsor	Representative Thomas		
Requester	House Health and Social Services Committee	Component Number	354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2010) cost: None

POSITIONS

Full-time							
Part-time							
Temporary							

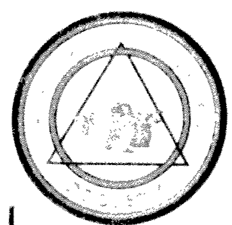
ANALYSIS: *(Attach a separate page if necessary)*

This bill would prohibit health care insurers that provide dental care coverage from setting a minimum age for receiving dental care coverage, allow those insurers to set a maximum age for receiving dental care coverage as a dependent, and prohibit those insurers from setting fees that a dentist may charge for dental services not covered under the insurer's policy.

The department does not expect additional operating expenses as a result of this legislation.

Prepared by: Linda Hall, Director — Phone 907-269-7900
Division: Insurance — Date/Time 2/5/10 2:22 PM
Approved by: Emil Notti, Commissioner — Date 2/5/2010
Department of Commerce, Community and Economic Development

(Revised 11/6/2009 OMB)



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(907) 563-3003 • FAX: 563-3009
akdental@alaska.net

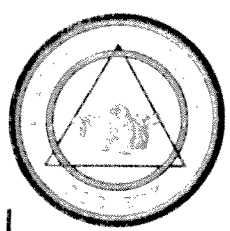
HB309

HB309 will prohibit dental managed care insurance plans from setting fee limits on noncovered procedures and setting minimum age limitations for covered services. A national trend has developed where dental managed care insurance plans are setting caps on dentists' fees for services not covered by the insurance plan. Dental managed care plans offer a service providing consumers with dental care at reduced rates in exchange for limitations on the numbers of dentists who participate and services that are covered. The insurance companies' actions are causing dentists to reevaluate their decision to participate in plans due to philosophical opposition to insurance companies dictating fee levels for services not covered and the economic impact on their practices. The result is increasing numbers of dentists stopping their participation in managed care plans leaving the consumers with fewer choices for participating providers. Patients could then lose the benefit provided and either have to pay more to stay with their dental home, or seek care from another practitioner causing disruption to treatment.

A second, more recent, trend is dental managed care plans setting minimum age restrictions before benefits are allowed. Dental cavities in very young children continue to be a problem in Alaska and arbitrarily limiting the age dependants receive covered benefits will handicap efforts to restore dental health to this vulnerable population.

The insurance companies are requiring state plans to amend provider contracts in a way that allows the managed care plans to control what dentist's charge, even for services they DO NOT cover. The contract amendment says that dentists serving covered patients will not be able to charge the patient a fee in excess of the managed care plans prescribed fee for the non-covered service. It should be noted the two services that fee caps have been set for are orthodontics and veneers, services that are generally discretionary and rarely covered under any insurance plan.

The managed care plans decision to set fee limitations for noncovered services raises questions about the sincerity of their most recent approach to lowering costs. Managed care plans artificially capping a dentist's fee without providing a concurrent benefit for the patient amounts to a subsidy from participating dentists for the insurance companies marketing. At the outset, the reduced fees help the insurer attract customers and, therefore improves the insurer's bottom line. Dentists front the costs of this marketing approach and have a tough decision to make when faced with a contract amendment that caps the non-covered fees



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HB309

- Encourages increased access to dental care
- Prevents insurance companies from intruding on patient-dentist relationship
- Ensures at risk children will continue to receive dental benefits
- Prohibits insurance companies from setting fees on services they do not provide dental benefits for
- Insures dental plans work for the patients best interest not the insurance companies best interest

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20 January 2010

To whom it may concern:

On behalf of the members of the Alaska Dental Society I urge the swift passage of HB309

HB309 will prohibit dental managed care insurance plans from setting fee limits on noncovered procedures and setting minimum age limitations for covered services. A national trend has developed where dental managed care insurance plans are setting caps on dentists' fees for services not covered by the insurance plan. Dental managed care plans offer a service providing consumers with dental care at reduced rates in exchange for limitations on the numbers of dentists who participate and services that are covered. The insurance companies' actions are causing dentists to reevaluate their decision to participate in plans due to philosophical opposition to insurance companies dictating fee levels for services not covered and the economic impact on their practices. The result is increasing numbers of dentists stopping their participation in managed care plans leaving the consumers with fewer choices for participating providers. Patients could then lose the benefit provided and either have to pay more to stay with their dental home, or seek care from another practitioner causing disruption to treatment.

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Sincerely,

Gary A Moeller

Gary A. Moeller, DDS
President, Alaska Dental Society

Noncovered services: House supports legislative action to counter trend

Posted Nov. 12, 2009

By Arlene Furlong

Honolulu—Seeking legislative action to prevent dental plans from capping the amount dentists can charge for services a plan doesn't cover, the 2009 House of Delegates adopted Resolution 59H-2009.

Dental plans began implementing contract provisions holding dentists to maximum allowed fees for services for which no benefit is available with increasing frequency last year.

Many dentists fear such provisions limit access.

"Why should insurance companies be able to charge for things that aren't even in their benefit packages?" asked Dr. Robert Plage, chair of the ADA Dental Benefit Information Service. "If dentists aren't reimbursed for services, the insurance companies won't suffer but the public may. Exercising this contract provision doesn't cost insurers a dime."

ADA News has heard from insurers on the issue. Insurers say including a maximum allowable fee as part of the benefit or plan design allows patients access to services that otherwise would not be covered. They also say the competition is doing it—a reason for employing the provision.

In its first provision, Res. 59H-2009—Maximum Fees for Noncovered Services—establishes ADA policy supporting legislative action to stop the capping of fees for nonscheduled dental services. It resolves that:

• as a matter of policy, the American Dental Association opposes any third-party contract provisions that establish fee limits for nonscheduled dental services.

"The importance of having ADA policy calling for legislative action on this is to let the insurance companies and our members know exactly where we stand on this," said Dr. Plage.

The second resolving clause says the ADA will continue to actively pursue federal legislation to prohibit ERISA covered plans from applying such provisions (ERISA supercedes state plans) and the third directs the ADA to encourage individual states to pursue legislation to prohibit insurance plans from applying noncovered services provisions. (In June, Rhode Island passed a bill preventing dental plans there from capping the amount dentists can charge for services the plan doesn't cover.)

The Employee Retirement Income Security Act of 1974 is a federal law that sets minimum standards for retirement and health benefit plans in private industry.

The second and third clauses of Res. 59H-2009—Maximum Fees for Noncovered Services—resolves as follows:

• that the American Dental Association continue to actively pursue passage of federal legislation to prohibit ERISA covered plans from applying such provisions

• that the American Dental Association encourage constituent dental societies to work for the passage of state legislation to prohibit insurance plans from applying such provisions

The Council on Dental Benefit Programs prioritizes the noncovered services issue as one of dentists' top concerns and is working with the Council on Government Affairs to introduce federal legislation that would get directly at the issue for ERISA plans (federally regulated plans). State legislatures cannot effect changes to ERISA.

"This resolution accomplishes a lot," commented Dr. Plage. "It formally establishes our policy, while giving our members and our respective state dental societies direction on what to do."

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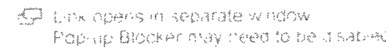

WSDA WASHINGTON STATE DENTAL ASSOCIATION

Non-Covered Services

Non-Covered Services Talking Points

WSDA has proposed legislation for the 2010 session which would prohibit dental insurers from limiting fees for services not included in dental benefit plans.

Why is legislation necessary?

In July 2009 Washington Dental Services , the state's largest dental insurer, announced new provider contract provisions, allowing it to limit fees charged by its contracted dentists for services that are not covered by the insurer's dental plans. WDS said it was doing so to stay competitive with other insurers implementing similar provisions, however WDS also indicated it disagreed with this policy and was forced to implement it due to its alliance nationally with the Delta Dental system.

- Unless prohibited by insurance law, these provisions constitute an unjust interference in the financial affairs of dental practices.
- Some dental insurers have also added contract provisions to force dental practices to reduce charges when patients reach annual benefit maximum limits.
- Non-covered services vary by insurer and include such items as use of nitrous oxide to control dental fear and anxiety, implants, and posterior composite restorations. While a complete list from WDS is not yet available, WSDA understands these will likely be elective procedures that are consented to by the patient after discussion with the dentist.
- Limiting fees for non-covered services will force dental practices to cost shift. This will result in higher fees charged to uninsured patients and reduced participation in low-reimbursement plans, such as a Medicaid.
- Rhode Island enacted a prohibition on non-covered fee limits in June 2009.
- The National Conference of Insurance Legislators is now considering model legislation to prohibit non-covered service fee limits. Federal legislation is also being pursued to prohibit this practice by ERISA plans not regulated under state laws.

This directory does not yet contain any files.

Supplied by Academy of General Dentistry: http://www.agd.org/issuesadvocacy/hotissues/casonfees/

1/19/2010

Putting Caps on Fees for Non-Reimbursed Services

Several major dental benefits carriers are adding language to provider participation agreements to allow them to set fees for dental services that they do not pay for, i.e., non-covered services. That is, if a dentist agrees to the contract language, he or she will be required to charge the patient what the carrier has told him or her to charge even when the carrier will not pay for the service.

To enact a fee cap on non-covered services, a dental benefits carrier must amend the current contract it has with its existing providers. Here's an example of such an amendment:

Dentist may bill a Member for non-covered services (which are defined as any service for which no payment is made under the applicable plan or arrangement for any reason, including but not limited to, services in excess of contractual maximums, services not covered under plan design, and services denied due to contractual limitations). Dentist's charge to Member for non-covered services may not exceed the Maximum Allowable Charge for the applicable CDT code as specified in the most current Maximum Allowable Charge schedule. Fees for all non-covered services will be collected from the Member, and not billed to the Carrier.

Note that this is just one of many variations of such a provision that you may find in your participation contract. The provider then has the choice of signing the new contract, thus accepting the new fee caps, or terminating his or her contract. If the provider elects not to sign, then he or she will be excluded from the provider networks presented to patients by that carrier's dental plans.

What are the non-covered services?

Non covered services are those services that a patient's dental plan has chosen not to pay for. Note that a carrier may offer numerous dental plans. Often however, dental plans without coverage for expensive, cosmetic, or other dental services are cheaper for employers to purchase for their employees. This is especially attractive to employers in the current economic climate. Each dental plan may have a different list of non-covered services, and therefore one cannot specify any particular services as universal "non-covered services."

Scope of the issue

Because dental benefits carriers can fall under the protection of the Employee Retirement Income Security Act of 1974 (ERISA), this is both a national and state issue. ERISA is a federal law that sets minimum standards for retirement and health benefit plans in private industry. Insurers that cover large employee groups who self-insure will more likely fall under ERISA. Some state laws do not exempt dentists from ERISA dental insurance plans that want to implement this policy change.

Rationale of carriers enacting such policy

To stay competitive with one another, dental benefits carriers use the argument of market pressure or gaining a marketing advantage as one of the reasons they are implementing this policy. Market need, the carriers assert, is being driven by patients who can save money on services not covered by their dental benefits plan and see value in limiting their out-of-pocket expenses. However, limiting dentists' charge to patients for non-covered services allows these carriers to market their dental plans as costing patients less without bearing any of the financial risk of the discount; that is, these carriers gain the marketing advantage by shifting the risk to the providers. Therefore, the market trend will drive all carriers to implement similar restrictions in order to avoid a competitive disadvantage. Accordingly, any legislation enacted against the practice of fee-capping for non-covered services must be sufficiently broad to prevent all carriers from engaging in this practice

**Supplied by Academy of General Dentistry: http://www.agd.org/issuesadvocacy/hotissues/casonfees/*

Impact to Patients and the Practice of Dentistry
As primary care providers of oral health care, general dentists strive first and foremost for access to quality care for all as the ultimate goal of the profession. However, to serve its patients, a dental office must be viable and sustainable. Today, more patients than ever rely upon dental insurance to be able to afford oral health care. Studies have shown that, without dental insurance, far fewer persons will choose to see a dentist. Understandably, in the present economy, each of us must make cutbacks to our expenses in order to survive. Public awareness and understanding of the impact of oral health on systemic health issues such as diabetes and cardiovascular afflictions is still at its fledgling stages. Therefore, out-of-pocket expenses for oral health are often among the first to be avoided by the public.

Concurrently, businesses including those of dental benefits carriers and employers are also seeking cutbacks. Carriers striving to maintain or increase their revenues and marketshare in this economy offer employers cheaper plans for their employees by covering fewer services and paying less than true market value even for those services they cover. However, by covering fewer services, carriers compel patients to pay for more services out-of-pocket, which they may be unable or unwilling to do. Second, by paying less for the services they do cover, carriers compel dentists to function at a net loss when providing these covered services.

Therefore, today's dentist must often rely upon billing at market rates for non-covered services to compensate for the loss he or she absorbs in accepting paltry fees from carriers for covered services. However, unlike the carriers' actions of limiting services they cover, the dentists' actions do not impose an undue burden upon patients. Here's why. In the absence of fee-caps for non-covered services, dentists work with each patient on a case-by-case basis to charge what each patient may be able to afford with an understanding that some patients may be able or willing to afford more than others.

Fee capping takes away this opportunity! If fees for non-covered services are capped across the board without regard to what each patient can afford, the practice of the participating dentist may become unsustainable. The result may be two-fold. He or she may no longer be able to offer that specific service to that carrier's patients, thus limiting the patients' treatment options. In some markets, providers may feel compelled to stop participating with certain carriers in order to survive. In either case, the patients would face decreased access care.

**Surgeon General fact sheet on oral health Children's Oral Health, National Center for Chronic Disease Prevention and Health*

Oral Health 2000: Facts and Figures

- The oral health of children has improved significantly over the past few decades.
- Today most American children enjoy excellent oral health, **but a significant subset suffers a high level of oral disease. The most advanced disease is found primarily among children living in poverty, some racial/ethnic minority populations, disabled children, and children with HIV infection.**
- We know enough about health promotion and disease prevention measures to improve the oral health and well-being of all children.
- Tooth decay remains one of the most common diseases of childhood – 5 times as common as asthma and 7 times as common as hay fever.
- More than half of children aged 5-9 have had at least one cavity or filling; 78 percent of 17-year-olds have experienced tooth decay.
- By age 17, more than 7 percent of children have lost at least one permanent tooth to decay.
- Each year, 8,000 babies are born with cleft lip and/or cleft palate, making these among the most common birth defects. Cleft lip and cleft palate interfere with normal appearance, eating, and speech.
- Injuries to children, intentional and non-intentional, often involve trauma to the head, neck, and mouth. The leading causes of oral and head injuries are sports, violence, falls, and motor vehicle crashes.
- Tobacco-related oral lesions are common in teenagers who use spit (smokeless) tobacco. The lesions occur in 35 percent of snuff users and 20 percent of chewing tobacco users.
- One in four American children are born into poverty (annual income of $17,000 or less for a family of four). Children and adolescents living in poverty suffer twice as much tooth decay as their more affluent peers, and their disease is more likely to go untreated.
- **Children from families without medical insurance are 2.5 times less likely than insured children to receive dental care. Children from families without dental insurance are 3 times more likely than insured children to have unmet dental needs.**
- For every child without medical insurance, *there are 2.6 who lack dental insurance*
- Fewer than one in five Medicaid-covered children had a preventive dental visit during a recent year-long study.
- The daily reality for children with untreated oral disease is often persistent pain, inability to eat comfortably or chew well, embarrassment at discolored and damaged teeth, and distraction from play and learning.

Surgeon General fact sheet on oral health Children's Oral Health, National Center for Chronic Disease Prevention and Health

- More than 51 million school hours are lost each year because of dental-related illness.

- Pregnant women should get prenatal care and eat a healthy diet that includes folic acid to prevent neural tube defects and possibly cleft lip/palate. During pregnancy avoid tobacco and alcohol, and check with a doctor before taking any medications.

- Put only water in your baby's bottle at bedtime or naptime. Milk, formula, juices, and other drinks contain sugar. Prolonged exposure to sugary drinks while baby sleeps – when saliva flow is reduced – increases the risk of tooth decay.

- **Take your child for an oral health assessment between ages 1-2, and every six months thereafter.**

- Protect your child's teeth with fluoride. Use a fluoridated toothpaste, putting only a pea-sized amount on your child's toothbrush. If your drinking water is not fluoridated, talk to a dentist or physician about the best way to protect your child's teeth.

- Encourage your children to eat regular nutritious meals and to avoid frequent between-meal snacking.

- Talk to your child's dentist about dental sealants, which protect teeth from decay.

- Make sure your child wears a helmet when bicycling and uses protective headgear and mouth guards in other sports activities.

- The nation's oral health is the best it has ever been, yet oral diseases remain common in the United States.

- The burden of oral diseases is spread unevenly throughout the population. Many more poor people and some racial/ethnic minority groups have untreated oral disease than does the population as a whole.

- Safe and effective measures for preventing oral disease are underused. These include water fluoridation, dental sealants, and regular professional care, as well as tobacco cessation.

- Tooth decay is one of the most common childhood diseases—5 times as common as asthma and 7 times as common as hay fever in 5-to-17-year-olds.

- **18 percent of 2-to-4-year-old children have experienced tooth decay, and 16 percent have untreated decay.**

- Only 23 percent of 8-year-old children have at least one dental sealant on their molar teeth.

- By age 17, 78 percent of young people have had a cavity, and 7 percent have lost at least one permanent tooth.

- *Among adults aged 35 to 44 years, 69 percent have lost at least one permanent tooth.*

- Among adults aged 65 to 74, 26 percent have lost all their natural teeth

Surgeon General fact sheet on oral health Children's Oral Health, National Center for Chronic Disease Prevention and Health

- Untreated tooth decay remains a problem. About one-third of persons across all age groups have untreated decay.
- Among adults aged 35 to 44, 48 percent have gingivitis, and 22 percent have destructive gum disease. Tobacco use increases the risk of gum disease.
- In the U.S., 30,000 people are diagnosed with mouth and throat cancer each year, and 8,000 die of these cancers.
- Mouth and throat cancers are the sixth most common cancers in U.S. males and the fourth most common in African American men.
- Oral clefts are one of the most common birth defects in the United States. The prevalence of cleft lip/palate in the general population is about 1 per 1,000 births.
- Community water fluoridation reaches over 144 million people, or 62 percent of Americans on public water supplies. One hundred million Americans do not have fluoridated water.
- In 1998, a total of $53.8 billion was spent on dental care—48 percent was paid by dental insurance, 4 percent by government programs, and 48 percent was paid out-of-pocket. Expenditures in the year 2000 are expected to exceed $60 billion.
- More than 108 million Americans do not have dental insurance. For every child without medical insurance, there are 2.6 without dental insurance.

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Atlanta, GA 30341
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Content source: Division of Oral Health, National Center for Chronic Disease Prevention and Health Promotion