

SB

258

<target><bill>SB 258</bill><subject>SB
258</subject><comm>HFIN26</comm></target>

ALASKA STATE LEGISLATURE

Senate District H
600 E. Railroad Avenue
Wasilla AK 99654
907-376-4866
907-373-4724 - Fax
Senator_Charlie_Huggins@legis.state.ak.us



State Capitol, Room 119
Juneau AK 99801-1182
907-465-3878
Fax: 907-465-3265
800-862-3878
www.akrepublicans.org/huggins/

Charlie Huggins Senator

SPONSOR STATEMENT SB 258 VS E

Upon passage SB 258 gives consumers greater access to dental care, as a result of the broadened choices which will be available to dentists entering into managed care agreements.

The bill limits an insurer, selling managed care policies, from unilaterally requiring providers to accept fee caps on services for which the insurer does not pay a benefit. Fee capping, a growing nationwide effort on the part of insurance companies, drives providers away from preferred provider agreements or toward cost shifting their losses, in the form of increased charges, to patients with traditional insurance or no insurance. Fewer dentists participating in managed care plans leaves consumers with fewer dental options, which usually results in greater costs both financially and in quality of care.

This version is the result of the stakeholders, professional care givers, the insurance industry and small business working together to craft a compromise. It allows insurers to offer alternative contracts,

- ❖ one which dictates discounted fee schedules for services on which a benefit is paid, as well as for services on which benefits are not paid; and
- ❖ another which caps fees ONLY on services for which the insurer pays a benefit.

Dentists can choose one of two options when participating in preferred provider/managed care programs. Uninsured consumers or those under traditional insurance plans will benefit from a reduction in cost shifting, which occurs when dentists are forced to discount non covered services for managed care patients.

SB 258 goes a long way towards fostering greater access to dental care. I strongly urge your support of SB 258.

NFIB

The Voice of Small Business®

ALASKA

March 25, 2010

The Honorable Charlie Huggins
State Capitol Building
Juneau, Alaska 99801-1182

Dear Senator Huggins:

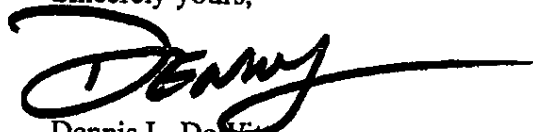
RE: SB 258 Proposed Committee Substitute

On behalf of the National Federation of Independent Business/Alaska, I wish to respectfully remove our opposition to Senate Bill 258. The National Federation of Independent Business is the largest small-business advocacy group in Alaska.

We want to express our appreciation of your willingness to address our previous concerns and to propose a committee substitute that eliminates the portion of the bill that we opposed.

Thus, the NFIB/AK no longer has any concerns with Senate Bill 258.

Sincerely yours,



Dennis L. DeWitt
Alaska State Director

Cc: NFIB/AK Leadership Council
Senate Labor & Commerce Committee




April 2, 2010

Alaska State Legislature
State Capitol Room 3
Juneau, Alaska 99801-1182

To Whom It May Concern:

Delta Dental of Alaska is in support of SB258. We do not believe non-contracted services should be restricted by insurers unless there is a mutual agreement between the dentist and the insurance company. We do have concerns about section 3 (A) (ii) concerning marketing materials and the inability to only list those dentists that have signed a contract but this concern does not outweigh our support of SB258.

Sincerely,

William S. Ten Pas
Senior Vice President

Delta Dental of Alaska
601 West 5th Avenue
Suite 510
Anchorage, AK 99501

Telephone: 907-278-2626
Toll-free: 888-374-8910
Fax: 907-278-2900

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 529

BY BUSINESS COMMITTEE

AN ACT

1 RELATING TO INSURANCE CONTRACTS WITH PROVIDERS OF DENTAL SERVICES;
2 AMENDING CHAPTER 18, TITLE 41, IDAHO CODE, BY THE ADDITION OF A NEW
3 SECTION 41-1849, IDAHO CODE, TO PROVIDE PROVISIONS FOR CONTRACTS WITH
4 PROVIDERS OF DENTAL SERVICES, TO DEFINE "COVERED SERVICES" AND TO
5 PROVIDE APPLICATION; AMENDING CHAPTER 34, TITLE 41, IDAHO CODE, BY THE
6 ADDITION OF A NEW SECTION 41-3444, IDAHO CODE, TO PROVIDE PROVISIONS
7 FOR CONTRACTS WITH PROVIDERS OF DENTAL SERVICES, TO DEFINE "COVERED
8 SERVICES" AND TO PROVIDE APPLICATION.
9

10 Be It Enacted by the Legislature of the State of Idaho:

11 SECTION 1. That Chapter 18, Title 41, Idaho Code, be, and the same is
12 hereby amended by the addition thereto of a NEW SECTION, to be known and
13 designated as Section 41-1849, Idaho Code, and to read as follows:

14 41-1849. CONTRACTS WITH PROVIDERS OF DENTAL SERVICES. (1) No person
15 contracting with dentists to provide coverage or reimbursement for
16 dental services may require, as an element of any dental care provider
17 participation contract, that any provider agree to adopt fees set by the
18 person for services that are not covered services under the contract.
19 "Covered services" as used in this section means services under the
20 applicable dental plan, dental plan contract or plan benefits subject to
21 such contractual limitations on benefits of the dental plan, dental plan
22 contracts or plan benefits as may apply.

23 (2) This section shall apply to any contract with providers for dental
24 services that is issued after January 1, 2011. Contracts that are in
25 existence on January 1, 2011, shall be brought into compliance on the next
26 anniversary date, renewal date, or the expiration date of the applicable
27 collective bargaining contract, if any, whichever date is latest.

28 SECTION 2. That Chapter 34, Title 41, Idaho Code, be, and the same is
29 hereby amended by the addition thereto of a NEW SECTION, to be known and
30 designated as Section 41-3444, Idaho Code, and to read as follows:

31 41-3444. CONTRACTS WITH PROVIDERS OF DENTAL SERVICES. (1) No person
32 contracting with dentists to provide coverage or reimbursement for
33 dental services may require, as an element of any dental care provider
34 participation contract, that any provider agree to adopt fees set by the
35 person for services that are not covered services under the contract.
36 "Covered services" as used in this section means services under the
37 applicable dental plan, dental plan contract or plan benefits subject to
38 such contractual limitations on benefits of the dental plan, dental plan
39 contracts or plan benefits as may apply.

1 (2) This section shall apply to any contract with providers for dental
2 services that is issued after January 1, 2011. Contracts that are in
3 existence on January 1, 2011, shall be brought into compliance on the next
4 anniversary date, renewal date, or the expiration date of the applicable
5 collective bargaining contract, if any, whichever date is latest.

AN ACT

ENTITLED, An Act to prohibit dental insurers from setting fees for noncovered services.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

Section 1. No contract between an insurer and a dentist may require a dentist to provide services for an insured at a fee set by the contract unless the services are covered services under the terms of the insured's plan or policy. For the purposes of this section, the term, covered services, means services reimbursable under the plan, policy, or contract, subject to such contractual limitations on benefits as may apply, including deductibles, waiting periods, frequency limitations, or charges over the benefit maximum.

An Act to prohibit dental insurers from setting fees for noncovered services.

I certify that the attached Act
originated in the
SENATE as Bill No. 108

Secretary of the Senate

President of the Senate

Attest:

Secretary of the Senate

Speaker of the House

Attest:

Chief Clerk

Senate Bill No. 108
File No. _____
Chapter No. _____

Received at this Executive Office
this ____ day of _____,
20__ at _____ M.

By _____
for the Governor

The attached Act is hereby
approved this _____ day of
_____, A.D., 20__

Governor

STATE OF SOUTH DAKOTA,
ss.
Office of the Secretary of State

Filed _____, 20__
at _____ o'clock __ M.

Secretary of State

By _____
Asst. Secretary of State

**Enrolled
House Bill 3665**

Sponsored by COMMITTEE ON HEALTH CARE (at the request of the Oregon Dental Association)

CHAPTER

AN ACT

Relating to dental services contracts; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Section 2 of this 2010 Act is added to and made a part of the Insurance Code.

SECTION 2. (1) As used in this section:

(a) "Dental services contract" means a contract between an insurer and a provider or a group of providers to provide dental health services for enrollees. "Dental services contract" does not include a contract of employment or a contract creating legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other similar professional organizations permitted by statute.

(b) "Enrollee" means a person entitled to receive dental health benefits from an insurer.

(c) "Provider" means a person licensed or otherwise authorized by the laws of this state to administer dental health services in the ordinary course of business or practice of a profession.

(2) A dental services contract may not restrict the price that a provider may charge for services provided to an enrollee unless the services are covered by the insurer.

SECTION 3. Section 2 of this 2010 Act applies to dental services contracts entered into or renewed on or after the effective date of this 2010 Act.

SECTION 4. Section 2 of this 2010 Act is repealed on January 2, 2015.

SECTION 5. This 2010 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2010 Act takes effect on its passage.

Passed by House February 9, 2010

Repassed by House February 23, 2010

.....
Chief Clerk of House

.....
Speaker of House

Passed by Senate February 22, 2010

.....
President of Senate

Received by Governor:

.....M,....., 2010

Approved:

.....M,....., 2010

.....
Governor

Filed in Office of Secretary of State:

.....M,....., 2010

.....
Secretary of State

Chapter 041
2009 -- H 5454 SUBSTITUTE A AS AMENDED
Enacted 06/18/09

A N A C T
RELATING TO INSURANCE - DENTAL SERVICE CORPORATIONS

Introduced By: Representative John J. McCauley
Date Introduced: February 12, 2009

It is enacted by the General Assembly as follows:

SECTION 1. Chapter 23-17.13 of the General Laws entitled "Health Care Accessibility and Quality Assurance Act" is hereby amended by adding thereto the following section:

23-17.13-6. Contracts with providers for dental services. - (a) No contract between a dental plan of a health care entity and a dentist for the provision of services to patients may require that a dentist provide services to its subscribers at a fee set by the health care entity unless said services are covered services under the applicable subscriber agreement. "Covered services," as used herein, means services reimbursable under the applicable subscriber agreement, subject to such contractual limitations on subscriber benefits as may apply, including, for example, deductibles, waiting period or frequency limitations.

(b) For the purposes of this section "dental plan" shall include any policy of insurance which is issued by a health care entity which provides for coverage of dental services not in connection with a medical plan.

SECTION 2. This act shall take effect upon passage.

=====
LC01675/SUB A/2
=====

2010 SESSION

ENROLLED

ENROLLED

HB1263ER

1 VIRGINIA ACTS OF ASSEMBLY — CHAPTER

2 An Act to amend and reenact §§ 38.2-4214, 38.2-4319, and 38.2-4509 of the Code of Virginia and to
3 amend the Code of Virginia by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered
4 38.2-3407.17, relating to limitations by a dental plan on reimbursements for certain services
5 provided by dentists and oral surgeons.

6 [H 1263]
7 Approved

8 Be it enacted by the General Assembly of Virginia:
9 1. That §§ 38.2-4214, 38.2-4319, and 38.2-4509 of the Code of Virginia are amended and reenacted
10 and that the Code of Virginia is amended by adding in Article 1 of Chapter 34 of Title 38.2 a
11 section numbered 38.2-3407.17 as follows:

12 § 38.2-3407.17. Payment for services by dentists and oral surgeons.

13 A. As used in this section:

14 "Covered services" means the health care services for which benefits under a policy, contract, or
15 evidence of coverage are payable by a dental plan, including services paid by the insureds, subscribers,
16 or enrollees because the annual or periodic payment maximum established by the dental plan has been
17 met.

18 "Dental plan" includes (i) an insurer proposing to issue individual or group accident and sickness
19 insurance policies providing hospital, medical, and surgical or major medical coverage on an
20 expense-incurred basis, (ii) an entity providing individual or group accident and sickness subscription
21 contracts, (iii) a dental services plan offering or administering prepaid dental services, (iv) a health
22 maintenance organization providing a health care plan, and (v) a dental plan organization.

23 B. No contract between a dental plan and a dentist or oral surgeon may establish the fee or rate
24 that the dentist or oral surgeon is required to accept for the provision of health care services, or
25 require that a dentist or oral surgeon accept the reimbursement paid as payment in full, unless the
26 services are covered services under the applicable dental plan.

27 C. This section shall apply with respect to any contract between a dental plan and a dentist or oral
28 surgeon for the provision of health care to patients that is entered into, amended, extended, or renewed
29 on or after July 1, 2010.

30 D. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of
31 this section.

32 § 38.2-4214. Application of certain provisions of law.

33 No provision of this title except this chapter and, insofar as they are not inconsistent with this
34 chapter, §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230,
35 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through
36 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017,
37 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2
38 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1315.1, 38.2-1317 through
39 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836,
40 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3406.2, 38.2-3407.1 through
41 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.16 38.2-3407.17, 38.2-3409, 38.2-3411 through
42 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3501, 38.2-3502, subdivision 13 of § 38.2-3503,
43 subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, §§ 38.2-3516 through 38.2-3520 as they
44 apply to Medicare supplement policies, §§ 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1,
45 38.2-3541, 38.2-3541.1, 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35,
46 §§ 38.2-3600 through 38.2-3607, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.),
47 Chapter 58 (§ 38.2-5800 et seq.) and § 38.2-5903 of this title shall apply to the operation of a plan.

48 § 38.2-4319. Statutory construction and relationship to other laws.

49 A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this
50 chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218
51 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through
52 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.),
53 §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1306.1,
54 § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of
55 Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800
56 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9

57 through 38.2-3407.16 38.2-3407.17, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1:01, 38.2-3414.1,
 58 38.2-3418.1 through 38.2-3418.15, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision
 59 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through
 60 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3541.1, 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et
 61 seq.) of Chapter 35, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58
 62 (§ 38.2-5800 et seq.) and § 38.2-5903 of this title shall be applicable to any health maintenance
 63 organization granted a license under this chapter. This chapter shall not apply to an insurer or health
 64 services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200
 65 et seq.) of this title except with respect to the activities of its health maintenance organization.

66 B. For plans administered by the Department of Medical Assistance Services that provide benefits
 67 pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title
 68 except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136,
 69 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229,
 70 38.2-232, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through
 71 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, § 38.2-1306.1,
 72 Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et
 73 seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et
 74 seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6 and
 75 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions 1, 2, and 3 of subsection F
 76 of § 38.2-3407.10, 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, and 38.2-3407.14,
 77 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500,
 78 subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1
 79 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.),
 80 Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) and § 38.2-5903 shall be applicable to
 81 any health maintenance organization granted a license under this chapter. This chapter shall not apply to
 82 an insurer or health services plan licensed and regulated in conformance with the insurance laws or
 83 Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health
 84 maintenance organization.

85 C. Solicitation of enrollees by a licensed health maintenance organization or by its representatives
 86 shall not be construed to violate any provisions of law relating to solicitation or advertising by health
 87 professionals.

88 D. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful
 89 practice of medicine. All health care providers associated with a health maintenance organization shall
 90 be subject to all provisions of law.

91 E. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health
 92 maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to
 93 offer coverage to or accept applications from an employee who does not reside within the health
 94 maintenance organization's service area.

95 F. For purposes of applying this section, "insurer" when used in a section cited in subsections A and
 96 B of this section shall be construed to mean and include "health maintenance organizations" unless the
 97 section cited clearly applies to health maintenance organizations without such construction.

98 § 38.2-4509. Application of certain laws.

99 A. No provision of this title except this chapter and, insofar as they are not inconsistent with this
 100 chapter, §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229,
 101 38.2-316, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620,
 102 38.2-900 through 38.2-904, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.)
 103 and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1315.1, Article 4
 104 (§ 38.2-1317 et seq.) of Chapter 13, §§ 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836,
 105 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3407.10, 38.2-3407.13, 38.2-3407.14, 38.2-3407.15, 38.2-3407.17,
 106 38.2-3415, 38.2-3541, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, §§ 38.2-3600 through 38.2-3603,
 107 Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) and § 38.2-5903 of this title shall
 108 apply to the operation of a plan.

109 B. The provisions of subsection A of § 38.2-322 shall apply to an optometric services plan. The
 110 provisions of subsection C of § 38.2-322 shall apply to a dental services plan.

111 C. The provisions of Article 1.2 (§ 32.1-137.7 et seq.) of Chapter 5 of Title 32.1 shall not apply to
 112 either an optometric or dental services plan.

example

Rhode Island

Chapter 041
2009 -- H 5454 SUBSTITUTE A AS AMENDED
Enacted 06/18/09

A N A C T
RELATING TO INSURANCE - DENTAL SERVICE CORPORATIONS

Introduced By: Representative John J. McCauley
Date Introduced: February 12, 2009

It is enacted by the General Assembly as follows:

SECTION 1. Chapter 23-17.13 of the General Laws entitled "Health Care Accessibility and Quality Assurance Act" is hereby amended by adding thereto the following section:

23-17.13-6. Contracts with providers for dental services. – (a) No contract between a dental plan of a health care entity and a dentist for the provision of services to patients may require that a dentist provide services to its subscribers at a fee set by the health care entity unless said services are covered services under the applicable subscriber agreement. "Covered services," as used herein, means services reimbursable under the applicable subscriber agreement, subject to such contractual limitations on subscriber benefits as may apply, including, for example, deductibles, waiting period or frequency limitations.

(b) For the purposes of this section "dental plan" shall include any policy of insurance which is issued by a health care entity which provides for coverage of dental services not in connection with a medical plan.

SECTION 2. This act shall take effect upon passage.

=====
LC01675/SUB A/2
=====

[Home](#) | [Contact](#) | [Login](#)



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.



Alaska Dental Society, Inc.

9170 Jewel Lake Road, Suite 203
Anchorage, Alaska 99502-5390
(907) 563-3003 • FAX: 563-3009
akdental@alaska.net

HB309/SB258

- 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



Alaska Dental Society

9170 Jewel Lake Road, Suite 203
Anchorage, Alaska 99502-5390
(907) 563-3003 • FAX: 563-3009
info@akdental.org

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/SB 258

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

Sincerely,

Gary A. Moeller, DDS
President, Alaska Dental Society

access

children

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: SB 258
(S) Publish Date: 2/17/10

Identifier (file name): SB258-CED-INS-2-11-10 Dept. Affected: DCCED
Title: Dental Care Insurance RDU: Insurance
Component: Insurance
Sponsor: Senator Huggins
Requester: Senate 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						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
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	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	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 2/11/10 9:30 AM
Approved by: Emil Notti, Commissioner Date 2/11/2010
Department of Commerce, Community and Economic Development

List of States (20)
that have introduced this legislation to-date in 2010

AK, AZ, CO, FL, HI, ID, IL, IN, IA, KS, MD, MS,

MO, ME, OK, OR, PA, SD, VA, WA.

From American Dental Association
February 15, 2010

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: SB 258
(S) Publish Date: 2/17/10

Identifier (file name): SB258-CED-INS-2-11-10 Dept. Affected: DCCED
Title: Dental Care Insurance RDU: Insurance
Component: Insurance
Sponsor: Senator Huggins
Requester: Senate 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						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
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	0.0

CAPITAL EXPENDITURES								
-----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES ()								
-------------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

	FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
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

	FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
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
Division: Insurance
Approved by: Emil Notti, Commissioner
Department of Commerce, Community and Economic Development

Phone 907-269-7900
Date/Time 2/11/10 9:30 AM
Date 2/11/2010