HB 309

HOUSE COMMITTEE REPORT

(7)
Date Referred to Committee: January 19, 2010 **FURTHER REFERRALS: Finance**

Date of Committee Action: March 25, 2010

The HEALTH AND SOCIAL SERVICES Committee considered: **HB 309**

HOUSE BILL NO. 309
"An Act prohibiting health care insurers that provide dental care coverage from setting a minimum age for receiving dental care coverage, allowing those insurers to set a maximum age for receiving dental care coverage as a dependent, and prohibiting those insurers from setting fees that a dentist may charge for dental services not covered under the insurer's policy."

HB 309 DENTAL CARE INSURANCE

Recommends it be replaced with [ ] HCS *or* [✓] CS *for* HB 309 (HSS)
For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR_____ **[ ] Same Title [✓] New Title**

[ ] attach amendments
[ ] add new referral to _____Committee
[ ] Letter of Intent_____Committee

List of Abbrev for Depts.:
ADM
CED
COR
CRT
EED
DEC
DFG
GOV
DHS
LWF
LAW
LEG
MVA
DNR
DPS
REV
DOT
UA

***NEW* FISCAL NOTES**
*Assigned by Chief Clerk's Office

List by Dept(s):	*FN#	Fiscal	Indet.	Zero
CED				✓

***PREVIOUS* FISCAL NOTES**

List by Dept(s):	FN#	Fiscal	Indet.	Zero

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
	Holmes			X	
Tammie Wilson	T Wilson			X	
Paul R Seaton	SEATON			X	
	LYNN	X			
Chair: Wes Keller	Keller			X	
Chair:	HERRON			X	

Adopted

moved by Rep. Herron

AMENDMENT #1

Offered in : House Health & Social Services Committee

By:

To: HB 309 work draft 26-LS1315\C

Page 1, Line 14

After (2)

Insert "not"

26-LS1315\C
Bailey
3/24/10

CS FOR HOUSE BILL NO. 309( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE THOMAS

A BILL

FOR AN ACT ENTITLED

"An Act prohibiting health care insurers that provide dental care coverage from setting fees that a dentist may charge under a preferred provider contract for dental services not covered under the insurer's policy, and relating to preferred provider contracts between insurers and dentists."

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

*** Section 1.** AS 21.42.392(c) is amended to read:

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

(1) reimburse a covered person at a different rate because of the person's choice of a dentist if the dentist is not a part of the covered person's dental network or preferred provider organization agreement**; the** [. THE] covered expense for non-network providers may not be less than that allowed to a network provider, although the covered expense may be reimbursed at a lower percentage or with higher deductibles than if the service had been provided within the network**;**

(2) limit a fee set by a dentist for a service unless the service is covered under the insurer's plan or contract, except as provided under (3) of this

subsection; and

(3) offer a dentist the option of entering into a preferred provider contract with the insurer that provides a fee schedule for covered services only or a fee schedule for both covered and uncovered services; under this paragraph,

(A) the health care insurer may not

(i) take an action against the dentist based on the dentist's refusal to enter into a contract with an insurer;

(ii) fail to list a dentist who does not enter into a contract with an insurer in the insurer's marketing materials; or

(iii) take action against the dentist during the management or administration of a contract based on the dentist's choice of contract;

(B) the terms or provisions of the contract

(i) may not violate AS 45.50.562 - 45.50.566; and

(ii) ~~may~~ Shall require both authorize the insurer and the dentist to provide information to the insured describing the dentist's choice of contract and fee schedules;

(C) "covered service" means a health care service for which a health care insurer pays a benefit for all or part of the service, including a benefit that is available but limited by deductible, coinsurance, or frequency terms under the contract between the insurer and the insured.

Adopted
Mandy Sailor
Conceptual
#2

CS HB 309 26LS1315\C

Bailey 3/24/10

Page 1, Line 2 and 3

DELETE All

Page 1, Line 4

DELETE "Insurers from setting"

Page 1, Line 4

after "for" INSERT "under preferred provider contract"

Page 1, Line 5

After "policy" INSERT ", and relating to preferred provider contracts between insurers and dentists"

Page 2

DELETE ALL

INSERT "; (2) limit a fee set by a dentist for a service unless the service is covered under the insurer's plan or contract, except as provided under (3) of this subsection; and

(3) offer a dentist the option of entering into a preferred provider contract with the insurer that provides a fee schedule for covered services only or a fee schedule for both covered and uncovered services; under this paragraph,

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(i) take an action against the dentist based on the dentist's refusal to enter into a contract with an insurer;

(ii) fail to list a dentist who does not enter into a contract with an insurer in the insurer's marketing materials; or

(iii) take action against the dentist during the management or administration of a contract based on the dentist's choice of contract;

(B) the terms or provisions of the contract

(i) may not violate AS 45.50.562 – 45.50566; and

(ii) may authorize the insurer to provide information to the insured describing the dentist's choice of contract and fee schedules;

(C) "covered service" means a health care service for which a health care insurer pays a benefit for all or part of the service, including a benefit that is available but limited by deductible, coinsurance, or frequency terms under the contract between the insurer and the insured."

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

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Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 9, 2010

SUBJECT: Does AS 21.42.345 cover dependents for dental care?
(HB 309, Work Order No. 26-LS1315\R)

TO: Representative Bill Thomas
Attn: Cecile Elliott

FROM: Dennis C. Bailey
Legislative Counsel

You have asked whether AS 21.42.345, which requires an insurer to insure the children of an insured under a policy with dependent coverage, would override the proposed provision of HB 309, which would prohibit insurers from setting a minimum age under which a child would not receive coverage for dental care. This memorandum reviews the terms of AS 21.42.345 and the proposed change to AS 21.42.392 in HB 309 and concludes that the two provisions conflict.

AS 21.42.385.
AS 21.42.345 provides:

> **Sec. 21.42.345. Required provision for coverage of dependents.** (a) A health care insurance plan providing coverage for a dependent of a covered individual shall, as to the dependent's coverage, also provide that the health care insurance benefits applicable for dependents shall be payable with respect to
>
> (1) a newly born child of a covered individual from the moment of birth;
>
> (2) a child adopted by a covered individual from the date of adoption;
>
> (3) a child placed with a covered individual for adoption from the date of placement for adoption; and
>
> (4) a spouse from not later than the first day of the first month beginning after the date the request for enrollment is received, but the insurer may require that a request for enrollment be received within 31 days of the date of marriage.
>
> (b) The coverage for a newly born child under this section shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.
>
> . . .

To paraphrase, AS 21.42.345 requires that a health care insurance plan that provides for dependent coverage must include coverage for newborn children, adopted children, and new spouses. This section only applies to policies that provide dependent coverage, and would not apply, for example, if a group plan sponsored by an employer either did not provide coverage for an employee's dependents or allowed the insured to elect coverage without dependent benefits.

AS 21.42.345, however, does not state whether dental care is included in the required coverage for dependent children. That question is answered by AS 21.12.050, which defines health care insurance as follows (emphasis added):

> **Sec. 21.12.050. Health and health care insurance defined.** (a) Health insurance is insurance of human beings (1) against bodily injury, disablement, or death by accident or accidental means; (2) against the resulting expenses of the injury, disablement, or death; (3) against disablement or expense resulting from sickness or childbirth; (4) against expense incurred in prevention of sickness; (5) for dental care; and (6) including every insurance that applies to injury, disablement, or death. Transaction of health insurance includes disability insurance and stop-loss insurance but does not include workers' compensation insurance. Health care insurance described in (b) of this section is a type of health insurance under this subsection.
>
> (b) Health care insurance means that part of health insurance that provides benefits for medical care whether provided directly, through reimbursement, or other method.
>
> . . .

Under subsection (a), the meaning of that health care insurance includes coverage for dental care. Also, under subsection (b), health care insurance includes coverage for "medical care." The definition of "medical care" includes amounts paid for "diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body." *See.* AS 21.90.900(30). Under these definitions, it is reasonable to conclude that health care insurance would include dental services.

In summary, one may conclude that AS 21.42.345 requires coverage, including dental coverage, for newborn and adopted children under a health care insurance plan that covers dependents.[1]

---

[1] AS 21.42.385 requires a health care insurer to offer a plan sponsor or individual minimum dental coverage "not less than the dental . . . coverage provided on January 1, 2009, to an individual entitled to medical benefits under AS 39.35.535 (public employees retirement system of Alaska)." AS 39.35.535 identifies who is eligible for the coverage but does not describe the coverage provided as of that date.

AS 21.42.392.
HB 309 proposes amendments to AS 21.42.392 to prohibit a health care insurer who provides coverage for dental care from setting a minimum age for receiving dental care coverage in a health care insurance plan. Under this prohibition, a health care insurer presumably would not be allowed to limit coverage based on an age set by an insurer and could not restrict coverage for newborn children, the lowest age limit possible. Therefore, the proposed amendment prohibiting a health care insurer from setting a minimum age for dental care coverage conflicts with AS 21.42.345.

Keep in mind, though, that AS 21.42.345 only applies to a plan that includes dependent coverage. Conversely, if the plan did not provide dependent coverage, an insurer is not obligated to provide coverage for newborn children, adopted children, and new spouses and the conflict would not longer exist.

The last question presented is whether the date of coverage for dependents begins at birth or at the time of adoption. Coverage for a newly born child is required from the moment of birth and, for an adoption, from the date of adoption under AS 21.42.345(a).

If I may be of further assistance, please advise.

DCB:ljw
10-142.ljw

NFIB

The Voice of Small Business•

ALASKA

March 25, 2010

The Honorable Bill Thomas
State Capitol Building
Juneau, Alaska 99801-1182

Dear Representative Thomas:

RE: HB 309 Proposed Committee Substitute

On behalf of the National Federation of Independent Business/Alaska, I wish to respectfully remove our opposition to House Bill 309. 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 House Bill 309.

Sincerely yours,

Dennis L. DeWitt
Alaska State Director

Cc: NFIB/AK Leadership Council
House Health & Social Services Committee

CS FOR HOUSE BILL NO. 309(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVE THOMAS

A BILL

FOR AN ACT ENTITLED

"An Act prohibiting health care insurers that provide dental care coverage from setting fees that a dentist may charge under a preferred provider contract for dental services not covered under the insurer's policy, and relating to preferred provider contracts between insurers and dentists."

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

*** Section 1.** AS 21.42.392(c) is amended to read:

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

(1) may reimburse a covered person at a different rate because of the person's choice of a dentist if the dentist is not a part of the covered person's dental network or preferred provider organization agreement**; the** [. THE] covered expense for non-network providers may not be less than that allowed to a network provider, although the covered expense may be reimbursed at a lower percentage or with higher deductibles than if the service had been provided within the network**;**

(2) may not limit a fee set by a dentist for a service unless the service is covered under the insurer's plan or contract, except as provided under

(3) of this subsection; and

(3) may offer a dentist the option of entering into a preferred provider contract with the insurer that provides a fee schedule for covered services only or a fee schedule for both covered and uncovered services; under this paragraph,

(A) the health care insurer may not

(i) take an action against the dentist based on the dentist's refusal to enter into a contract with an insurer;

(ii) fail to list a dentist who does not enter into a contract with an insurer in the insurer's marketing materials; or

(iii) take action against the dentist during the management or administration of a contract based on the dentist's choice of contract;

(B) the terms or provisions of the contract

(i) may not violate AS 45.50.562 - 45.50.566; and

(ii) must require both the insurer and the dentist to provide information to the insured describing the dentist's choice of contract and fee schedules;

(C) "covered service" means a health care service for which a health care insurer pays a benefit for all or part of the service, including a benefit that is available but limited by deductible, coinsurance, or frequency terms under the contract between the insurer and the insured.

26-LS1315\R.1
Bailey
3/6/10

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE KELLER

TO: HB 309

Page 1, lines 1 - 5:

Delete all material and insert:

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

Page 2, line 1, following "**:**":

Insert "**or**"

Page 2, line 2:

Delete all material.

Renumber the following paragraph accordingly.

3651

26-LS1315\S
Bailey
2/16/10

CS FOR HOUSE BILL NO. 309( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE THOMAS

A BILL

FOR AN ACT ENTITLED

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

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

*** Section 1.** AS 21.42.392(a) is amended to read:

(a) A health care insurer who provides coverage for dental care may not include in the health care insurance plan or contract a provision that

(1) prohibits a covered person from obtaining dental care services from a dentist of the person's choice, including a specialist;

(2) restricts a covered person's right to receive full information from the person's dentist regarding the care or treatment options that the dentist believes are

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

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

(4) permits an insurer to limit a fee set by a dentist for a service unless the service is covered under the insurer's plan or contract.

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

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

(1) reimburse a covered person at a different rate because of the person's choice of a dentist if the dentist is not a part of the covered person's dental network or preferred provider organization agreement**; the** [. THE] covered expense for non-network providers may not be less than that allowed to a network provider, although the covered expense may be reimbursed at a lower percentage or with higher deductibles than if the service had been provided within the network**; and**

(2) set the maximum age for a person to receive coverage for dental care as a dependent child.

REPRESENTATIVE BILL THOMAS

ALASKA STATE LEGISLATURE DISTRICT 5

e-mail: Representative.Bill.Thomas@legis.state.ak.us

webpage: www.akrepublicans.org/thomas/

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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.

REPRESENTATIVE BILL THOMAS
ALASKA STATE LEGISLATURE DISTRICT 5
e-mail: Representative.Bill.Thomas@legis.state.ak.us
webpage: www.akrepublicans.org/thomas/

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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
Dept. Affected: DCCED
Title: Dental Care Insurance
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)

3656

Alaska Dental Society, Inc.
9170 Jewel Lake Road, Suite 203
Anchorage, Alaska 99502-5390
(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.

Division of Oral Health, MS F-10
4770 Buford Highway, NE
Atlanta, GA 30341
1-888-CDC-2306
http://www.cdc.gov

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Division of Oral Health, MS F-10
4770 Buford Highway, NE
Atlanta, GA 30341
1-888-CDC-2306
http://www.cdc.gov**National Institute of Dental and Craniofacial Research**
National Institutes of Health
Building 45, Room 4AS-19
45 Center Drive MSC 6400
Bethesda, MD 20892-6400
http://www.nidcr.nih.gov

From the office of the Surgeon General

4770 Buford Highway, NE
Atlanta, GA 30341
1-888-CDC-2306
http://www.cdc.gov

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

February 18, 2010

The Honorables Bob Herron and Wes Keller
Co-Chairs, House Health & Social Service Committee
The Alaska State Legislature
Capitol Building
Room 106
Juneau, Alaska 99801

Dear Chairmen Herron and Keller;

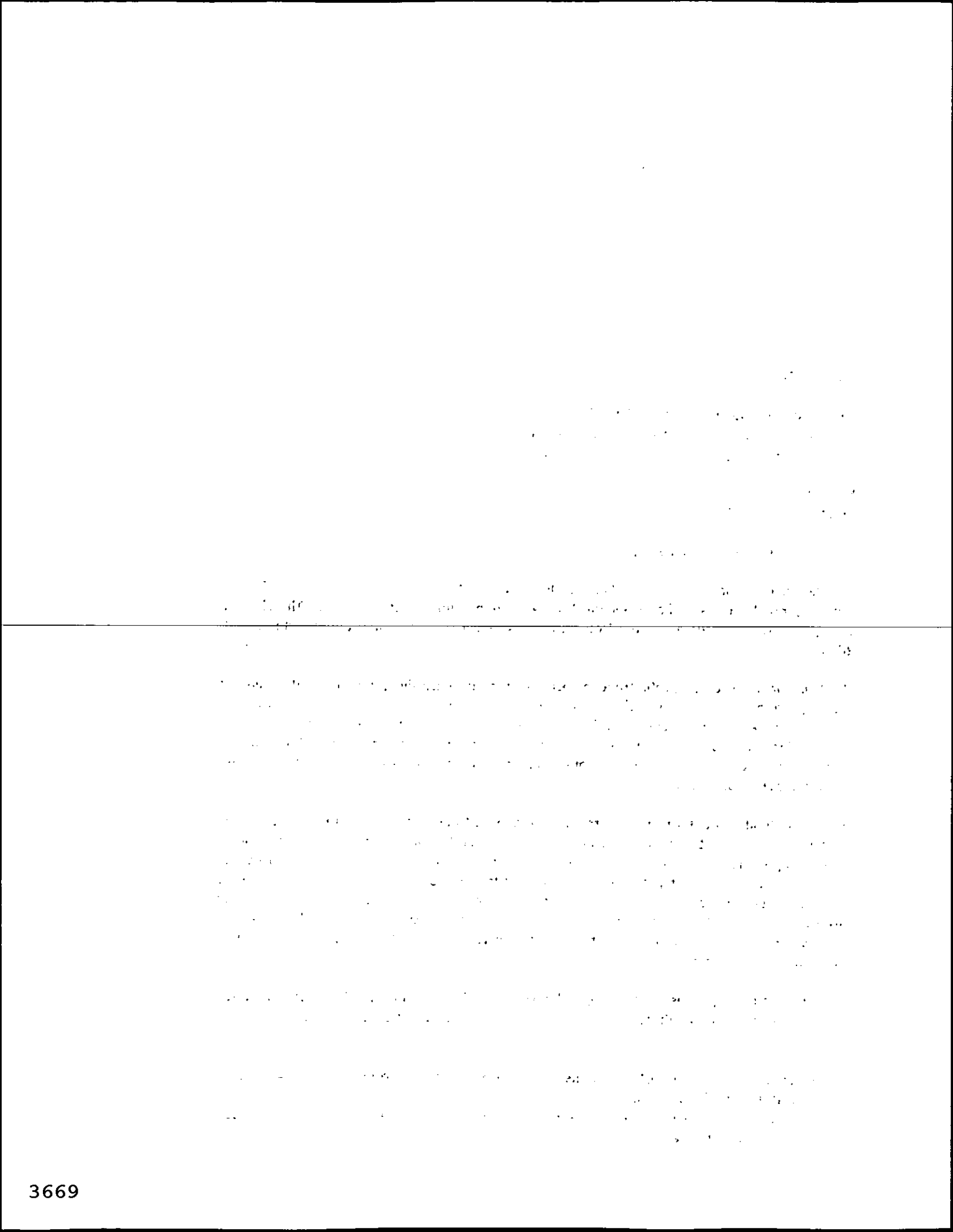
The National Association of Dental Plans (NADP) would like to comment on Alaska House Bill 309 regarding oral health, specifically Section 1 (a) (4) on dental non-covered services. The bill is on the agenda to be discussed by the House Health & Social Service Committee on February 11, 2010.

NADP is the largest non-profit trade association focused exclusively on the dental benefits industry, i.e. dental HMOs, dental PPOs, discount dental plans and dental indemnity products. NADP's members provide dental benefits to over 82% of the 176 million Americans with dental benefits, including 282,000 consumers with private policies in the state of Alaska. Our members include major commercial carriers, regional and single state companies, as well as companies organized as non-profit plans.

HB 309 prohibits a dental plan from requiring a dentist to accept a negotiated fee set by the dental plan unless the dental plan compensates the dentist for such services. This type of payment agreement is common in many dental carriers' provider contracts, a standard aspect of their contractual relationship that serves to defray the cost of dental care for plan enrollees when they need services that the purchaser or employer may have chosen not to cover in the interest of keeping their group dental premium affordable. Dentists knowingly enter into contracts with these provisions in return for the increased patient volume that comes with joining a dental plan network.

NADP respectfully opposes the HB 309, and encourages the Health & Social Service Committee to fully investigate the ramifications this bill may have on their constituents and employers in the state.

- Consumers' out-of-pockets expenses may increase due to the loss of the discounts on certain dental procedures.
- Employers may experience complaints due to employee dissatisfaction at increased costs for non-covered services.



Background:

- Dentists choose to join a dental network and accept the contracted fees in return for increased access to patients who are customers of the dental carrier.
- While most policies cover the majority of frequently utilized procedures, a range of dental benefit plans, with appropriately varied premium ranges, is available in the marketplace to meet employer and employee budgets.
- Employers' demand for flexibility and affordability means not every dental plan design covers every single procedure on a dentist's contracted fee schedule. Often, the insurer pays 80% and the insured pays 20% of the contracted fee for a category of procedures that is selected and specified by the purchaser, in consultation with a benefits broker, consultant or the dental carrier. For other categories of specified services, the insurer pays 100% and the insured pays 0% of the contracted fee. Non-covered services are those for which the insurer pays 0% and the insured pays 100%. The value of having dental coverage when choosing these services lies in the lower rate the dentist has agreed to when collecting 100% of the contracted fee.

In short, prohibiting contracted discounts for non-covered services is financially harmful to the consumer, leads to higher costs and ultimately is confusing for individuals and families.

Attached is a detailed overview of non-covered services which was developed for the National Conference of Insurance Legislators as they deliberated a non-covered services draft model last November. The draft model was tabled until this March due to voiced concern from several legislators on the interference of business contracts by the draft model. This legislation is a stated priority of organized dentistry at state and national levels, with the primary purpose to increase dentist income which ultimately raises out of pocket costs directly from consumers. In Virginia, opposition has been heard from state groups such as the local chamber of commerce, AFL-CIO, the state employees, and more.

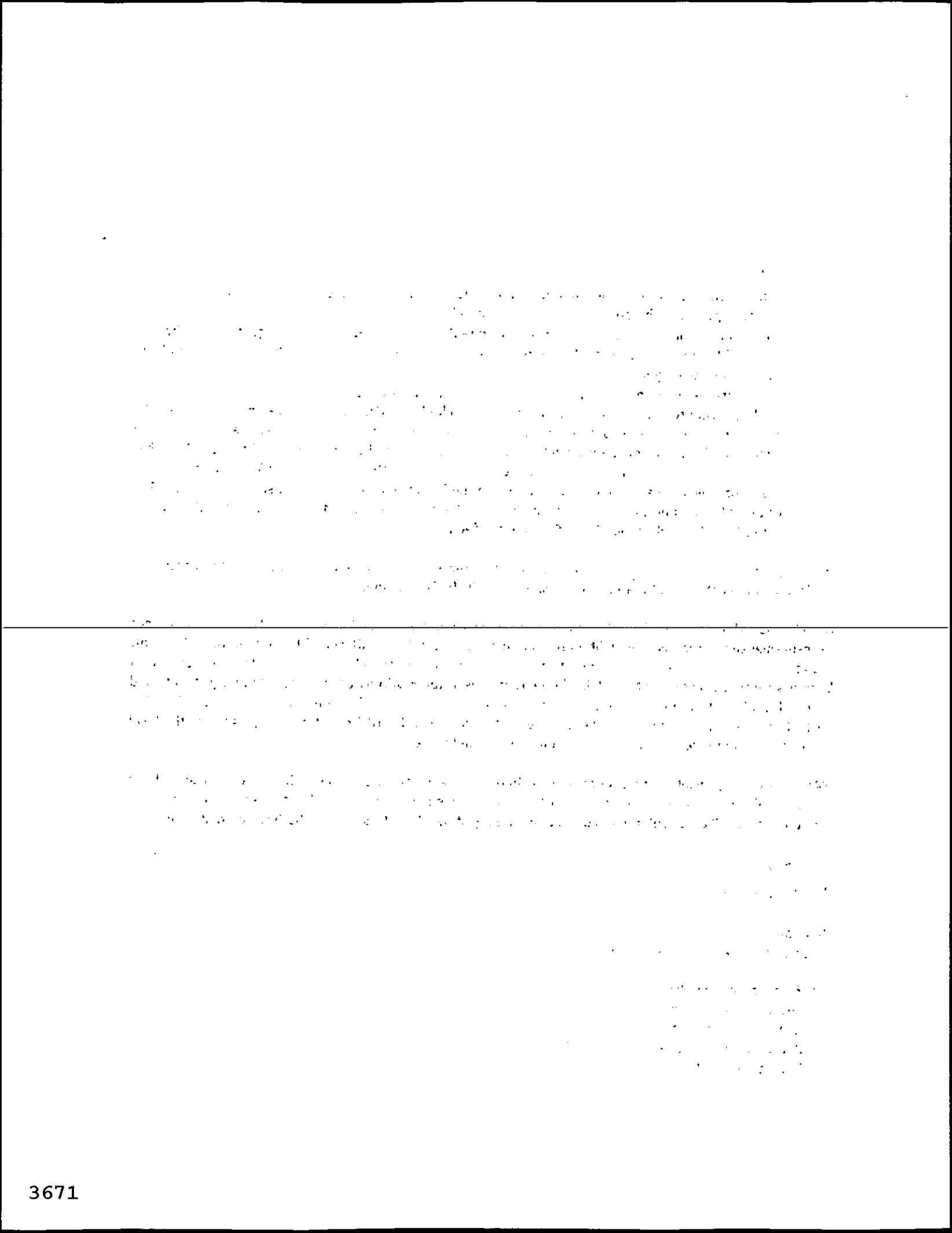
NADP greatly appreciates the opportunity to share our views, and we are available to answer any of the Committee's questions. In addition to the NCS summary, we have also attached our Alaska State Fact Sheet for your review. Please feel free to contact me directly at 972.458.6998x111 or khathaway@nadp.org.

Sincerely,

Kris Hathaway

Kris Hathaway
Director of Government Relations

cc: Representative Wilson, Vice Chair
Representative Lynn
Representative Seaton
Representative Cissna
Representative Homes



National Association of Dental Plans

An Overview of Dental Non-Covered Services

NCOIL is considering an Act that would prohibit a dental insurance plan from requiring a contracted dentist to accept a payment fee set by the dental plan unless the dental plan compensates the dentist for such services. While prohibiting discounts on non-covered services does not impact the plan's revenue, it will have a direct and lasting negative impact on a consumer's out-of-pocket costs.

Dental plans cover a wide array of dental services; however, most have an annual maximum benefit per plan year. After the annual maximum amount is met, consumers can continue to benefit from insurance coverage when discounts are afforded to them through contracted fees between their dental plan, and that plan's contracted dentists.

- **Prohibiting contracted discounts for non-covered services is financially harmful to the consumer and leads to higher costs and confusion for individuals and families.**

Minimizing American's out-of-pocket health costs is one of the primary goals for federal health care reform. Dental consumers, dental plans and dentists have a responsibility to work together to offer competitive costs for dental services. Dentists who contract with a dental plan may agree to accept the fees for dental services specified in the contract, regardless of the payment source. The dental plan pays for covered services in part or in whole, and the consumer pays for non-covered services. Regardless of the payment source, the total the dentist receives is the agreed upon contracted fee, thus providing benefits to the consumer and the employer as described below:

- **Contracted Fees - Benefits to the Consumer**:
  - Consumers receive the contracted fee even if the service is not covered by their insurance plan. Without the contracted fees, consumer costs for non-covered services are generally higher.
  - Cost of dental care is predictable for the consumer when the same contracted fees are applied to needed services even after the annual maximum is met. Dental plans and consumers can better calculate expected costs up front when a single fee schedule is adopted for all services, covered or not, and this helps avoid surprised "sticker-shock" that might otherwise result from non-contracted fees for dental services.
  - Cost savings realized when consumers receive non-covered services at a contracted fee encourages them to seek treatment in a timely manner and not delay care due to cost restraints. Paying a higher, non-contracted fee can put significant financial strain on individuals and families.

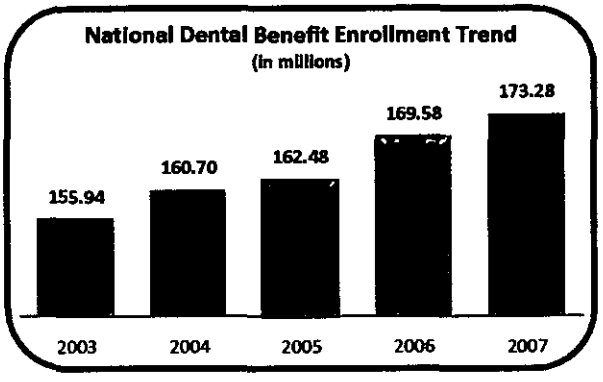
- **Contracted Fees - Benefits to the Employer**:
  - Due to rising medical premiums, employers are facing hard choices with their health care benefit options. A dental plan's ability to offer a single contracted fee schedule for all services under a group employer dental plan increases the scope of benefits without increasing premiums, thereby increasing the overall value of the program for employees.
  - Employers review their employees' utilization and customize their dental plan selection accordingly. The design of the dental policy selected by the employer dictates what services are covered under a plan. This allows the employer to offer a plan at an affordable cost to both the employer and the consumer. Dental plans contract fees with dentists, and offer multiple policies based on the contracted fee. The Act being considered by NCOIL would limit employer flexibility, and reduce their product choices.

- **Contracted Fees - Dentist Topics**:
  - Dentists may be initially in favor of prohibiting discounts on non-covered services; however, there is little evidence to support increased revenue by supporting this measure. A recent study by Delta Dental Plans Association of all Delta plans showed only a .44 percent difference in total approved claims costs are even affected. Dentists can do their part in health care reform by holding their costs to the contracted fees already agreed to for patients covered by dental insurance.
  - Dentists have the choice to join a dental plan's network and accept the contracted fees for both covered and

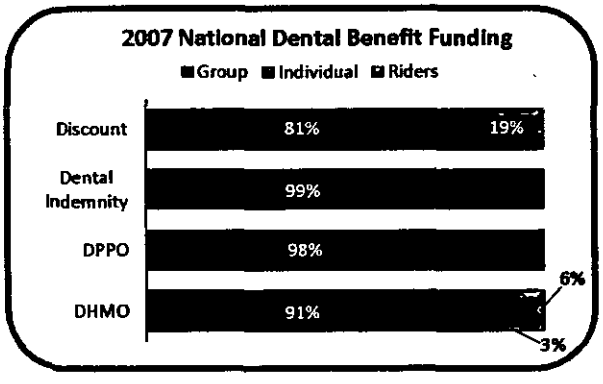
National Association of Dental Plans

Alaska 2008 Dental Benefits Fact Sheet

NATIONAL



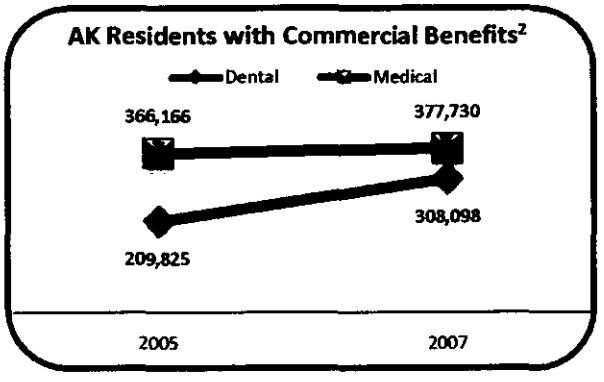
In 2007, at least 57% of all Americans had some form of dental benefits.



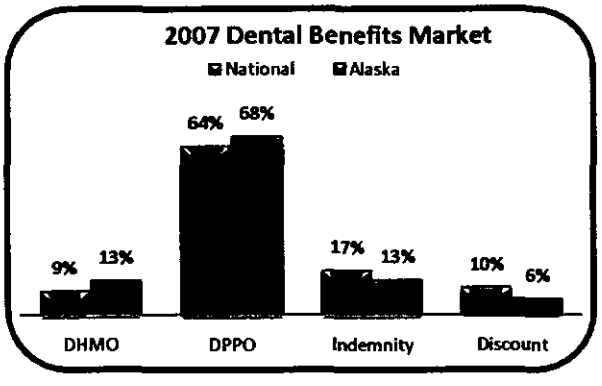
Nearly all enrollment in dental benefit plans is through group-sponsored plans while Discount Dental plans are offered more often directly to individuals.

STATE

In 2007, the estimated population of Alaska was 683,478.[1] NADP represents 35 plans operating both directly and indirectly in Alaska.



The chart below compares the prevalence of dental plan types based on total enrollment nationally and in Alaska.



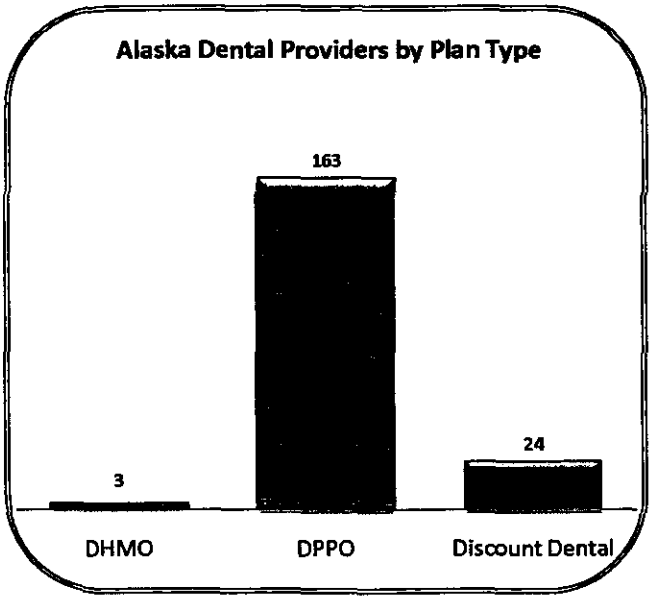
ABOUT NADP

The National Association of Dental Plans (NADP), a nonprofit corporation with headquarters in Dallas, Texas, is the "representative and recognized resource of the dental benefits industry." NADP is the only national trade organization that includes the full spectrum of dental benefits companies operating in the United States

Alaska Dental Benefit Fact Sheet

PROVIDERS & NETWORKS

To be adequately served there should be 3.33 practicing dentists per 10,000 population.[1] There are 490 dentists actively practicing in Alaska or 7.17per 10,000 population.[2]

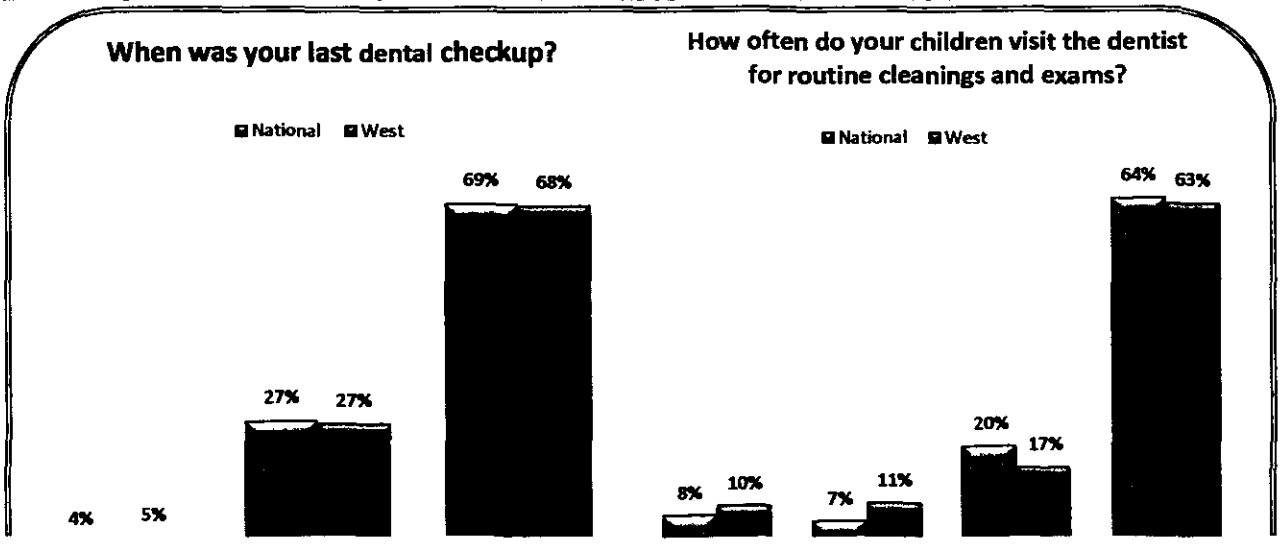


In total, Alaska consumers have access to an estimated 3 dental HMO providers, 163 dental PPO providers and 24 discount dental providers.

- 0.04 Alaska dentists provide services through a Dental HMO per 10,000 population statewide compared to 1.03 per 10 ,000 population nationally
- 2.39 Alaska dentists provide services through a Dental PPO per 10,000 population statewide compared to 3.42 per 10 ,000 population nationally
- 0.35 Alaska dentists provide services through a Discount Dental Plan per 10,000 population statewide compared to 2.34 per 10 ,000 population nationally

The ratio of dentists to population may vary by community.

CONSUMER ORAL HEALTH BEHAVIOR[3]



LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 24, 2010

SUBJECT: Limiting dental insurer policy (HB 309)
(Work Order No 26-LS1315\R)

TO: Representative Bill Thomas
Attn: Cecile Elliott

FROM: Dennis C. Bailey DCB
Legislative Counsel

You have asked whether the provision in HB 309 that prohibits an insurer who provides coverage for medical care from setting a fee for a service that is not covered under the insurer's policy violates art. I, sec. 15 of the Alaska Constitution.

Article I, sec. 15, provides:

> SECTION 15. Prohibited State Action. No bill of attainder or ex post facto law shall be passed. No law impairing the obligation of contracts, and no law making any irrevocable grant of special privileges or immunities shall be passed. No conviction shall work corruption of blood or forfeiture of estate.

I assume that you are concerned with the "contracts clause," which states that "no law impairing the obligation of contract . . . shall be passed."

The contracts clause prohibits the passing of a law that changes an existing contract. The rule is based on preventing retroactive changes to contracts already in place. *See, Hageland Aviation Servs. v. Harms*, 210 P.3d 444 (Alaska 2009) (retroactive removal of existing contract rights . . . violated the contracts clause). Several Alaska cases have interpreted the contracts clause.[1]

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[1] *See Stepanov v. Homer Elec. Ass'n, Inc.*, 814 P.2d 731, 736 (Alaska 1991) (rejecting the claim that a state commission's effective revision of the claimants' contracts violated the Alaska and federal contract clauses); *Wien Air Alaska v. Arant*, 592 P.2d 352, 363 (Alaska 1979) (dismissing the argument that the maximum rate table of a workers' compensation law impairs obligations under the claimant's insurance contract in violation of the Alaska and federal contract clauses), overruled on other grounds by

The state commonly regulates the contents of insurance policies in AS 21. The effect of changes to the law are usually prospective not retrospective in order to avoid impairment of existing policies. A statute is prospective unless it is expressly made retrospective. AS 01.10.090.

In my opinion, the change in AS 21.42.392(a) that prohibits an insurer that provides dental insurance from limiting a fee set by a dentist for a service unless the service is covered by the policy would not violate art. I, sec. 15 of the Alaska Constitution. The provision has a prospective effect and does not impair or affect an existing contract.

Although not required, in order to emphasize the prospective effect of the change, you could add an applicability clause similar to the following:

*Sec. **. The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. The amendments to AS 21.42.392 enacted in secs. 1 and 2 of this Act apply to an insurance plan, contract, or policy that is offered, issued for delivery, delivered, or renewed on or after the effective date of this Act.

If I may be of further assistance, please advise.

DCB:ljw
10-129.ljw

Fairbanks N. Star Borough Sch. Dist. v. Crider, 736 P.2d 770 (Alaska 1987).

Hageland Aviation Servs. v. Harms, 210 P.3d 444, 452, n. 30 (Alaska 2009).