

SB

258

ALASKA STATE LEGISLATURE

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Charlie Huggins Senator

SPONSOR STATEMENT SB 258

SB 258 protects access to dental care by prohibiting insurance companies from setting fee limits on non-covered procedures and also prevents them from setting age limitations for covered services.

A national trend has developed where dental managed care insurance plans limit a patient's access to dental care by setting caps on dentist's fees for services that are not even 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 non-covered 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 results in greater costs both financially and 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.

SB 258 goes a long way towards protecting consumers' access to care and preventing the aforementioned problems, thus ensuring that Alaskans continue to receive the dental care they need. I strongly urge your support of SB 258.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: SB 258
 () Publish Date: _____

Identifier (file name): SB258-CED-INS-2-11-10
 Title: Dental Care Insurance
 Dept. Affected: DCCED
 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								
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CHANGE IN REVENUES ()								
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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
 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

SUPPORTING DOCUMENTS RECEIVED FROM:

1. Alaska Dental Society - Gary Moeller, DDS President

1



Alaska Dental Society

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Anchorage, Alaska 99502-5390
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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.

access

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.

children

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



Alaska Dental Society, Inc.

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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

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.

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LC01675/SUB A/2
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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.

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.



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You & Your Practice

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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SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 2/5/10

FURTHER: Labor and Commerce

Date of 5-Day Notice: 2/11/2010
 (in accordance with Uniform Rule 23)

DATE TURNED
 IN TO OFFICE: 2/16/2010

Health and Social Services Committee considered SENATE BILL NO. 258

SB 258 DENTAL CARE INSURANCE

"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."

and recommends:

- be replaced with SCS or CS _____ (_____)
- adopt previous SCS or CS _____ (_____)
- attached amendment(s)
- adopt _____ Letter of Intent
- further referral to _____ Committee

SENATE BILL:	
<input type="checkbox"/>	Same Title
<input type="checkbox"/>	New Title
<hr/>	
HOUSE BILL:	
<input type="checkbox"/>	Same Title
<input type="checkbox"/>	Technical Title Change
<input type="checkbox"/>	New Title w/ SCR # _____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
Dept. of Comm Insurance	2/11/2010	✓		✓	

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
<i>John Ellis</i>	ELLIS	X			
<i>John Thomas</i>	THOMAS	✓			
<i>Bob Parkin</i>	PARKIN			X	
CHAIR: <i>Benny Davis</i>					