L.D. 403

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BANKING AND INSURANCE

Reported by:

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STATE OF MAINE
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COMMITTEE AMENDMENT "A" to S.P. 127, L.D. 403, Bill, "An Act to Provide Health Insurance Coverage for General Anesthesia and Associated Facility Charges for Dental Procedures for Certain Vulnerable Persons"

Amend the bill by striking out everything after the enacting clause and before the summary and inserting in its place the following:

'**Sec. 1. 24 MRSA §2332-M** is enacted to read:

§2332-M. Coverage for general anesthesia for dentistry

1. Enrollee defined. For the purposes of this section, unless the context otherwise indicates, "enrollee" means a person who is covered under an individual or group health insurance contract provided by a nonprofit hospital and medical service organization.

2. General anesthesia and associated facility charges. All individual and group nonprofit hospital and medical service organization contracts must provide coverage for general anesthesia and associated facility charges for dental procedures rendered in a hospital when the clinical status or underlying medical condition of an enrollee requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital. The nonprofit hospital and medical service organization may require prior authorization of general anesthesia and associated charges required for dental care procedures in the same manner that prior authorization is required for other covered diseases or conditions.

3. Limitations on coverage. This section applies only to general anesthesia and associated facility charges for only the

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following enrollees if the enrollees meet the criteria in subsection 2:

A. Enrollees, including infants, exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, can not be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result;

B. Enrollees demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy;

C. Extremely uncooperative, fearful, anxious or uncommunicative children or adolescents with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; and

D. Enrollees who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.

4. Dental procedures and dentist's fee not covered. This section does not require a nonprofit hospital and medical service organization to cover any charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist. Coverage for anesthesia and associated facility charges pursuant to this section is subject to all other terms and conditions of the individual or group contract that apply generally to other benefits.

5. Coordination of benefits with dental insurance. If an enrollee eligible for coverage under this section is also eligible for coverage for general anesthesia and associated facility charges under a dental insurance policy or contract, the nonprofit health care service organization or insurer providing dental insurance is the primary payer responsible for those charges and the nonprofit hospital and medical service organization is the secondary payer.

Sec. 2. 24-A MRSA §2759 is enacted to read:

§2759. Coverage for general anesthesia for dentistry

1. Enrollee defined. For the purposes of this section, unless the context otherwise indicates, "enrollee" means a person

who is covered under an individual health insurance contract provided by an insurer.

2. General anesthesia and associated facility charges. An insurer that issues individual health insurance contracts shall provide coverage for general anesthesia and associated facility charges for dental procedures rendered in a hospital when the clinical status or underlying medical condition of an enrollee requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital. The insurer may require prior authorization of general anesthesia and associated charges required for dental care procedures in the same manner that prior authorization is required for other covered diseases or conditions.

3. Limitations on coverage. This section applies only to general anesthesia and associated facility charges for only the following enrollees if the enrollees meet the criteria in subsection 2:

A. Enrollees, including infants, exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, can not be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result;

B. Enrollees demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy;

C. Extremely uncooperative, fearful, anxious or uncommunicative children or adolescents with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; and

D. Enrollees who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.

4. Dental procedures and dentist's fee not covered. This section does not require an insurer that issues individual contracts to cover any charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist. Coverage for anesthesia and associated facility charges pursuant to this section is subject to all other terms and

conditions of the individual contract that apply generally to other benefits.

5. Coordination of benefits with dental insurance. If an enrollee eligible for coverage under this section is also eligible for coverage for general anesthesia and associated facility charges under a dental insurance policy or contract, the nonprofit health care service organization or insurer providing dental insurance is the primary payer responsible for those charges and the insurer providing individual health insurance is the secondary payer.

Sec. 3. 24-A MRSA §2847-J is enacted to read:

§2847-J. Coverage for general anesthesia for dentistry

1. Enrollee defined. For the purposes of this section, unless the context otherwise indicates, "enrollee" means a person who is covered under a group health insurance contract provided by an insurer.

2. General anesthesia and associated facility charges. An insurer that issues group health insurance contracts shall provide coverage for general anesthesia and associated facility charges for dental procedures rendered in a hospital when the clinical status or underlying medical condition of an enrollee requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital. The insurer may require prior authorization of general anesthesia and associated charges required for dental care procedures in the same manner that prior authorization is required for other covered diseases or conditions.

3. Limitations on coverage. This section applies only to general anesthesia and associated facility charges for only the following enrollees if the enrollees meet the criteria in subsection 2:

A. Enrollees, including infants, exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, can not be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result;

B. Enrollees demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy;

C. Extremely uncooperative, fearful, anxious or uncommunicative children or adolescents with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; and

D. Enrollees who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.

4. Dental procedures and dentist's fee not covered. This section does not require an insurer that issues group contracts to cover any charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist. Coverage for anesthesia and associated facility charges pursuant to this section is subject to all other terms and conditions of the group contract that apply generally to other benefits.

5. Coordination of benefits with dental insurance. If an enrollee eligible for coverage under this section is also eligible for coverage for general anesthesia and associated facility charges under a dental insurance policy or contract, the nonprofit health care service organization or insurer providing dental insurance is the primary payer responsible for those charges and the insurer providing group health insurance is the secondary payer.

Sec. 4. 24-A MRSA §4249 is enacted to read:

§4249. Coverage for general anesthesia for dentistry

1. Enrollee defined. For the purposes of this section, unless the context otherwise indicates, "enrollee" means a person who is covered under an individual or group contract provided by a health maintenance organization.

2. General anesthesia and associated facility charges. All individual and group health maintenance organization contracts must provide coverage for general anesthesia and associated facility charges for dental procedures rendered in a hospital when the clinical status or underlying medical condition of an enrollee requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital. The insurer may require prior authorization of general anesthesia and associated charges required for dental care procedures in the same manner that prior authorization is required for other covered diseases or conditions.

3. Limitations on coverage. This section applies only to general anesthesia and associated facility charges for only the following enrollees if the enrollees meet the criteria in subsection 2:

A. Enrollees, including infants, exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, can not be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result;

B. Enrollees demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy;

C. Extremely uncooperative, fearful, anxious or uncommunicative children or adolescents with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; and

D. Enrollees who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.

4. Dental procedures and dentist's fee not covered. This section does not require a health maintenance organization to cover any charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist. Coverage for anesthesia and associated facility charges pursuant to this section is subject to all other terms and conditions of the individual or group contract that apply generally to other benefits.

5. Coordination of benefits with dental insurance. If an enrollee eligible for coverage under this section is also eligible for coverage for general anesthesia and associated facility charges under a dental insurance policy or contract, the nonprofit health care service organization or insurer providing dental insurance is the primary payer responsible for those charges and the health maintenance organization providing health coverage is the secondary payer.

Sec. 5. Applicability. This Act applies to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed on or after January 1, 2002. All

policies, contracts and certificates are deemed to be renewed no later than the next yearly anniversary of the contract date.'

Further amend the bill by inserting at the end before the summary the following:

FISCAL NOTE

The state employees health plan within the Department of Administrative and Financial Services will incur some minor additional costs to provide coverage for general anesthesia and associated facility charges for dental procedures rendered in hospitals for certain eligible enrollees. These costs can be absorbed within the plan's existing budgeted resources.

The Bureau of Insurance within the Department of Professional and Financial Regulation will incur some minor additional costs to review any additional contract filings for compliance. These costs can be absorbed within the bureau's existing budgeted resources.'

SUMMARY

This amendment is the majority report of the committee and replaces the bill. The amendment requires that health insurers and health maintenance organizations provide coverage for general anesthesia and associated facility charges for dental procedures rendered in a hospital for certain eligible enrollees, including persons with developmental disabilities and persons whose health is compromised and for whom general anesthesia is medically necessary. The amendment does not provide coverage for charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist. The amendment clarifies that coverage under a dental insurance policy is primary and health insurance coverage is secondary and makes other clarifications in the language.

The amendment applies to all policies, contracts and certificates issued or renewed on or after January 1, 2002. The amendment also adds a fiscal note to the bill.