BMQ
R. of S.

L.D. 900

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Minority

INSURANCE AND FINANCIAL SERVICES

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STATE OF MAINE

SENATE

128TH LEGISLATURE

FIRST REGULAR SESSION

COMMITTEE AMENDMENT "A" to S.P. 302, L.D. 900, Bill, "An Act Regarding Insurance Coverage of Certain Dental Services"

Amend the bill by striking out all of sections 2 to 5 and inserting the following:

'**Sec. 2. 24-A MRSA §2770** is enacted to read:

§2770. Limits on fees for dental services

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Covered service" means a dental care service for which reimbursement is available under an enrollee's plan contract or for which reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments or any other limitation.

B. "Dental provider" means a dentist, independent practice dental hygienist or dental hygiene therapist licensed under Title 32, chapter 143 who is providing dental services within the lawful scope of practice of the dentist, independent practice dental hygienist or dental hygiene therapist.

C. "Enrollee" means an individual who is covered under an individual health insurance contract provided by an insurer.

2. Limits on fees. An insurer that issues individual dental insurance or health insurance that includes coverage for dental services may not restrict, limit or otherwise control a fee that a dental provider charges an enrollee for a service unless the service is a covered service under the patient's policy or contract.

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

§2847-V. Limits on fees for dental services

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Covered service" means a dental care service for which reimbursement is available under an enrollee's plan contract or for which reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments or any other limitation.

B. "Dental provider" means a dentist, independent practice dental hygienist or dental hygiene therapist licensed under Title 32, chapter 143 who is providing dental services within the lawful scope of practice of the dentist, independent practice dental hygienist or dental hygiene therapist.

C. "Enrollee" means an individual who is covered under a group health insurance contract provided by an insurer.

2. Limits on fees. An insurer that issues group dental insurance or health insurance that includes coverage for dental services may not restrict, limit or otherwise control a fee that a dental provider charges an enrollee for a service unless the service is a covered service under the patient's policy or contract.

Sec. 4. 24-A MRSA §4260 is enacted to read:

§4260. Limits on fees for dental services

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Covered service" means a dental care service for which reimbursement is available under an enrollee's plan contract or for which reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments or any other limitation.

B. "Dental provider" means a dentist, independent practice dental hygienist or dental hygiene therapist licensed under Title 32, chapter 143 who is providing dental services within the lawful scope of practice of the dentist, independent practice dental hygienist or dental hygiene therapist.

C. "Enrollee" means an individual who is covered under an individual or group health maintenance organization contract.

2. Limits on fees. An individual or group health maintenance organization contract that includes coverage for dental services may not restrict, limit or otherwise control a fee that a dental provider charges an enrollee for a service unless the service is a covered service under the patient's policy or contract.

Sec. 5. Application. The requirements of this Act apply to contracts between a dental provider, as defined in the Maine Revised Statutes, Title 24-A, sections 2770, 2847-V and 4260, and an insurer or health maintenance organization that issues

individual or group coverage for dental services executed or renewed on or after January 1, 2018.'

SUMMARY

This amendment is the minority report of the committee and replaces most of the bill. Like the bill, the amendment prohibits insurers and health maintenance organizations offering individual and group coverage from limiting dental fees that are not covered by the insurer. The amendment also adds a definition of "covered service" to clarify that a dental provider must charge the contracted fee for a service that a health plan or dental plan would be obligated to pay but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments or any other limitations.

The amendment changes the term "dentist" to "dental provider" with the intent to include independent practice dental hygienists and dental hygiene therapists as well as dentists.

The amendment also eliminates references in the bill that appear to permit balance billing of a patient.

The amendment applies to contracts executed or renewed on or after January 1, 2018.