F I S C A L I M P A C T R E P O R T

SPONSOR Cravens **ORIGINAL DATE** 02/09/11 **LAST UPDATED** **HB**

SHORT TITLE Fees in Dental Insurance Plans **SB** 260

ANALYST Wilson

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Non-Rec	Fund Affected
FY11	**FY12**		
	NFI		

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION

LFC Files

Responses Received From
Department of Health (DOH)
General Services Department (GSD)
Public Regulation Commission (PRC)
Public School Insurance Authority (NMPSIA)

SUMMARY

Synopsis of Bill

Senate Bill 260 amends the New Mexico Insurance Code to prohibit a dental insurance plan from requiring participating net work dentists from accepting negotiated fee allowances on non-covered dental services.

The bill carries an emergency clause.

FISCAL IMPLICATIONS

No fiscal implications

SIGNIFICANT ISSUES

Under this bill, dentists will not be limited in the reimbursement of dental services that are not covered under a dental insurance plan with which they are contracted, nor could such a dental insurance plan set fees for services that are not covered under the dental insurance plan. Limiting a dentist's ability to be reimbursed for dental services that are not covered by a dental insurance plan may generate a delay in treatment.

Access to treatment is an important issue in the state. There is a shortage of dentists in New Mexico and nationwide, especially of those providing services to the Medicaid population. New Mexico continues to face a critical shortage of health care professionals overall and its inadequate supply and uneven distribution of providers have resulted in shortages in all specialties of health care providers.

Today, there are many different types of dental insurance plans and dental discount plans, including indemnity insurance plans which pay the dentist on a traditional fee-for-service basis. A monthly premium is paid by the client and/or the employer to an insurance company, which then reimburses the dentist for the services rendered. An insurance company usually pays between 50% - 80% of the dentist's fees for covered procedures; the remaining 20% - 50% is paid by the client. These plans often have a pre-determined or set deductible amount which varies from plan to plan. Indemnity plans can also limit the amount of services covered within a given year and pay the dentist based on a variety of fee schedules.

ADMINISTRATIVE IMPLICATIONS

Agencies affected by this bill can handle the provisions of this bill with existing staff as part of ongoing responsibilities.

OTHER SUBSTANTIVE ISSUES

Dental HMOs are insurance plans, also known as capitation plans, that operate like medical HMOs. This type of dental plan provides comprehensive dental care to enrolled patients through a designated provider dentist. A Dental Health Maintenance Organization (DHMO) is a common example of a capitation plan. The dentist is paid on a per capita basis rather than for actual treatment provided. Participating dentists receive a fixed monthly fee based on the number of patients assigned to the office. In addition to premiums, client co-payments may be required for each visit.

Preferred Provider Organizations (PPO) are insurance plans that fall somewhere between an indemnity plan and a dental HMO. Such plans allow a particular group of patients to receive dental care from a defined panel of dentists. Participating dentists agree to charge lower fees than usual to this specific patient base, providing savings for the plan purchaser. If the patient chooses to see a dentist who is not designated as a "preferred provider," that patient may need to pay a greater share of the fee-for-service. A group of dentists agrees to provide services at a deeply discounted rate, giving the client substantial savings - as long as a person stays in their network. Unlike the more restrictive DHMO, though, one can go out of network and still receive some benefits.

Dental discount plans are not insurance. In the case of Dental Discount Plans, the managing organizations negotiate with local dental offices to establish a set price for a particular dental procedure and offer deep discounts some up to 70% off the regular American Dental Association pricing code. This plan may have several advantages over traditional dental insurance plans, namely, there are no exclusions for pre-existing conditions. This allows a patient to receive immediate coverage for work without meeting any waiting period requirements.

Direct Reimbursement Plans are also not insurance. They are self-funded benefit plans in which an employer pays for dental care with its own funds, rather than paying premiums to an

insurance company or third-party administrator. The patient pays the full amount directly to the dentist, then gets a receipt detailing services rendered and their cost, which the patient shows to their employer. The employer reimburses them for part or all of the dental costs, depending on their specific benefits. For example, the company might reimburse 100% of the first $100 of dental expenses, 80% of the next $500, and 50% of the next $2,000, with a total annual maximum benefit of $1,500. Such a company might reimburse only 50% of their first $1,000, resulting in a $500 yearly cap.

DW/bym