A Report to the Joint Standing Committee on Health Coverage, Insurance and Financial Services of the 130th Maine Legislature

Review and Evaluation of 441
An Act to Expand Adult Dental Health Insurance Coverage

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I. Executive Summary

The Joint Standing Committee on Health Coverage, Insurance and Financial Services (Committee) of the 130th Maine Legislature directed the Bureau of Insurance (Bureau) to review LD 441, An Act to Expand Adult Dental Health Insurance. The review was conducted as required by 24 A M.R.S.A § 2752 to answer prescribed questions about the bill including the estimated cost. This document and review are a collaborative effort of NovaRest, Inc. and the Bureau of Insurance, and are intended to respond to the Committee's request.

LD 441 has two parts. Part A proposes that a carrier offering a health plan shall provide coverage for comprehensive dental services. "Comprehensive dental services" means any services necessary to maintain oral health and prevent disease, restore oral structures to health and function, and treat emergency conditions." The requirements would apply to all policies, contracts, and certificates starting January 1, 2022. Part B of the bill states that the Maine Health Data Organization shall develop and maintain a database on available dentists in the state who provide dental services to MaineCare members, including children, and post that information on a publicly accessible website. We note Part B as written would not impact the insurance carriers.

This report addresses the impact of Part A, and includes information from several sources to provide more than one perspective on the proposed mandate with the intention of providing an unbiased report. As a result, there may be some conflicting information within the contents. Although we only used sources that we considered credible, we do not offer any opinions regarding whether one source is more credible than another, leaving it to the reader to develop his/her own conclusions.

The Affordable Care Act (ACA) describes a broad set of benefits that must be included in any Essential Health Benefits (EHB) package. In its December 2011 bulletin, the Department of Health and Human Services (HHS) provided guidance on the types of health benefit plans each state could consider when determining a benchmark EHB plan for its residents. Each state had the opportunity to update its benchmark plan effective for 2017. Maine has chosen the small group Anthem Health Plans of Maine (Anthem BCBS) PPO Off Exchange Blue Choice as its 2017-2022 benchmark plan. [1] Anthem BCBS does not cover benefits for general comprehensive dental under the benchmark plan. 45 CFR § 155.170 of the ACA requires states to fund the cost of any mandates that are not included in the state-specific EHBs for policies purchased through the Health Exchange Market.

Comprehensive dental services for adults are not covered by the benchmark plan. Therefore, we believe this bill would require a new benefit where the cost would be paid by the state, but this is

[1] Centers for Medicare and Medicaid Services. "2017-2020 EHB Benchmark Plan Information." https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html#North%20Dakota. Accessed September 13, 2021.

not a legal interpretation, nor should it be considered legal advice. With an estimated 62,250 members in Maine enrolled in individual qualified health plans, the estimated cost to the state to defray the new mandate could be $11.7 to $16.5 million.

NovaRest anticipates this bill will result in increases in health insurance premiums between 2.8% to 4.0% or $15 to $22 PMPM. The cost of this benefit varies for several reasons:

1. Many large group plans already provide dental coverage, therefore the cost in this market would be less than the individual and small group markets where dental coverage is currently purchased by the members separately.
2. Not all carriers currently offer dental plans. For example, Harvard Pilgrim would need to create a dental network and contract with providers. This would represent a high start-up cost and the contracts may not be as favorable for carriers just entering the market.
3. Dental care may be "embedded" meaning the benefits would be administered by the carrier, or a carrier may contract with another carrier who specializes in dental benefits such as Delta Dental.
4. Comprehensive dental services are not currently defined, so different carriers may provide different cost sharing.
5. Dental plans typically have a lower deductible and annual limit than major medical plans. Including dental benefits with the medical plan will likely raise both, creating higher costs for the consumer.

NovaRest has the following concerns regarding the language of the bill:

1. "Comprehensive dental services" needs to be more clearly defined. Minimum cost sharing levels for routine preventive care, fillings and other basic procedures, etc. and annual or lifetime limits should be stated. The bill should also state whether orthodontia services will be required to be covered as well. Several carriers were unable to provide cost estimates because of the lack of detail provided in the bill language.

II. Background

Condition

Family Choice Dental lists the five most common dental procedures as fillings, dental crowns, tooth extractions, dental implants, and braces.[2] These procedures can be treated at a general dental practitioner's office.

[2] "5 Most Common Dental Procedures from a General Dentist." Family Choice Dental Albuquerque New Mexico, 21 Feb. 2019, https://familychoicedentistry.com/blog/5-most-common-dental-procedures-from-a-general-dentist/.

According to 2019 data, an estimated 85.9% of children in the U.S. aged 2 – 17 and 64.9% of adults over 18 had a dental visit in the previous year.[3] Some Maine dental plans cover 100% of preventive care such as regular check-ups, x-rays, dental cleaning, etc. and 80% of basic procedures that include root canals, fillings, cavity cleaning, etc. These dental plans also typically cover 50% of major procedures, which include dentures, implants, bridges, and tooth extractions.[4]

Incidence

Oral diseases are estimated to affect 3.5 billion people worldwide, with caries of permanent teeth being the most common condition. In addition, these diseases disproportionally affect the poor and socially disadvantaged members of society. In the US, there are an estimated 13.2% of children aged 5 – 19 and 25.9% of adults aged 20 – 44 with untreated dental caries. In 2015, three out of four low-income adults in Maine who did not visit the dentist in the past year indicated cost was the reason.[5]

Cost

The World Health Organization estimates that even in high income settings, dental treatment is costly, averaging 5% of total health expenditure and 20% of out-of-pocket expenditure.[6] Maine is 1 of 10 states that provides emergency-only adult dental benefits to its Medicaid (MaineCare) members. The Health Policy Institute (HPI) report on expanding adult dental to MaineCare estimated the net cost to the state of Maine of implementing comprehensive adult dental benefits to be $2.7 million annually, or $1.41 per enrollee per month. Furthermore, HPI estimates the additional broader economic impact results from increased spending on services, facilities, utilities, and other impacts from increased dental spending to be $21.6 million annually, with nearly half the additional economic impact in rural areas.[7] Another source states that the average cost of dental insurance is about $350 per year. In Maine, the average premium costs range from $20 to $50 per month for an individual dental plan for an adult.[8]

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[3] National Center for Health Statistics. "Diseases and Conditions – Oral and Dental Health." https://www.cdc.gov/nchs/fastats/dental.htm. Accessed September 13, 2021.
[4] "Best Dental Insurance in Maine: Policy Advice." PolicyAdvice, 11 Sept. 2021, https://policyadvice.net/insurance/best/dental-maine/.
[5] "Summary of Health Policy Institute Research on Costs and Savings of Creating an Adult Dental Benefit in MaineCare." Maine Equal Justice, https://maineequaljustice.org/site/assets/files/2452/dental_hpi_report_summary.pdf.
[6] Oral Health Key Facts (n 2)
[7] https://maineequaljustice.org/site/assets/files/2452/dental_hpi_report_summary.pdf
[8] Policy Advice (n 4)

III. Social Impact

A. Social Impact of Mandating the Benefit

1. The extent to which the treatment or service is utilized by a significant portion of the population.

Studies suggest that dental services will be utilized by a significant portion of the population. According to a report done in 2013, as of 2008, only 53% of adults in Maine had dental insurance.[9]

2. The extent to which the service or treatment is available to the population.

The recommended services and treatments performed by dentists are widely available. According to Dentagraphics, a dental demographic resource, there are 326 general practices and 144 specialty practices in Maine. They estimate an average of 4,134 residents per general dental practice in Maine, which is higher than the current US average of 3,402. In addition, there an average of 9,362 residents per specialty dental practice in Maine, which is also higher than the US average of 8,578.[10]

3. The extent to which insurance coverage for this treatment is already available.

Dental services are not generally covered for health plans providing medical coverage. However, stand alone dental plans are widely available. Comprehensive dental services and treatments may currently be covered under these plans, but we did not survey carriers providing dental plans.

Aetna stated that "Dental services provided for the routine care, treatment, or replacement of teeth or structures (e.g., root canals, fillings, crowns, bridges, dental prophylaxis, fluoride treatment, and extensive dental restoration) or structures directly supporting the teeth are generally excluded from coverage under Aetna's medical plans. Additional coverage may be added at the plan level."

Anthem's individual, small group, and large group plans do not provide coverage for routine adult dental services other than treatment of accidental injuries.

[9] Oral Health in Maine. Maine Center for Disease Control and Prevention, Jan. 2013, https://www.maine.gov/dhhs/mecdc/population-health/odh/documents/oral-health-in-Maine-2013.pdf.
[10] "Mainedental Demographics." Dentagraphics, https://dentagraphics.com/maine-infographic.

Cigna offers dental as a separate policy, not as part of medical.

Community Health Options does not provide services to maintain oral health and prevent disease or restore oral structures. They do, however, provide coverage for the following medically necessary dental services:

a. Setting a jaw fracture.
b. Removing a tumor (but not a root cyst)
c. Removing impacted or unerupted teeth in a non-Hospital or non-Rural Health Center setting;
d. Treatment to repair or replace natural teeth resulting from an accidental injury to sound natural teeth and gums when the course of treatment for the Accidental Injury is received within 6 months of the date of the injury or the Member's effective date of coverage, whichever is later;
e. Repairing or replacing dental prostheses caused by an accidental bodily injury within six months of the injury or within six months of the effective date of coverage, whichever, is later.

Harvard Pilgrim HealthCare provides emergency dental care when provided within 3 days of the initial injury. Dental prostheses are covered under the emergency dental benefit or individual and small group plans if they are provided within six months of injury or within six months of the member's effective date, whichever is later.

United Healthcare did not specifically indicate what coverage they provide, although they provided a cost estimate for dental coverage so we assume they do not currently provide that coverage.

4. If coverage is not generally available, the extent to which the lack of coverage results in a person being unable to obtain the necessary health care treatment.

If coverage by the medical plan is not generally available, treatment may be covered under a person's dental plan. For example, Delta Dental's (Maine's largest stand-alone dental carrier) low family plan covers diagnostic, preventive, periodontics, oral surgery, denture repair, implant services, and crowns among other procedures.[11] If a person does not have dental coverage, they would have to pay out of pocket for services.

[11] Outline of Coverage. Delta Dental, https://nedelta.com/SiteMedia/SiteResources/downloads/Exchange/ME/oocme20222.pdf.

5. If coverage is not generally available, the extent to which the lack of coverage involves unreasonable financial hardship.

Dental services and treatment not covered by medical health plans may be covered by dental plans. Individuals without dental insurance plans could incur significant costs for dental procedures especially the longer the treatment is delayed

6. The level of public demand and the level of demand from providers for this treatment or service.

We do not know the level of public demand for this treatment or service.

7. The level of public demand and the level of demand from the providers for individual or group coverage of this treatment.

The Joint Standing Committee on Health Coverage, Insurance and Financial Services received mixed opinions regarding this bill. There were 3 public hearing testimonies written in opposition and 3 written in support of this bill.

Public hearing testimonies in opposition to the bill, submitted by MetLife, Delta Dental, and Maine Association of Health Underwriters, argue that this bill would diminish the effectiveness of stand-alone dental plans. One of the advantages of a stand-alone dental plan is that they operate under a preventative model which is designed to help stop serious issues before they begin. In addition, stand-alone dental plans provide comprehensive benefits at a reasonable cost, and they have contracted dental provider networks to provide insureds with greater access to participating providers. Many believe this bill would significantly increase the cost of medical insurance.

Representatives from the Maine Council on Aging, Maine Equal Justice, and an individual from China Village wrote in support of this bill, stating that the mouth and teeth are part of the body and should be included with healthcare. In order to keep good health, individuals should have access to preventative health services, including oral health services.

8. The level of interest in and the extent to which collective bargaining organizations are negotiating privately for the inclusion of this coverage by group plans.

No information is available.

9. The likelihood of meeting a consumer need as evidenced by the experience in other states.

While some insurance carriers offer some form of dental coverage, we could not find any other states that have included comprehensive adult dental services in their benchmark plan.

10. The relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.

No information provided.

11. The alternatives to meeting the identified need.

There is no alternative to dental services, however, dental insurance is currently widely available.

12. Whether the benefit is a medical or a broader social need and whether it is inconsistent with the role of insurance and the concept of managed care.

The benefit is a medical need that is necessary for managed health care. According to a 2010 study of emergency room use in Maine, the top diagnostic reason for ER visits among both MaineCare and uninsured patients aged 15 – 44 was dental disease.[12]

13. The impact of any social stigma attached to the benefit upon the market.

Postponing dental work for conditions such as tooth decay or gum disease can lead to many severe consequences like tooth extraction. There is a significant level of psychological and social impact of tooth loss. According to one source, many people with missing teeth are viewed as people who do not properly care for themselves. In addition, people with missing teeth are less likely to socially interact with others, and many completely withdraw.[13]

14. The impact of this benefit upon the other benefits currently offered.

Currently, there are standalone dental plans that are being offered which would be impacted by the coverage of this benefit. As MetLife's public hearing testimony stated, this bill would

[12] Contributor, Opinion. "Maine's Dental Crisis Is an Unseen Factor in Our Workforce Shortage." Bangor Daily News, 11 Oct. 2019, https://bangordailynews.com/2019/10/11/opinion/maines-dental-crisis-is-an-unseen-factor-in-our-workforce-shortage/.
[13] "The Psychological and Social Impact Associated with Missing Teeth." Wichita Periodontists, 29 Mar. 2019, https://wichitaperiodontists.com/the-psychological-and-social-impact-associated-with-missing-teeth/.

diminish the effectiveness of stand-alone dental plans and the advantages they provide.[14] Furthermore, Delta Dental states that "mandating that health insures provide a comprehensive dental benefit would raise health insurance costs without providing additional value to groups, individuals or the market."[15] There is the possibility that individuals may opt out of their insurance plan because premiums have become too high.

However, there could be a reduction in other medical costs for example mental health benefit costs. As stated in the previous question, tooth loss, decay, bad breath, etc. can lead to less social interaction, and in turn, depression. Coverage of dental health benefits may help people get access to services they would have otherwise not have.

15. The impact of the benefit as it relates to employers shifting to self-insurance and the extent to which the benefit is currently being offered by employers with self-insured plans.

As premiums increase due to mandated benefits, some employers may choose to self-insure or drop coverage entirely in order to have more control over the benefits that they provide to employees and control the cost of health insurance premiums. This benefit would represent a significant premium increase, and as the state would not have to defer costs in the large group market (over 50 employees), these costs would be passed to the companies and potentially to their employees. This may incentivize some companies in the large group market to shift to becoming self-insured, where this mandate would not be applicable. We do not have the information required to determine how many groups would leave the fully-insured market.

16. The impact of making the benefit applicable to the state employee health insurance program.

Anthem estimates the cost of this coverage for the State Employee Health Plan to be $12.20 PMPM. Their assumptions include 100% co-insurance for routine preventive care, 80% for fillings and other basic procedures, and 50% for crowns, bridges, and others. However, the proposed mandate does not specify any levels of co-insurance, nor does it define "comprehensive services".

[14] "130th Maine Legislature, First Special Session." LD 665, HP 492, Text and Status, 130th Legislature, First Special Session, https://legislature.maine.gov/legis/bills/display_ps.asp?LD=665&snum=130.
[15] Ibid.

IV. Financial Impact

B. Financial Impact of Mandating Benefits

1. The extent to which the proposed insurance coverage would increase or decrease the cost of the service or treatment over the next five years.

As discussed earlier in the report, the number of residents per dentist in Maine is higher than the US average. There may be pent-up demand for dental services for those that currently have not purchased dental insurance. By mandating coverage, we would expect an increase in utilization of dental services which could increase the cost of dental services, although we do not have the information to determine the magnitude of the increase.

2. The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next five years.

While dental plans may currently cover these benefits, we would expect an increase in the appropriate use of recommended care for those who do not have dental insurance. This would be because in addition to the current population that has standalone dental plans, individuals with medical insurance would also get dental benefits.

3. The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service.

We are unaware of alternative treatments. Treating dental problems early may serve to lower cost than if the condition worsens and requires more invasive procedures.

4. The methods which will be instituted to manage the utilization and costs of the proposed mandate.

There is no language in the bill that prohibits medical management. Carriers will be able to limit services to those that they determine to be medically necessary. If treatment is not effective, medical management could discontinue coverage of the treatment.

5. The extent to which insurance coverage may affect the number and types of providers over the next five years.

As of 2011, the number of dentists per county in Maine ranged from 6 dentists in Piscataquis to 231 dentists in Cumberland.[16] Pent-up demand from mandating coverage for those who currently have not purchased dental insurance would likely increase utilization. As discussed earlier in the report, while Maine is higher than the US average for residents per dentist, the mandated coverage may lead to more demand for dental services and may increase the number of dentists over time.

6. The extent to which the insurance coverage of the health care service or providers may be reasonably expected to increase or decrease the insurance premium or administrative expenses of policyholders.

Carrier Estimates:

Aetna: Our actuarial department would require clarification on what benefits are included in mandate LD 441 to determine a pricing impact.

Anthem: The proposed mandate does not define "comprehensive dental services". For the purposes of this response, we have assumed coverage of the following services:

Services:	**Co-insurance**
Routine Preventive Care	100%
Fillings and other Basic Procedures	80%
Crowns, Bridges, and others	50%

The table below provides the Per Member Per Month (PMPM) cost estimates for coverage under the proposed mandate based upon the assumptions described above:

Individual	$12.86
Small Group	$12.37
Large Group	$11.78

This estimate does not include coverage for orthodontia services, if such services are to be included, the cost impact will be increased.

[16] Nazare, Santash. "1. Dental Workforce: Active Dentists by County Maine 2011." Maine Center for Disease Control and Prevention, Dec. 2011. https://www.maine.gov/dhhs/mecdc/population-health/odh/documents/maps/1-dental-workforce-active-dentists-by-county-maine.pdf

Cigna: Claim cost implications to cover comprehensive adult dental is estimated to be in the range of $30-$35 PMPM assuming no current dental coverage. In addition to the cost of adding coverage, there would be a very large administrative cost as the Cigna Medical claim systems is not set up to process Dental claims and the Cigna Dental claims system is not set up to process claims under the Medical benefit. Cigna Medical and Dental also are not set up for cross accumulations for things like maximums and deductibles.

Community Health Options: Without more information as to the specific services to be covered, permissible limits or exclusions and the population risk profile which will be seeking coverage, we are unable to estimate an impact on the rates; however, we believe the increase to premiums will be greater than the range of premiums in the marketplace for stand-alone plans which cover Diagnostic and Preventive, Basic and Major Restorative and Orthodontic Benefits, because stand-alone plans cap annual benefits. Required coverage for additional benefits such as over-the-counter products, dental implants or absence of benefit limits also add substantial cost to premium.

Harvard Pilgrim HealthCare: There are several factors that would need to be considered before any estimate for comprehensive dental network typically included in a traditional insurance plan. The start-up cost of HPHC providing direct coverage would include creation of a dental network needed for the additional dental insurance. The cost may be partly offset in Medical coverage by avoidance of high cost medical services for treating dental related medical problems (i.e. emergency room).

United HealthCare: We estimate the cost of this coverage, as follows:

	EHB Indiv	EHB Small	EHB Large
Premium	$ 14.52	$ 10.59	$ 9.93
Admin & Profit	$ 4.13	$ 2.61	$ 1.99
Claims	$ 10.39	$ 7.98	$ 7.94

NovaRest Estimate

NovaRest anticipates this bill will result in increases in health insurance premiums between $15 and $22 PMPM. With an estimated 62,250 members in Maine enrolled in individual qualified health plans, we estimate the cost to the state of $11.7 to $16.5 million as required to defray the cost of any additional mandated benefits under the ACA. The additional premium cost to medical plans will depend on a number of factors that were not captured entirely in this estimate.

Embedded dental plans have a different cost than stand alone plans, and insurance carriers might choose to implement dental coverage in either way. Contracting will also play a significant role. Some carriers already contract with dental providers as they offer some form of dental benefits or a separate stand-alone dental plan while others do not.

Assumptions are as follows:

- For the cost estimate, our starting point was Delta Dental's rates. Since they hold about 80% of the market share for dental services in Maine,[17] and service a large portion of the population currently.
- Delta Dental's cheapest plan did not cover major restorative, which we believe would be required by LD 441. Therefore, we used Delta Dental's Premium Plan with a premium of $38.59 PMPM. This appears to offer comprehensive coverage, as specified by LD 441, although LD 441 does not specify cost sharing.
- Delta Dental's Premium Plan includes 100% coinsurance for preventive services, 50% for basic restorative services, and 25% for major restorative services. The deductible is $100 and the annual maximum is $1,500. We find these cost sharing amounts reasonable and believe they would meet the requirements of LD 441.
- Delta Dental's Premium Plan included 32% of premium for non-benefit expenses. While we recognize there may be some additional administrative cost in the short term, we assume non-benefit expenses would be similar to the medical plans in the long term, therefore we have removed these non-benefit expenses.
- We found that about 66% of people with medical coverage in Maine already have some form of dental coverage.[18] This might change if this bill passes. Some people might choose to leave their stand-alone dental plan since dental benefits would now be covered as part of their medical insurance. We assumed a range of 30% - 50% of consumers would leave their stand-alone dental plans.
- Annual claims, premiums, risk adjustment, and membership for 2020 was from the National Association of Insurance Commissioners 2020 Annual Statement.

7. The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the cost and benefits of coverage.

We do not believe there will be any additional cost effect beyond benefit and administrative costs.

[17] S&P Global Market Intelligence. "Insurance Statutory Market Share." Health Industry Dental Only in Maine. 2020.
[18] National Association of Health Insurance Commissioners. 2020 Annual Statement. Dental Only Covered Lives/Total Covered Lives in the Individual, Small Group, and Large Group markets.

8. The impact on the total cost of health care, including potential benefits and savings to insurers and employers because the proposed mandated treatment or service prevents disease or illness or leads to the early detection and treatment of disease or illness that is less costly than treatment or service for later stages of a disease or illness.

One study suggests that covering dental services will reduce health care costs for those with diabetes, cardiovascular disease, and Mainers who are pregnant by $1,997,273 in year two and $3,994,546 in year three. In addition, total health savings per enrollee per month are estimated to be $2.16, $1.71, and $1.41 in years 1, 2, and 3, respectively.[19] In addition, Anthem stated that "there is a study that indicates preventive dental care may result in improved diabetes control and decreased risk of ischemic stroke and myocardial infarctions (Burden of Oral Disease Among Older Adults and Implications for Public Health Priorities Am J Public Health. 2012 March)."

Other carriers also agreed that there may be potential savings. United HealthCare mentioned that preventive dental does provide cost savings by reducing the utilization of crowns, restoration services and root canals, and other more expensive dental services. Harvard Pilgrim HealthCare stated that "the cost (of providing coverage) may be partly offset in Medical coverage by avoidance of high-cost medical services for treating dental related medical problems (i.e. emergency room)."

9. The effects of mandating the benefit on the cost of health care, particularly the premium and administrative expenses and indirect costs, to employers and employees, including the financial impact on small employers, medium-sized employers and large employers.

We believe that the cost of this benefit will increase premiums between 2.8% to 4.0% or $15 to $22 PMPM. Additionally, some carriers may experience increased administrative expenses. This increase in cost may be passed on to medium-sized and large employers, potentially incentivizing some of these companies to self-insure or drop coverage, where this mandate would not be applicable.

10. The effect of the proposed mandates on cost-shifting between private and public payers of health care coverage and on the overall cost of the health care delivery system in this State.

Maine is one of only 13 states that has no adult dental benefit in Medicaid (MaineCare), except for limited emergency care (though this would change if LD 996 is passed). We do not expect cost-shifting, (even if LD 996 passes).

[19] Maine Equal Justice (n 6)

V. Medical Efficacy

C. The Medical Efficacy of Mandating the Benefit

1. The contribution of the benefit to the quality of patient care and the health status of the population, including any research demonstrating the medical efficacy of the treatment or service compared to the alternative of not providing the treatment or service.

Comprehensive dental services, which includes preventive dental care, would be very beneficial to the health status of the population. Preventive dental care does not only eliminate the likelihood of cavities, gum disease, and other oral diseases, but also prevents serious health problems. Good oral health can prevent conditions like diabetes, osteoporosis, heart disease, cancer, and respiratory disease.[20]

2. If the legislation seeks to mandate coverage of an additional class of practitioners:

The bill does not mandate coverage of an additional class of practitioners.

VI. Balancing the Effects

D. The Effects of Balancing the Social, Economic, and Medical Efficacy Considerations

1. The extent to which the need for coverage outweighs the cost of mandating the benefit for all policyholders.

Coverage for the treatment and services proposed is likely already covered by dental plans, which people are not mandated to purchase but many do.

2. The extent to which the problem of coverage can be resolved by mandating the availability of coverage as an option for policyholders.

Coverage for dental services is already widely available in stand-alone dental plans, which are available separate from medical plans. Purchasing this coverage is not mandatory.

[20] "10 Benefits of Preventive Dentistry." Doug Lewis Dentistry, 5 Mar. 2021, https://douglewisdmd.com/10-benefits-of-preventive-dentistry/.

3. The cumulative impact of mandating this benefit in combination with existing mandates on costs and availability of coverage.

NovaRest anticipates this bill will result in increases in health insurance premiums between 2.8% to 4.0% or $15 to $22 PMPM.

Other proposed mandates currently being considered could add another 1% or $4.48 to $5.60 PMPM.

The estimated cost of current Maine mandates is detailed in Appendix A. For most of these mandates, our estimate is based on the net impact on premiums as estimated at the time the mandate was enacted. Four of the mandates – mental health, substance abuse, chiropractic, and screening mammograms – require carriers to report annually the number of claims paid for these benefits and the estimates are based on that data. The true cost for the Maine mandates is impacted by the fact that:

1. Some services would be provided and reimbursed in the absence of a mandate.
2. Certain services or providers will reduce claims in other areas.
3. Some mandates are required by Federal law.

The addition of 4.0% of premiums for LD 441 to the estimated cost of current Maine mandates, would result in a cumulative cost as shown below:

Total cost for groups larger than 20:	16.59%
Total cost for groups of 20 or fewer:	16.64%
Total cost for individual contracts:	14.90%

Additionally, if the other two mandates for adult dental and child athletic prosthetics are considered this could add another 1% to premium.

VII. Actuarial Memoranda

Limitations

NovaRest has prepared this report in conformity with its intended use by persons technically competent to evaluate our estimate of the proposed bill. Any judgments as to the data contained

in the report or conclusions about the ramifications of that data should be made only after reviewing the report in its entirety, as the conclusions reached by review of a section or sections on an isolated basis by be incorrect. Appropriate staff is available to explain and/or clarify any matter presented herein. It is assumed that any user of this report will seek such explanations as to any matter in question.

NovaRest has developed projections in conformity with what we believe to be the current and proposed operating environments and are based on best estimates of future experience within such environments. It should be recognized that actual future results may vary from those projected in this report. Factors that may cause the actual results to vary from the projected include new insurance regulations, differences in implementation of the required coverage by carrier, accounting practices, changes in federal and/or local taxation, external economic factors such as inflation rates, investment yields and ratings and inherent potential for normal random fluctuations in experience.

Reliance and Qualifications

We are providing this report to you solely to communicate our findings and analysis of the bill's consideration. The reliance of parties other than the Maine Bureau of Insurance and the Joint Standing Committee on Health Coverage, Insurance and Financial Services on any aspect of our work is not authorized by us and is done at their own risk.

To arrive at our estimate, we made use of information provided by carriers included in the data call. We also made assumptions based on information gained from interviews with medical professionals. We did not perform an independent investigation or verification. If this information was in any way inaccurate, incomplete, or out of date, the findings and conclusions in this report may require revision. While we have relied on information without independent investigation or verification, the medical professionals we spoke to are fully qualified and knowledgeable in their field.

This memorandum has been prepared in conformity with the applicable Actuarial Standards of Practice. We have no conflicts of interest in performing this review and providing this report.

We are members of the American Academy of Actuaries and meet that body's Qualification Standards to render this opinion. We meet the Qualification Standards promulgated by these professional organizations to perform the analyses and opine upon the results presented in this Actuarial Report.

VIII. Appendices

Appendix A: Cumulative Impact of Mandates

Bureau of Insurance
Cumulative Impact of Mandates in Maine

Report for the Year 2020

This report provides data for medical insurance coverage of mandates as required by 24-A M.R.S.A. §2752 and compiled by the Bureau of Insurance. While some data was provided through annual mandate reports by insurers, other figures were estimated as a part of the proposed mandates study. The following provides a brief description of each state mandate and the estimated claim cost as a percentage of premium. Many of these mandates are now required by the federal Affordable Care Act (ACA). In addition, the ACA requires benefits covered by the benchmark plan which includes all state mandates to be covered by all individual and small group plans effective January 1, 2014. A summary chart is provided at the end of this report.

- ***Mental Health*** (Enacted 1983)

Mental health parity for group plans in Maine became effective July 1, 1996 and was expanded in 2003. The percentage of mental health group claims paid has been tracked since 1984 and has historically been between 3% - 4% of total group health claims. Claims jumped sharply in 2020 by 1.3% to 5.2% for groups after steadily declining by a half point per year for the previous 3 years.

Maine mental health parity was only a mandated offer for individual plans until it was included in the essential health benefits for ACA (Affordable Care Act) individual and small group plans beginning 2014. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) amended the PHS Act, ERISA, and the Code to provide increased parity between mental health and substance use disorder benefits and medical/surgical benefits and extended parity to all individual plans. As expected, mental health claims have stabilized back to a lower level of 2.5% in 2017 after meeting pent-up demand of 9.4% in 2015. From 2018 to 2020 claims have increased slightly to an average of 3.5%, but still within a stabilized range.

- ***Substance Abuse*** (Enacted 1983)

Maine's mandate only applied to group coverage. Effective October 1, 2003, substance abuse was added to the list of mental health conditions for which parity is required. Effective on January 1, 2014 the federal Affordable Care Act requires substance abuse treatment benefits for individual and small group plans as part of the essential health benefits. The percentage of claims paid for group plans has been tracked since 1984. Substance abuse claims paid have remained flat at 1.2% average for the past 3 years of the total group health claims. Individual substance abuse health claims have also remained flat at 1.0% for the past 3 years. As expected, substance abuse claims have leveled out as pent-up demand is met and carriers manage utilization.

- ***Chiropractic*** (Enacted 1986)

This mandate requires coverage for the services of chiropractors to the extent that the same services would be covered if performed by a physician. Using annual experience reports from the carriers, the percentage of claims paid has been tracked since 1986 and, in 2020, was 0.80% of total health claims. Prior to 2014, the level has typically been lower for individual than for group. Individual claims at 0.4% in 2020 have continued a trend of lower than group claims since 2017 when they were equivalent.

- ***Screening Mammography*** (Enacted 1990)

This mandate requires that benefits be provided for screening mammography. We estimate the current 2020 levels of 0.9% for group and 1.0% for individual going forward. Coverage is required by ACA for preventive services.

- ***Dentists*** (Enacted 1975)

This mandate requires coverage for dentists' services to the extent that the same services would be covered if performed by a physician. A 1992 study done by Milliman and Robertson for the Mandated Benefits Advisory Commission estimated that these claims represent 0.5% of total health claims and that the actual impact on premiums is "slight." It is unlikely that this coverage would be excluded in the absence of a mandate. We include 0.1% as an estimate.

- ***Breast Reconstruction*** (Enacted 1998)

This mandate requires coverage for reconstruction of both breasts to produce a symmetrical appearance after a mastectomy. At the time this mandate was being considered in 1995, one carrier estimated the cost at $0.20 per month per individual. We do not have a more recent estimate. We include 0.02% in our estimate of the maximum cumulative impact of mandates.

- ***Errors of Metabolism*** (Enacted 1995)

This mandate requires coverage for metabolic formula and prescribed modified low-protein food products. At the time this mandate was being considered in 1995, Blue Cross estimated the cost at $0.10 per month per individual. We do not have a more recent estimate. We include 0.01% in our estimate.

- ***Diabetic Supplies*** (Enacted 1996)

This mandate requires that benefits be provided for medically necessary diabetic supplies and equipment. Based on data collected in 2006, most carriers reported that there would be no cost increase or an insignificant cost increase because they already provide this coverage. Based on our report we estimate 0.2%.

- ***Minimum Maternity Stay*** (Enacted 1996)

This mandate requires that if a policy provides maternity benefits, the maternity (length of stay) and newborn care benefits must be provided in accordance with "Guidelines for Prenatal Care." Based on carrier responses indicating that they did not limit maternity stays below those recommended, we estimate no impact.

- ***Pap Smear Tests*** (Enacted 1996)

This mandate requires that benefits be provided for screening Pap smear tests. HMOs would typically cover these costs and, for non-HMO plans, the relatively small cost of this test would not in itself satisfy the deductible, so there would be no cost unless other services were also received. We estimate a negligible impact of 0.01%. Coverage is required by ACA for preventive services.

- ***Annual GYN Exam Without Referral*** (Enacted 1996)

This mandate only affects HMO plans and similar plans, and it requires the provision of benefits for annual gynecological exams without prior approval from a primary care physician. To the extent the Primary Care Physician (PCP) would, in absence of this law, have performed the exam personally rather than referring to an OB/GYN, the cost may be somewhat higher; therefore, we include 0.1%.

- ***Breast Cancer Length of Stay*** (Enacted 1997)

This mandate requires that benefits for breast cancer treatment be provided for a medically appropriate period of time as determined by the physician in consultation with the patient. Group claims in 2020 were 2.0% compared to individual claims at 1.4% with the combined impact remaining level with past years at 1.7%.

- ***Off-label Use Prescription Drugs*** (Enacted 1998)

This mandate requires coverage of off-label prescription drugs in the treatment of cancer, HIV, and AIDS. Our 1998 report stated a "high-end cost estimate" of about $1 per member per month (0.6% of premium) if it is assumed there is currently no coverage for off-label drugs. Because the HMOs claimed to already cover off-label drugs, in which case there would be no additional cost; and, providers testified that claims have been denied on this basis, we include half this amount, or 0.3%.

- ***Prostate Cancer*** (Enacted 1998)

This mandate requires prostate cancer screenings. Our report estimated additional claims cost would approximate $0.10 per member per month. With the inclusion of administrative expenses, we would expect a total cost of approximately $0.11 per member per month, or approximately 0.07% of total premiums. Coverage is required by ACA for preventive services.

- ***Nurse Practitioners and Certified Nurse Midwives*** (Enacted 1999)

This law mandates coverage for nurse practitioners and certified nurse midwives and allows nurse practitioners to serve as primary care providers. This mandate is estimated to increase premium by 0.16%.

- ***Coverage of Contraceptives*** (Enacted 1999)

This mandate requires health plans that cover prescription drugs to cover contraceptives. Our report estimated an increase of premium of 0.8%.

- ***Registered Nurse First Assistants*** (Enacted 1999)

This mandate requires health plans that cover surgical first assistants to cover registered nurse first assistants if an assisting physician would be covered. No material increase in premium is expected.

- ***Access to Clinical Trials*** (Enacted 2000)

This mandate requires that coverage be provided for an eligible enrollee to participate in approved clinical trials. Our report estimated a cost of 0.19% of premium.

- ***Access to Prescription Drugs*** (Enacted 2000)

This mandate only affects plans with closed formularies. Our report concluded that enrollment in such plans is minimal in Maine and therefore the mandate will have no material impact on premiums.

- ***Hospice Care*** (Enacted 2001)

No cost estimate was made for this mandate because the Legislature waived the requirement for a study. Because carriers generally covered hospice care prior to the mandate, we assume no additional cost.

- ***Access to Eye Care*** (Enacted 2001)

This mandate affects plans that use participating eye care professionals. Our report estimated a cost of 0.04% of premium.

- ***Dental Anesthesia*** (Enacted 2001)

This mandate requires coverage for general anesthesia and associated facility charges for dental procedures in a hospital for certain enrollees for whom general anesthesia is medically necessary. Our report estimated a cost of 0.05% of premium.

- ***Prosthetics*** (Enacted 2003)

This mandate requires coverage for prosthetic devices to replace an arm or leg. Our report estimated a cost of 0.03% of premium for groups over 20, and a cost of 0.08% of premium for small employer groups and individuals.

- ***LCPCs*** (Enacted 2003)

This mandate requires coverage of licensed clinical professional counselors. Our report on mental health parity indicated no measurable cost impact for coverage of LCPCs.

- ***Licensed Pastoral Counselors and Marriage & Family Therapists*** (Enacted 2005)

This mandate requires coverage of licensed pastoral counselors and marriage & family therapists. Our report indicated no measurable cost impact for this coverage.

- ***Hearing Aids*** (Enacted 2007 and revised 2019)

The prior mandate required coverage for a hearing aid for each ear every 36 months for children age 18 and under. The mandate was phased-in between 2008 and 2010, and our report estimated a cost of 0.1% of premium. For 1/2020 the hearing aid mandate is expanded to require adult hearing aids. Based on rate filings and a proposed mandate study we estimate 0.2% addition impact to rates to provide hearing aids to adults.

- ***Infant Formulas*** (Enacted 2008)

This mandate requires coverage for amino acid-based elemental infant formulas for children two years of age and under, regardless of delivery method. This mandate is effective January 2009, and our report estimated a cost of 0.1% of premium.

- ***Colorectal Cancer Screening*** (Enacted 2008)

This mandate requires coverage for colorectal cancer screening. This mandate is effective January 2009. No carriers stated they denied coverage prior to this mandate; therefore, our report estimated no impact on premium. Coverage is required by ACA for preventive services.

- ***Independent Dental Hygienist*** (Enacted 2009)

This mandate requires individual dental insurance or health insurance that includes coverage for dental services to provide coverage for dental services performed by an independent practice dental hygienist. This mandate applies only to policies with dental coverage; therefore, there is no estimated impact on medical plan premiums.

- ***Autism Spectrum* Disorders** (Enacted 2010)

This mandate was effective January 2011 and required all contracts to provide coverage for the diagnosis and treatment of autism spectrum disorders for individuals five years of age or under. It was expanded to age 10 for January 2014 effective dates. A recent report estimated a cost of 0.3% of premium once the mandate is fully implemented if it included those under age 10. Based on that estimate and recently reported experience we are estimating this going forward.

- ***Children's Early Intervention Services*** (Enacted 2010)

This mandate requires all contracts to provide coverage for children's early intervention services from birth to 36 months for a child identified with a developmental disability or delay. This mandate was effective January 2011, and our report estimated a cost of 0.05% of premium.

- ***Chemotherapy Oral Medications*** (Enacted 2014)

Policies that provide chemotherapy treatment must provide coverage for prescribed orally administered anticancer medications equivalent to the coverage for IV or injected anticancer medication. No material increase in premium is expected.

- ***Bone Marrow Donor Testing*** (Enacted 2014)

Reimbursement for human leukocyte antigen testing to register as a bone marrow donor. Limited to $150 per lifetime. May not be applied to any deductible or other cost share. No material increase in premium is expected.

- ***Dental Hygienist*** (Enacted 2014)

Coverage for services provided by a dental hygiene therapist for policies with dental coverage. No material increase in premium is expected.

- ***Abuse-Deterrent Opioid Analgesic Drugs*** (Enacted 2015)

Coverage for abuse-deterrent opioid analgesic drugs on a basis not less favorable than that for opioid analgesic drugs that are not abuse-deterrent and are covered by the health plan. No material increase in premium is expected.

- ***Preventive Health Services*** (Enacted 2018)

Coverage for preventive health services including evidence-based items or services with a rating of A or B in the United States Preventive Services Task Force or equivalent, preventive care and screenings and immunizations supported by the federal DHHS. Currently covered and no material increase in premium is expected.

- ***Naturopathic Doctor*** (Enacted 2018)

Coverage for services provided by a naturopathic doctor when those services are covered when provided by any other health care provided and within the lawful scope of practice of the naturopathic doctor. No material increase in costs is expected and if the services are a substitute for medical doctor services, there may be a decrease in cost for some patients.

- ***Abortion Coverage*** (Enacted 2019)

This mandate requires that health insurance carriers who provide coverage for maternity services also provide coverage for abortion services except for employers granted a religious exclusion.

- ***Coverage for certified registered nurse anesthetists (CRNA)*** (Enacted 2021)

This mandate requires insurers, health maintenance organizations and nonprofit hospitals or medical service organizations to provide coverage for the services of certified registered nurse anesthetists provided to individuals.

- ***Coverage for certified midwives.*** (Enacted 2021)

This mandate requires insurers, health maintenance organizations and nonprofit hospitals or medical service organizations to provide coverage under those contracts for services performed by a certified nurse midwife to a patient who is referred to the certified nurse midwife by a primary care provider when those services are within the lawful scope of practice of the certified nurse midwife.

- ***Coverage for HIV prevention drugs.*** (Enacted Federal 2021)

This mandate requires health insurance carriers to provide coverage for an enrollee for HIV prevention drugs that have been determined to be medically necessary by a health care provider.

COST OF EXISTING MANDATED HEALTH INSURANCE BENEFITS

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium
1975	Must include benefits for **dentists'** services to the extent that the same services would be covered if performed by a physician.	All Contracts	0.10%
1983	Benefits must be included for treatment of **alcoholism and drug dependency**.	Groups	1.24%
		Individual	1.13%
1975 1983 1995 2003	Benefits must be included for **Mental Health Services**, including psychologists and social workers.	Groups	5.15%
		Individual	3.58%
1986 1994 1995 1997	Benefits must be included for the services of **chiropractors** to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services.	Group	0.83%
		Individual	0.61%
1990 1997	Benefits must be made available for screening **mammography**.	Group	0.85%
		Individual	0.96%
1995	Must provide coverage for **reconstruction of both breasts** to produce symmetrical appearance according to patient and physician wishes.	All Contracts	0.02%
1995	Must provide coverage for **metabolic formula** and up to $3,000 per year for prescribed modified low-protein food products.	All Contracts	0.01%
1996	If policies provide maternity benefits, the **maternity (length of stay**) and newborn care benefits must be provided in accordance with "Guidelines for Prenatal Care."	All Contracts	0
1996	Benefits must be provided for medically necessary equipment and supplies used to treat **diabetes** and approved self-management and education training.	All Contracts	0.20%
1996	Benefits must be provided for **screening Pap tests**.	All	0.01%
1996	Benefits must be provided for **annual gynecological exam** without prior approval of primary care physician.	Group managed care	0.10%
1997	Benefits provided for **breast cancer treatment** for a medically appropriate period of time determined by the physician in consultation with the patient.	All Contracts	2.57%
1998	Coverage required for **off-label use of prescription drugs** for treatment of cancer, HIV, or AIDS.	All Contracts	0.30%
1998	Coverage required for **prostate cancer screening**.	All Contracts	0.07%

1999	Coverage of nurse **practitioners and nurse midwives** and allows nurse practitioners to serves as primary care providers.	All Managed Care Contracts	0.16%
1999	Prescription drug must include **contraceptives**.	All Contracts	0.80%
1999	Coverage for **registered nurse first assistants**.	All Contracts	0
2000	Access to **clinical trials**.	All Contracts	0.19%
2000	Access to **prescription drugs**.	All Managed Care Contracts	0
2001	Coverage of **hospice care services** for terminally ill.	All Contracts	0
2001	Access to **eye care**.	Plans with participating eye care professionals	0.04%
2001	Coverage of **anesthesia** and facility charges for certain **dental** procedures.	All Contracts	0.05%
2003	Coverage for **prosthetic devices** to replace an arm or leg	Groups >20	0.03%
		All other	0.08%
2003	Coverage of licensed clinical professional counselors	All Contracts	0
2005	Coverage of licensed pastoral counselors and marriage & family therapists	All Contracts	0
2007	Coverage of hearing aids for children	All Contracts	0.1%
2008	Coverage for amino acid-based elemental **infant formulas**	All Contracts	0.1%
2008	Coverage for **colorectal cancer screening**	All Contracts	0
2009	Coverage for **independent dental hygienist**	All Contracts	0
2010	Coverage for **autism spectrum**	All Contracts	0.3%
2010	Coverage for **children's early intervention services**	All Contracts	0.05%
2014	Coverage for **chemotherapy oral medications**	All Contracts	0
2014	Coverage for **human leukocyte antigen testing**	All Contracts	0
2014	Coverage for **dental hygienist**	All Contracts	0
2015	Coverage for **abuse-deterrent opioid analgesic medications**	All Contracts	0
2018	Coverage for **naturopath**	All Contracts	0
2018	Coverage for **preventive services**	All Contracts	0
2019	Coverage for **adult hearing aids**	All Contracts	0.20%
2019	Coverage for **abortion services**	Individual	0.14%
		Group	0.19%
2021	Coverage for **certified registered nurse anesthetists**	All Contracts	0
2021	Coverage for **certified midwives**	All Contracts	0
2021	Coverage for **HIV prevention drugs**	All Contracts	0
	Total cost for groups larger than 20:		**12.59%**
	Total cost for groups of 20 or fewer:		**12.64%**
	Total cost for individual contracts:		**10.90%**

Appendix B: Letter from the Committee on Health Coverage, Insurance and Financial Services with Proposed Legislation

SENATE

HEATHER B. SANBORN, DISTRICT 28, CHAIR
STACY BRENNER, DISTRICT 30
HAROLD "TREY" L. STEWART, III, DISTRICT 2

COLLEEN MCCARTHY REID, SR. LEGISLATIVE ANALYST
CHRISTIAN RICCI, COMMITTEE CLERK

HOUSE

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JOSHUA MORRIS, TURNER
MARK JOHN BLIER, BUXTON
JONATHAN M. CONNOR, LEWISTON
TRACY L. QUINT, HODGDON

STATE OF MAINE
ONE HUNDRED AND THIRTIETH LEGISLATURE
COMMITTEE ON HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

June 30, 2021

Eric A. Cioppa
Superintendent
Bureau of Insurance
34 State House Station
Augusta, Maine 04333

Dear Superintendent Cioppa:

Title 24-A Maine Revised Statutes Annotated, Section 2752 requires the Joint Standing Committee on Health Coverage, Insurance and Financial Services to submit legislation proposing health insurance mandates to the Bureau of Insurance for review and evaluation if there is substantial support for the mandate among the committee after a public hearing on the proposed legislation. Pursuant to that statute, we request that the Bureau of Insurance prepare a review and evaluation of **LD 441, An Act To Expand Adult Dental Health Insurance Coverage.**

A copy of the bill is enclosed. Please prepare the evaluation using the guidelines set out in Title 24-A § 2752. In addition, we ask that the Bureau provide an analysis of the extent to which the bill expands coverage beyond the State's essential benefits package and, if so, the estimated costs to the State to defray the costs of including the coverage in qualified health plans.

Please submit the report to the committee no later than January 1, 2022 so the committee can take final action on LD 441 before the end of the Second Regular Session. If you have any questions, please do not hesitate to contact us or our legislative analyst, Colleen McCarthy Reid.

Sincerely,

Sen. Heather B. Sanborn
Senate Chair

Rep. Denise A. Tepler
House Chair

Enclosure: LD 441

cc: Marti Hooper, Bureau of Insurance
Rep. Heidi Brooks

Appendix C: LD 441

130th MAINE LEGISLATURE

FIRST REGULAR SESSION-2021

Legislative Document **No. 441**

H.P. 317 House of Representatives, February 16, 2021

An Act To Expand Adult Dental Health Insurance Coverage

Received by the Clerk of the House on February 11, 2021. Referred to the Committee on Health Coverage, Insurance and Financial Services pursuant to Joint Rule 308.2 and ordered printed pursuant to Joint Rule 401.

Robert B. Hunt

ROBERT B. HUNT
Clerk

Presented by Representative BROOKS of Lewiston.

Be it enacted by the People of the State of Maine as follows:

PART A

Sec. A-1. 24 MRSA §2317-B, sub-§22, as amended by PL 2019, c. 605, §3, is further amended to read:

22. Title 24-A, section 4320-M. Coverage for abortion services, Title 24-A, section 4320-M; ~~and~~

Sec. A-2. 24 MRSA §2317-B, sub-§23, as enacted by PL 2019, c. 605, §4, is amended to read:

23. Title 24-A, sections 2766-A and 2847-W. The prohibition on a dental benefit waiting period for persons under 19 years of age, Title 24-A, sections 2766-A and 2847-W~~.~~; and

Sec. A-3. 24 MRSA §2317-B, sub-§24 is enacted to read:

24. Title 24-A, section 4320-P. Coverage for comprehensive dental services, Title 24-A, section 4320-P.

Sec. A-4. 24-A MRSA §4320-P is enacted to read:

§4320-P. Coverage for comprehensive dental services

1. Definition. As used in this section, unless the context otherwise indicates, "comprehensive dental services" means any services necessary to maintain oral health and prevent disease, restore oral structures to health and function and treat emergency conditions.

2. Required coverage. A carrier offering a health plan in this State shall provide coverage for comprehensive dental services.

3. Limits; coinsurance; deductibles. A health plan that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

4. Coordination of benefits with dental insurance. If an enrollee eligible for coverage under this section is also eligible for coverage under a dental insurance policy or contract, the insurer providing dental insurance is the primary payer responsible for charges under subsection 2 and the carrier is the secondary payer.

Sec. A-5. Application. The requirements of this Part apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2022. For purposes of this Part, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

PART B

Sec. B-1. 22 MRSA §8718 is enacted to read:

§8718. Dental provider database

The organization shall develop and maintain a database to provide information on available dentists in this State who provide dental services to MaineCare members,

including children. The database of available dentists must be posted on a publicly accessible website for use by the public. The organization shall collaborate with the department as necessary on the development and maintenance of the database of available dentists.

SUMMARY

Part A of the bill requires health insurance carriers to provide coverage for comprehensive dental services. Part A applies to policies and contracts issued or renewed on or after January 1, 2022.

Part B of the bill requires the Maine Health Data Organization to develop and maintain a database of dentists providing dental care to MaineCare members, including children, and to post that information on a publicly accessible website.