INSURANCE
ADMINISTRATION

REPORT ON
DENTAL PROVIDER CONTRACTS
AND DENTAL PROVIDER PANELS

DECEMBER 2009

For further information concerning this document, please contact:

Tinna Damaso Quigley, Esq.
Director of Government Relations and Policy Development
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
410-468-2202

This document is available in an alternate format upon request from a qualified individual with a disability
1-800-735-2258 (TTY)

Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
410-468-2000* 1-800-492-6116 (toll free)

www.mdinsurance.state.md.us

Executive Summary

Dental coverage can be provided through several types of carriers in Maryland. Insurers, nonprofit health service plans, and dental plan organizations may all offer dental coverage in Maryland through stand-alone dental contracts. Health maintenance organizations (HMOs) may sell dental coverage only as an additional benefit to medical benefit contracts. Insurers and nonprofit health service plans may also offer dental coverage as an additional benefit or rider to medical benefit contracts.

Dental plans, which can be licensed as nonprofit health service plans or dental plan organizations in Maryland, sell only this single service type of contract. A listing of the dental plans licensed in Maryland is found in Appendix 1.

Dental plans and HMOs offering dental coverage may contract with dentists to form a capitated dental provider panel, a non-capitated dental provider panel or both. If a dental plan or HMO has both types of provider panels, the dentist may elect to participate on the capitated dental provider panel, the non-capitated dental provider panel or both.

Some carriers have more than one fee schedule in each type of dental provider panel. When this is the case, the dentist must agree to accept all fee schedules included in the applicable provider panel. When a carrier introduces a new fee schedule, the dentist's only option is to continue to participate on the respective provider panel or terminate participation.

This arrangement allows a carrier to build a dental provider panel and respond to changes in demand for different types of dental benefit plans. It also has the potential to limit the dentist's negotiating power when new fee schedules are introduced as the dentist's only leverage is to decline to continue to participate on the carrier's dental provider panel.

In order to provide a dentist with additional negotiating power, the Maryland Insurance Administration recommends the General Assembly allow a dentist to opt out of a new fee schedule introduced by the carrier after the date the dentist and the carrier entered into a contract.

Introduction

During the 2009 Legislative Session, the General Assembly enacted Senate Bill 481 / House Bill 145, Health Insurance – Dental Provider Panels – Provider Contracts (Chapters 549 and 550). This bill allows dentists to elect to participate in a capitated dental provider panel, a non-capitated dental provider panel or both. During deliberations on this bill, the General Assembly considered whether to permit dentists to reject a fee schedule applicable to a capitated dental provider panel or a non-capitated dental provider panel and continue to participate on the respective provider panel.

The General Assembly did not enact this provision and directed the Maryland Insurance Administration ("MIA") to conduct a review of dental provider contracts, the terms and conditions of the contracts, and the impact that the contracts have on the dental profession and report its findings and recommendations to the General Assembly by December 31, 2009. The remainder of this report summarizes the MIA's review, findings and recommendations.

Dental Insurance Market

Dental coverage can be provided through several types of carriers in Maryland. Insurers, nonprofit health service plans, and dental plan organizations may all offer dental coverage in Maryland through stand-alone dental contracts. Health maintenance organizations (HMOs) may sell dental coverage only as an additional benefit to the full medical benefit HMO contract. Insurers and nonprofit health service plans may also offer dental coverage as an additional benefit or rider to medical benefit contracts.

Dental plans, which can be licensed as nonprofit health service plans or dental plan organizations in Maryland, sell only this single service type of contract. A listing of the dental plans licensed in Maryland and their premiums for 2008 is found in Appendix 1.

Determining the presence of insurers in Maryland in the dental market is more difficult. Of the 472 life insurers licensed in Maryland in 2008, only 270 wrote health insurance premiums in Maryland in 2008. The Annual Statement for life insurers identifies the total health insurance premium written in Maryland, which includes dental insurance, but does not provide a breakdown of health insurance premium written by line. Thus, it is impossible to tell which of these life insurers offered dental insurance in Maryland or the life insurer's market share for dental insurance.

Consequently, the MIA is unable to provide a complete picture of Maryland's dental insurance market.

Dental Provider Panels

Dental plans and HMOs may require an insured, subscriber or enrollee (collectively "member") to obtain dental services from a dentist on the carrier's provider panel. However,

if the carrier limits the member to its provider panel, the carrier must offer a dental point-of-service option whereby the member may receive dental services from other dentists. See *Insurance Article, § 15-114.*

When establishing a dental provider panel, a carrier must follow certain procedures set forth in the Insurance Article. The carrier must maintain standards for the availability of health care providers to meet the health care needs of enrollees in accordance with regulations adopted by the Insurance Commissioner. See *Insurance Article, § 15-112 (b).*

The carrier must accept the uniform credentialing form established by the Insurance Commissioner. See *Insurance Article, § 15-112.1.* If the dentist submits the uniform credentialing form to the carrier and the carrier elects to proceed with credentialing, the carrier must adhere to the credentialing timeframes set forth in § 15-112 of the Insurance Article.

When entering into a contract with a dental plan or an HMO, the dentist may elect to participate in the capitated dental provider panel, the non-capitated dental provider panel or both. See *Insurance Article, § 15-112.2.*

A carrier may not assign the dentist's contract to an insurer offering personal injury protection without the dentist's express written consent. The carrier may not require the dentist to participate on a provider panel for workers' compensation services. See *Insurance Article, § 15-125.*

At the time of contract, the carrier must provide the dentist with a copy of the schedule of applicable fees for up to the 50 most common services billed by a dentist, a description of the coding guidelines used by the carrier, and the methodology the carrier uses to increase or decrease the reimbursement level or provide a bonus. This same information must be provided in writing 30 days prior to a change and at any time upon written request from the dentist. See *Insurance Article, § 15-113.*

Dental Provider Panel Contracts

Dental plans and HMOs are required to file a copy of the dental provider contract with the application for a certificate of authority with the MIA. See *Insurance Article, § 14-405*, COMAR 31.12.04.08, *Health-General Article, § 19-708*, and COMAR 31.12.02.13. Insurers and nonprofit health service plans are not required to file their provider contracts.

The MIA reviewed the dental provider contracts filed by seven dental plans. For primary dentists, five of these dental plans only have a capitated dental provider panel; one has a capitated and a non-capitated dental provider panel; and one only has a non-capitated dental provider panel. For specialty dentists, these dental plans only have a non-capitated dental provider panel.

Because the filed provider contracts do not include a copy of the fee schedule(s) attached to the provider contract, the MIA contacted these same dental plans to verify that the dental plans had a capitated provider panel and a non-capitated provider panel and the number of fee schedules included in each type of dental provider panel.

There is no consistent pattern or practice among the dental plans. Some report there is one fee schedule associated with each type of provider panel. Others report multiple fee schedules for each type of provider panel.

None of the dental plans that have more than one fee schedule in a provider panel allow a participating dentist to opt out of a fee schedule and continue to participate on the respective capitated provider panel or the non-capitated provider panel.

Market Experience

The MIA met separately with representatives of dentists and carriers. The dentists and carriers confirmed the MIA's review of dental plan provider contracts: there is no consistent reimbursement arrangement for dentists by carriers.

The dentists reported carriers provide a copy of the fee schedules at the time of contract and 30 days prior to a change. However, when the carrier changes a fee schedule, the dentist may not simply reject the change. If the dentist and the carrier cannot reach a mutually agreeable resolution to the fee arrangement, the dentist's only option is to opt out of the dental provider panel.

Similarly, if the carrier introduces a new fee schedule, the dentist may not simply reject the new fee schedule. If the dentist and the carrier cannot reach a mutually agreeable resolution to the fee arrangement, the dentist's only option is to opt out of the dental provider panel.

The carriers pointed to some additional reimbursement arrangements. Some have a guaranteed reimbursement amount. In this case, a fee is established for each dental service. The amount the dentist collects from the patient varies by the benefit plan design. The dentist always knows how much he or she will be paid for a service but must check with the carrier to determine what amount to collect from the patient directly and what amount will be reimbursed by the carrier. The MIA believes a guaranteed reimbursement amount for various services is one fee schedule.

There are carriers with unique fee schedules for each dental benefit plan design. As new benefit plan designs are created, new fee schedules may be sent to the dentists. The dentist may not reject a new fee schedule; he or she must agree to accept the new fee schedule or opt out of the applicable provider panel.

Findings and Recommendations

Because of data gaps, the MIA cannot provide a complete or accurate picture of the dental insurance market in Maryland. Some carriers have one fee schedule for each type of provider panel; others have many more.

At the time of contract, the carrier provides the dentist with a copy of the applicable fee schedules. The dentist has the opportunity to ask the carrier about its dental benefit plans and its membership. Based on this information and an assessment by the dentist of his or her practice costs, the dentist makes an informed decision to join a capitated provider panel, non-capitated provider panel or both.

When a carrier introduces a new fee schedule, the dentist does not have the option of declining the new fee schedule. The dentist's only option is to continue to participate on the respective provider panel or terminate participation.

This arrangement allows a carrier to build a dental provider panel and respond to changes in demand for different types of dental benefit plans. It also has the potential to limit the dentist's negotiating power when new fee schedules are introduced. The dentist's only leverage is to decline to continue to participate on the carrier's dental provider panel.

In order to provide a dentist with additional negotiating power, the MIA recommends the General Assembly allow a dentist to opt out of a new fee schedule introduced by the carrier after the date the dentist and the carrier entered into a contract. Appendix 2 provides suggested language should the General Assembly wish to consider this change to § 15-112.2 of the Insurance Article.

Appendix 1

DENTAL PLAN ORGANIZATIONS AND LIMITED HEALTH SERVICE ORGANIZATIONS MARYLAND DIRECT PREMIUM 2008			
			MARYLAND
			DIRECT
NAIC		STATE OF	WRITTEN
NO.	COMPANY NAME	DOMICILE	PREMIUMS 2008
	DOMESTIC COMPANIES		
48119	Cigna Dental Hlth of MD Inc	MD	12,362,638
47074	Denta Chek of MD Inc	MD	386,724
52040	DentaQuest Mid Atlantic Inc	MD	12,051,243
95846	Group Dental Serv of MD Inc	MD	17,257,354
13130	The Dental Network, Inc.	MD	8,028,065
95253	United Concordia Dental Plans	MD	16,302,036
	TOTALS		**66,388,060**
	FOREIGN COMPANIES		
95910	Aetna Dental Inc	TX	2,913,345
95163	Alpha Dental Programs Inc	TX	488,277
11217	Atlantic Southern Dental Found	NJ	138,250
11228	Compbenefits Dental Inc	IL	817,355
54798	Delta Dental of PA	PA	16,409,339
52053	Dental Benefit Providers of Il, Inc.	IL	2,856,519
95657	Dominion Dental Serv Inc	VA	486,756
95251	National Pacific Dental Inc	TX	39,531
54739	The Dental Concern Inc	KY	37,772
	TOTALS		**24,187,144**
	GRAND TOTALS		**90,575,204**

Appendix 2: Suggested Statutory Change

BY adding to
Article – Insurance
Section 15-112.2(f)
Annotated Code of Maryland
(2008 Replacement Volume and 2009 Supplement)

15–112.2.

(F) IF A CARRIER PROPOSES AN AMENDMENT TO A DENTAL PROVIDER CONTRACT TO INCLUDE AN ADDITIONAL NEW FEE SCHEDULE, THE AMENDMENT MAY NOT CONTAIN A PROVISION THAT REQUIRES THE DENTAL PROVIDER AS A CONDITION OF PARTICIPATION IN THE CAPITATED DENTAL PROVIDER PANEL OR THE NON-CAPITATED DENTAL PROVIDER PANEL TO ACCEPT THE ADDITIONAL NEW FEE SCHEDULE.