2011 HOUSE HUMAN SERVICES

HB 1183

2011 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

HB 1183
January 18, 2011
Job #13000

☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Explanation or reason for introduction of bill/resolution:

Prevent insurance companies from setting fees on dental services they do not cover under their plan.

Minutes: See attached Testimonies #1-3

Chairman Weisz: Called the hearing to order on HB 1183.

Rep. Kaiser: Sponsored and introduced the bill. This bill is coming out of a lot of work that was done at National Conference of Insurance Legislators (NCOIL). They have been deliberating on this issue for about two years. There really isn't per say a model bill as much as that a position has been developed relative to this issue. This is an insurance bill. It is a fight between the insurance companies and dental providers. The insurance companies will frequently enter into contractual agreements with dental providers. Some of you may have dental insurance. What the interpretation of the insurance companies is, once we have negotiated a rate on a service; that the rate applies regardless of that utilization of that service. My wife and I currently through her health plan have dental insurance and it covers one cleaning every six months and funds that at 100%. We take advantage of that and have our teeth cleaned every six months. When at my appointment my dentist makes me another appointment in 6 months so that it will be paid for. What if for some reason I had to go back in and have my teeth cleaned prior to the elapse of the six month period. The dental insurance company is going to argue that we have a contracted rate and we are only going to pay the reimbursement at that contracted rate. The provider says, wait a minute, you have a contracted rate, but it is limited to the application of once every six months. Insurance providers hold a large stick in the arena of dental insurance. They are basically saying, take it or leave it because their argument and it is a somewhat legitimate argument is, we are bringing you all these customers that are in this dental healthcare plan. Therefore, we are going to tell you we are only going to reimburse at that rate. If you look at part 2 that is really the heart of this bill on lines 12 – 14. On the one hand you'd say, whatever the contract says, work by the contract. You cannot circumvent the contract, but they do circumvent it and are currently circumventing it based on the buying power that they provide. There are a lot of very large companies. General Motors for example has testified in opposition to this position at the NCOIL meetings because they prefer their insurance premium of course is based on utilization and the charges that are imposed. And they want to minimize the impact on any of their service plans including

dental. They think this is a way of price control to which I say simply it is a matter of contract. The dilemma is you can take them to court and win and then you are out of their system and you no longer get their customers. So they are going state by state asking the states to take a position on this issue and say, look, this is fair; you have a contract, you have to live within the contract; don't go outside the contract and impose standards that aren't there. Or say, then we just won't sign a contract with you and you will lose access to all of these customers. That is the intent of this bill and will be happy to answer any questions.

Chairman Weisz: Can you tell me how many states already have these types of provisions?

Rep. Kaiser: I cannot absolutely answer. I know the state of Rhode Island for sure has passed it. Several other states I believe have passed it, but there might be somebody here that may have that measure, but I don't.

Dr. Steve Erlandson: President of the ND Dental Association testified in support of the bill. (See Testimony #1.)

Chairman Weisz: Dr. you stated 17 states have adopted legislation. Has most of this been recent?

Dr. Erlandson: In the last couple of years.

Chairman Weisz: So this is a relatively new animal that has appeared.

Dr. Erlandson: That is correct.

Chairman Weisz: Do most or all practices entering into some contract with insurance companies?

Dr. Erlandson: Most do.

OPPOSITION

Dan Ulmer: From BC/BS testified in opposition. (See Testimony #2.)

Rep. Porter: If the contract is very specific in what services are contracted, then how does the insurance company feel that they can regulate outside of the contract? If you are limited service based on your contract or procedures based on your contract, then how do you get outside of that boundary and think that is within your responsibilities?

Ulmer: I would assume it is in the contract.

Rep. Porter: So the contract (Ulmer interrupts)

Ulmer: If is not in the contract we have to place to regulate it.

Rep. Porter: So the contract is one size fits all. This is our dental contract either take it or leave it.

Ulmer: Yes.

Rep. Porter: Once you agree to the terms of the contract it is specified in that contract that it covers covered and non-covered services by this set fee schedule?

Ulmer: I don't know if we have any sense of non-covered services. It is just an appreciation that indeed we wanted to negotiate with someone to do so we could. This would prohibit us from even doing that.

Rep. Porter: Is it possible to get a copy of your contract with providers?

Ulmer: I imagine it would be.

Rep. Holman: How does the dental insurance plan like I and many of us here have compare to what Medicaid does when they cover? How does Medicaid deal with this type of rate setting?

Ulmer: I'm not sure. All I know is that Medicaid has a devil of a time contracting with any of the dentist. I assume it is the normal problem of underpaying.

Joe Cichy: Director of the ND Dental Association. Medicaid has a fee schedule and that is what we dentist work under and it is less than what BC/BS provides. It is a comprehensive coverage for both children and adults. With regard to covered services, Mr. Ulmer talked about two crowns covered, but the third crown wouldn't be. It wouldn't be covered, but it would be at the same rate. This bill does not affect that. Any covered service that the rate is set for continues if they need additional services in that area. Three cleanings instead of two.

Chairman Weisz: In the testimony from Rep. Kaiser, what he indicated is opposite of what you just said. His scenario was you have a cleaning and it is x amount of dollars, but if you decide to have your teeth cleaned more often, it would have to be as a covered service because there is only one cleaning per six months. Now you are telling us that it is only the covered services and the third procedure wouldn't be considered a covered service.

Cichy: I hate to contradict what Rep. Kaiser said, but that is not the intent or what the bill does. It is only for non-covered services. Any covered service that you need additional treatment in that area is charged out at that same rate. There was a bunch of discussion at NCOIL concerning that issue and that was one of the big hang-ups with getting any sort of model legislation approved. After you meet your maximums, after you meet your two cleanings a year, what about the third one? There was a big fight over whether that should be at the regular rate that the dentists charge or the discounted rate that is under the policy. This bill maintains it at the discounted rate under the policy. Just so you are clear on that. I think Rep. Kaiser had that turned around because of that discussion.

Chairman Weisz: But, if a procedure was never a covered service to start with, then you are saying this would never affect it.

Cichy: Maybe I'm confusing everybody. If it was never a covered service our point is the insurance companies should not cap that service. If it was a covered service and they have exceeded (interrupted by the Chairman)

Chairman Weisz: You are saying they can under this scenario then?

Cichy: Yes, for covered services that fee will continue for the patient.

Chairman Weisz: The question seems to be is, what truly is a covered service? How you define what covered service is then. There obviously is some concern or gray area of what is meant by covered services. Covered service areas within the contract or not number versus how much is covered of that covered service in the contract.

Cichy: I believe that is defined under the (inaudible) legislation. Covered services that are contracted for that fee continues no matter how many times that service is used. It is the non-covered services that they are attempting to cap that we are opposed to and that what this bill prevents.

Rep. Holman: How does this become something that is controlled by the contract?

Cichy: They make it part of the contract. They make this reduced fee schedule part of the contract and that is the problem. Dentists cannot negotiate with the insurance companies. The only recourse we have is to come to the legislature and ask for some help and that is what we are doing here. The dentists are at a terrible disadvantage when a situation like this occurs because they are capping services and we don't know how many times they will be used. It is totally unfair. Seventeen states have enacted it. This is a new phenomenon in the last two years and many other states are looking at it during this session.

Chairman Weisz: Do you read the bill the same way?

Ulmer: Yes. Let me go back to Rep. Porter's question. The provider agreement is filed with the department so it is public information if you want to get it. How does that sound? I understand the dilemma they are in terms of the contracting, but these are non-covered services. I don't know what we don't cover. We have a pretty broad package for dental service. What this bill does would prohibit us from ever doing that. It is not something you can negotiate or put within the contract. It says, thou shalt not. We won't be able to say we have some non-covered services that would be advantageous to our members. That they are not covered now, we couldn't negotiate a lesser fee than what the dentist wants. Our task is to reduce the cost for our members and make it more efficient so they have better health care. There is a lot of truth to the notion of insurers will drive a lot of folks to a given dentist. They are also not forced to sign the contract and this is a voluntary process on both sides.

Rep. Louser: How does a customer or a patient get billed for a non-covered service?

Ulmer: I imagine directly. I really don't know for sure.

Rep. Kilichowski: If this bill goes through, does that still limit you from trying to negotiate?

Ulmer: I think what it says, "except for fees for covered services, a preferred provider arrangement for a dental plan may not directly or indirectly set or otherwise regulate the fees charged by the provider". Yeah, I think it basically says we can't talk about setting fees for services that aren't covered. We would be prohibited from even discussing them.

Rep. Porter: If Mr. Magnuson could get us some examples of provider agreements for the dental industry that would be much appreciated.

Chairman Weisz: Pull some random ones if you could. (Addressing Mr. Magnuson.) Thank you. Closed the hearing on HB 1183.

Handed in Testimony after the hearing.

Joe Cichy: Director of the ND Dental Association. (See Testimony #3.)

2011 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

HB 1183
January 25, 2011
Job #13776

☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz: Called the committee to order. We are going to take up 1183 and I'm going to handout information from the Blues. That handout is for the next bill. This is the one that prohibition for contracts and dental services. I don't know if anyone talked to their providers. I did have a conversation with my dentist. One, I asked him how much of his services by private third party payers, he figured it was around 2%. Asked him if he ever had an issue with these types of contracts and he said no. He does do a fair mix of Medicaid and Medicare and everything else. He didn't even see it as an issue that he was aware of. Any questions or discussions?

Rep. Porter: I still have a little issue with the provider setting the price for the things that they don't cover. I think that is what the purpose at least the testimony from Mr. Cichy relates to. I don't know all the testimony was as accurate as it could have been on the side of the bill. It seems to me that if your policy doesn't cover an item where they aren't going to pay for it anyway, how can we expect the provider to be forced to accept their price when it is something they aren't paying for? That is where I am having an issue with this bill. If it was clear that the policy dictates the coverage and whatever is inside of the policy is the contract; but when you have a contract that is that encompassing, that it also includes prices that aren't contracted for, I can understand the concerns of the dentists for bringing this legislation forward.

Chairman Weisz: I can agree where there are some concerns, but I think to me the key was the fact that very little of their business is with those. As far as I know there are only three companies that are trying to enforce that provision. Obviously the provider has the ability to say no and doesn't have to accept the contracts. I know there was questions of anti-trust, but the reality is, they were aware of this or they wouldn't have brought the bill before us. They are also aware that they could just say no.

Rep. Devlin: My problem with this bill from the beginning was that we are wanting big brother or the state of ND in this case to get into the middle of contract negotiations between two private parties. That is exactly what it is. We've got a willing buyer and willing seller and some may argue that the person buying it or the dentist in this case are under pressure or else they wouldn't get the coverage. We are in the middle of contract negotiations between two private parties and I would oppose the bill for that reason alone.

Rep. Louser: Motion for a DO PASS

Rep. Paur: Second.

Vote: 6 yes, 7 no Motion Failed.

Rep. Devlin: I motion a DO NOT PASS

Rep. Hofstad: Second

Vote: 7 yes 6 no Motion Carried on a DO NOT PASS

Bill Carrier: Rep. Devlin

Date: 1-25-11
Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1183

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Louser Seconded By Rep. Paur

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ		✓	REP. CONKLIN	✓	
VICE-CHAIR PIETSCH		✓	REP. HOLMAN	✓	
REP. ANDERSON		✓	REP. KILICHOWSKI	✓	
REP. DAMSCHEN		✓			
REP. DEVLIN		✓			
REP. HOFSTAD		✓			
REP. LOUSER	✓				
REP. PAUR	✓				
REP. PORTER	✓	✓			
REP. SCHMIDT					

Total (Yes) 6 No 7

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 1-25-11
Roll Call Vote # 2

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1183

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☒ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Devlin Seconded By Rep. Hofstad

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ	✓		REP. CONKLIN		✓
VICE-CHAIR PIETSCH	✓		REP. HOLMAN		✓
REP. ANDERSON	✓		REP. KILICHOWSKI		✓
REP. DAMSCHEN	✓				
REP. DEVLIN	✓				
REP. HOFSTAD	✓				
REP. LOUSER		✓			
REP. PAUR		✓			
REP. PORTER		✓			
REP. SCHMIDT	✓				

Total (Yes) 7 No 6

Absent _____

Floor Assignment Rep. Devlin

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1183: Human Services Committee (Rep. Weisz, Chairman) recommends **DO NOT PASS** (7 YEAS, 6 NAYS, 0 ABSENT AND NOT VOTING). HB 1183 was placed on the Eleventh order on the calendar.

2011 SENATE HUMAN SERVICES

HB 1183

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1183
3-7-2011
Job Number 15022

☐ Conference Committee

Committee Clerk Signature PMonson

Explanation or reason for introduction of bill/resolution:

Relating to preferred provider arrangements with dental service providers; and to provide for application.

Minutes: Attached testimony.

Vice Chairman, **Senator Gerald Uglem**, opened the hearing on HB 1183.

Dr. Steve Erlandson, Dentist in Grand Forks, introduced HB 1183 and provided testimony in support. He urged a do pass. If passed, there is no financial implication for the insurance companies and all insurance companies will be playing by the same rules when it comes to contracting with dentists. Attachment #1

Senator Gerald Uglem asked how many dental insurance companies they need to work with and if they are nationwide or regional.

Dr. Erlandson said he didn't have the number – there are a lot. They are lucky in the state of ND right now because the major carrier BC/BS does not do this practice. The problem is that other major insurance companies are starting to come into the state. They want to be proactive to stop them from doing this.

Senator Tim Mathern wondered what the "healthcare system that works" on page 2 of his testimony refers to.

Dr. Erlandson replied that what they mean is that it is a fair market approach – small practices working, self proprietors as a business model working.

Senator Judy Lee said it was her observation that a lot of things are left out of dental insurance.

Dr. Erlandson said that is the stuff they are trying to tell them what they can charge for.

Senator Spencer Berry asked what their motivation is if it is something they don't cover.

Dr. Erlandson said he didn't know.

Senator Dick Dever asked for clarification on Section 2. Does it mean that any policies that are in play now are not affected to this and it only applies to future contracts?

Joe Cichy, ND Dental Association, responded that the contracts in place now will remain in place. When they are renewed they will be renewed under the new law.

Senator Gerald Uglem asked how often contracts are renewed.

No one had an answer to that question.

Mr. Cichy replied to the question by Senator Spencer Berry asking about what the motivation would be. In selling a dental plan to a large employer like Altru in Grand Forks, Delta came in and sold them on the fact that not only are they covering these but they are restricting what the dentists can charge the employees for dental care on the other procedures even though they aren't covering them. BC/BS does not do that. It puts them at an unfair disadvantage in negotiating their contracts with employers.

Senator Spencer Berry reported that a concern from a constituent was that, if this is passed, it will allow cost shifting from those things that are covered to those that are not covered.

Dr. Erlandson replied that if they do cap it you would see cost shifting because then you would be raising your fees for the people who don't have insurance. If the non covered is capped the market place will take care of that.

Discussion – Cost shifting is taking place if the bill isn't passed not if the bill is passed.
How this works in practice – the companies will send stuff to the dentists who need to see how the plan would affect their practice.

Senator Dick Dever asked if, in the free market, the insurance company should be allowed to negotiate their contracts however they want and then decide whether or not they are going to accept them.

Dr. Erlandson said what happens is that, after you build a patient base a company comes in and gets employer groups, you are pretty much forced to accept it. It's not fair because they are determining fees of which they have no risk at. The risk is totally taken by the dentist. It's not really contracting – it's take it or leave it.

Senator Dick Dever offered that if all the dentists feel like that and none sign the contract.

Dr. Erlandson said they can't get together – antitrust.

Senator Dick Dever said the question in his mind is whether government should step in.

Dr. Erlandson replied that if it is unfair the only way they can do it is by the legislature.

Dan Ulmer, BC/BS, reported that they opposed this in the House under the notion that it begins to intrude into the right to private contracting. Since then they have discovered the people they represent (they administer the dental service plan for the dentists) want this bill. They have backed away from their opposition and input.

There was no further testimony and the hearing was closed.

Committee discussion followed – Senator Spencer Berry didn't see the need to cap non-covered services. Dr. Erlandson talked about the non-covered procedures and how it can hurt the consumer.
Medically necessary is a complicated process. The model between medicine and dental is quite different.

Senator Tim Mathern asked if this would be addressed in health care reform – the ability to set charges for uncovered services.

Mr. Ulmer wasn't aware of any.

Senator Dick Dever wondered if the language in the bill is consistent with other states.

Dr. Erlandson said it is pretty close.

Senator Tim Mathern moved a **Do Pass**.

Seconded by **Senator Spencer Berry**.

Roll call vote 5-0-0. **Motion carried**.

Carrier is **Senator Tim Mathern**.

Date: 3-7-2011

Roll Call Vote # _____

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1183

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By **Sen.** Mathern Seconded By **Sen.** Berry

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		**Sen. Tim Mathern**	✓	
Sen. Dick Dever	✓				
Sen. Gerald Uglem, V. Chair	✓				
Sen. Spencer Berry	✓				

Total (Yes) 5 No 0

Absent 0

Floor Assignment Sen. Mathern

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1183: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** (5 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1183 was placed on the Fourteenth order on the calendar.

2011 TESTIMONY

HB 1183

January 18, 2011

Testimony before the House Human Services Committee
House Bill 1183
Representative Robin Weisz, Chairman

HB 1183- Capping of Non-covered dental fees

Chairman Weisz, members of the House Human Services Committee, my name is Dr. Steve Erlandson and I am president of the North Dakota Dental Association. I appear here in support of House Bill 1183. This bill seeks to prevent insurance companies from placing a cap on fees charged by dentist's services not covered under the insurance companies' plan. The National Council of Insurance Legislatures adopted a model bill banning fee schedule for uncovered dental services insurers. House Bill 1183 incorporates language from that model legislation.

This is a simple bill that prevents insurance companies from setting fees for services that are not covered under a dental plan. It defines the term "covered services" and establishes that the cost of these covered services remain the same for the patient even after the limits of the plan's coverage have been exceeded. Although this provision for covered services is an acceptable contractual arrangement between dentists and dental insurance companies, some insurance companies have been implementing new policy that sets a cap on the fees that participating dentists can bill for services **not** covered by its dental plan. This policy arbitrarily sets a maximum allowable fee on non-covered services and should not be permitted.

Concern with this practice includes that allowing non-covered services to be capped would affect the doctor/patient relationship by allowing third parties to participate in that relationship while not providing any benefits, which we believe is not right or fair.

There is no compelling indication for such interference with the free-market approach to delivery of dental services in our state. Maintaining a free-market economic model has enabled dentistry to be the "healthcare system that works" for a hundred years while controlled market systems in other areas of healthcare has failed.

NDDA's current policy, adopted with overwhelming support of the membership, holds that when a dental plan elects to exclude certain services from its benefit plan, the fees for those services should remain a private matter between the dentist and the patient only. Simply reducing fees artificially under the insurers limitations does not mean the costs of running the business disappear. What will likely result instead is cost shifting to make up for lost revenue which would clearly burden those least able to pay.

When dentists sign contracts with insurance companies, they agree to provide treatment for patients within the network and the dentists also agree to predetermined fees for a list of procedures covered in the plan. These fees are often set at a "discounted" rate and are generally lower than fees that are considered "usual and customary". They generally do not cover more complex procedures. Although dentists have an understanding of the services and fees that are covered by the plan and those that are not, some insurance companies are now informing dentists, providers and patients in their plans that fees for services not covered under the contract agreement are also being "set or determined" by the insurance company.

This arbitrary capping of non-covered services in provider agreements would contractually limit the fees for treatment, even though the insurance company does not share in any risk for that coverage. It adds significant risk to the dentist without any risk being born by the insurance company. For example, although both insurance companies

and dentists know and understand how frequently patients' teeth are likely to be cleaned and checked, and can factor this into their cost for coverage, neither can accurately predict what number of patients might request non-covered elective services such as dental implants, crowns or bridges. As a result, although insurance companies "have no skin in the game" with regard to providing capped non-covered services, dentists do.

You may hear the argument that these contracts are negotiated with dentists. The truth of the matter is that agreeing to a contract that caps non-covered services is a take-it or leave-it situation for dentists, it is not negotiation. Not taking the contracts, especially after the dentist has been a contract provider for a long time, is financial suicide for the dentist. Basically the dentist is placed in an unfair situation of take-it or leave-it, whether to accept a plan that is unfair or risk loosing a patient base that has been built over years of practice. Also, the insurance companies can unilaterally and arbitrarily change the list of covered and non-covered services over time.

Dentists do not have the ability to collectively or individually negotiate. The "take it or leave it" nature of the dental contract offered is not "negotiation." Dentists cannot contest certain parts of the contract in order to achieve a fair contractual relationship. Nor can they band together to change it as that would be an anti-trust violation. The only protection they can pursue is through the legislature. That is why we are here asking for your help. Seventeen (17) states have adopted legislation that bans this practice.

We believe this practice is unfair, and ask you to concur, and stop the practice by giving a do pass recommendation on House Bill 1183. Thank you.

#2

Testimony on HB 1183

House Human Serrivces 1/18/11

Mr Chairman I'm Dan Ulmer representing Blue Cross Blue Shield of North Dakota and we oppose this bill as it may severely limit our right to privately contract with dentists. We have a corporation that we provide management and administrative services for : Dental Service Corporation.

We contract with numerous dentists around the state and we believe this bill would interfere with that process by prohibiting us from creating voluntary discount programs for our members as we would not be allowed to set or negotiate fees for services that aren't covered under our insurance even if we had dentists that were willing to do so.

Like any health care provider, contracting with dentists is also a voluntary process, no one is mandated to contract with anyone therefore all contracts are open and subject to buyer beware process. In this case let's say that our insurance covers 2 crowns per year and we have a member that needs 3. We could not negotiate with the dentist to give the patient the same discount s/he gives us thus costing our member more.

Private contracting is a private matter between private entities and as such we can't help but wonder how far the state wants to intrude into this process. Once this bill passes will one party insist that the state begin to set dental rates, should they be allowed to determine where dentist practice on and on.

In essence this bill gives the dentist a significant advantage over consumers by prohibiting insurers from negotiating better prices for members. In the end this is a dentist friendly bill and not a consumer friendly bill and we strongly oppose it.

#t-3

NORTH DAKOTA DENTAL ASSOCIATION

M E M O R A N D U M

To: Representative Weisz and House Human Service Committee Members

From: Joe Cichy

Date: January 19, 2011

RE: House Bill 1183

House Bill 1183 simply seeks to prevent insurance companies from setting fees on dental services they do not cover under their plan. The question was asked regarding how fees for non covered services are billed, they are billed directly to the patient and there is no involvement by the insurance company.

This bill does not affect the ability of insurance companies to negotiate fees for services covered by the dental plan, nor affect the Insurance companies contractual authority to audit patient records.

This bill only covers non covered services; it does not cover yearly limitation of some procedures that our sponsor of the bill implied in his testimony.

Some dental services not covered by most plans include but are not limited to: 1) All aesthetics procedures which may include tooth whitening, veneers, crowns, replacement of silver amalgam to white composite fillings. 2) Placement and restoration of dental implants. 3) Some Oral and Periodontal surgical procedures.

It is our understanding that Delta Dental's national policy is to cap non covered fees. Insurance companies that currently cap non-covered procedures are SIGNA, AETNA and Met Life. Again this bill only affects services not covered under a dental plan.

The Dental Service Corporation (BCBS of ND) currently does not cap non covered services. Their testimony was not in favor of this bill. However, the bill would actually help BCBS by limiting other insurance companies from coming into ND and changing the insurance playing field concerning non covered services.

Attached is the legislation passed last year in South Dakota, Kansas and Iowa.

AN ACT

ENTITLED, An Act to prohibit dental insurers from setting fees for noncovered services.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

Section 1. No contract between an insurer and a dentist may require a dentist to provide services for an insured at a fee set by the contract unless the services are covered services under the terms of the insured's plan or policy. For the purposes of this section, the term, covered services, means services reimbursable under the plan, policy, or contract, subject to such contractual limitations on benefits as may apply, including deductibles, waiting periods, frequency limitations, or charges over the benefit maximum.

An Act to prohibit dental insurers from setting fees for noncovered services.

I certify that the attached Act originated in the

SENATE as Bill No. 108

_____
Secretary of the Senate

_____
President of the Senate

Attest:

_____
Secretary of the Senate

_____
Speaker of the House

Attest:

_____
Chief Clerk

Senate Bill No. 108
File No. ____
Chapter No. _____

Received at this Executive Office this _____ day of _____,

20____ at _____ M.

By _____
for the Governor

The attached Act is hereby approved this _____ day of _____, A.D., 20___

_____
Governor

STATE OF SOUTH DAKOTA,
ss.
Office of the Secretary of State

Filed _____, 20___
at _____ o'clock __ M.

_____
Secretary of State

By _____
Asst. Secretary of State

In bill text the following have special meaning:
green underline denotes added text
~~dark red struck out text denotes deleted text~~
red text denotes vetoed text

IA 2009 H 2229	AUTHOR:	Commerce
	VERSION:	Enacted
	VERSION DATE:	04/29/2010

House File 2229

AN ACT

PROHIBITING THE IMPOSITION BY A DENTAL PLAN OF FEE SCHEDULES FOR THE PROVISION OF DENTAL SERVICES THAT ARE NOT COVERED BY THE PLAN.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. NEW SECTION. 514C.3B Dental coverage -- fee schedules.

1. A contract between a dental plan and a dentist for the provision of services to covered individuals under the plan shall not require that a dentist provide services to those covered individuals at a fee set by the dental plan unless such services are covered services under the dental plan.

2. A person or entity providing third-party administrator services shall not make available any dentists in its dentist network to a dental plan that sets fees for dental services that are not covered services.

3. For the purposes of this section:

a. "Covered services" means services reimbursed under the dental plan.

b. "Dental plan" means any policy or contract of insurance which provides for coverage of dental services not in connection with a medical plan that provides for the coverage of medical services.

4. Nothing in this section shall be construed as limiting the ability of an insurer or a third-party administrator to restrict any of the following as they relate to covered services:

a. Balance billing.

b. Waiting periods.

c. Frequency limitations.

d. Deductibles.

e. Maximum annual benefits.

In bill text the following has special meaning
green underline denotes added text
~~dark red struck out text denotes deleted text~~
red text denotes vetoed text

KS 2009 S 389	**AUTHOR:**	Financial Institutions and Insurance
	VERSION:	Enacted - Final
	VERSION DATE:	04/08/2010

SENATE BILL No. 389

AN ACT concerning dental benefits under health insurance.

Be it enacted by the Legislature of the State of Kansas:

Section 1. No contract issued or renewed after July 1, 2010 between a health insurer and a dentist who is a participating provider with respect to such health insurer's health benefit plan shall contain any provision which requires the dentist who provides any service to an insured under such health benefit plan at a fee set or prescribed by the health insurer unless such service is a covered service.

Sec. 2. For the purposes of this act:

(a) "Covered service" means a service which is reimbursable under the health benefit plan subject to any deductible, coinsurance, waiting period, frequency limitation, annual or lifetime benefit maximum or other contractual limitation contained in the health benefit plan.

(b) "Health benefit plan" shall have the meaning ascribed to it in K.S.A. 40-4602 and amendments thereto. Health benefit plan shall also include:

(1) Any subscription agreement issued by a nonprofit dental service corporation.

(2) Any policy of health insurance purchased by an individual.

(3) To the extent permitted by law, the health insurance plan for Kansas children established pursuant to K.S.A. 38-2001 et seq. and amendments thereto.

(4) To the extent permitted by law, the state medical assistance program under medicaid established pursuant to K.S.A. 39-708c and amendments thereto.

(c) "Health insurer" shall have the meaning ascribed to it in K.S.A. 40-4602 and amendments thereto. Health insurer shall also include a nonprofit dental service corporation as such term is used in K.S.A. 40-19a01 et seq. and amendments thereto.

(d) "Insured" shall have the meaning ascribed to it in K.S.A. 40-4602 and amendments thereto. Insured shall also include a subscriber to a subscription agreement issued by a nonprofit dental service corporation as such term is used in K.S.A. 40-19a01 et seq. and amendments thereto.

(e) "Participating provider" shall have the meaning ascribed to it in K.S.A. 40-4602 and amendments thereto. Participating provider shall also include any dentist who has entered into a participation agreement with a nonprofit dental service corporation.

(f) "Provider" shall have the meaning ascribed to it in K.S.A. 40-4602 and amendments thereto. Provider shall also include any dentist licensed by the Kansas dental board.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

Copyright 2010 State Net. All Rights Reserved.

PPO dentist participation agreement

[redacted]ndersigned individual dentist or other dental entity ("Dentist") and Ameritas Life Insurance Corp. affiliates, ("Ameritas") hereby enter into the Ameritas Participation Agreement ("PPO Agreement").

In consideration of the covenants and mutual agreements set forth below, the parties hereto agree as follows:

I. Purpose

Ameritas and Dentist enter into this PPO Agreement to establish a Participating Provider Organization ("PPO" provide professional dental services through individual and group contracts ("Dental Plans") with employee gro insurance companies and other payors ("Payors") and to make such dental services available to eligible employe and their covered dependents ("Covered Persons").

II. Definitions

(A) "Ameritas PPO" means the organization of dentists who have entered into written agreements with A to dental plans and comply with reimbursement, service, and certain terms and conditions establishe

(B) "Dental Plans" means a dental program organized by a Payor which uses the Ameritas PPO network to provide Covered Services for which benefits or services are provided with an insurance policy or s

(C) "Payor" means an employer, union, association, insurance company or other entity, which has an ag is obligated to make payments for Covered Services on behalf of the Covered Person in accordance w or self-funded dental benefit plan.

(D) "Covered Services" means all necessary dental services which are provided by Dentist to a Covered P efit is provided under an applicable PPO Plan, subject to the exclusions and limitations of the plan.

(E) "Covered Persons" means those individuals who are insured under a Dental Plan at the time Dentist's s

III. Licensure

Dentist represents and agrees that he/she is duly licensed and credentialed and shall comply with all applicable laws, statutes, ordinances, orders and regulations.

IV. Services

(A) Patient Care/Availability

Dentist agrees to render dental services to Covered Persons, and to provide such services in the same man services to his/her other patients. Dentist shall remain solely responsible for the quality of dental services to the Covered Person. Dentist understands and agrees that no financial incentive program exists that dir or providing less than medically necessary and appropriate care to his/her patients.

Dentist shall also provide or arrange for twenty-four (24) hour per day, seven days per week emergenc that his/her office will arrange for coverage of emergencies during vacations and/or other periods his/her o or make other arrangements for such coverages at Dentist's expense. Dentist shall offer appointments to al within a reasonable time. For non-emergency appointments other than exam, cleaning, and/or x-ray(s), a not be more than thirty (30) days. However, in some states, laws and regulations require that routine appo nonurgent care shall be available within a specified time frame. Such requirements shall apply to this Agre

Dentist shall identify Covered Persons by presentation of an identification card and benefit coverage number(s). When appropriate, Dentist will refer Covered Persons to other Dentists who have entered int

(B) Independent Contractors

Ameritas and Dentist shall remain independent entities, solely responsible for its employees and agents. shall have any expressed or implied right or authority to assume or create any obligation or responsibilit the other party.

(C) Network Leasing

Ameritas reserves the right to lease its network of Ameritas PPO providers to any employer, union, associ other entity, which enters into a leasing agreement with Ameritas and is obligated to make payments for Covered Person. Dentist agrees to abide by the terms of this Agreement and shall make no distinction wh network leasing agreement.

In the event an Ameritas contracted provider is also contracted with other Ameritas leased networks, precedence. Any other situations arising from multiple contracts will be resolved by Ameritas' internal p

(D) Claims Processing & Coverage Information

Ameritas shall promptly process all claims that have been properly prepared after receipt of an itemized mation deemed by Ameritas or the Payor to be necessary to determine claims liability. Ameritas will ma telephone number in which Dentist may utilize to obtain information concerning eligibility, plan benefit or information relied upon to calculate any such payments and adjustments. A description of how the p of such calculations and adjustments will be provided by form of an Explanation of Payment, which is d conclusion of the claims processing.

V. Payment

(A) Billing of Covered & Non-Covered Services

Dentist shall bill for services rendered to Covered Persons at his or her customary intervals using the then Procedures and Nomenclature to identify services and supplies rendered. Dentist agrees to promptly prov Ameritas or the appropriate payor to assist with the determination of claims liability pursuant to the appli

1. Covered Services
   a. Dentist shall accept payment directly from Ameritas for Covered Services and agrees to accept his/her usual and customary fee or the fee shown in Exhibit 1 ("Ameritas Maximum Fee Allow Exhibit 1-S ("Ameritas Specialist Maximum Fee Allowances") for a Specialist Dentist. Dentist a and customary fee on the claim form, and;
   b. The Orthodontist or a General Dentist performing orthodontic services agrees to accept eighty pe and customary fee for the procedure performed. Dentist agrees to indicate his/her usual and custo

2. Non-Covered Services or Services Not Subject to Reimbursement by Ameritas
Dentist agrees that for all non-Covered Services or for Covered Services that are not subject to reimbursement from Ameritas that are rendered to Covered Persons, Dentist will accept from the Covered Person the amount listed on the then-current Exhibit 1 or Exhibit 1-S as payment in full. If a particular non-Covered Service or Covered Service not subject to reimbursement is not listed on one of these Exhibits, Dentist agrees to limit the charges to eighty percent (80%) of Dentist's usual and customary fee for such service. Dentist agrees to indicate his/her usual and customary fee on the claim form.

For Orthodontic procedures that are non-Covered Services or for Covered Services not subject to reimbursement by Ameritas, the Orthodontist or General Dentist, as the case may be, agrees to limit the charges to eighty percent (80%) of the usual and customary fee for such service.

(B) Billing Restrictions
Dentist agrees that he/she is not entitled to receive payment from Ameritas for services that (a) are not Covered Services; or (b) are otherwise not subject to reimbursement from Ameritas. Dentist shall not waive or forgive co-payments, coinsurance amounts or deductibles and moreover, shall be entitled to bill and collect any such amounts for Covered Services from the Covered Person at the time services are performed if Dentist has called Ameritas to obtain the applicable amount according to the terms of the Covered Person's Dental Plan. Dentist shall communicate the benefit information obtained from Ameritas to the Covered Person.

(C) Pre-statement of Benefits
Ameritas recommends that whenever reasonably possible, Dentist submit a pre-statement claim form in advance of performing Covered Services each time the total charges will equal two hundred dollars ($200.00) or more. Dentist shall cooperate further by providing other treatment related information which may be requested by Ameritas.

(D) Alternate Benefits
Ameritas' dental plans include provisions for alternate benefits. If two or more procedures are adequate and appropriate treatment to correct a certain condition, Ameritas' payment will be based on the charge for the least expensive procedure. Should Dentist perform a different method of treatment, the Dentist may collect from the Covered Person the difference in amounts described in Section V. (A) between the procedure actually reported and the alternate benefit.

VI. Program Requirements

(A) Credentialing/Re-Credentialing
Dentist agrees to participate in, cooperate with Ameritas' credentialing and re-credentialing program. Dentist acknowledges that Dentist's participation pursuant to this Agreement may be terminated or suspended as a result of the information obtained by Ameritas through this process. Provider represents and warrants that the information provided in accordance with the credentialing program, including but not limited to the information provided in Dentist's application, continues to be true and complete. Dentist agrees to notify Ameritas immediately of changes in that information. A description of the credentialing/re-credentialing program is available to Dentist upon request.

(B) Insurance
Dentist shall maintain, at his/her own expense, professional liability insurance, in the greater of, the following amounts:
1. The amounts required by the state of practice; or
2. a. $300,000 per claim and $600,000 annual in the aggregate for a General Dentist; or
   b. $500,000 per claim and $1,000,000 annual in the aggregate for a Specialist Dentist, Orthodontist or a General Dentist performing Orthodontic services.

Dentist shall deliver to Ameritas certificates evidencing the insurance provided and at Ameritas' request provide evidence of the continuation of such insurance. Dentist shall immediately advise Ameritas of any termination of such insurance or any reduction below the above stated amounts of such insurance.

(C) Utilization Review
Dentist shall participate in, cooperate with and abide by the conclusions and decisions resulting from the utilization review and quality assurance program provided by Ameritas. Reviews will be performed prospectively, concurrently and retrospective in order to determine that dentists' services and record keeping practices are consistent with the methods and procedures established for the Ameritas PPO. Failure of the Dentist to abide by the conclusions and decisions resulting from the utilization review and quality assurance program shall be a material breach of this Agreement and shall subject the Agreement to immediate termination.

(D) Onsite Office Visits, Books and Records, Confidentiality
Ameritas, or its authorized representatives shall have the right to conduct onsite office visits or reviews of Dentist's office in order to determine compliance with Ameritas' standards and requirements. Dentist agrees that Ameritas may conduct such visits or reviews in order to determine whether Ameritas will enter into this Agreement with Dentist and periodically thereafter. Ameritas shall treat all records that it has access to as a result of such visits or reviews as confidential so as to comply with all state and federal laws regarding confidentiality. Dentist and Ameritas agree that all Covered Persons records will be available for review by Ameritas during business hours upon prior notification by Ameritas to the Dentist. Upon request, Dentist shall furnish Ameritas or their duly authorized representative with such documents or reports as may be reasonably necessary to verify the accuracy of the charges, services and supplies rendered as reflected on Dentist's bills and claim forms.

Ameritas, the Dentist and/or their independent auditors agree to maintain the confidentiality of dental health records of Covered Persons in accordance with applicable local, state and federal laws. The information will not be used for any purpose other than its intended use relating to the patients' dental care or the requirements under this Agreement.

Ameritas, the Dentist and/or their independent auditors will not release any information specifically related to a patient's medical condition without prior written authorization by the patient to the extent required by state and federal law.

Dentist agrees that all patient records shall be maintained in locked cabinets, stored electronically and/or in an area not accessible to the general public.

(E) Disciplinary Actions
Dentist shall immediately notify Ameritas of any disciplinary actions initiated against his/her license by any governmental agency regulating or supervising the practice of dentistry and any professional malpractice proceedings initiated against him/her based upon Dentist's practice or the practices of any partner or shareholder of Dentist. Dentist hereby authorizes any governmental agency regulating or supervising the practice of dentistry to release to Ameritas information relating to any such complaints or disciplinary actions. Ameritas will hold any such information as confidential.

(F) Additional Offices
If Dentist relocates any office within or outside of the state or adds any new office locations, Dentist's participation at such locations is subject to written approval of Ameritas. Should Dentist choose to discontinue his/her participation under the Ameritas PPO program at any office, Dentist agrees to the notification requirements as defined in Section VII. (A) and (D).

VII. Terminations

(A) **Termination Without Cause**
This Agreement may be terminated without cause by either Party, upon ninety (90) days' advance written notice to the other Party.

(B) **Termination With Cause**
Any party has the right to terminate this Agreement upon at least 30 days' advance written notice of such termination to the other party if the party to whom such notice is given breaches any material provision of this Agreement. The party claiming the right to terminate shall provide the facts underlying its claim of breach and cite the relevant sections of this Agreement that are claimed to have been breached. Remedy of such breach to the satisfaction of the other party, within 30 days of the receipt of such notice, shall revive this Agreement for the remaining portion of its then-current term, subject to any other rights of termination contained in this Article.

(C) **Automatic Termination**
Not withstanding Sections VII. (A) and (B), Ameritas may immediately terminate this Agreement for any of the following reasons:
(i) risk of imminent harm to the health of a Covered Person;
(ii) Dentist is convicted of a felony or any crime of moral turpitude;
(iii) Dentist's license, certification or registration required by law to perform dental services has been suspended, limited or revoked;
(iv) the loss by Dentist of the malpractice insurance or failure to meet the insurance requirements.

(D) For a period of not less than six (6) months after termination of this Agreement, Dentist agrees to give notice to any Covered Person seeking services from Dentist that services are no longer being provided under the Ameritas PPO program pursuant to this Agreement.

VIII. General Provisions

(A) **Term**
This Agreement shall be in effect for one year, and shall be renewed automatically at the end of the first year and each year thereafter for successive one-year terms unless terminated as provided in Section VII.

(B) **Indemnification**
Dentist and Ameritas agree to indemnify and hold the other harmless against any claims or liabilities rising out of the activities contemplated by this Agreement which are the responsibility of the other. However, Ameritas and Dentist are each responsible for their own acts or omissions, and are not liable for the acts or omissions of, or the costs of defending, others.

(C) **Assignment**
Dentist may not assign or transfer any of his/her rights or obligations hereunder, without the prior written consent of Ameritas.

(D) **Waiver**
Waiver of a term, condition or a breach of any provision of this Agreement shall not be deemed a waiver of any other term, condition or a subsequent breach of the same provision.

(E) **Notice**
Any notice required to be given under this Agreement shall be in writing and forwarded to the other party at their respective places of business.

(F) **Grievance Procedure**
Dentist shall cooperate with Covered Persons and Ameritas in resolving any Covered Persons' grievances in order to resolve disputed incorrect or incomplete records or information. Dentist shall provide Ameritas and the Department of Health, if requested, with access to Covered Persons patient records for the purposes of quality oversight and grievance resolution. Dentist and Ameritas agree to adjust any such payments and adjustments which have been calculated by relying on any such incorrect or incomplete records or information so disputed; provided, however, that nothing herein shall be deemed to authorize or require the disclosure of personally identifiable patient information or information related to other individual health care providers or the plan's proprietary data collection systems, software or quality assurance or utilization review methodologies.

(G) **Names**
Ameritas shall not use Dentist's name, symbols, trademarks or service marks in advertising, promotional materials, publications or otherwise without prior written consent of Dentist, but prior consent is not needed with respect to: (a) use of Dentist's name and specialties in communications to Covered Persons and (b) use of Dentist's name and specialties in listings, including but not limited to news media listings, of participants in the Ameritas PPO program. In the event Dentist's participation in the Ameritas PPO program terminates or is scheduled to terminate, Ameritas may also use Dentist's name, symbols, trademarks and service marks without prior consent of Dentist in communications advising brokers, Covered Persons and other necessary parties that Dentist's participation in the Ameritas PPO program has or will terminate. Dentist shall not use Ameritas' names, symbols, trademarks or service marks in advertising, promotional materials, publications or otherwise without prior written consent of Ameritas.

(H) **Holding Covered Persons Harmless**
Dentist agrees that in no event, including but not limited to non-payment by Ameritas, Ameritas' insolvency or breach of this Agreement, shall Dentist bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Covered Person or persons acting on a Covered Person's behalf for Covered Services. This provision shall not prohibit collection from Covered Persons of non-covered services, deductibles, coinsurance, or copayments in accordance with the terms of this Agreement and the Covered Persons' plan. This provision shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of the Covered Persons. This provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Dentist and a Covered Person or persons acting on a Covered Person's behalf.

(I) **Modifications to Agreement**
The Agreement may be modified at any time pursuant to a written agreement executed by Dentist and Ameritas. In addition, Ameritas may modify the Agreement by giving Dentist thirty (30) days' written notice of the modification. If the Dentist fails to object in writing within the thirty (30) day period to the modification as proposed by Ameritas, the modification shall be deemed effective and binding upon the parties at the end of the thirty (30) day period. If Dentist objects in writing to the modification within the thirty (30) day period, the modification will not become effective unless agreed to by both parties in writing. Notwithstanding the foregoing, any changes to this Agreement which are required as a result of changes or modifications to the applicable insurance laws or regulations shall be binding upon both parties following the expiration of the thirty (30) day period without either party having the right to object to such changes. Ameritas agrees to clearly identify any such state-required Agreement modifications in its written notice to Dentist. Nothing contained in this subsection shall be construed as limiting the right of either party to terminate this Agreement, as such right is described elsewhere in this Agreement.

(J) Dispute Resolution

Should any dispute between Ameritas and Dentist arise out of this Agreement, the parties will use good faith efforts to resolve the dispute informally. If the dispute is not fully resolved within a reasonable period of time following receipt of the initial written notice of the dispute, the parties agree that the dispute will be finally settled by arbitration administered by the American Arbitration Association ("AAA") in accordance with its Commercial Arbitration Rules and the Federal Arbitration Act. If the AAA is not then in existence, the arbitration shall be governed by the Commercial Arbitration Rules last in effect. Any party seeking arbitration must give the other(s) 30 days written notice of that intent. The arbitrator(s) deciding the dispute at issue shall interpret this Agreement pursuant to Nebraska law and shall base any decision or award on applicable law and judicial precedent. Any arbitration shall be conducted in the location of the party not demanding the arbitration, unless the parties mutually agree to another location. The arbitrator(s) shall not, under any circumstances, have any authority to award punitive or exemplary damages.

All expenses associated with obtaining and utilizing the services of the AAA and arbitrator(s) shall be shared equally by the parties hereto, and the arbitrator(s) shall request payment separately from each party for these expenses. Each party shall bear its own expenses of preparing for and participating in the arbitration, including without limitation attorney and witness fees. The decision or award of the arbitrator shall be final, binding, and enforceable in any court of competent jurisdiction. This subsection shall survive the termination of the Agreement.

(K) Effect of Agreement

This Agreement supersedes and replaces any PPO Dentist Participation Agreement or similar agreement that may be in effect between Dentist and Ameritas.

Execution of Agreement

Dentist

Business Name

Owner Signature

Print Name

Title

ox ID no. / Social Security No.

Address

City / State / ZIP

Date

Ameritas Life Insurance Corp.
5900 O Street
Lincoln, NE 68510-2252

Signature

Title

Execution Date

Dental Service Corporation
of North Dakota

THE DENTAL SERVICE CORPORATION OF NORTH DAKOTA

PARTICIPATING PROVIDER AGREEMENT

This Participation Agreement ("Agreement") including any attachments, addenda, amendments and exhibits, is effective as of the date set forth herein, by and between The Dental Service Corporation of North Dakota ("DSC"), a non-profit dental service corporation organized under the laws of the state of North Dakota and _____ ("Provider").

WHEREAS, the Provider agrees to provide Covered Services to Members subject to the terms and conditions set forth in this Agreement and any attachments, addenda, amendments, and exhibits to this Agreement;

WHEREAS, the Provider must be licensed, registered or certified by the appropriate state agency where the Covered Services are performed and provided in accordance with the Provider's scope of licensure as required by law. Where there is no appropriate state agency, the Provider must be registered or certified by the appropriate professional body;

WHEREAS, the Provider is compliant with all applicable federal, state and local laws and regulations;

WHEREAS, the Provider has the authority to bind its employees to the terms and conditions of the Agreement; and,

WHEREAS, the Provider agrees to comply with the bylaws, policies and procedures promulgated by DSC.

NOW, THEREFORE in consideration of the premises, and of the mutual covenants and promises herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree as follows:

1. DEFINITIONS

This section defines the terms used by DSC throughout this Agreement. These terms are capitalized throughout this Agreement when referred to in the context defined. DSC shall determine the interpretation and application of the definitions in each and every situation.

1.1 **Allowance or Allowed Charge** means the maximum dollar amount on which payment for Covered Services is based, as determined by DSC.

1.2 **Cost Share Amounts** mean the financial responsibility of the Member pursuant to the terms of the Member's Dental Group Benefit Plan. Cost Share Amounts include but are not limited to deductible, copayment and coinsurance amounts.

1.3 **Covered Services** means all services and supplies that are appropriate and necessary for the treatment of a dental disease or accident for which a Member is entitled to benefits pursuant to the terms of the Member's Dental Group Benefit Plan.

1.4 **Dental Group Benefit Plan** ("Benefit Plan") means the agreement between DSC and the Subscriber outlining the benefits to which a Member is entitled.

1.5 **Member** means a person eligible for Covered Services pursuant to the terms of the Dental Group Benefit Plan.

1.6 **Provider** means a Doctor of Dental Medicine (D.M.D.), a Doctor of Dental Surgery (D.D.S.), or a Doctor of Medicine (M.D.) who has agreed to participate with DSC to provide Covered Services to a Member at the reimbursement level set forth in paragraph 2.1 of this Agreement.

1.7 **Subscriber** means a person with whom DSC has entered into a Dental Group Benefit Plan.

1.8 **Treatment Plan** means a written report describing treatment of any dental disease, defect or injury for a Member as recommended by the Provider.

2. RESPONSIBILITIES OF DSC

DSC shall:

2.1 Reimburse the Provider for Covered Services rendered to a Member on a fee equal to the lesser of 1) the Provider's billed charges or 2) the Allowance or Allowed Charge, in effect at the time the services are provided, excluding Cost Sharing Amounts, and as set forth in Exhibit A, attached hereto and made a part hereof by this reference. Exhibit A is composed of separate schedules and information which fully identify the DSC payment system. The total compensation set forth in Exhibit A includes information sufficient for the Provider to determine the compensation for dental services and procedures rendered pursuant to the provision of Covered Services, including:

1. The manner of payment, such as fee-for-service, capitation, or risk sharing;

2. The fee schedule for procedure codes reasonably expected to be billed by the Provider for services provided pursuant to this agreement, and the associated payment of compensation for each procedure code. DSC shall provide, upon request, the fee schedule for any other procedure codes requested. DSC shall provide a fee schedule for the procedure codes when a material change related to payment or compensation occurs. A Provider who receives fee schedule information may only use or disclose the information for the purpose of practice management, billing activities, and other business operations, or to disclose the information to the Insurance Commissioner;

3. The methodology used to calculate any fee schedule, such as relative value unit system and conversion factor, percentage of Medicare payment system, or percentage of billed charges. As applicable, the methodology disclosure shall include the name of any relative value system, its version, edition, or publication date, and any applicable conversion or geographic factor. DSC shall state the effects of edits, if any, on payment or compensation. DSC may satisfy this requirement by providing a clearly understandable, readily available mechanism, such as through THOR, that allows a Provider to determine the effect of edits on payment or compensation before service is provided or a claim is submitted; and

4. A description and copy of the coding guidelines, including any underlying bundling, recoding, or other payment process applicable to specific procedures that DSC will receive under the agreement. A Provider may only use or disclose the information for the purpose of practice management, billing activities, and other business operations, or to disclose the information to the Insurance Commissioner.

Except as provided below in this section 2.1, changes to the Allowance or Allowed Charge for Covered Services are permitted only once every calendar year, and no payment withholds may be imposed. Notice of such annual changes shall be sent to the Provider at least five (5) days prior to the effective date of the annual changes.

The Provider specifically acknowledges and agrees that the limit on annual updates to the Allowance or Allowed Charge for Covered Services anticipated under this provision shall not apply to adjustments or modifications imposed exclusively as a result of any of the following: (i) scheduled coding changes to American Dental Association (ADA) codes; (ii) adjustments or modifications made by the ADA; (iii) clerical errors, such as errors in computation or data entry; and (iv) services which are not priced individually and are deemed to be "By Report" or "Individual Consideration."

To the extent this section 2.1 is inconsistent with any other provisions of this Agreement, this section 2.1 supersedes all such provisions.

2.2 Provide a summary of the payments issued for Covered Services and the noncovered services and Cost Share Amounts on a weekly basis.

2.3 Process clean claims within 15 business days of receipt; clean claims are claims which require no further documentation or research.

2.4 Develop policies and procedures for Provider and communicate them via the Dental Service Corporation Bulletin, Dental Service Corporation Manual, or special Provider notifications.

2.5 Provide toll free telephone service during regular business hours, to respond to inquiries regarding claims administration policies and procedures, pending claims, a Member's eligibility status, and benefits and claims payment.

2.6 Develop and maintain an appeals process for Providers and Members.

2.7 Issue identification card(s) to the Subscriber.

2.8 Have sole discretionary authority to determine whether a service or supply is a Covered Service, and whether an individual is a Member.

3. RESPONSIBILITIES OF THE PROVIDER

The Provider shall:

3.1 Accept as payment in full the Allowance or Allowed Charge for Covered Services as set forth in paragraph 2.1 of this Agreement. This Allowance or Allowed Charge fully discharges the reimbursement liability of DSC and the Member except for noncovered services and Cost Share Amounts.

3.2 Warrant the charges for Covered Services provided to a Member will not exceed the regularly established charges made to the general public for the same services. The Provider shall not waive or reduce any Member Cost Share Amounts, including coinsurance, copayment and deductible amounts. This provision does not prohibit the Provider from accepting a lesser amount in individual hardship cases.

3.3 Bill the Member for noncovered services and Cost Share Amounts identified in the weekly payment summary sent by DSC to the Provider.

3.4 Ensure the Provider and all dental hygienists and dental assistants employed by the Provider are licensed, registered and/or certified as required in the state in which Covered Services are provided. Further, the Provider agrees to allow DSC to audit the Provider's facilities and records to ascertain all dental hygienists and dental assistants employed by the Provider are licensed, registered and/or certified.

3.5 Agree to notify DSC within 31 days if the professional license, of the Provider is revoked, suspended or restricted.

3.6 Within 31 days of the date that services were rendered, submit claims for processing on behalf of the Member in accordance with guidelines provided by DSC.

3.7 Submit for approval a Treatment Plan when required, pursuant to the Member's Benefit Plan.

3.8 Maintain records and documentation necessary to support dental standards and practices for Covered Services provided, in compliance with applicable state and federal laws related to privacy and confidentiality of medical records.

3.9 Obtain all releases required by federal and state laws and regulations allowing DSC access to and copies of a Member's dental records and accounts.

3.10 Provide DSC, upon request and at no cost, access to the treatment and billing records for the purpose of verifying a Member's claims information, and compliance with the terms of this Agreement. The right of audit by either party shall survive the termination of this Agreement.

3.11 Allow DSC to use the Provider's name for purposes of promotion and marketing of DSC products.

3.12 Comply with DSC's policies and procedures communicated to the Provider via educational bulletins, or special provider notifications.

3.13 Acknowledge that DSC maintains exclusive control over its service marks and symbols ("service marks"). The Provider acknowledges that it does not have a license to use the service marks and any references to them are subject to prior review and approval by DSC. In addition, the following rules apply to any references to the service marks:

1. the service marks are to be used by the Provider exclusively;

2. the service marks may be referenced for the sole purpose of promoting and advertising services and/or membership as a Provider under the terms of this Agreement;

3. all DSC requirements governing use of the service marks must be strictly adhered to and followed;

4. all proposed promotional material and/or advertisements must be submitted to DSC for review and approval prior to final printing and distribution; and

5. DSC reserves the right to revoke or cancel any approval for any failure by the Provider to follow all of the terms and conditions of this provision, or for any other breach of the terms of this Agreement.

4. TERM AND TERMINATION

4.1 The initial term of this Agreement begins on the date this Agreement is accepted by DSC and continues through the end of the current calendar year. Thereafter this Agreement shall automatically renew for consecutive one-year terms unless either party provides written notice to the other party.

4.2 After the initial term, this Agreement may be terminated at any time, without cause, by giving 60 days written notice to the other party.

4.3 In the event of material breach of this Agreement by either party, the nonbreaching party may terminate this Agreement by giving written notice to the breaching party. The breaching party shall have 31 days to fully cure the breach. If the breach is not cured within 31 days after written notice, this Agreement shall automatically and immediately terminate.

4.4 The Provider agrees that in no event, including but not limited to nonpayment by DSC, insolvency by DSC or breach of this Agreement, shall the Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against a Subscriber, Member, or person (other than the Provider) acting on their behalf for services provided pursuant to this Agreement. This provision does not prohibit the Provider from collecting Cost Sharing Amounts, as specifically provided in the Benefit Plan, or fees for non-covered services delivered on a fee-for-service basis to Members.

5. PRIVACY AND USE OF INFORMATION

5.1 The Provider agrees to establish and maintain procedures and controls to ensure that no confidential, sensitive or privileged information contained in its records, which was obtained from DSC under the terms of this Agreement or from other parties carrying out the terms of this Agreement, shall be used or disclosed by the party, its agents, officers, or employees in violation of any federal or state law or regulation prescribed thereunder.

5.2 All information and materials provided by DSC to the Provider shall remain proprietary to the disclosing party, including contracts, reimbursement rates and methodology, operation manuals and any information regarding DSC's business activities, which are not otherwise available to the general public. The Provider shall not disclose any such information or materials or use them except as may be required to perform the obligations of this Agreement or required by law.

5.3 Notwithstanding any other provisions in this Agreement and regardless of any benefit or coverage exclusions or limitations associated with Dental Group Benefit Plan, Provider shall not be prohibited from discussing fully with Members any issues related to Member's health including recommended treatments, treatment alternatives, treatment risks and the consequences of any benefit coverage or payment decisions made by DSC or any other party. Nothing in this Agreement shall prohibit Provider from disclosing to Members the general methodology by which Provider is compensated under this Agreement, provided no dollar amounts or other specific terms of the compensation arrangement are mentioned to Members. DSC shall not refuse to allow the participation or refuse to compensate any Provider eligible to participate with DSC, in connection with services provided by any eligible Provider solely because such Provider has in good faith communicated with one or more of their current, former or prospective Members regarding the provisions, terms or requirements of the Dental Group Benefit Plan as they relate to the health needs of Members.

6. RELATIONSHIP OF THE PARTIES

6.1 The relationship of the Provider to DSC shall be that of independent contractor. Nothing in this Agreement shall be construed as creating the relationship of employer and employee between the party's officers, employees, partners or agents of the other party. Nothing in this Agreement shall be construed as creating an agency, partnership, or joint venture relationship between the Provider and DSC.

6.2 The Provider acknowledges and agrees this Agreement was not entered into based upon representations by any person or entity other than DSC and that no person, entity, or organization other than DSC shall be held accountable or liable to the Provider for any of DSC's obligations to the Provider created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of DSC other than those obligations created under other provisions of this Agreement.

7. GENERAL PROVISIONS

7.1 **Principles of Reimbursement**. The Provider agrees to refer all questions of interpretation of the principles of reimbursement under this Agreement to DSC. This provision is not intended to supersede the provisions of section 2.1.

7.2 **Limitation of Liability**. DSC shall not be liable for any consequential damages, loss or processing expense arising from the use of the computer programs, software or written materials utilized in claims.

7.3 **Time is of the Essence**. Time is of the essence of each provision of this entire Agreement and all of its terms and conditions.

7.4 **Notice**. Any notice required or permitted under the terms of this Agreement shall, in all cases, be construed to mean notice in writing, signed by or on behalf of the party giving said notice. Notice may be served either on a party, or the agent for the other party, by certified mail, return receipt requested, postage prepaid, at the address stated in the signature section of this Agreement, unless notification of a change of such address is provided by either party.

7.5 **Assignment**. Neither party may assign this Agreement, or any of the obligations or duties mandated under the terms of this Agreement.

7.6 **Waiver**. No delay or omission by either party to exercise any right or power under the terms of this Agreement shall preclude the exercise of such right or power in subsequent instances or be construed to be a waiver thereof. A waiver by either party hereto of any of the covenants to be performed by the other party shall not be construed to be a waiver of any covenant herein contained, and the waiver of any breach of covenant shall not be construed to be a waiver of any succeeding breach thereof. All remedies provided in this Agreement shall be cumulative, in addition to and not in lieu of any other remedies available to either party at law, in equity, or otherwise.

7.7 **Entire Agreement**. This Agreement shall constitute the entire Agreement between the parties and shall supersede any prior agreements, understandings, or representations of any kind preceding the date of this Agreement and shall not be binding upon either party except to the extent expressly set forth in this Agreement.

7.8 **Modification**. Any modification of this Agreement or additional obligations assumed by either party in connection with this Agreement shall be binding only if evidenced in writing and signed by each party or an authorized representative of each party.

7.9 **Severability**. If any provision of this Agreement is held invalid or unenforceable for any reason, the remainder of this Agreement shall continue in full force and effect.

7.10 **Counterparts**. This Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original, but all of which together shall constitute but one and the same instrument.

7.11 **Paragraph Headings**. The titles to the paragraphs of this Agreement are solely for the convenience of the parties and shall not be used to explain, modify, simplify or aid in the interpretation of the provisions of this Agreement.

7.12 **Attorney's Fees**. If any legal action, arbitration or other proceeding is brought for the enforcement of this Agreement, or because of an alleged dispute, breach, default or misrepresentation in connection with any of the provisions of this Agreement, and if DSC prevails or is successful, DSC shall be entitled to recover reasonable attorney's fees and other costs incurred in that action or proceeding, in addition to any other relief to which it may be entitled.

7.13 **Force Majeure**. Neither party shall be liable for excess costs or failure to perform any of the duties or obligations under the terms of this Agreement if such failure arises out of causes beyond the control and without the fault or negligence of that party. Such causes may include, but are not restricted to, acts of God or of the public enemy, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes and unusually severe weather, but in every case the failure to perform must be beyond the control and without the fault of the party failing to perform.

7.14 **Required Approvals**. Where agreement, approval, acceptance, or consent by either party is required by any provision of this Agreement, such agreement, approval, acceptance, or consent shall not be unreasonably delayed or withheld.

7.15 **Governing Law**. It is agreed that this Agreement shall be governed by, construed, interpreted, and enforced in accordance with the laws of the state of North Dakota.

7.16 **Binding Effect**. This Agreement is binding on the parties hereto, and to their successors and assigns, including any parent or subsidiary corporation.

7.17 **Dispute Resolution**. In the event that any claim or controversy arising out of or relating to this Agreement, or any claimed breach thereof, cannot be resolved by the parties in the normal course of business, each party shall designate a member of its executive staff to meet in an attempt to resolve the dispute.

8. INDEMNIFICATION

The parties agree to indemnify and hold harmless the other party for actions, causes of action, suits, claims, judgments, settlements, liabilities, damages, penalties, losses, expenses, including without limitation, extra-contractual damages, court costs, attorneys' fees, punitive and exemplary damages resulting from or arising out of any function under this Agreement, if the liability was the direct consequence of the action of the indemnifying party.

Provider's Name **Mailing Address** **City, State, Zip**	**The Dental Service Corporation of North Dakota** **4510 13th Avenue S** **Fargo, ND 58121-0001**
Provider's Signature	**Tim Huckle, President**
Print Name & Title	Date
Date Signed	**DSC Acceptance Date**

UNITED CONCORDIA

Participating Dentist Agreement with United Concordia Companies, Inc.

Under the applicable laws of the State of North Dakota, I am duly authorized to engage in the practice of dentistry. In consideration for being registered as a participating dentist in the Fee for Service Dental Network (the "Network") of United Concordia Companies, Inc. and its affiliates (collectively, "United Concordia"), I ("Dentist") do hereby agree as follows:

1.a. Dentist acknowledges that United Concordia, on consideration of certain Selection Criteria, may decline to enroll, or to retain, providers in the Fee for Service Dental Network. Dentist shall submit a Credentialing Application attesting to information relevant to the Selection Criteria upon application for acceptance to the Network, and thereafter upon request. The Selection Criteria will comply with any state regulatory requirements (which may differ depending on Dentist's state of licensure) and will be available to all participating dentists. Dentists may appeal any decision regarding selection or retention for the Network through United Concordia's appeal process.

b. Dentist represents and warrants that he/she is licensed to practice in the aforementioned State and that such license has not been suspended, revoked or limited within the past five (5) years. Dentist further represents and warrants that his/her employees and facilities are licensed to the extent required by State law and shall only provide those services to Members as defined within the scope of their respective licenses. All of Dentist's rights and United Concordia's obligations under this Agreement are conditioned upon Dentist's and his/her employees continued maintenance of such licensure with no restrictions. United Concordia may begin the process to terminate this Agreement immediately upon notice if Dentist's license is suspended, revoked or limited in any way or if Dentist's conduct may result in immediate injury or damage to the health/safety of any Member.

c. During the term of this agreement, the Dentist agrees to maintain professional liability insurance at: (a) the level required by any applicable state mandate, (b) $200,000 per occurrence and $600,000 for aggregate occurrences, or (c) other level acceptable to United Concordia, based on accepted standards in Dentist's geographic area and risk factors applicable to Dentist's practice.

d. Dentist agrees to accept communications from United Concordia via mail, facsimile or e-mail at the addresses/numbers shown on Dentist's Credentialing Application.

2. Dentist agrees to participate at all practice locations with all United Concordia Fee for Service Programs and in any other plan, program or arrangement for which United Concordia has agreed to provide access to the Network ("Network Access Arrangements"). Dentist specifically authorizes United Concordia to enter into Network Access Arrangements and agrees to provide services to Members enrolled under any Network Access Arrangement, subject to all of the terms and conditions of this Agreement. A listing of all currently effective Network Access Arrangements is available on United Concordia's web site, www.unitedconcordia.com. Dentist will comply with all policies and procedures governing the administration of United Concordia's Fee for Service Plans and all Network Access Arrangements, including but not limited to: claim submission, complaints, grievances, utilization review, and quality management, as set forth in the most current version Dental Reference Guide, as it may be amended from time to time. The most current version of the Dental Reference Guide will be available for review on United Concordia's web site, www.unitedconcordia.com.

3. Dentist agrees to report all covered services for eligible Members on a timely basis following the date the services were rendered using an ADA claim form or other form acceptable to United Concordia.

4. Dentist agrees to accept his/her charge or the United Concordia Maximum Allowable Charge, whichever is lower, as payment in full for covered services and to bill the Member only for applicable deductibles, coinsurance, or amounts exceeding contractual maximums. In agreeing to this provision, Dentist understands that the most current applicable versions of the Maximum Allowable Charge (MAC) schedules will apply to reimbursement for all covered services. The current schedule of Maximum Allowable Charges, and dental policies that may affect the manner in which such charges are billed and reimbursed, are available on United Concordia's web site, www.unitedconcordia.com.

5. Dentist may bill a Member for non-covered services (which are defined as any service for which no payment is made under the applicable plan or arrangement for any reason, including but not limited to, services in excess of contractual maximums, services not covered under plan design, and services denied due to contractual limitations). Dentist's charge to Member for non-covered services may not exceed the Maximum Allowable Charge for the applicable CDT code as specified in the most current Maximum Allowable Charge schedule. Fees for all non-covered services will be collected from the Member, and not billed to United Concordia.

6. Dentist agrees that the services provided and charges made to United Concordia Members shall be consistent with those to his/her other patients.

7. Dentist may not bill a Member for charges itemized and distinguished from the professional services provided, including but not limited to, office overhead expenses, fees for completing claim forms, OSHA compliance surcharges, or costs of submitting additional information to United Concordia.

8. The determination of whether any services performed by Dentist for a Member are covered by that Member's contract shall be made by United Concordia. Fees for covered services deemed not dentally necessary shall not be collected from the Member unless the Dentist informs the Member of his/her specific financial liability in writing and the Member chooses to receive the service. The Dentist should appropriately note such notification to the Member in the Dentist's records.

9. Dentist shall be responsible, at all times, for maintaining emergency coverage provided in accordance with the guidelines of the ADA or applicable state laws.

10. Dentist will maintain accurate and complete dental records for all Members enrolled in the Plan.

11. Dentist shall furnish any information deemed necessary by United Concordia to make determinations of coverage and shall permit United Concordia representatives to make reasonable examinations of his/her clinical records, including x-rays, relating to covered services when such examination is necessary to resolve any question concerning such services.

12. Dentist is not an employee of United Concordia, and United Concordia shall do nothing to interfere with the customary Dentist-patient relationship.

13. All personally identifiable information about United Concordia dental plan Members ("Protected Health Information") is subject to various privacy standards, including the regulations adopted by the Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160, 162 and 164, and various state statutes and regulations protecting individual privacy. The parties will use or disclose Protected Health Information received from the other only as

(Continued)

permitted by such privacy standards, or to comply with judicial process or regulatory mandate.

14. Dentist shall indemnify and hold harmless United Concordia, those groups which have entered into contracts with United Concordia, and Members from any and all claims, liability, cost, damage or expense, for or as a result of any damage or loss occurring by reason of any failure by Dentist to comply with this Agreement, or as a result of any negligence, misfeasance, malfeasance or malpractice on the part of Dentist in performing services for Members.

15. United Concordia shall indemnify and hold harmless Dentist from any and all claims, liability, cost, damage or expense to the extent that such claims, liability, costs, damages, or expenses are solely caused by the negligence, misfeasance, malfeasance, nonfeasance on the part of United Concordia.

16. Dentist agrees not to discriminate in the treatment of Members as to the quality of service delivered because of race, sex, marital status, veteran status, age, religion, color, creed, sexual orientation, national origin, and disability, place of residence, health status or method of payment.

17. This agreement shall be effective only upon acceptance by United Concordia and shall continue in effect thereafter, until terminated by either party according to the following provisions:

a. Either party may terminate this Agreement upon sixty (60) days prior written notice. United Concordia agrees to continue member coverage with Dentist through the sixty (60) day period.

b. United Concordia may terminate this Agreement immediately if Dentist fails to comply with the terms of this Agreement.

c. United Concordia may terminate this Agreement if Dentist no longer meets the Selection Criteria.

18. This Agreement may be modified or amended by United Concordia upon written notice to Dentist. If Dentist fails to object to the amendment within thirty (30) days of its receipt, the amendment will be deemed approved by Dentist.

19. Dentist's contractual rights and responsibilities hereunder shall not be assigned or delegated without the prior written consent of United Concordia. This Agreement shall be assignable by United Concordia to a subsidiary, affiliate, or Successor Corporation.

20. Dentist agrees that in no event, including but not limited to nonpayment, or insolvency, or breach of agreement by United Concordia, affiliate, or Successor, shall Dentist bill, charge, collect a deposit from, seek payment or reimbursement from, or have recourse against a member or their representative for services provided under this Agreement. This provision does not prohibit Dentist from collecting deductibles, coinsurance, or amounts exceeding contractual maximums. Dentist may also continue to provide services at the member's expense as long as Dentist clearly informs member that United Concordia, affiliate, or Successor may not cover or continue to cover services. Dentist further agrees that; (a) this provision shall survive the termination of this agreement, (b) this provision supersedes any oral or written contrary agreement. Modifications, additions, or deletions to this provision shall become effective on a date no earlier than fifteen (15) business days after the insurance commissioner has received written notice of change from United Concordia, affiliate, or Successor.

IN WITNESS WHEREOF, the parties have executed this Agreement on the date below.

To be completed by DENTIST:

Date: _____ Signature: _____

Provider No.: _____ Print Name: _____

SS No.: _____ Office Address: _____

Tax ID No.: _____ _____

NPI No.:_____ Telephone No.: ( ) _____

To be completed by UNITED CONCORDIA:

Date: _____ Signature: _____

EACH PROVIDER IN PRACTICE SHOULD SIGN A SEPARATE AGREEMENT
PLEASE ATTACH A COPY OF YOUR CURRENT DENTAL LICENSE

UNITED CONCORDIA

AMENDMENT TO ALL FORMS OF THE PARTICIPATING DENTIST AGREEMENT WITH UNITED CONCORDIA COMPANIES, INC.

All forms of the Participating Dentist Agreement with United Concordia Companies, Inc., (referred to herein as the "Agreement") are hereby amended as follows:

Section 2 is amended to read:

Dentist agrees to participate at all practice locations with all United Concordia Fee for Service Programs and in any other plan, program or arrangement for which United Concordia has agreed to provide access to the Network ("Network Access Arrangements"). Dentist specifically authorizes United Concordia to enter into Network Access Arrangements and agrees to provide services to Members enrolled under any Network Access Arrangement, subject to all of the terms and conditions of this Agreement. A listing of all currently effective Network Access Arrangements is available on United Concordia's web site, www.unitedconcordia.com. Dentist will comply with all policies and procedures governing the administration of United Concordia's Fee for Service Plans and all Network Access Arrangements, including but not limited to: claim submission, complaints, grievances, utilization review, and quality management, as set forth in the most current version Dental Reference Guide, as it may be amended from time to time. The most current version of the Dental Reference Guide will be available for review on United Concordia's web site, www.unitedconcordia.com.

Section 4 is amended by adding the following sentence at the end thereof:

The current schedule of Maximum Allowable Charges, and dental policies that may affect the manner in which such charges are billed and reimbursed, are available on United Concordia's web site, www.unitedconcordia.com.

Section 5 is amended to read:

Dentist may bill a Member for non-covered services (which are defined as any service for which no payment is made under the applicable plan or arrangement for any reason, including but not limited to, services in excess of contractual maximums, services not covered under plan design, and services denied due to contractual limitations). Dentist's charge to Member for non-covered services may not exceed the Maximum Allowable Charge for the applicable CDT code as specified in the most current Maximum Allowable Charge schedule. Fees for all non-covered services will be collected from the Member, and not billed to United Concordia.

Section 8 is amended to read:

The determination of whether any services performed by Dentist for a Member are covered by that Member's contract shall be made by United Concordia. Fees for covered services deemed not dentally necessary shall not be collected from the Member unless the Dentist informs the Member of his/her specific financial liability in writing and the Member chooses to receive the service. The Dentist should appropriately note such notification to the Member in the Dentist's records.

tion 17 is amended to Read:

This agreement shall be effective only upon acceptance by United Concordia and shall continue in effect thereafter, until terminated by either party according to the following provisions:

a. Either party may terminate this Agreement upon sixty (60) days prior written notice. United Concordia agrees to continue member coverage with Dentist through the sixty (60) day period.
b. United Concordia may terminate this Agreement immediately if Dentist fails to comply with the terms of this Agreement.
c. United Concordia may terminate this Agreement if Dentist no longer meets the Selection Criteria.

Section 19 is amended to read:

Dentist's contractual rights and responsibilities hereunder shall not be assigned or delegated without the prior written consent of United Concordia. This Agreement shall be assignable by United Concordia to a subsidiary, affiliate, or Successor Corporation.

Dentist accepts the above amendments on the date indicated below.

To be completed by DENTIST:

Date: _____ Signature: _____

Provider No.: _____ Print Name: _____

SS No.: _____ Office Address: _____

Tax ID No.: _____ _____

NPI No.:_____ Telephone No.: ( ) _____

To be completed by UNITED CONCORDIA:

Date: _____ Signature: _____

#1

March 7, 2011

Testimony before the Senate Human Services Committee
House Bill 1183
Senator Judy Lee, Chairman

HB 1183- Capping of Non-covered dental fees

Chairman Lee, members of the Senate Human Services Committee, my name is Dr. Steve Erlandson, I am a practicing dentist in Grand Forks and president of the North Dakota Dental Association. I appear here in support of House Bill 1183. This bill seeks to prevent insurance companies from placing a cap on fees charged by dentist's for services not covered under the insurance companies' plan. The National Council of Insurance Legislators adopted a model bill banning policies that dictate fee schedules for dental services the plan does not cover. House Bill 1183 incorporates language from that model legislation.

Again, this is a simple bill. It prevents insurance companies from setting fees for services that are not covered under a dental plan. It defines the term "covered services" and establishes that the costs of these covered services remain the same for the patient even after the limits of the plan's coverage have been exceeded. Although the provision for covered services is an acceptable contractual arrangement between dentists and dental insurance companies, some insurance companies have been implementing new policy that sets a cap on the fees that participating dentists can bill for services **not** covered by its dental plan. This policy arbitrarily sets a maximum allowable fee on non-covered services and should not be permitted.

Concern with this practice includes that allowing non-covered services to be capped would affect the doctor/patient relationship by allowing third parties to participate

in that relationship while not providing any benefits. We believe this is not right or fair. There is no compelling reason for such interference with the free-market approach to delivery of dental services in our state. Maintaining a free-market economic model has enabled dentistry to be the "healthcare system that works" for a hundred years, while controlled market systems in other areas of healthcare have failed.

NDDA's current policy, adopted with overwhelming support of the membership, holds that when a dental plan elects to exclude certain services from its benefit plan, the fees for those services should remain a private matter between the dentist and the patient only. Simply reducing fees artificially under the insurer's limitations does not mean the costs of running the dental practice disappear. What will likely result instead is cost shifting to make up for lost revenue, which would clearly burden those least able to pay.

When dentists sign contracts with insurance companies, they agree to provide treatment for patients within the network and the dentists also agree to pre-determined fees for a list of procedures covered in the plan. These fees are often set at a "discounted" rate and are generally lower than fees that are considered "usual and customary". These procedures typically include basic services like exams, cleanings, x-rays, fillings, crowns and extractions. They generally do not cover esthetic procedures which may include, tooth whitening, veneers and crowns to create a "new" smile, or replacing silver fillings with tooth colored composite fillings. They also may not cover placement and restoration of dental implants, and certain oral and periodontal surgical procedures. Although dentists have an understanding of the services and fees that are covered by the plan and those that are not, some insurance companies are now informing

dental providers in their plans that fees for services not covered under the contract agreement are also being "set or determined" by the insurance company.

This arbitrary capping of non-covered services in provider agreements would contractually limit the fees for treatment, even though the insurance company does not share in any risk for that coverage. It adds significant risk to the dentist without any risk being born by the insurance company. For example, although both insurance companies and dentists know and understand how frequently patients' teeth are likely to be cleaned and checked, and can factor this into their cost for coverage, neither can accurately predict what number of patients might request non-covered services. As a result, although insurance companies "have no skin in the game" with regard to providing capped non-covered services, dentists do.

You may hear the argument that these contracts are negotiated with dentists. The truth of the matter is that agreeing to a contract that caps non-covered services is a take-it or leave-it situation for dentists. It is not negotiation. Not taking the contracts, especially after the dentist has been a contract provider for a long time, is financial suicide for the dentist. Basically, the dentist is placed in an unfair situation of take-it or leave-it, whether to accept a plan that is unfair or risk loosing a patient base that has been built over years of practice. Also, the insurance companies can unilaterally and arbitrarily change the list of covered and non-covered services over time.

Dentists do not have the ability to collectively or individually negotiate. The "take it or leave it" nature of the dental contract offered is not "negotiation." Dentists cannot contest certain parts of the contract in order to achieve a fair contractual relationship. Nor can they band together to change it, as that would be an anti-trust violation. The

only protection they can pursue is through the legislature. That is why we are here asking for your help. Seventeen (17) states have adopted legislation that bans this practice.

We believe this practice is unfair, and ask you to concur, and stop the practice by giving a do pass recommendation on House Bill 1183. Thank you.