FISCAL IMPACT REPORT

SPONSOR SJC **LAST UPDATED** **ORIGINAL DATE** 3/11/2023

SHORT TITLE Dental Insurance Changes **BILL NUMBER** Senate Bill 17/SJCS

ANALYST Toal/Simon

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*

(dollars in thousands)

	FY23	FY24	FY25	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
		No fiscal impact	No fiscal impact		Recurring	NMPSIA Benefits Fund; GSD Group Benefits Fund APS Benefits Fund

Parentheses ( ) indicate expenditure decreases.
*Amounts reflect most recent analysis of this legislation.

Sources of Information

LFC Files

Responses Received From
Retiree Health Care Authority (NMRHCA)
Office of the Superintendent of Insurance (OSI)
Public School Insurance Authority (NMPSIA)
General Services Department (GSD)

Responses Not Received From
Albuquerque Public Schools (APS)

SUMMARY

The Senate Judiciary Committee substitute for Senate Bill 17 (SB17/SJCS) creates new requirements for dental insurance plans. The bill would

- Require dental insurers to provide prior authorization on submission of valid request and prohibit a dental insurer from later denying a claim included in a prior authorization, except in certain circumstances;
- Require dental insurers to provide direct payments to dentists, regardless of whether or not the dentist is included in the insurer's network;
- Require dental insurers to establish policies and procedures for recovering erroneously paid claims;
- Prohibit a dental insurer from restricting the form of payment to only credit cards; and

- Section 5 would prohibit a dental insurer from offering a third-party access to the dental insurer's network without the agreement of the providers within that network.

SB17/SJCS would amend both the Health Care Purchasing Act and the Short-Term Health Plan and Excepted Benefits Act to meet the above requirements.

The provisions of the bill would apply to plans issued or renewed on or after January 1, 2024.

FISCAL IMPLICATIONS

The bill does not include an appropriation.

The bill amends the Health Care Purchasing Act, which was created to provide for the consolidated purchasing of publicly financed health insurance. Four entities are covered by the Health Care Purchasing Act: the Risk Management Division of the General Services Department (GSD), the Retiree Health Care Authority (RHCA), the Public School Insurance Authority (NMPSIA), and any healthcare program of a public school district with an enrollment of more than 60 thousand students. Currently, Albuquerque Public Schools (APS) is the only school district that provides benefits independent of NMPSIA.

Plans offered by APS, NMPSIA, and GSD are self-insured, meaning the agency is responsible for paying claims. The plan's carriers—currently Delta Dental and United Concordia—are paid an administrative fee to process claims. Analysis from NMPSIA notes the bill could have an impact on the overall dental market, which could have a downstream impact on the self-insured plans. However, both GSD and NMPSIA report that any impact would be indirect and not material to the plans.

The Retiree Health Care Authority provides a fully insured dental plan option to members, but the plan is not subsidized by the agency. Benefits provided through the authority are entirely paid by the member, meaning the bill does not have a direct fiscal impact on the agency.

Current rates for dental insurance vary between $172 per year and $462 per year for single coverage or between $513 per year and $1,316 per year for family coverage. For APS, NMPSIA, and GSD, a portion of the total premium is covered by the employer and a portion by the employee.

Although the bill assigns additional duties to the Office of Superintendent of Insurance (OSI), the agency does not report a fiscal impact.

SIGNIFICANT ISSUES

Prior Authorization

The bill would require dental insurers to prove prior authorization for services covered by a members plan. Under the bill, prior authorizations could be submitted by the provider in a format required by the dental insurer. One a dental insurer had provided prior authorization, it would not be able to later deny a claim unless one of the following occurred:

- The member had reached their benefit limit;
- The documentation submitted by provider fails to support service that was originally authorized;

- The member's condition changes so that the previously authorized service became no longer medically necessary;
- New services are provided that would have, at the time of the prior authorization, required disapproval;
- Another entity is responsible for payment;
- The provider was already paid for the service;
- The claim was fraudulent, based on erroneous information; or
- The member was no longer eligible for care.

Direct Payment of Covered Benefits

The bill would require dental insurers to directly pay providers for a covered service, regardless of if the provider is in the dental insurer's network. Currently, if a member visits a provider not in the dental insurer's network, the dental insurers may require that the member pay for a service out-of-pocket. The member can later apply for reimbursement from the insurer. The bill would require the dental insurer to pay the provider directly, which could reduce the burden placed on an individual member visiting an out-of-network provider and improve collection rates for providers.

Claims Recovery

The bill requires dental insurers to establish policies and procedures for payment recovery in the event a claim was paid in error. The procedures must include notifying the provider of the error, explaining why the recovery is being sought, and providing the opportunity for the provider to appeal the insurer's recovery. Further, dental insurers cannot attempt to recover what was paid by withholding payment on other claims unless the plan notifies the provider within 12 months of the payment and advises that an automatic deduction will occur unless the provider submits a written appeal. The appeals process would be governed by the grievance rules issued by the superintendent of insurance. The bill limits payment recoveries to 24 months after the original claim was made but does not apply to duplicate payments or if the claim was fraudulent or misrepresented.

Credit Card Payments

The bill would prohibit dental insurers from requiring that providers process credit card payments as the only acceptable form of payment. The bill would also prohibit the insurer from charging providers a fee to transmit the payment, unless the fee is disclosed to the provider and the provider agrees to pay a fee. The provider must be given the option to receive the payment in another manner without paying the fee.

Coverage Networks

The would prohibit dental insurers from requiring providers to allow the plan to share their coverage network with a third party. Currently, a dental insurer may provide a third party with access to its coverage network, usually for a fee, which gives this third party access to the services and discounts negotiated by the dental insurer and the provider. The bill would allow an insurer to contract with a third party if the network contract allows the practice, the third party agrees to abide by the terms of the network contract, and the dental insurer identifies the third

parties to the provider and on its website and gives providers a chance to opt out. A plan cannot end its contractual relationship with a provider if the provider decides to opt out. However, this section does not apply to dental plan operating under the same brand or that is an affiliate.

ADMINISTRATIVE IMPLICATIONS

Analysis from RHCA notes the authority's authorizing statute generally provides the authority's board discretion to develop and administer its plan offerings. Provisions of the bill would limit this discretion by adding new requirements to the Health Care Purchasing Act.

RT/JWS/al/ne/hg