

Frequently Asked Questions: AB 895 and Coordination of Benefits

1) When did the new law become effective?

AB 895 was passed by the Legislature on July 20, 2007; was signed by the Governor on July 30; and became law on January 1, 2008. It does not apply to claims for treatment where the date of service was prior to January 1, 2008, even though a dental plan may have processed a claim for 2007 treatment after January 1 of this year.

2) Who does the new law affect?

AB 859 amended both the Knox-Keene Act of the California Health and Safety Code, and the California Insurance Code. Consequently, the provisions of the new law affect all managed care dental plans, all preferred provider organizations (PPO) covering dental benefits, and indemnity dental insurance policies. In other words, it affects all commercial dental benefit carriers doing business in California.

3) How do I know if the insurance company is bound by California law?

The Department of Managed Health Care (DMHC) licenses 21 managed care dental plans in California. Each of these plans is bound by the provisions of the Knox-Keene Act, including the coordination of benefits law. The Department of Insurance issues certificates of authority to insurance companies doing business in California. "Doing business" means a company that sells insurance either in the individual market, or to groups located in California, or where the group has a majority of its members in California. If, for example, an insurance company is located outside of California, and sells coverage to a group that is also located outside of California, but the employer group has employees living and working in California, while the insurance company may cover those California residents, the insurance company is not subject to California law, unless a majority of its employees live in California. Where there's a question of whether an out-of-state insurer must comply with California's insurance laws, CDA will need to assess the insurer's status. "Self-insured" dental plans are regulated under the federal Employee Retirement Income Security Act (ERISA), and are typically exempt from California law.

4) The insurance company is under DMHC, but I am still receiving secondary payment with the non-dup attached, why?

The only likely reason that the new law would not apply to a DMHC-licensed dental plan is that the plan is contracted as a third-party administrator of a self-funded, ERISA-regulated dental benefit plan. In that case, because the plan is essentially regulated by federal and not state law, the provisions of AB 895 wouldn't apply, even if the company has other lines of business that come under the regulation of DMHC.

5) Is this law retro-active?

No. It went into effect on January 1, 2008, and applies only to claims for dates of service on or after January 1 of this year.

6) What about orthodontic cases where treatment was already in progress when the law went into effect? I receive monthly payments. Shouldn't this apply to all payments made after January 1, 2008?

Not necessarily. Most dental plans consider the “date of service” to be when the treatment plan has been completed for the orthodontic patient, and bands are first put in place. The date of service is the key. If this occurred before the first of the year, the old law applies.

7) What do I do if I continue to receive EOBs from secondary payers in which the non-dup clause has been applied and the group is governed by California Law?

CDA has been advised by both the State Departments of Managed Health Care and Insurance to file complaints with the departments. The failure to pay as a secondary payer would be considered a compliance issue for which the appropriate department is responsible for enforcing.

Should your office encounter a dental benefit carrier failing to pay as a secondary, where it is clear they should, file a complaint with the following:

- Contact the DMHC Provider Complaint Unit at 877-525-1295, or file a complaint online at http://www.hmohelp.ca.gov/providers/clm/clm_comp.asp
- Contact the Department of Insurance at 800-927-HELP, or file a complaint in writing through a form available at <http://www.insurance.ca.gov/0100-consumers/hcpcomplaints.cfm>

8) I'm not contracted with the primary payer and received payment based on my office UCR and the patient has an out-of-pocket balance remaining. I am contracted with secondary and due to secondary adjusting my fees to that of my contracted fees – they are not making payment claiming this was paid in full. Shouldn't the secondary pay up to what they would have paid had they been primary – picking up the patient co-payment (whichever is lesser)?

What constituted “paid-in-full” is no longer based upon the definition of the secondary payer. AB 895 determines the payment responsibility of the secondary payer, regardless of whether you are contracted with the primary payer or not. The law states that when a dental plan or insurer is “acting as a secondary dental benefit plan, [it] shall pay the lesser of either the amount that it would have paid in the absence of any other dental benefit coverage, or the enrollee's total out-of-pocket cost payable under the primary dental benefit plan for benefits covered under the secondary plan.” In other words, whatever amount is left over on the patient's bill that wasn't paid by the patient's primary carrier is now the responsibility of the secondary carrier to pay, with these conditions: the residual

amount is for procedures that are benefits of the secondary plan; the secondary payer is responsible for an amount only up to what it is contracted to pay under its primary responsibility of coverage to the enrollee; and only up to what the actual out-of-pocket responsibility of the patient is with their primary carrier. In cases of routine care such as a regular six-month recall, the amount the secondary pays may be ten or twenty dollars, whatever the patient's copay responsibility is. For more major procedures, the secondary payer may be responsible for the unpaid balance of the billed amount.

9) Does this law affect dependents that have coverage through both parents? When I was reading about it, only information pertaining to spouses was mentioned.

The law refers to "enrollee," not "spouses," so it would pertain to the payment of care for dependents on an enrollee. In the case of dependents, state regulations define which parent's plan is considered "primary" and which is "secondary" (e.g., the "birthday rule"), but once the primary and secondary benefit carriers are determined, the law does not distinguish or establish a different rule for the secondary plan's payment responsibility solely because the patient is a dependent.

10) Where can I find the wording of AB895?

There are a variety of sources for bill text. Here's one: <http://www.senate.ca.gov/>, which is the homepage of the California State Senate. On the homepage, click on the link to "Legislation," and type-in "AB 895" in the field for the bill number, for the 2007-2008 legislative session. The search results will provide links to information on both AB 895 and SB 895 from this session...make sure you click on the link to AB 895. On the next page, you can select a copy of the "chaptered bill," meaning the text of the bill as signed by the Governor.

11) Where can I locate information regarding AB895?

Both Senate and Assembly committee and floor analyses of AB 895 are also available through the State Senate site mentioned above.

Also, more AB 895 information will soon be added to CDA Online.

12) Now that AB895 is in effect does this mean that the secondary should pick up payment for additional frequencies (cleanings, exams, x-rays, etc.) that were not covered by primary?

Most likely, no. If a secondary carrier benefit contract with its enrollees pay for two cleanings a year, that's how many the plan should pay for. AB 895 does not change the scope of benefits of any dental plan. In fact, it ties its responsibility to pay as a secondary payer to a plan's contracted benefits.

13) Does CDA anticipate this law being adopted nationwide.

ADA requested a copy of AB 895 once it was approved by the Legislature. While that is no guarantee that the bill will become law in the rest of the nation, other states often follow where California leads.

14) How do I know if the insurance company is being honest with me?

When in doubt, contact CDA and we'll make further contact on your behalf, both with the dental plan, and with the applicable state regulator.