



Bureau of Insurance

A Report to the Joint Standing Committee on
Insurance and Financial Services
124th Maine Legislature

Review and Evaluation of LD 234
An Act To Expand Access to Oral Health Care

May 2009

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I. Executive Summary

The Joint Standing Committee on Insurance and Financial Services of the 124th Maine Legislature directed the Bureau of Insurance to review LD 234, An Act To Expand Access to Oral Health Care. The review was conducted as required by 24-A M.R.S.A., § 2752. In addition to the statutory criteria, the Committee also asked that the review consider whether LD 234 might address issues related to access to routine dental care for those persons currently covered by dental insurance and whether adding a requirement that an independent practice dental hygienist must be affiliated with a dentist for the purpose of referrals would have any financial impact or social impact or affect the medical efficacy of the bill. This review was a collaborative effort of NovaRest, Inc. and the Maine Bureau of Insurance (the Bureau).

Last year a licensing law was enacted in Maine recognizing independent practice dental hygienists (IPDHs). LD 234 would require all individual and group health insurance policies that include coverage for dental services issued or renewed on or after January 1, 2010 to provide coverage for “dental services performed by an independent practice dental hygienist.” This would only apply if the services would otherwise be covered under the policy and those services are within the lawful scope of practice of the IPDH. Note, IPDHs do not diagnose dental conditions and currently cannot take x-rays. The bill would permit provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions. A survey of other states found that Colorado has legislation similar to LD 234.

Currently there are fewer than 700 dentists practicing in Maine. Maine Cooperative Health Workforce Resource Inventory indicates the state has a ratio of one dentist to 2,165 residents, which is significantly lower than the national average of one to 1,656. Half of the counties in Maine are designated as dental shortage areas and all Maine counties have some areas so designated. Even with these shortages, 70.2% of adults and 77.2% of children in Maine had a routine dental visit in 2005, which is consistent with national averages.

Proponents have provided anecdotal information concerning the overall health benefits derived from dental care, which is in short supply in Maine. There are 14 licensed IPDHs in Maine. IPDHs reportedly charge less for services. According to one proponent and IPDH, Beryl Cole, the charge for routine cleaning by an IPDH is approximately \$68 versus the \$166 reportedly charged by full service dental offices.

Opponents of LD 234 are concerned about the administrative costs and the increase in cost of insurance.

Some insurers surveyed predicted that premiums might increase, at least in the short run before

LD 234, 124th Maine State Legislature
An Act to Expand Access to Oral Health Care

savings occur due to prevention of other, more costly dental problems. Although there is no reliable data, we anticipate that any increase in premium due to this act would be minimal and temporary. We estimate that any impact on rates would be no more than 0.02% in the early years and after five years the cost would be more than offset by savings.

With regard to medical efficacy, increased access to IPDHs could help compensate for the shortage of dentists and thereby improve dental health. Small pilot studies conducted in California and Colorado found good quality of care and increased utilization when IPDHs are available.

It is unclear what the ultimate social impact, financial impact, and effect on medical efficacy would be if IPDHs were required to affiliate with dentists for the purpose of referrals. The requirement would increase the team approach toward dental care, but IPDHs report that they are already establishing these affiliations, when possible. On the other hand, it may be difficult to find a dentist willing to affiliate. There may be areas that do not have dentists accepting new patients and the IPDH would need to find a dentist elsewhere who is willing to affiliate. In that case, the requirement could inhibit an IPDH from starting a practice in areas where they could do the most good. Perhaps requiring that the IPDHs provide patients with a list of dental providers without a requiring a formal agreement for referrals, would be sufficient.

II. Background

The Joint Standing Committee on Insurance and Financial Services of the 124th Maine Legislature directed the Bureau of Insurance to review LD 234, An Act to Expand Access to Oral Health Care. The review was conducted as required by 24-A M.R.S.A., § 2752. In addition to the statutory criteria, the Committee also asked that the review consider whether LD 234 might address issues related to access to routine dental care for those persons currently covered by dental insurance and whether adding a requirement that an independent practice dental hygienist must be affiliated with a dentist for the purpose of referrals would have any financial impact or social impact or affect the medical efficacy of the bill. This review was a collaborative effort of NovaRest, Inc. and the Maine Bureau of Insurance (the Bureau).

Last year a licensing law was enacted in Maine recognizing independent practice dental hygienists (IPDHs). LD 234 would require all individual and group health insurance policies issued or renewed on or after January 1, 2010 to provide coverage for “dental services performed by an independent practice dental hygienist.” This would only apply if the services would otherwise be covered under the policy or contract and those services are within the lawful scope of practice of the IPDH.

The American Dental Association recommends that children and adults see their dentist regularly for cleaning and oral exams.¹ Going to the dentist regularly allows dental-care providers to address routine maintenance and preventative processes that can help to stop or prevent tooth decay. Regular checkups can prevent oral cancer and cavities. The visits also, allow the dentist to take note of any serious problems that may be developing.

¹ Cleaning Your Teeth and Gums (Oral Hygiene), <http://www.ada.org/public/topics/cleaning.asp>.

III. Social Impact

A. Social Impact of Mandating the Benefit

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

At the present time, it is estimated that 70% of the Maine population receives dental hygiene services every year.² Because the licensing law in Maine recognizing IPDHs is very recent and there is currently no insurance reimbursement, it is difficult to measure the utilization for this type of provider.

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

Dental hygienist services are currently available through independent practitioners and in dentist offices. There are 14 licensed IPDHs under the newly enacted law that allows them to practice independently. Not all of these providers have opened offices yet. Currently there are fewer than 700 dentists practicing in Maine. Maine Cooperative Health Workforce Resource Inventory indicates the state has a ratio of one dentist to 2,165 residents, which is significantly lower than the national average of one to 1,656.³ With the shortage of dentists in Maine, the service is not as available as would be recommended. Even with the shortages, 70.2% of adults and 77.2% of children in Maine had a routine dental visit in 2005, which is consistent with national averages.⁴

Adding a requirement that IPDHs must be affiliated with a dentist for the purpose of referrals could have a negative social impact, due to the shortage of dental offices, which would in turn result in a lack of available dentists to accept affiliations. In areas where dentists are currently not available, the IPDH would need to find a dentist elsewhere who is willing to affiliate. That would have a negative impact on the potential increase in dental hygiene access from the use of IPDHs.

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

IPDHs are currently not covered by insurance plans in Maine. Dental hygienists

² State of Maine, Department of Health and Human Services, Dashboard Performance Indicators, 2008.

³ Maine's Health Care Workforce January 2009; http://www.mainerdh.org/09HealthWorkforce_1_.pdf

⁴ State of Maine, Department of Health and Human Services, Dashboard Performance Indicators, 2008

operating in a dentist office are covered by dental insurance policies.

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

Individuals do have access to dental hygienists services in full service dental offices, but there is currently a shortage of dentists in Maine resulting in long waits for appointments in some areas.⁵ If IPDHs were covered by insurance, individuals might be able to get appointments more quickly. Currently, individuals can make appointments with independent hygienists, but their insurance would not cover the services.

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

According to one proponent and IPDH, Beryl Cole, the services of a dental hygienist would be approximately \$68 and visits are recommended twice a year. This may be beyond some family budgets. Depending on the number of visits actually scheduled in a year, the cost for a family of four would be between \$260 (one visit each) and \$520 (two visits each).

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

The American Dental Association emphasizes the importance of the types of services provided by IPDHs in dental and gum health.

There is no information on public demand for IPDHs, but in general, there is a shortage of dental providers in Maine. Eight of the sixteen counties in Maine are designated as Dental Health Shortage Areas.⁶ The remaining eight counties all have areas that have designated shortages. The Maternal and Child Health Services Title V Block Grant Annual Report for 2006 reports progress in improving access to dental services, but continued deficiencies in access to care.⁷

Requiring reimbursement of IPDHs in Maine would also allow more IPDHs to open offices in areas where there currently no dental offices.

⁵ MEGIS report based on Federal Division of Designation Compiled by the Maine Office of Rural Health & Primary Care.

⁶ MEGIS report based on Federal Division of Designation Compiled by the Maine Office of Rural Health & Primary Care.

⁷ Maternal and Child Health Services Title V Block Grant State Narrative for Maine, Application for 2008, Annual

The Maine Dental Hygienists Association reports that trends in dental education demonstrate that beginning in 2014 more dentists will be retiring from the workforce than graduating from dental school.⁸

The following chart shows population, licensed dentists, and licensed IPDHs by county:

Geographic Area	Population 7/1/2008	Dentists	Dentists per 10,000	Independent Practice Dental Hygienists
Maine	1,316,456	659	5.01	14
Androscoggin County	106,877	47	4.40	
Aroostook County	71,676	23	3.21	1
Cumberland County	276,047	214	7.75	7
Franklin County	29,857	11	3.68	
Hancock County	53,137	28	5.27	1
Kennebec County	120,959	74	6.12	1
Knox County	40,686	27	6.64	1
Lincoln County	34,628	14	4.04	1
Oxford County	56,741	15	2.64	
Penobscot County	148,651	72	4.84	
Piscataquis County	16,961	5	2.95	
Sagadahoc County	36,332	22	6.06	
Somerset County	51,377	11	2.14	
Waldo County	38,342	8	2.09	
Washington County	32,499	11	3.38	
York County	201,686	77	3.82	2

For the most part, the IPDHs currently are in counties that already have relatively high dentist ratios, although they may be in underserved parts of those counties.

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

IPDHs report that potential patients have told them that the lack of insurance coverage has caused them to wait for available services in a dental office where services would be

Report for 2006; October 04, 2007.

⁸ Maine's Health Care Workforce; UNE: Leading the Way in Health Care Workforce Development; http://www.mainerdh.org/09HealthWorkforce_1_.pdf.

covered by insurance rather than use the services of an IPDH.

Without being able to attract patients with dental insurance, IPDHs report that it is difficult to build a viable practice. Based on this, IPDHs are asking for insurance coverage.

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

No information is available.

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

The American Dental Hygienists' Association identifies 19 states as having "varying forms of unsupervised practice or less restrictive supervision" for dental hygienist.

Based on a survey of other states, Colorado may be the only state with a mandate similar to LD 234. In Colorado, a small pilot study was conducted with the participation of six dental hygienists, one-third of the independent practitioners at the time. The dental hygienists had practiced for an average of 13 years prior to establishing their practices. Four of the six practices were office-based, one was institution-based, and one was office and institution-based. The general office audit revealed compliance with infection control, office protocols for emergency situations, and practice management protocols. The patient record audit indicated a high standard for process of care for the practice sites.⁹

One insurer, Aetna, indicated that:

Colorado has independent hygienists, and 64 dental hygienists are participating Medicaid providers. These dental hygienists served 2,000 children from February 2003 to January 2004. This was more than double the number of children seen from February 2002 to January 2003. So utilization increased by 1,000 procedures in one year.

In CT: ..., dental hygienists can practice "without supervision" in certain settings; approx. 55,000 procedures were performed during one year's time, including over 7,000 prophylaxis, 5,800 sealants and 15,000 oral exams.

⁹ Pilot study of six Colorado dental hygiene independent practices, Journal of Dental Hygiene , Wntr, 1998 by

MetLife's response was, "The theory that a hygienist would be charging less would probably not prove out over time and hasn't been our experience with the state of Colorado which allows hygienists to be compensated directly."

MetLife also indicates that, "If enacted, it should be clear as to what procedures are to be compensated within the scope of a hygienists license. Lack of clarity results in claims denials and general dissatisfaction amongst members. The Professions Codes in states are often written in such a fashion that it is difficult to tell what dental procedures should be referred to dentists."

Ten experimental independent dental hygiene practices operating in California were studied between 1987 and 1990. All of the practices attracted new patients for each quarter in operation. These practices mostly provided prophylaxis treatments; however, a wide variety of services were provided. Fees charged in the office-based practices were less than comparable fees charged in dentists' offices. At least one-third of patients received a referral to or an opinion about a dentist from the dental hygienist. The authors of this report did suggest further study to test these findings.¹⁰

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

Other state agencies did not provide findings pertaining to the proposed legislation.

11. *Alternatives to meeting the identified need.*

Delta Dental indicated that, "To truly have an impact on access for the uninsured, having a requirement that an independent hygienist practice in an area or among populations that have limited access to dental care be more effective. The California Registered Dental Hygienist in Alternative Practice (RDHAP) provides such a model. These additionally trained dental hygienists deliver dental hygiene care and preventive services to the homebound, in schools, residential facilities, institutions and in dental healthcare shortage areas."

Ameritas stated that, "The path to expanded access to dental care could be explored through the dental practice act that stipulates licensing requirements for dentists and

Deborah Bailey Astroth, Gail N. Cross-Poline.

¹⁰ The California demonstration project in independent practice. J Dent Hyg 1994; Perry DA, Freed JR, Kushman

duties for hygienists and auxiliaries. Easing licensure for dentists coming into the state or broadening responsibilities of dental professionals may have greater impact on access to dental care than imposition of insurance reimbursement requirements.”

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

The requirements of LD 234 are consistent with the role of health insurance.

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

There is little or no social stigma attached to having coverage for IPDHs.

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

The increased access to IPDHs could increase the identification of dental and gum problems, which then could be treated, increasing the appropriate use of these benefits.

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

There is no evidence that this benefit is currently being offered by employers with self-insured plans. Because we do not believe that health insurance premiums would increase measurably, there should not be a shift to self-insurance due to this mandate.

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

Delta Dental, the current carrier for state employee dental benefits, indicated that “it is unlikely that adding additional providers of covered services will result in any premium reduction and could, in fact, result in increased cost experience due to a greater number of services being provided. Depending on how independent hygienists are to be treated on our claims and administrative systems, there could also be additional administrative expense associated with the mandate.”

IV. Financial Impact

B. Financial Impact of Mandating Benefits

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

The increased access to IPDHs is anticipated to decrease the cost of the services performed by these professionals over the current cost of those services in a dental office. It can be anticipated that the current cost of IPDH services will increase if covered by insurance, but will remain below the cost of the same services performed in a dentist office for a period of time.

Adding a requirement that IPDHs must be affiliated with a dentist for the purpose of referrals may not have any financial impact, unless the shortage of dental offices results in a lack of dentists accepting affiliations. This could result in IPDHs not being able to establish practices, particularly in areas where dentists are not available or where dentists refuse affiliations. That would negate the financial impact on the cost of services in these areas. One dental insurer, AFLAC, thought that having an IPDH affiliated with a dentist would allow electronic claims filing with the dentist, but we have found that IPDHs have access to software that allow them to file electronically without affiliation with a dentist.

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

It is likely that LD 234 would increase the use of IPDHs for routine dental cleanings. To the extent that these services are provided to those currently unable to access adequate care due to the shortage of dentists in Maine, LD 234 would increase the appropriate use of dental hygienist services.

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

The use of IPDHs would be an alternative to the same services provided in a dental office at a higher cost at the start, although MetLife said that fees in Colorado were not lower than dentists' fees over time. According to one proponent and IPDH, Beryl Cole, the current charge for routine cleaning by an IPDH is approximately \$68 versus the \$166 reportedly charged by full service dental offices.

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

LD 234 does not prohibit health plans from covering the services of IPDHs with the same medical management used for the same services in a dental office.

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

It is likely that LD 234 would result in more dental hygienists becoming independent since accommodating patients with insurance coverage would allow them to build up a patient base more easily. It is unclear whether LD 234 would result in more dental hygienists in total.

There are two Dental Hygiene (DH) Schools in Maine:

- University of New England in Westbrook, a private school, and
- University College of Bangor, part of University of Maine System.

The Bangor school expects to have 24 students graduate with an Associates degree in dental hygiene this year, while next year's class is at 17 due to attrition from the 20 admitted. With their distance learning program, they can enroll up to 24 new dental assisting students for next year.¹¹

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

Although there is no reliable data, we anticipate that any increase in premium due to this act would be minimal. As explained below, we anticipate that any impact on rates would be no more than 0.02% in the early years and after five years the cost would be offset by savings from the prevention of other, more costly dental problems. After that, the benefit from increased preventive dental services there would result in an overall savings. In the short run, the number of IPDHs would be small and their fees lower than in a dentist's office. Over time, the number of IPDHs would likely increase, as would their fees, but so would the savings from increased prevention.

There are currently very few licensed IPDHs and even fewer that have set up their offices.

¹¹ Catherine J. Kasprak, CDA, RDH, AAS, IPDH, President of the Maine Dental Hygienists' Association.

Currently these services are covered by dental benefit policies if they are performed in a dental office. If there was insurance coverage for IPDHs, there might be an increase of dental hygienist services because they would be more accessible, but this increase may or may not increase claims costs. The services performed in an IPDH's office are currently less expensive than if performed in a dentist office. Although they are likely to increase if covered by insurance, this increase would not be immediate. MetLife stated their experience in Colorado is that IPDH fees were not lower than dentist fees over time. More access to these services by individuals who do not currently have access, may prevent more severe and expensive conditions resulting from the lack of early care, which would offset the increase in IPDH fees. Sun Life indicated that there are potential savings due to a lower cost provider or earlier prevention of a possible worsening dental condition in the long term.

Since dental hygiene services performed in a dentist office are often combined with other services, there may be an increase in the number of claims if they are billed separately by an IPDH. This increase in the number of claims would result in increased administrative costs.

Insurance providers surveyed indicate that an increase in utilization and administrative cost may result. Although not indicated by the insurers surveyed, this increase could be offset by lower per service cost (currently less than half the cost in a dental office) and the prevention of more serious dental problems resulting in more frequent dental hygiene services.

Sun Life responded that:

Assuming the cost for services is the same as currently charged when those services are provided under the direction and supervision of a dentist then it is estimated that dental insurance premiums might increase 2-3% per year for the first 5 years based on an assumption that there would be an increase in utilization of services due to an increase in availability of hygienist access. Beyond 5 years, the cost could reduce by 5% per year due to an overall improvement in oral care and in prevention of more costly services.

Delta Dental responded that it did not have data to determine the cost implications but that:

It is unlikely that adding additional providers of covered services will result in

any premium reduction and could, in fact, result in increased cost experience due to a greater number of services being provided. Depending on how independent hygienists are to be treated on our claims and administrative systems, there could also be additional administrative expense associated with the mandate.

We determined that if half of the current IPDHs were at full capacity and if one-third of their insured patients would otherwise go to dental offices and pay higher rates with the remaining two-thirds being patients who would otherwise not have received services, the increase in premium would be approximately 0.02%. We anticipated that this could happen as early as the second year after the implementation of LD 234. Before that level of increased utilization there would be no impact on dental costs or premiums. Based on Sun Life's estimate of savings starting in the fifth year and our modeling of eventual savings due to the reduction of more serious services, we anticipated that there would be a savings in the fifth year. In years three and four, increased use of IPDHs would increase costs, but some initial saving would start to appear resulting in a net increase of 0.02% or less.

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

There would not be any additional cost effect beyond benefit and administrative costs.

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

This mandate could reduce the total cost of health care. Dental hygiene services performed in an IPDH's office are typically less expensive than if performed in a dentist office. More access to these services may prevent more severe and expensive conditions resulting from the lack of early care.

Sun Life projected that "beyond 5 years the cost could reduce by 5% per year due to an overall improvement in oral care and in prevention of more costly services."

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

Overall, we do not believe that health insurance premiums would increase measurably in

the long run, although there may be a small increase (0.02%) before the benefits of better preventative dental care are realized. There would be no difference in premium impact based on the size of the employer.

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

Independent dental hygienists are currently not covered by MaineCare, but legislation (LD 233) is pending to change that. Therefore, there could be a shift of cost from the public to the private sector if LD 234 passes and LD 233 does not, but significant financial impact is unlikely.

V. Medical Efficacy

C. The Medical Efficacy of Mandating the Benefit.

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

IPDHs can perform the following services:

- Regular hygiene duties on adults and youngsters;
- Regular cleanings,
- Gross Debridement,¹²
- Periodontal Maintenance,
- Sealants,
- Fluoride application.

The American Dental Association recommends these services in order to maintain good tooth and gum health.¹³ Major health issues that are linked to oral health are cardiovascular disease, diabetes, lung disease, and birth of low weight and premature babies

2. *If the legislation seeks to mandate coverage of an additional class of practitioners:*
 - a. *The results of any professionally acceptable research demonstrating medical results achieved by the additional practitioners relative to those already covered.*

A survey study published in 1997 by the University of California School of Dentistry concluded that independent practice by dental hygienists provided access to dental hygiene care and encouraged visits to the dentist.¹⁴

In Colorado, a small pilot study was conducted with the participation of six dental hygienists, one-third of the independent practitioners at the time. The general office audit revealed compliance with infection control, office protocols for emergency situations, and practice management protocols. The patient record audit indicated a

¹² Debridement is a process for removing thick deposits on the teeth. It must be performed before a regular cleaning if a person has developed very heavy plaque or calculus.

¹³ Preventing Periodontal Disease; http://www.ada.org/prof/resources/pubs/jada/patient/patient_08.pdf.

¹⁴ Characteristics of patients seeking care from independent dental hygienist practices. J Public Health Dent. 1997

high standard for process of care for the practice sites.¹⁵

- b. *The methods of the appropriate professional organization that assure clinical proficiency.*

The Maine Board of Dental Examiners (MBDE) states that¹⁶:

Through the licensing process, the Board ensures that all practicing dental professionals have an appropriate level of education and training and that high professional standards are maintained. The Dental Practice Act specifies the education and training an applicant must have to qualify for a Maine license. Education and training is verified by Board staff. Applicants are also required to have passed comprehensive written and clinical examinations, as well as a Board-administered written jurisprudence examination. A background check is conducted to ensure that applicants who hold license(s) in another state(s) are of good professional reputation and standing.

Dentists, dental hygienists (both IPDH and RDH) and denturists must renew their licenses every two years. Each licensee must demonstrate that they have obtained the necessary continuing education credits and certify that they have maintained the accepted standard of practice and conduct.

In order to apply to be an IPDH an individual has to have been a Registered Dental Hygienist (RDH) with 6,000 hours (three years) of experience if they hold an Associate's Degree; 2,000 hours (one year) of experience if they hold a Bachelor's Degree.¹⁷ Every applicant has to go through the application and sit for an interview at the MBDE and then be approved for IPDH licensure. Every RDH has to have passed the ADA's CODA courses in dental hygiene school, taken & passed the National and Practical Board, and passed each state's jurisprudence exam to be licensed. All of these levels are guided by ADA or other Dentist governing group/board. RDH & IPDH licenses require 30 hours of continuing education every 2 years of the licensure start/finish date.

It is unclear if adding a requirement that IPDHs must be affiliated with a dentist for the purpose of referrals will affect the medical efficacy of the bill. Currently IPDHs report that they do have affiliations when there is a dentist in the area that accepts referrals. It may be difficult for IPDHs to find dentists to work with in areas with a shortage of dentists that are accepting new patients and these are just the areas that

Spring;57(2):76-81.

¹⁵ Pilot study of six Colorado dental hygiene independent practices, Journal of Dental Hygiene , Wntr, 1998 by Deborah Bailey Astroth, Gail N. Cross-Poline.

¹⁶ <http://www.mainedental.org/how.htm>.

¹⁷ <http://www.mainedental.org/forms/ipdh.pdf>.

would most benefit from access to IPDHs. Delta Dental indicated that, “From a clinical point of view and in the best interests of the patients, an affiliation requirement would be beneficial as we believe a team approach to oral healthcare delivery is most effective. Because dental hygienists do not receive training in comprehensive oral diagnosis and treatment planning, a requirement for a collaborative relationship with a dentist will better ensure that patients have access to the full range of preventive, restorative, and surgical dental services that can only be provided by a dentist.”

VI. Balancing the Effects

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

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

The American Dental Association¹⁸ recommends regular professional cleanings in order to prevent periodontal disease. Having access to IPDHs could increase the access to these services in areas with a shortage of dentists with minimal or no financial impact.

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

Mandating the availability of coverage for IPDHs in dental policies would be possible. There are currently mandates to offer coverage for the services of acupuncturists and licensed counselors. However, if there is no significant cost to adding IPDH coverage, there would seem to be no advantage to making it optional.

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

The Bureau's estimates of the premium increases due to existing mandates are displayed in Appendix B. We do not anticipate that this bill would add to those estimates in the long run. There may be a small increase (0.02%) after the first year and before the impact of increased access to preventative dental care is felt.

¹⁸ Preventing Periodontal Disease; http://www.ada.org/prof/resources/pubs/jada/patient/patient_08.pdf.

III. Appendices

Appendix A: Letter from the Committee on Insurance and Financial Services with Proposed Legislation

LD 234, 124th Maine State Legislature
An Act to Expand Access to Oral Health Care

Senate

PETER B. BOWMAN, CHAIR
JUSTIN L. ALFOND
EARLE L. MCCORMICK

COLLEEN MCCARTHY REID, LEGISLATIVE ANALYST
JENNIFER RITCH-SMITH, COMMITTEE CLERK



House

SHARON ANGLIN TREAT, CHAIR
CHARLES R. PRIEST
PAULETTE G. BEAUDOIN
HENRY E.M. BECK
ADAM GOODE
EDWARD P. LEGG
TERRY K. MORRISON
WESLEY E. RICHARDSON
WINDOL C. WEAVER
LESLIE T. FOSSEL

STATE OF MAINE
ONE HUNDRED AND TWENTY-FOURTH LEGISLATURE
COMMITTEE ON INSURANCE AND FINANCIAL SERVICES

March 20, 2009

Marti Hooper
Senior Insurance Analyst
Life and Health Division
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34 State House Station
Augusta, Maine 04333

Dear Ms. Hopper:

Title 24-A Maine Revised Statutes Annotated, Section 2752 requires the Joint Standing Committee on Insurance and Financial Services to submit legislation proposing health insurance mandates to the Bureau of Insurance for review and evaluation if there is substantial support for the mandate among the committee after a public hearing on the proposed legislation. Pursuant to that statute, we request that the Bureau of Insurance prepare a review and evaluation of **LD 234, An Act to Expand Access to Oral Health Care**.

A copy of the bill is enclosed. Please prepare the evaluation using the guidelines set out in Title 24-A § 2752. In addition to the statutory criteria, the committee also asks that the review consider whether LD 234 might address issues related to access to routine dental care for those persons currently covered by dental insurance. The committee is also interested in whether adding a requirement that an independent practice dental hygienist must be affiliated with a dentist for the purpose of referrals will have any financial impact or social impact or affect the medical efficacy of the bill. Please submit the report to the committee on or before May 15, 2009 so the committee can take final action on LD 234 before adjournment of the First Regular Session. If you have any questions, please do not hesitate to contact us or our legislative analyst, Colleen McCarthy Reid.

Sincerely,

Handwritten signature of Peter B. Bowman.

Peter B. Bowman
Senate Chair

Handwritten signature of Sharon Anglin Treat.
Sharon Anglin Treat
House Chair

cc: Members. Insurance and Financial Services Committee
Rep. Pat Jones

Appendix B: Cumulative Impact of Mandates

Following are the estimated claim costs for the existing mandates:

- ♦ ***Mental Health*** (Enacted 1983) – The mandate applies only to group plans. It applies to all group HMO plans but does not apply to non-HMO employee group plans covering 20 or fewer employees. Mental health parity for listed conditions was effective 7/1/96 but does not apply to any employer with 20 or fewer employees, whether under HMO or other coverage. The list of conditions for which parity is required was expanded effective 10/1/03. The amount of claims paid has been tracked since 1984 and has historically been in the range of 3% to 4% of total group health claims. The percentage had remained in the 3.27% to 3.47% range from 1998 to 2002 but then decreased, reaching 2.90% in 2005, 3.18% in 2006 and 2.62% in 2007. For 2007, this broke down as 2.76% for HMOs and 2.51% for other plans. The decrease in 2005 occurred despite the fact that an expansion of the list of conditions for which parity is required was fully implemented in 2005. Either the expansion has had a delayed impact or the impact was offset by other factors such as the continuing shift from inpatient care to outpatient care. We estimate a continuation of 2007 levels going forward. For HMO plans covering employers with 20 or fewer employees, we use half the value for larger groups to reflect the fact that parity does not apply. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent. However, this overstatement is offset by the fact that the data is an aggregate of all groups, while groups of 20 or fewer are exempt from the parity requirement in the case of HMO coverage and from the entire mandate in the case of non-HMO coverage.
- ♦ ***Substance Abuse*** (Enacted 1983) – The mandate applies only to groups of more than 20 and originally did not apply to HMOs. Effective 10/1/03, substance abuse was added to the list of mental health conditions for which parity is required. This applies to HMOs as well as other carriers. The amount of claims paid has been tracked since 1984. Until 1991, it was in the range of 1% to 2% of total group health claims. This percentage showed a downward trend from 1989 to 2000 when it reached 0.31%. It then increased and leveled off at a range of 0.59% to 0.65% for 2002 through 2007 (low of 0.58% in 2004, high of 0.72% in 2006) despite implementation of the parity requirement. The long-term decrease for HMOs was probably due to utilization review, which sharply reduced the incidence of inpatient care. Inpatient claims decreased from about 93% of the total in 1985 to 41% in 2007. Claims for substance abuse were 0.65% of total group claims for 2007. This broke down as 0.58% for HMOs and 0.75% for other plans. We estimate substance abuse benefits to remain at the current levels going forward. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent. However, this overstatement is offset by the fact that the data is an aggregate of all groups, while the

mandate applies only to groups larger than 20.

- **Chiropractic** (Enacted 1986) – The amount of claims paid has been tracked since 1986 and has been approximately 1% of total health claims each year. However, the percentage increased from 0.84% in 1994 to a high of 1.51% in 2000. Since then, it has decreased to 1.23% in 2007. The level varies significantly between group and individual. For 2007, the percentages for group plans were 1.44% for HMO plans, 1.01% for other plans, and an aggregate of 1.23%. For individual plans, it was 0.07% for HMO plans, 0.88% for other plans, and an aggregate of 0.87%. We estimate the current levels going forward. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.
- **Screening Mammography** (Enacted 1990) – The amount of claims paid has been tracked since 1992. It increased from 0.11% of total claims in 1992 to 0.7% in 2002, decreasing to 0.65% in 2007, which may reflect increasing utilization of this service followed by a leveling off. There was no significant difference between HMO plans and other plans. We estimate 0.65% in all categories going forward. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.
- **Dentists** (Enacted 1975) – This mandate requires coverage to the extent that the same services would be covered if performed by a physician. It does not apply to HMOs. A 1992 study done by Milliman and Robertson for the Mandated Benefits Advisory Commission estimated that these claims represent 0.5% of total health claims and that the actual impact on premiums is "slight." It is unlikely that this coverage would be excluded in the absence of a mandate. We include 0.1% as an estimate.
- **Breast Reconstruction** (Enacted 1998) – At the time this mandate was being considered in 1995, Blue Cross and Blue Shield of Maine estimated the cost at \$0.20 per month per individual. We do not have a more recent estimate. We include 0.02% in our estimate of the maximum cumulative impact of mandates.
- **Errors of Metabolism** (Enacted 1995) – At the time this mandate was being considered in 1995, Blue Cross estimated the cost at \$0.10 per month per individual. We do not have a more recent estimate. We include 0.01% in our estimate.
- **Diabetic Supplies** (Enacted 1996) – Our report on this mandate indicated that most of the 15 carriers surveyed in 1996 said there would be no cost or an insignificant cost because they already provide coverage. One carrier said it would cost \$.08 per month for an individual. Another said .5% of premium (\$.50 per member per month) and a third said 2%. We include 0.2% in our estimate.

- ♦ ***Minimum Maternity Stay*** (Enacted 1996) – Our report stated that Blue Cross did not believe there would be any cost for them. No other carriers stated that they required shorter stays than required by the bill. We therefore estimate no impact.
- ♦ ***Pap Smear Tests*** (Enacted 1996) – No cost estimate is available. HMOs would typically cover these anyway. For non-HMO plans, the relatively small cost of this test would not in itself satisfy the deductible, so there would be no cost unless other services were also received. We estimate a negligible impact of 0.01%.
- ♦ ***Annual GYN Exam Without Referral*** (managed care plans) (Enacted 1996) – This only affects HMO plans and similar plans. No cost estimate is available. To the extent the PCP would, in absence of this law, have performed the exam personally rather than referring to an OB/GYN, the cost may be somewhat higher. We include 0.1%.
- ♦ ***Breast Cancer Length of Stay*** (Enacted 1997) – Our report estimated a cost of 0.07% of premium.
- ♦ ***Off-label Use Prescription Drugs*** (Enacted 1998) – The HMOs claimed to already cover off-label drugs, in which case there would be no additional cost. However, providers testified that claims have been denied on this basis. Our 1998 report did not resolve this conflict but stated a "high-end cost estimate" of about \$1 per member per month (0.6% of premium) if it is assumed there is currently no coverage for off-label drugs. We include half this amount, or 0.3%.
- ♦ ***Prostate Cancer*** (Enacted 1998) – No increase in premiums should be expected for the HMOs that provide the screening benefits currently as part of their routine physical exam benefits. Our report estimated additional claims cost for non-HMO plans would approximate \$0.10 per member per month. With the inclusion of administrative expenses, we would expect a total cost of approximately \$0.11 per member per month, or about 0.07% of total premiums.
- ♦ ***Nurse Practitioners and Certified Nurse Midwives*** (Enacted 1999) – This law mandates coverage for nurse practitioners and certified nurse midwives and allows nurse practitioners to serve as primary care providers. This mandate is estimated to increase premium by 0.16%.
- ♦ ***Coverage of Contraceptives*** (Enacted 1999) – Health plans that cover prescription drugs are required to cover contraceptives. This mandate is estimated to increase premium by 0.8%.
- ♦ ***Registered Nurse First Assistants*** (Enacted 1999) – Health plans that cover surgical first assisting are mandated to cover registered nurse first assistants if an assisting physician would be covered. No material increase in premium is expected.

- ♦ ***Access to Clinical Trials*** (Enacted 2000) – Our report estimated a cost of 0.46% of premium.
- ♦ ***Access to Prescription Drugs*** (Enacted 2000) – This mandate only affects plans with closed formularies. Our report concluded that enrollment in such plans is minimal in Maine and therefore the mandate will have no material impact on premiums.
- ♦ ***Hospice Care*** (Enacted 2001) – No cost estimate was made for this mandate because the Legislature waived the requirement for a study. Since carriers generally cover hospice care already, we assume no additional cost.
- ♦ ***Access to Eye Care*** (Enacted 2001) – This mandate affects plans that use participating eye care professionals. Our report estimated a cost of 0.04% of premium.
- ♦ ***Dental Anesthesia*** (Enacted 2001) – This mandate requires coverage for general anesthesia and associated facility charges for dental procedures in a hospital for certain enrollees for whom general anesthesia is medically necessary. Our report estimated a cost of 0.05% of premium.
- ♦ ***Prosthetics*** (Enacted 2003) – This mandate requires coverage for prosthetic devices to replace an arm or leg. Our report estimated a cost of 0.03% of premium for groups over 20 and 0.08% for small employer groups and individuals.
- ♦ ***LCPCs*** (Enacted 2003) – This mandate requires coverage of licensed clinical professional counselors. Our report on mental health parity indicated no measurable cost impact for coverage of LCPCs.
- ♦ **Licensed Pastoral Counselors and Marriage & Family Therapists** (Enacted 2005) – This mandate requires coverage of **licensed pastoral counselors and marriage & family therapists**. Our report indicated no measurable cost impact for this coverage.
- ♦ ***Hearing Aids*** (Enacted 2007) – This mandate requires coverage for \$1,400 for each ear every 36 months for children age 18 and under. The mandate is phased-in by requiring coverage from birth to age 5 effective 1/08, age 6-13 effective 1/09 and age 14-18 effective 1/10. Our report estimated a cost of 0.1% of premium once fully implemented.
- ♦ ***Infant Formulas*** (Enacted 2008) – This mandate requires coverage for amino acid-based elemental infant formulas for children 2 years of age and under, regardless of delivery method. This mandate is effective 1/09. Our report estimated a cost of 0.1% of premium.
- ♦ ***Colorectal Cancer Screening*** (Enacted 2008) – This mandate requires coverage for colorectal cancer screening for persons fifty years of age or older, or less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society. This mandate is effective 1/09. No other carriers stated they denied

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coverage, therefore our report estimated no impact on premium.

These costs are summarized in the following table.

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium	
			Non-HMO	HMO
1975	Maternity benefits provided to married women must also be provided to unmarried women.	All Contracts	0 ¹	0 ¹
1975	Must include benefits for dentists' services to the extent that the same services would be covered if performed by a physician.	All Contracts except HMOs	0.10%	--
1975	Family Coverage must cover any children born while coverage is in force from the moment of birth, including treatment of congenital defects.	All Contracts except HMOs	0 ¹	--
1983	Benefits must be included for treatment of alcoholism and drug dependency .	Groups of more than 20	.75%	0.58%
1975 1983 1995 2003	Benefits must be included for Mental Health Services , including psychologists and social workers.	Groups of more than 20	2.51%	2.70%
		Groups of 20 or fewer	--	1.35%
1986 1994 1995 1997	Benefits must be included for the services of chiropractors to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services. HMOs must allow limited self referred for chiropractic benefits.	Group	1.04%	1.44%
		Individual	0.88%	0.07%
1990 1997	Benefits must be made available for screening mammography .	Group	0.65%	0.65%
		Individual	0.65%	0.65%
1995	Must provide coverage for reconstruction of both breasts to produce symmetrical appearance according to patient and physician wishes.	All Contracts	0.02%	0.02%
1995	Must provide coverage for metabolic formula and up to \$3,000 per year for prescribed modified low-protein food products.	All Contracts	0.01%	0.01%
1996	Benefits must be provided for maternity (length of stay) and newborn care, in accordance with "Guidelines for Prenatal Care."	All Contracts	0	0
1996	Benefits must be provided for medically necessary equipment and supplies used to treat diabetes and approved self-management and education training.	All Contracts	0.20%	0.20%
1996	Benefits must be provided for screening Pap tests .	Group, HMOs	0.01%	0
1996	Benefits must be provided for annual gynecological exam without prior approval of primary care physician.	Group managed care	--	0.10%

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Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium	
			Non-HMO	HMO
1997	Benefits provided for breast cancer treatment for a medically appropriate period of time determined by the physician in consultation with the patient.	All Contracts	0.07%	0.07%
1998	Coverage required for off-label use of prescription drugs for treatment of cancer, HIV, or AIDS.	All Contracts	0.30%	0.30%
1998	Coverage required for prostate cancer screening .	All Contracts	0.07%	0
1999	Coverage of nurse practitioners and nurse midwives and allows nurse practitioners to serve as primary care providers.	All Managed Care Contracts	--	0.16%
1999	Prescription drug must include contraceptives .	All Contracts	0.80%	0.80%
1999	Coverage for registered nurse first assistants .	All Contracts	0	0
2000	Access to clinical trials .	All Contracts	0.46%	0.46%
2000	Access to prescription drugs .	All Managed Care Contracts	0	0
2001	Coverage of hospice care services for terminally ill.	All Contracts	0	0
2001	Access to eye care .	Plans with participating eye care professionals	0	0.04%
2001	Coverage of anesthesia and facility charges for certain dental procedures.	All Contracts	0.05%	0.05%
2003	Coverage for prosthetic devices to replace an arm or leg	Groups >20	0.03%	0.03%
		All other	0.08%	0.08%
2003	Coverage of licensed clinical professional counselors	All Contracts	0	0
2005	Coverage of licensed pastoral counselors and marriage & family therapists	All Contracts	0	0
2007	Coverage of hearing aids for children	All Contracts	0.1%	0.1%
2008	Coverage for amino acid-based elemental infant formulas	All Contracts	0.1%	0.1%
2008	Coverage for colorectal cancer screening	All Contracts	0	0
	Total cost for groups larger than 20:		7.27%	7.81%
	Total cost for groups of 20 or fewer:		4.06%	5.93%
	Total cost for individual contracts:		3.89%	3.11%

Appendix C: Licensing Statute for Independent Practice Dental Hygienists – Title 32, Chapter 16, Subchapter 3-B

Subchapter 3-B: INDEPENDENT PRACTICE DENTAL HYGIENISTS

32 §1094-I. INDEPENDENT PRACTICE

An independent practice dental hygienist licensed by the board pursuant to this subchapter may practice without supervision by a dentist to the extent permitted by this subchapter. Any licensee of the board may be the proprietor of a place where independent practice dental hygiene is performed and may purchase, own or lease equipment necessary for the performance of independent practice dental hygiene.

A person practicing independent practice dental hygiene as an employee of another shall cause that person's name to be conspicuously displayed at the entrance of the place where the practice is conducted.

32 §1094-J. QUALIFICATIONS FOR LICENSURE

To qualify for licensure under this subchapter as an independent practice dental hygienist, a person must:

- 1. Eighteen years of age.** Be 18 years of age or older;
- 2. Licensure as dental hygienist.** Possess a valid license to practice dental hygiene issued by the board pursuant to subchapter 4 or qualify for licensure as an independent practice dental hygienist by endorsement pursuant to section 1094-L; and
- 3. Education and experience.** Meet the educational and experience requirements described in section 1094-K.

32 §1094-K. EDUCATION AND EXPERIENCE

An applicant for licensure under this subchapter as an independent practice dental hygienist must:

- 1. Bachelor's degree and 2,000 hours experience.** Possess a bachelor's degree from a dental hygiene program accredited by the American Dental Association Commission on Dental Accreditation, or its successor organization, and document one year or 2,000 work hours of clinical practice in a private dental practice during the 2 years preceding application; or
- 2. Associate degree and 6,000 hours experience.** Possess an associate degree from a dental hygiene program accredited by the American Dental Association Commission on Dental Accreditation, or its successor organization, and document 3 years or 6,000 work hours of clinical practice in a private dental practice during the 6 years preceding application.

32 §1094-L. LICENSURE BY ENDORSEMENT

A person eligible for licensure as a dental hygienist by endorsement pursuant to section 1098-D, subsection 2 or 1099 is also eligible for licensure under this subchapter as an independent practice dental hygienist by endorsement if the applicant meets the education and experience requirements set forth in section 1094-K.

32 §1094-M. APPLICATION

An applicant for licensure as an independent practice dental hygienist shall apply to the board on forms provided by the board. The applicant shall include as part of the application such information and documentation as the board may require to act on the application. The application must be accompanied by the application fee set under section 1094-O.

32 §1094-N. LICENSE; BIENNIAL RENEWAL; DISCONTINUATION OF DENTAL HYGIENIST LICENSE

The board shall issue a license to practice as an independent practice dental hygienist to a person who has met the requirements for licensure set forth in this subchapter and has paid the application fee under section 1094-O. There is an initial license fee only for independent practice dental hygienists licensed by endorsement. The license must be exhibited publicly at the person's place of business or employment. The initial date of expiration of the license is the original expiration date of the person's dental hygienist license issued by the board pursuant to subchapter 4 or, for independent practice dental hygienists licensed by endorsement, January 1st of the first odd-numbered year following initial licensure. On or before January 1st of each odd-numbered year, the independent practice dental hygienist shall pay to the board a license renewal fee. Independent practice dental hygienists who have not paid the renewal fee on or before January 1st must be reinstated upon payment of a late fee before February 1st of the year in which license renewal is due. Failure to be properly licensed by February 1st results in automatic suspension of a license to practice as an independent practice dental hygienist. Reinstatement of the independent practice dental hygienist license may be made, if approved by the board, by payment of a reinstatement fee to the board.

A dental hygienist license issued by the board pursuant to subchapter 4 of this chapter automatically expires upon issuance under this subchapter of an independent practice dental hygienist license to the same person.

32 §1094-O. FEES

The board may establish by rule fees for purposes authorized under this subchapter in amounts that are reasonable and necessary for their respective purposes, except that the fee for any one purpose may not exceed \$275. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

32 §1094-P. CONTINUING EDUCATION

As a condition of renewal under this subchapter of a license to practice, an independent practice dental hygienist must submit evidence of successful completion of 30 hours of continuing education consisting of board-approved courses in the 2 years preceding the application for renewal. The board and the independent practice dental hygienist shall follow and are bound by the provisions of section 1084-A in the implementation of this section.

Continuing education completed pursuant to section 1098-B may be recognized for purposes of this section in connection with the first renewal of an independent practice dental hygienist license. The board may refuse to issue a license under this subchapter to a person who has not completed continuing education required by section 1098-B or may issue the license on terms and conditions set by the board.

32 §1094-Q. SCOPE OF PRACTICE

1. Independent practice. An independent practice dental hygienist licensed under this subchapter may perform only the following duties without supervision by a dentist:

- A. Interview patients and record complete medical and dental histories;
- B. Take and record the vital signs of blood pressure, pulse and temperature;
- C. Perform oral inspections, recording all conditions that should be called to the attention of a dentist;
- D. Perform complete periodontal and dental restorative charting;
- E. Perform all procedures necessary for a complete prophylaxis, including root planing;
- F. Apply fluoride to control caries;
- G. Apply desensitizing agents to teeth;
- H. Apply topical anesthetics;
- I. Apply sealants;
- J. Smooth and polish amalgam restorations, limited to slow speed application only;
- K. Cement pontics and facings outside the mouth;
- L. Take impressions for athletic mouth guards and custom fluoride trays;
- M. Place and remove rubber dams;
- N. Place temporary restorations in compliance with the protocol adopted by the board; and
- O. Apply topical antimicrobials, excluding antibiotics, including fluoride, for the purposes of bacterial reduction, caries control and desensitization in the oral cavity. The independent practice dental hygienist shall follow current manufacturer's instructions in the use of these medicaments.

For the purposes of this subsection, "topical" includes superficial and intraoral application.

2. Practice under supervision. An independent practice dental hygienist licensed under this subchapter may perform duties under the supervision of a dentist as set forth in the rules of the board pursuant to section 1095.

32 §1094-R. RESPONSIBILITIES

An independent practice dental hygienist licensed under this subchapter has the duties and responsibilities set out in this section with respect to each patient seen in an independent capacity pursuant to section 1094-Q, subsection 1.

1. Acknowledgment. Prior to an initial patient visit, an independent practice dental hygienist licensed under this subchapter shall obtain from the patient or the parent or guardian of a minor patient written acknowledgment of the patient's or parent's or guardian's understanding that the independent practice dental hygienist is not a dentist and that the service to be rendered does not constitute restorative care or treatment.

2. Referral plan. An independent practice dental hygienist licensed under this subchapter shall provide to a patient or the parent or guardian of a minor patient a written plan for referral to a dentist for any necessary dental care. The referral plan must identify all conditions that should be called to the attention of the dentist.

32 §1094-S. MENTAL OR PHYSICAL EXAMINATION

For the purposes of this section, by application for and acceptance of a license to practice under this subchapter, an independent practice dental hygienist is considered to have given consent to a mental or physical examination when directed by the board. The board may direct an independent practice dental hygienist to submit to an examination whenever the board determines the independent practice dental hygienist may be suffering from a mental illness that

may be interfering with the competent independent practice of dental hygiene or from the use of intoxicants or drugs to an extent that they are preventing the independent practice dental hygienist from practicing dental hygiene competently and with safety to patients. An independent practice dental hygienist examined pursuant to an order of the board may not prevent the testimony of the examining individual or prevent the acceptance into evidence of the report of an examining individual. Failure to comply with an order of the board to submit to a mental or physical examination results in the immediate suspension of the license to practice independent dental hygiene by order of the District Court until the independent practice dental hygienist submits to the examination

32 §1094-T. USE OF FORMER EMPLOYERS' LISTS

An independent practice dental hygienist may not use or attempt to use in any manner whatsoever any prophylactic lists, call lists, records, reprints or copies of those lists, records or reprints, or information gathered from these materials, of the names of patients whom the independent practice dental hygienist might have served in the office of a prior employer, unless these names appear on the bona fide call or prophylactic list of the present employer and were caused to so appear through the independent practice of dentistry, denturism or independent practice dental hygiene as provided for in this chapter. A dentist, denturist or independent practice dental hygienist who employs an independent practice dental hygienist may not aid or abet or encourage an independent practice dental hygienist employed by such person to make use of a so-called prophylactic call list, or to call by telephone or to use written letters transmitted through the mails to solicit patronage from patients formerly served in the office of a dentist, denturist or independent practice dental hygienist that formerly employed the independent practice dental hygienist.