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Dental Care Bill of Rights

HB 1154 – Dental Insurance Reform

Contents:

1. Definitions *

* (Dental coverage definitions and statutory language encompassing organizations that are engaged in financing dental care in return for a subscription fee can be complex. Multiple designs of dental coverage within health insurance or benefit plans make it nearly impossible to land on one definition that covers all designs. The intent of this model is to extend the benefits of the law to all situations where a patient is deemed covered by a commercial/private third party. The definitions below are taken from existing state laws; state bill drafting efforts should ensure as broad a reach as possible consistent with existing statutory construct.

The nature of definitions should be consistent with jurisdiction in a manner that is inclusive of all iterations of commercially available dental coverage designs and programs; definitions should be comprehensive and commensurate with state's statutory construct. Examples provided below for guidance)

"Contracting entity" means any person or entity that enters into direct contracts with providers for the delivery of dental services in the ordinary course of business, including a third party administrator and a dental carrier.

"Covered person" means an individual who is covered under a dental benefits or health insurance plan that provides coverage for dental services.

"Credit card payment" means a type of electronic funds transfer in which a dental benefit plan or its contracted vendor issues a single-use series of numbers associated with the payment of dental services performed by a dentist and chargeable to a predetermined dollar amount, whereby the dentist is responsible for processing the payment by a credit card terminal or Internet portal. Such term shall include virtual or online credit card payments, whereby no physical credit card is presented to the dentist and the single-use credit card expires upon payment processing;

"Dental benefit plan" means a benefits plan which pays or provides dental expense benefits for covered dental services and is delivered or issued for delivery by or through a dental carrier on a stand-alone basis. (Note: some health insurers or health insurance plans integrate dental benefits and should be considered dental benefits plans for the purposes of this Act and in the provisions therein.)

"Dental carrier" means a dental insurance company, dental service corporation, dental plan organization authorized to provide dental benefits, or a health benefits plan that includes coverage for dental services.

"Dental services" means services for the diagnosis, prevention, treatment, or cure of a dental condition, illness, injury, or disease. Dental services shall not include those services delivered by a provider that are billed as medical services.

“Dental Service Contractor” means any person who accepts a prepayment from or for the benefit of any other person or group of persons as consideration for providing to such person or group of persons the opportunity to receive dental services at such times in the future as such services may be appropriate or required, but shall not be construed to include a dentist or professional dental corporation that accepts prepayment on a fee-for-service basis for providing specific dental services to individual patients for whom such services have been prediagnosed.

"Dentist" means any dentist licensed or otherwise authorized in this state to furnish dental services;

"Dentist agent" means a person or entity that contracts with a dentist establishing an agency relationship to process bills for services provided by the dentist under the terms and conditions of a contract between the agent and health care provider. Such contracts may permit the agent to submit bills, request reconsideration and receive reimbursement;

"Electronic funds transfer payment" means a payment by any method of electronic funds transfer other than through the Automated Clearing House Network (ACH), as codified in 45 CFR Sections 162.1601 and 162.1602;

"Health insurance plan" means any hospital or medical insurance policy or certificate; qualified higher deductible health plan; health maintenance organization subscriber contract; contract providing benefits for dental care whether such contract is pursuant to a medical insurance policy or certificate; stand-alone dental plan, health maintenance provider contract or managed health care plan; and

"Health insurer" means any entity or person that issues health insurance plans, as defined in this section.

"Prior authorization" means any communication indicating that a specific procedure is, or multiple procedures are, covered under the patient's dental plan and reimbursable at a specific amount, subject to applicable coinsurance and deductibles, and issued in response to a request submitted by a dentist using a format prescribed by the insurer.

"Provider" means an individual or entity which, acting within the scope of licensure or certification, provides dental services or supplies defined by the health benefits or dental benefit plan. "Provider" shall not include a physician organization or physician hospital organization that leases or rents the physician organization's or physician hospital organization's network to a third party.
"Provider network contract" means a contract between a contracting entity and a provider specifying the rights and responsibilities of the contracting entity and providing for the delivery of and payment for dental services to covered persons.

"Third party" means a person or entity that enters into a contract with a contracting entity or with another third party to gain access to the dental services or contractual discounts of a provider network contract.

"Third party" shall not include any employer or other group for whom the contracting entity or dental carrier provides administrative services, including at least the payment of claims.

2. Fairness in Collection of Overpayments by Health Insurers and Health Plans Covering Dental Services Act

An Act establishing time limits for dental benefit carriers to collect certain overpayments made to dentists; requiring notice; establishing policies and procedures allowing for challenges; exceptions.

Section I. Post-Payment of Claim/Payment Recovery Limitations

a. Other than recovery for duplicate payments, dental benefit plans or dental services contractors, whenever engaging in overpayment recovery efforts, shall provide written notice to the dentist that identifies the error made in the processing or payment of the claim and justifies the overpayment recovery.

b. Dental benefit plans or dental services contractors shall provide dentists with the opportunity to challenge an overpayment recovery, including the sharing of claims information, and shall establish written policies and procedures for dentists to follow to challenge an overpayment recovery.

c. Dental benefit plans or dental services contractors shall not initiate overpayment recovery efforts more than [Insert desired limit; suggest 6 - 12 months or emulate prevailing insurer limit on filing claims] after the original payment for the claim was made. No such time limit shall apply to overpayment recovery efforts which are:

   i. Based on reasonable belief of fraud, abuse, or other intentional misconduct;

   ii. required by, or initiated at the request of, a self-insured plan; or

   iii. required by a state or federal government plan.

Waiver Prohibited. The provisions of this section cannot be waived by contract. Any contractual arrangement in conflict with the provisions of this section or that purports to waive any requirements of this section is null and void.

3. Prior Authorizations/Claim Payments Act

An Act prohibiting dental carriers from denying, revoking, limiting, conditioning, or otherwise restricting preapproved dental care claims or claims approved in prior authorizations; exceptions.

Section I. Authorized Service(s) Claim Denial Prohibited/Exceptions

Dental benefit plans shall not deny any claim subsequently submitted by a dentist for procedures specifically included in a prior authorization unless at least one of the following circumstances applies for each procedure denied:

a. Benefit limitations such as annual maximums and frequency limitations not applicable at the time of the prior authorization are reached due to utilization subsequent to issuance of the prior authorization;

b. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;

c. If, subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care;

d. If, subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would at that time required disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was used; or

e. The denial of the dental service contractor was due to one of the following:

    i. another payer is responsible for payment,

    ii. the dentist has already been paid for the procedures identified on the claim,

    iii. the claim was submitted fraudulently or the prior authorization was based in whole or material part on erroneous information provided to the dental service contractor by the dentist, patient, or other person not related to the carrier, or

    iv. the person receiving the procedure was not eligible to receive the procedure on the date of service and the dental service contractor did not know, and with the exercise of reasonable care could not have known, of their eligibility status.

DRAFTING NOTE: Dental services are authorized through prior authorizations, not pretreatment estimates.

Section II. Penalties
(*Establish appropriate penalties for any violation of this Act.*)

Waiver Prohibited. The provisions of this section cannot be waived by contract. Any contractual arrangement in conflict with the provisions of this section or that purports to waive any requirements of this section is null and void.

4. Virtual Credit Card – Claim Payment/Transaction Fees Options Act

An Act concerning insurance; prohibiting certain restrictions on method of payment to health care providers; requiring certain notifications; prohibiting certain additional charges; prohibiting certain contracts, clauses or waivers; providing for enforcement by the Insurance Commissioner.

Section I. Method of Payment Option
No dental benefit plan shall contain restrictions on methods of payment from the dental benefit plans or its vendor or the health maintenance organization to the dentist in which the only acceptable payment method is a credit card payment.

If initiating or changing payments to a dentist using electronic funds transfer payments, including virtual credit card payments, a dental benefit plan or its contracted vendor or health maintenance organization shall:

a. Notify the dentist if any fees are associated with a particular payment method; and

b. Advise the dentist of the available methods of payment and provide clear instructions to the dentist as to how to select an alternative payment method.

A dental benefit plan or its contracted vendor or health maintenance organization that initiates or changes payments to a dentist through the Automated Clearing House Network, as codified in 45 CFR Sections 162.1601 and 162.1602, shall not charge a fee solely to transmit the payment to a dentist unless the dentist has consented to the fee. A dentist's agent may charge reasonable fees when transmitting an Automated Clearing House Network payment related to transaction management, data management, portal services and other value-added services in addition to the bank transmittal.

The provisions of this section shall not be waived by contract, and any contractual clause in conflict with the provisions of this section or that purport to waive any requirements of this section are void.

Violations of this section shall be subject to enforcement by the Insurance Commissioner.

5. Fair and Transparent Network Contracting Act

An Act concerning practical dental provider network administration; enhancing contractual transparency and freedom of choice in network participation/contracting.

Section I. Responsible Leasing Requirements when Leasing Networks

a. A contracting entity may grant a third-party access to a provider network contract, or a provider's dental services or contractual discounts provided pursuant to a provider network contract if the requirements of subdivisions (b) and (c) are met.

b. At the time the contract is entered into or renewed, or a when there are material modifications to a contract relevant to granting access to a provider network contract to a third party, the dental carrier allows any provider which is part of the carrier's provider network to choose to not participate in third party access to the contract or to enter into a contract directly with the health insurer that acquired the provider network. If a provider opts out of lease arrangements, this shall not permit the contracting entity to cancel or otherwise end a contractual relationship with the provider. When initially contracting with a provider, a contracting entity must accept a qualified provider even if a provider rejects a network lease provision. Subsection I(B) shall not apply to contracting entities who are not a health insurer or dental carrier.

DRAFTING NOTE: Subsection Ib is intended to apply to insurers only, and not to leasing companies. Providers contract with leasing companies with the explicit understanding and expectation that they will be leased. Because applying opt out requirements to these entities would impair their central purpose as understood by all parties, they should be specifically excluded from such provisions in legislation. However, the transparency provisions outlined in Subsection Ic are intended to apply to all contracting entities, including leasing companies.

c. A contracting entity may grant a third-party access to a provider network contract, or a provider's dental services or contractual discounts provided pursuant to a provider network contract, if all of the following are met:

i. The contract specifically states that the contracting entity may enter into an agreement with third parties allowing the third parties to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity, and when the contracting entity is a dental carrier, the provider chose to participate in third party access at the time the provider network contract was entered into or renewed. If the contracting entity is an insurer, the third-party access provision of any provider contract shall also specifically state that the contract grants third-party access to the provider network and, for contracts with dental carriers, that the dentist has the right to choose not to participate in third-party access.

ii. The third party accessing the contract agrees to comply with all of the contract's terms;

iii. The contracting entity identifies, in writing or electronic form to the provider, all third parties in existence as of the date the contract is entered into or renewed;

iv. The contracting entity identifies all third parties in existence in a list on its internet website that is updated at least once every 90 days;

v. The contracting entity notifies network providers that a new third party is leasing or purchasing the network at least 30 days in advance of the relationship taking effect;

vi. The contracting entity requires a third party to identify the source of the discount on all remittance advices or explanations of payment under which a discount is taken. This paragraph does not apply to electronic transactions mandated by the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191);

vii. The contracting entity notifies the third party of the termination of a provider network contract no later than 30 days from the termination date with the contracting entity;

viii. A third party's right to a provider's discounted rate ceases as of the termination date of the provider network contract;

ix. The contracting entity makes available a copy of the provider network contract relied on in the adjudication of a claim to a participating provider within 30 days of a request from the provider.

No provider shall be bound by or required to perform dental treatment or services under a provider network contract that has been granted to a third party in violation of this act.

Section II. Exceptions

The provisions of this Act shall not apply if any of the following is true:

a. Access to a provider network contract is granted to a dental carrier or an entity operating in accordance with the same brand licensee program as the contracting entity or to an entity that is an affiliate of the contracting entity. A list of the contracting entity's affiliates shall be made available to a provider on the contracting entity's website; or

b. A provider network contract for dental services provided to beneficiaries of the state sponsored health programs such as Medicaid and CHIP;

Section III. Penalties
(Establish appropriate penalties for any violation of this Act.)

Waiver Prohibited. The provisions of this section cannot be waived by contract. Any contractual arrangement in conflict with the provisions of this section or that purports to waive any requirements of this section is null and void.

6. Transparency of Patient Premiums Invested in Dental Care Act

An Act concerning requirements for certain health care service plans to file a Medical Loss Ratio (MLR) report; uniform reporting and terminology; verification of MLR annual report; public access; exemptions

a. A health care service plan that issues, sells, renews, or offers a specialized health care service plan contract covering dental services shall file a Medical Loss Ratio (MLR) with the [state insurance authority] that is organized by market and product type and contains the same information required in the 2013 federal Medical Loss Ratio (MLR) Annual Reporting Form (CMS-10418).

b. The MLR reporting year shall be for the calendar year during which dental coverage is provided by the plan. All terms used in the MLR annual report shall have the same meaning as used in the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), Part 158 (commencing with 158.101) of Title 45 of the Code of Federal Regulations, and Section 1367.003.

c. If data verification of the health care service plan's representations in the MLR annual report is deemed necessary, the [state authority] shall provide the health care service plan with a notification 30 days before the commencement of the financial examination.

d. The health care service plan shall have 30 days from the date of notification to submit to the [state authority] all requested data. The director may extend the time for a health care service plan to comply with this subdivision upon a finding of good cause.

e. The [state authority] shall make available to the public all of the data provided to the department pursuant to this section.

f. Exempts Health care service plans for health care services under Medicaid CHIP or other state sponsored health programs

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