As Amended by Senate Committee

As Amended by House Committee

Session of 2021

HOUSE BILL No. 2386

By Committee on Health and Human Services

2-12

AN ACT concerning insurance; relating to dental benefits; dental benefit plans and related coverage; establishing requirements and restrictions for the payment and reimbursement of dental services thereby.

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

Section 1. As used in sections 1 through ~~4~~ **3**, and amendments thereto:

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

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

(c) "Credit card payment" means a type of electronic funds transfer in which a dental benefit plan or such plan's 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 and in which the dentist is responsible for processing the payment by a credit card terminal or internet portal. "Credit card payment" includes a virtual or online credit card payment where no physical credit card is presented to the dentist, and the single-use credit card expires upon payment processing.

(d) "Dental benefit plan" means a benefits plan that 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. "Dental benefit plan" includes coverage for dental benefits integrated or otherwise incorporated into the terms and coverage of a health benefits plan.

(e) "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.

(f) "Dental services" means services for the diagnosis, prevention, treatment or cure of a dental condition, illness, injury or disease. "Dental

services" does not include services delivered by a provider that are billed as medical expenses under a health benefits plan.

(g) "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 times in the future as such services may be appropriate or required. "Dental service contractor" does not 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.

(h) "Dentist" means any dentist licensed or otherwise authorized in this state to provide dental services.

(i) "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 dentist, including contractual relationships that permit the agent to submit bills, request reconsideration and receive reimbursement.

(j) "Electronic funds transfer payment" means a payment by any method of electronic funds transfer other than through the automated clearing house network, as codified in 45 C.F.R. §§ 162.1601 and 162.1602.

(k) "Health insurance plan" means any: Hospital or medical insurance policy or certificate; qualified high-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.

(l) "Health insurer" means any entity or person that issues a health insurance plan.

(m) ~~"Prior authorization" means any communication indicating that a specific procedure is 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 health insurer.~~

~~(n)~~ "Provider" means an individual or entity that, acting within the scope of licensure or certification, provides dental services or supplies defined by the dental benefit plan. "Provider" does 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.

~~(o)~~**(n)** "Provider network contract" means a contract between a

contracting entity and a provider that specifies the rights and responsibilities of the contracting entity and provides for the delivery and payment of dental services to an enrollee.

~~(p)~~**(o)** "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" does not include any employer or other group for whom the dental carrier or contracting entity provides administrative services.

Sec. 2. (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, subject to the requirements of subsections (b) and (c).

(b) At the time the contract is entered into, sold, leased 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 shall allow any provider that 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. Opting out of lease arrangements shall not require dentists to cancel or otherwise end a contractual relationship with the original carrier that leases a provider network.

(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:

(1) The contract specifically states that the contracting entity may enter into an agreement with third parties, allowing such third parties to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity, or if 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. The third-party access provision of any provider contract shall be clearly identified in the provider contract, including notice that the contract grants third-party access to the provider network and that the dentist has the right to choose not to participate in third-party access;

(2) the third party accessing the contract agrees to comply with all of the contract's terms, including such third party's obligation concerning patient steerage;

(3) the contracting entity identifies to the provider, in writing or electronic form, all third parties in existence as of the date the contract is entered into, sold, leased or renewed;

(4) the contracting entity identifies all third parties in existence in a list on its website that is updated at least once every 90 days;

(5) 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, except that this paragraph shall not apply to electronic transactions mandated by the health insurance portability and accountability act of 1996, public law 104-191;

(6) the contracting entity notifies the third party of the termination of a provider network contract not later than 30 days from the termination date with the contracting entity; and

(7) a third party's right to a provider's discounted rate ceases as of the termination date of the provider network contract. The contracting entity shall make available a copy of the provider network contract relied on in the adjudication of a claim to a provider within 30 days of a request from the provider.

(d) 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 sections 1 through 4, and amendments thereto.

(e) The provisions of this section shall not apply to:

(1) Access to a provider network contract that 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

(2) a provider network contract for dental services provided to beneficiaries of state-sponsored health programs, including medical assistance and the children's health insurance program.

(f) The provisions of this section shall not 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 shall be null and void and unenforceable.

~~Sec. 3. (a) A dental benefit plan shall not deny any claim subsequently submitted by a dentist for procedures specifically included in a prior authorization, unless, for each procedure denied:~~

~~(1) Benefit limitations, including annual maximums and frequency limitations, that were not applicable at the time of the prior authorization are reached due to utilization subsequent to issuance of the prior authorization;~~

~~(2) the documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;~~

~~(3) new procedures are provided to the patient subsequent to the issuance of the prior authorization or the patient's condition changes such that the prior authorized procedure would no longer be considered~~

~~medically necessary, based on the prevailing standard of care;~~

~~(4) new procedures are provided to the patient subsequent to the issuance of the prior authorization or the patient's condition changes such that the prior authorized procedure would presently require 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~~

~~(5) the denial of the dental service contractor was because:~~

~~(A) Another payor is responsible for payment;~~

~~(B) the dentist has already been paid for the procedures identified on the claim;~~

~~(C) 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 another person not related to the carrier; or~~

~~(D) 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 such patient's eligibility status.~~

~~(b) The provisions of this section shall not 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 shall be null and void and unenforceable.~~

Sec. ~~4.~~ **3.** (a) No dental benefit plan shall contain restrictions on methods of payment to a dentist from the dental benefit plan, such plan's contracted vendor or health maintenance organization in which the only acceptable payment method is a credit card payment.

(b) If initiating or changing payments to a dentist using electronic funds transfer payments, including virtual credit card payments, a dental benefit plan, such plan's contracted vendor or health maintenance organization shall:

(1) Notify the dentist if any fees are associated with a particular payment method; ***and***

(2) 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~~; and~~

~~(3) notify the dentist if the dental benefit plan is sharing a part of the profit of the fee charged by the credit card company to pay the claim~~.

(c) A dental benefit plan, such plan's contracted vendor or health maintenance organization that initiates or changes payments to a dentist through the automated clearing house network, as codified in 45 C.F.R. §§ 162.1601 and 162.1602, shall not charge a fee solely to transmit the payment to a dentist unless the dentist has consented to such 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.

(d) The provisions of this section shall not 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 shall be null and void and unenforceable.

Sec. ~~5.~~ **4.** Any violation of sections 1 through ~~4~~ **3**, and amendments thereto, shall be subject to enforcement by the commissioner of insurance.

Sec. ~~6.~~ **5.** This act shall take effect and be in force from and after its publication in the statute book.