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H.B. 359

DENTAL BILLING AMENDMENTS

2021 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: _____

LONG TITLE

General Description:

This bill regulates dental claims and dental leasing contracts.

Highlighted Provisions:

This bill:

- defines terms;
- describes when an insurer may use bundling and downcoding;
- describes when a third party may lease a dental plan network;
- describes requirements for a dental lease contract; and
- allows a dental provider to opt out of a lease if leased by an insurer.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

ENACTS:

31A-22-646.1, Utah Code Annotated 1953

31A-26-301.7, Utah Code Annotated 1953

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **31A-22-646.1** is enacted to read:

H.B. 359

31A-22-646.1. Leasing requirements for dental plans.

(1) As used in this section:

(a) "Contracting entity" means a person 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 or a dental carrier.

(b) "Dental carrier" means a dental insurance company, dental service corporation, or dental plan organization authorized to provide a dental plan.

(c) "Dental plan" means the same as that term is defined in Section 31A-22-646.

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

(ii) "Dental services" does not include services that a provider delivers and bills as medical expenses under a health benefit plan.

(e) (i) "Dental service contractor" means an individual who:

(A) accepts prepayment for dental services; or

(B) for the benefit of another individual, accepts payment for providing to the individual the opportunity to receive dental services in the future.

(ii) "Dental service contractor" does not include a provider or professional dental corporation that accepts prepayment on a fee-for-service basis for providing specific dental services to individual patients for whom the services have been pre-diagnosed.

(f) (i) "Provider" means a person who, acting within the scope of licensure or certification, provides dental services or supplies defined by the dental plan.

(ii) "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.

(g) "Provider network contract" means a contract between a contracting entity and a provider that:

(i) specifies the rights and responsibilities of the contracting entity; and

(ii) provides for the delivery and payment of dental services to an enrollee.

(h) (i) "Third party" means a person 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.

(ii) "Third party" does not include an employer or other group for whom the dental carrier or contracting entity provides administrative services.

(2) A contracting entity may grant a third party access to a provider network contract regarding dental services, including a provider's dental services, or a contractual discount provided under a provider network contract for dental services if:

(a) if the contracting entity is an insurer, the insurer complies with Subsection (3);

(b) the contract between the contracting entity and a person subject to the third-party access complies with Subsection (4); and

(c) the contracting entity complies with Subsection (5).

(3) An insurer shall:

(a) at the time a contract is entered into or renewed, or when there is a material modification to a contract that is relevant to third-party access to a provider network contract, allow a provider which is part of the insurer's provider network to:

(i) choose to not participate in third-party access; or

(ii) enter into a contract directly with the third party that acquired the provider network;

(b) allow a provider to opt out of lease arrangements without canceling or ending a contractual relationship with the insurer; and

(c) when initially contracting with a provider, accept a qualified provider even if a provider rejects a network lease provision.

(4) A contracting entity described in Subsection (2) shall ensure that the contract described in Subsection (2)(b) includes the following:

(a) a provision indicating the contracting entity may enter into an agreement with a third party to allow the third party to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity;

(b) if the contracting entity is a dental carrier, a provision indicating that the provider chose to participate in third-party access at the time the provider network contract was entered into or renewed; and

(c) if the contracting entity is an insurer, a provision indicating:

(i) that the contract grants a third party access to the provider network; and

(ii) for a contract with a dental carrier, the dentist has the right to choose not to participate in third-party access.

(5) A contracting entity shall:

(a) provide a provider, in writing, each third party in existence as of the date the contract is entered into or renewed;

(b) maintain a list of each third party in existence on the contracting entity's website that is updated at least once every 90 days;

(c) notify network providers that a new third party is leasing or purchasing the network at least 30 days before the day on which the lease or purchase occurs;

(d) require a third party to identify the source of the discount on all remittance advices or explanations of payment under which a discount is taken unless the transaction is an electronic transaction mandated by the Health Insurance Portability and Accountability Act;

(e) notify a third party of the termination of a provider network contract no later than 30 days after the day on which the contract terminates with the contracting entity;

(f) make available to a participating provider, within 30 days after the day on which the provider makes a request, a copy of the provider network contract at issue in the adjudication of a claim; and

(g) maintain a list of the contracting entity's affiliates on the contracting entity's website.

(6) A third party that gains access to a contract under this section:

(a) shall comply with each term of the contract to which the third party gains access; and

(b) loses all rights to a provider's discounted rate as of the termination date of the provider network contract.

(7) A contracting entity or third party may not require a provider to perform services under a provider network contract if a third party gains access to a contract in violation of this section.

(8) This section does not apply to:

(a) a contracting entity granting access to a provider network contract to:

(i) an entity that operates in accordance with the brand licensee program of the contracting entity; or

(ii) an entity that is an affiliate of the contracting entity; and

(b) a provider network contract for dental services provided to beneficiaries of a state

sponsored health program, including Medicaid and the Children's Health Insurance Program.

(9) A contract executed or renewed after June 30, 2021:

(a) may not waive the provisions of this section; and

(b) is null and void if the contract contains provisions that conflict with the provisions of this section or that purports to waive a requirement of this section.

Section 2. Section **31A-26-301.7** is enacted to read:

31A-26-301.7. Dental claim transparency.

(1) As used in this section:

(a) "Bundling" means the practice of combining distinct dental procedures into one procedure for billing purposes.

(b) "Dental plan" means the same as that term is defined in Section 31A-22-646.

(c) "Downcoding" means the adjustment of a claim submitted to a dental plan to a less complex or lower cost procedure code.

(d) "Covered services" means the same as that term is defined in Section 31A-22-646.

(e) "Material change" means a change to:

(i) a dental plan's rules, guidelines, policies, or procedures concerning payment for dental services;

(ii) the general policies of the dental plan that affect a reimbursement paid to providers; or

(iii) the manner by which a dental plan adjudicates and pays a claim for services.

(2) An insurer that contracts or renews a contract with a dental provider shall:

(a) make a copy of the insurer's current dental plan policies available online; and

(b) if requested by a provider, send a copy of the policies to the provider through mail or electronic mail.

(3) Dental policies described in Subsection (2) shall include:

(a) a summary of all material changes made to a dental plan since the policies were last updated;

(b) the downcoding and bundling policies that the insurer reasonably expects to be applied to the dental provider or provider's services as a matter of policy; and

(c) a description of the dental plan's utilization review procedures, including:

(i) a procedure for an enrollee of the dental plan to obtain review of an adverse

determination in accordance with 31A-22-629; and

(ii) a statement of a provider's rights and responsibilities regarding the procedures described in Subsection (3)(c)(i).

(4) An insurer may not maintain a dental plan that:

(a) based on the provider's contracted fee for covered services, uses downcoding in a manner that prevents a dental provider from collecting the fee for the actual service performed from either the plan or the patient; or

(b) uses bundling in a manner where a procedure code is labeled as nonbillable to the patient unless, under generally accepted practice standards, the procedure code is for a procedure that may be provided in conjunction with another procedure.

(5) An insurer shall ensure that an explanation of benefits for a dental plan includes the reason for any downcoding or bundling result.