HB0359S01 compared with HB0359

~~{deleted text}~~ shows text that was in HB0359 but was deleted in HB0359S01.

inserted text shows text that was not in HB0359 but was inserted into HB0359S01.

DISCLAIMER: This document is provided to assist you in your comparison of the two bills. Sometimes this automated comparison will NOT be completely accurate. Therefore, you need to read the actual bills. This automatically generated document could contain inaccuracies caused by: limitations of the compare program; bad input data; or other causes.

Representative James A. Dunnigan proposes the following substitute bill:

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:

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 or electronic form, 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}c) 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}d) 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}e) 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}f) 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 on or after {June 30}January 1, {2021}2022:

(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.