As Introduced

136th General Assembly
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H. B. No. 845

Representative Craig

To enact sections 3902.75, 3902.751, 3902.752, 3902.753, 3902.754, and 3902.755 of the Revised Code regarding dental benefit plans.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 3902.75, 3902.751, 3902.752, 3902.753, 3902.754, and 3902.755 of the Revised Code be enacted to read as follows:

Sec. 3902.75. As used in sections 3902.75 to 3902.755 of the Revised Code:

(A) "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 or dental carrier.

(B) "Covered person," "health benefit plan," and "health plan issuer" have the same meanings as in section 3922.01 of the Revised Code.

(C) "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. "Credit card payment" includes virtual or online payments 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 benefit plan that covers dental services and is delivered by or through a dental carrier on an integrated or standalone basis.

(E) "Dental carrier" means a dental insurance company, dental service corporation, dental plan organization authorized to provide dental benefits, or a health benefit 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 benefit 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 the opportunity to receive dental services when services are 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 pre-diagnosed.

(H) "Dentist" means an individual licensed to practice dentistry under Chapter 4715. of the Revised Code.

(I) "Dentist agent" means any 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 the dentist.

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

(K) "Prior authorization" means any written communication indicating that a specific procedure is covered under a 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 a health plan issuer or dental carrier.

(L) "Provider" means an individual or entity acting within the scope of licensure or certification that provides dental services or supplies as defined by a health benefit plan that includes coverage for dental services or a 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.

(M) "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.

(N) "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 an employer or other group for whom the dental carrier or contracting entity provides administrative services.

Sec. 3902.751. A dental benefit plan shall not deny any claim subsequently submitted by a dentist for procedures specifically included in a prior authorization unless any of the following apply:

(A) Benefit limitations such as annual maximums and frequency limitations not applicable at the time of the prior authorization have been reached due to utilization after the prior authorization was issued.

(B) The documentation for the claim clearly fails to support the claim as originally authorized.

(C) After the prior authorization was issued, new procedures were provided to the patient or a change in the patient's condition occurred such that the prior authorized procedure is no longer considered medically necessary based on the prevailing standard of care.

(D) After the prior authorization was issued, new procedures were provided to the patient or a change in the patient's condition occurred such that the prior authorized procedure would at that time require disapproval under the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was used.

(E) The denial of the dental service contractor was due to any of the following:

(1) Another payer is responsible for payment.

(2) The dentist has already been paid for the procedures

identified on the claim.

(3) The claim was submitted fraudulently, or the prior authorization was based on erroneous information the dentist, patient, or another person not related to the carrier provided to the dental service contractor.

(4) 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 the person's eligibility status.

Sec. 3902.752. (A) No dental benefit plan shall contain restrictions on methods of payment from the dental benefit plan or its vendor or the health maintenance organization to the dentist in which the only acceptable method of payment is a credit card payment or another form of payment that requires fees or similar charges. Any dental benefit plan providing an automated clearinghouse network payment shall comply with the requirements specified in 45 C.F.R. 162.925(a).

(B) A dental benefit plan or its contracted vendor or a health maintenance organization may initiate or change payment methodology to a dentist using electronic funds transfer payments, including virtual credit card payments, if all of the following are satisfied:

(1) The dental benefit plan notifies the dentist if any fees are associated with a particular payment method.

(2) The dental benefit plan advises the dentist of the available methods of payment and provides clear instructions to the dentist regarding how to select an alternative payment method that does not impose fees or similar charges on the

provider.

(3) The provider or a designee of the provider elects, by clearly and directly agreeing in writing, to accept a payment of the claim using the credit card or electronic funds transfer payment method without ambiguity or implied actions.

(C) A dentist's selected form of claim payment methodology shall remain effective until the dentist chooses an alternative method of payment or a new contract is executed.

(D) A dental benefit plan or its contracted vendor or a health maintenance organization that initiates or changes payments to a dentist through the automated clearinghouse network 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 clearinghouse network payment related to transaction management, data management, portal services, and other value-added services in addition to the bank transmittal.

Sec. 3902.753. (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 all of the following are satisfied:

(1) The contract specifically permits the contracting entity to enter into an agreement with third parties and allows the third parties to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity. If the contracting entity is a health plan issuer or dental carrier, the third-party access provision of any provider contract shall specifically state that the contract grants third-party access to the provider network. The contract also

shall specifically state that a dentist has the right to choose to not participate in third-party access to the provider network.

(2) The third party accessing the contract agrees to comply with all of the contract's terms.

(3) The contracting entity identifies in writing all third parties in existence as of the date the contract is entered into or renewed.

(4) The contracting entity identifies all third parties in existence in a list on its internet web site that is updated at least once every ninety days.

(5) The contracting entity notifies network providers that a new third party is leasing or purchasing the network at least thirty days before the lease or purchase takes effect.

(6) Except with regard to electronic transactions subject to section 1320d-2 of the federal "Health Insurance Portability and Accountability Act of 1996," 42 U.S.C. 1320d-2, the contracting entity requires each third party to identify the source of the discount on all remittance advices or explanations of payment under which a discount is taken.

(7) The contracting entity notifies the third party of the termination of a provider network contract not later than thirty days after the termination date with the contracting entity.

(8) A third party's right to a provider's discounted rate ceases upon the termination date of the provider network contract.

(9) 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 thirty days after a request from the provider.

(B) When granting access to a third party under division (A) of this section, a dental carrier or health plan issuer acting as a contracting entity shall permit any provider that is part of the carrier or issuer's provider network to choose to not participate in third-party access to the contract or to enter into a contract directly with the dental carrier or health plan issuer that acquired the provider network. A provider electing not to participate in a lease arrangement does 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 shall accept a qualified provider even if the provider elects not to participate in a network lease.

(C) This section does not apply when access to a provider network contract is granted to a dental carrier or an entity operating in accordance with the same brand license program as the contracting entity or to an entity that is an affiliate of the contracting entity. A list of a contracting entity's affiliates shall be made available to a provider on the contracting entity's internet web site.

Sec. 3902.754. Sections 3902.75 to 3902.753 of the Revised Code cannot be waived by contract. Any contractual provision that conflicts with those sections or purports to waive them is void.

Sec. 3902.755. The superintendent of insurance shall adopt rules in accordance with Chapter 119. of the Revised Code to implement and enforce sections 3902.75 to 3902.754 of the Revised Code.