SESSION OF 2022

SUPPLEMENTAL NOTE ON HOUSE BILL NO. 2386

As Amended by Senate Committee on Public Health and Welfare

Brief*

HB 2386, as amended, would establish requirements and restrictions for the payment and reimbursement of dental services.

Defined Terms

The bill would define the following terms:

- "Contracting entity" would mean 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;
- "Covered person" would mean an individual who is covered under a dental benefits or health insurance plan that provides coverage for dental services;
- "Credit card payment" would mean 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

*Supplemental notes are prepared by the Legislative Research Department and do not express legislative intent. The supplemental note and fiscal note for this bill may be accessed on the Internet at http://www.kslegislature.org

internet portal. “Credit card payment” would include 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;

- “Dental benefit plan” would mean 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. A “dental benefit plan” would include coverage for dental benefits integrated or otherwise incorporated into the terms of coverage of a health benefits plan;

- “Dental carrier” would mean 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” would mean services for the diagnosis, prevention, treatment, or cure of a dental condition, illness, injury, or disease. “Dental services” would not include services delivered by a provider that are billed as medical expenses under a health benefits plan;

- “Dental service contractor” would mean 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;

- “Dentist” would mean any dentist licensed or otherwise authorized in this state to provide dental services;
- “Dentist agent” would mean 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 consideration, and receive reimbursement;
- “Electronic funds transfer payment” would mean a payment by any method of electronic funds transfer other than through the automated clearing house network, as codified in the Code of Federal Regulations;
- “Health insurance plan” would mean 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;
- “Health insurer” would mean any entity or person that issues a health insurance plan;
- “Provider” would mean 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” would 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” would mean 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; and

- “Third party” would mean a person or entity that enters into a contract with a contracting entity or with another third party to gain access to dental services or contractual discounts of a provider network contract. “Third party” would not include any employer or other group for whom the dental carrier or contracting entity provides administrative services.

Conditions for Third Party Access to Provider Network Contracts

Under the bill, a contracting entity would be permitted to 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, provided that:

- At the time the contract is entered into, sold, leased, or renewed, or 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 not to 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 agreements would not

require dentists to cancel or otherwise end a contractual relationship with the original carrier that leases a provider network; and

- A contracting entity would be permitted to 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 contract specifically states that the contracting entity would be permitted to enter into an agreement with third parties, allowing those third parties to obtain the contracting entity's right 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; and
    - The third party access provision is clearly identified in any provider contract, including notice that the contract grants third-party access to the provider network and that the dentist has the right to choose and not participate in third-party access;
    - 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;
    - 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;
    - The contracting entity identifies all third parties in existence in a list on its website that is updated at least once every 90 days;
    - 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;

- 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
- 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 the claim to a provider within 30 days of a request from the provider.

The bill would state that no provider would be bound by or required to perform dental treatment or services under a provider network contract granted to a third party in violation of the bill.

The bill would specify that the provisions of third-party access would not apply to:

- 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. The contracting entity must provide a list of such affiliates on its website; or
- 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.

The bill would specify that the provisions for third-party access shall not be waived by contract, and any contractual arrangement in violation of such provisions or that purports to waive the requirements of such provisions shall be null and void and unenforceable.

Methods of Payment

The bill would prohibit dental benefit plans from containing 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.

The bill would provide that 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:

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

The bill would prohibit a dental benefit plan, such plan's contracted vendor, or health maintenance organization that initiates or changes payments to a dentist through the automated clearinghouse network, from charging a fee solely to transmit the payment to a dentist unless the dentist has consented to such a fee. A dentist's agent would be permitted to 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 bill would prohibit provisions related to method of payment to be waived by contract. Any contractual arrangement in violation of such provisions or that purports to waive the requirements of such provisions would be null and void and unenforceable.

The bill would also provide that any violations of the provisions of the bill would be subject to enforcement by the Commissioner of Insurance.

Background

The bill was introduced by the House Committee on Health and Human Services.

House Committee on Health and Human Services

In the House Committee hearing on the bill, a representative of the Kansas Dental Association and two practicing dentists provided **proponent** testimony, stating the bill would address issues of transparency between dental providers and insurance companies. The representative from the Kansas Dental Association explained that a compromise was reached with Delta Dental of Kansas (Dental Dental) to not pursue the portion of the bill on prior authorization.

Neutral testimony was provided by a representative of Delta Dental.

Neutral written-only testimony was provided by a representative of the American Council of Life Insurers.

No **opponent** testimony was provided.

The House Committee amended the bill to strike the definition of prior authorization and the section of the bill regarding prior authorization, recognizing the compromise between the Kansas Dental Association and Delta Dental.

Senate Committee on Public Health and Welfare

In the Senate Committee hearing on March 16, 2022, the same conferees provided **proponent** testimony as in the previous hearing.

Neutral testimony was provided by a representative of Delta Dental of Kansas.

No other testimony was provided.

On March 17, 2022, the Senate Committee amended the bill to remove a provision that would have required a dental benefit plan, such plan's contracted vendor, or health maintenance organization to 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.

Fiscal Information

According to the fiscal note prepared by the Division of the Budget on the bill, as introduced, the Kansas Insurance Department, Department of Administration, Kansas Department of Health and Environment, and Kansas Dental Board all indicate that the bill would not have a fiscal effect.

Insurance; dental benefit plans; dental services; payment; reimbursement