AN ACT

relating to certain required disclosures and prohibited practices of certain employee benefit plans and health insurance policies that provide benefits for dental care services.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 1451.205, Insurance Code, is amended to read as follows:

Sec. 1451.205. DISCLOSURE OF BENEFIT TERMS. (a) An employee benefit plan or health insurance policy shall:

(1) if applicable, disclose that the benefit for dental care services offered is limited to the least costly treatment; and

(2) specify in dollars and cents the amount of the payment or reimbursement to be provided for dental care services or define and explain the standard on which payment of benefits or reimbursement for the cost of dental care services is based, such as:

(A) "usual and customary" fees;

(B) "reasonable and customary" fees;

(C) "usual, customary, and reasonable" fees; or

(D) words of similar meaning.

(b) A person or entity who provides or issues an employee benefit plan or health insurance policy or the employer or employee organization, if applicable, shall establish an Internet website to

provide resources and information to dentists, insureds, participants, employees, and members.

(c) An employee benefit plan or health insurance policy provider or issuer shall make accessible on the Internet website established under Subsection (b) information about the plan or policy sufficient for patients and dentists to determine the type of dental care services covered by the plan or policy, the percentage of the allowed charges for a covered service that will be paid or reimbursed under the plan or policy, and, for a contracting provider dentist, an estimate of the amount of the payment or reimbursement available for the provider's services under the plan or policy. Access to the Internet website must be at no charge to patients under the plan or policy and dentists providing dental care services to the patients.

(d) An employee benefit plan or health insurance policy provider or issuer is not required to comply with Subsection (b) or (c) for a plan or policy that:

(1) provides for payment of the benefit for dental care services under the plan or policy:

(A) as an indemnity benefit based on a fixed schedule, regardless of the cost of the dental care service;

(B) on a cash-payment-only basis;

(C) directly to the beneficiary of the plan or policy or to the beneficiary's assigns; and

(D) regardless of other coverage; and

(2) does not provide for a copayment, a deductible, a network, or contracting provider dentists.

SECTION 2. Section 1451.206(a), Insurance Code, is amended to read as follows:

(a) The employee benefit plan or health insurance policy shall:

(1) provide:

(A) [~~(1)~~] that payment or reimbursement for a noncontracting provider dentist shall be the same as payment or reimbursement for a contracting provider dentist; [~~and~~]

(B) [~~(2)~~] that the party to or beneficiary of the plan or policy may assign the right to payment or reimbursement to the dentist who provides the dental care services; and

(C) one or more methods of payment or reimbursement that provide the dentist 100 percent of the contracted amount of the payment or reimbursement and that do not require the dentist to incur a fee to access the payment or reimbursement; and

(2) disclose on the Internet website required under Section 1451.205 and on request of a dentist or a party to or beneficiary of the plan or policy the fees, if any, associated with the methods of payment or reimbursement available under the plan or policy.

SECTION 3. Sections 1451.207(a) and (c), Insurance Code, are amended to read as follows:

(a) An employee benefit plan or health insurance policy may not:

(1) interfere with or prevent an individual who is a party to or beneficiary of the plan or policy from selecting a

dentist of the individual's choice to provide a dental care service the plan or policy offers if the dentist selected is licensed in this state to provide the service;

(2) deny a dentist the right to participate as a contracting provider under the plan or policy if the dentist is licensed to provide the dental care services the plan or policy offers;

(3) authorize a person to regulate, interfere with, or intervene in the provision of dental care services a dentist provides a patient, including diagnosis, if the dentist practices within the scope of the dentist's license; [~~or~~]

(4) require a dentist to make or obtain a dental x-ray or other diagnostic aid in providing dental care services; or

(5) deduct the amount of an overpayment of a claim from a payment or reimbursement for a dental care service provided by a dentist who did not receive the overpayment.

(c) This section does not prohibit the predetermination of benefits for dental care expenses before the attending dentist provides treatment. In this subsection, "predetermination" means an estimate by the patient's employee benefit plan or health insurance policy provider or issuer of:

(1) the patient's eligibility under the plan or policy for benefits or covered services;

(2) the amount of the patient's deductible, copayment, or coinsurance related to benefits or covered services; and

(3) the maximum benefit limits for benefits or covered services.

SECTION 4. Subchapter E, Chapter 1451, Insurance Code, is amended by adding Section 1451.208 to read as follows:

Sec. 1451.208. PRIOR AUTHORIZATION OF DENTAL CARE SERVICES. (a) For purposes of this section, "prior authorization" means a written and verifiable determination that one or more specific dental care services are covered under the patient's employee benefit plan or health insurance policy and are payable and reimbursable in a specific stated amount, subject to applicable coinsurance and deductible amounts. The term:

(1) includes preauthorization or similar authorization; and

(2) does not include a predetermination as defined by Section 1451.207(c).

(b) For services for which a prior authorization is required, on request of a patient or treating dentist, an employee benefit plan or health insurance policy provider or issuer shall provide to the dentist a written prior authorization of benefits for a dental care service for the patient. The prior authorization must include a specific benefit payment or reimbursement amount. Except as provided by Subsection (c), the plan or policy provider or issuer may not pay or reimburse the dentist in an amount that is less than the amount stated in the prior authorization.

(c) An employee benefit plan or health insurance policy provider or issuer that preauthorizes a dental care service under Subsection (b) may deny a claim for the dental care service or reduce payment or reimbursement to the dentist for the service only if:

(1) the denial or reduction is in accordance with the patient's employee benefit plan or health insurance policy benefit limitations, including an annual maximum or frequency of treatment limitation, and the patient met the benefit limitation after the date the prior authorization was issued;

(2) the documentation for the claim fails to reasonably support the claim as preauthorized;

(3) the preauthorized dental care service was not medically necessary based on the prevailing standard of care on the date of the service, or is subject to denial under the conditions for coverage under the patient's plan or policy in effect at the time the service was preauthorized, because of a change in the patient's condition or because the patient received additional dental care services after the date the prior authorization was issued;

(4) a payor other than the employee benefit plan or health insurance policy provider or issuer is responsible for payment of the claim;

(5) the dentist received full payment for the preauthorized dental care service on which the claim is based;

(6) the claim is fraudulent;

(7) the prior authorization was based wholly or partly on a material error in information provided to the employee benefit plan or health insurance policy provider or issuer by any person not related to the provider or issuer; or

(8) the patient was otherwise ineligible for the dental care service under the patient's plan or policy, and the plan

or policy provider or issuer did not know and could not reasonably have known that the patient was ineligible for the dental care service on the date the plan or policy provider or issuer preauthorized the dental care service.

SECTION 5. The changes in law made by this Act apply only to an employee benefit plan or health insurance policy that provides benefits for dental care services that is delivered, issued for delivery, renewed, or contracted for on or after the effective date of this Act. An employee benefit plan or health insurance policy that provides benefits for dental care services that is delivered, issued for delivery, renewed, or contracted for before the effective date of this Act is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 6. This Act takes effect September 1, 2019.

President of the Senate

Speaker of the House

I certify that H.B. No. 2486 was passed by the House on April 25, 2019, by the following vote: Yeas 129, Nays 7, 1 present, not voting; and that the House concurred in Senate amendments to H.B. No. 2486 on May 24, 2019, by the following vote: Yeas 139, Nays 1, 2 present, not voting.

Chief Clerk of the House

I certify that H.B. No. 2486 was passed by the Senate, with amendments, on May 22, 2019, by the following vote: Yeas 30, Nays 1.

Secretary of the Senate

APPROVED: _____

Date

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Governor