BILL ANALYSIS

Senate Research Center
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H.B. 1527
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Health & Human Services
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Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Dentists across Texas have raised concerns that state law governing dental insurance is inadequate and lacks clarity with respect to the recovery of overpayments, clauses that disallow dentists to bill for services, and third party access to provider network contracts with dentists.

H.B. 1527 would limit the circumstances for overpayment recovery, prohibit disallowable clauses in contracts with dentists, and establish clear requirements for third party access to promote fairness and transparency.

H.B. 1527 amends current law relating to the relationship between dentists and certain employee benefit plans and health insurers.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 1451.206, Insurance Code, by adding Subsections (d) and (e), as follows:

(d) Prohibits an employee benefit plan or health insurance policy provider or issuer from recovering an overpayment made to a dentist unless:

(1) not later than the 180th day after the date the dentist receives the payment, the provider or issuer provides written notice of the overpayment to the dentist that includes the basis and specific reasons for the request for recovery of funds; and

(2) the dentist:

(A) fails to provide a written objection to the request for recovery of funds and does not make arrangements for repayment of the requested funds on or before the 45th day after the date the dentist receives the notice; or

(B) objects to the request in accordance with the procedure described by Subsection (e) and exhausts all rights of appeal.

(e) Requires an employee benefit plan or health insurance policy provider or issuer to provide a dentist with the opportunity to challenge an overpayment recovery request and establish written policies and procedures for a dentist to object to an overpayment recovery request. Requires that the procedures allow the dentist to access the claims information in dispute.

SECTION 2. Amends Section 1451.2065, Insurance Code, as follows:

Sec. 1451.2065. CONTRACTS WITH DENTISTS. (a) Defines "insurer." Makes nonsubstantive changes.

(b) Prohibits a contract between an insurer and a dentist from:

(1) limiting the fee the dentist is authorized to charge for a service that is not a covered service; or

(2) including a provision that both:

(A) allows the insurer to disallow a service, resulting in denial of payment to the dentist for a service that ordinarily would have been covered; and

(B) prohibits the dentist from billing for and collecting the amount owed from the patient for that service if there is a dental necessity, as defined by Section 32.054 (Dental Services), Human Resources Code, for that service.

SECTION 3. Amends Subchapter E, Chapter 1451, Insurance Code, by adding Section 1451.209, as follows:

Sec. 1451.209. REQUIREMENTS FOR THIRD PARTY ACCESS TO PROVIDER NETWORKS. (a) Requires an employee benefit plan or health insurance policy provider or issuer, at the time a provider network contract is entered into or when material modifications are made to the contract relevant to granting a third party access to the contract, to allow any dentist that is part of the provider network to elect not to participate in the third party access to the contract and to elect not to enter into a contract directly with the third party that will obtain access to the provider network. Provides that this subsection does not permit the plan or policy provider or issuer to cancel or otherwise end a contractual relationship with a dentist if the dentist elects to not participate in or agree to third party access to the provider network contract.

(b) Authorizes an employee benefit plan or health insurance policy provider or issuer that enters into a provider network contract with a dentist, or a contracting entity that has leased or acquired the provider network contract, to grant a third party access to the provider network contract or to a dentist's dental care services or contractual discounts provided under the contract only if:

(1) the provider network contract or each employee benefit plan or health insurance policy for which the provider network contract was entered into, leased, or acquired conspicuously states that the provider or issuer or contracting entity is authorized to enter into an agreement with a third party that allows the third party to obtain the provider's, issuer's, or contracting entity's rights and responsibilities as if the third party were the provider, issuer, or contracting entity;

(2) if the contracting entity is an employee benefit plan or health insurance policy provider or issuer, the entity's plan or policy for which the provider network contract is leased or acquired conspicuously states, in addition to the language required by Subdivision (1), that the dentist is authorized to elect not to participate in third party access to the provider network contract:

(A) at the time the provider network contract is entered into; or

(B) when there are material modifications to the provider network contract relevant to granting a third party access to the provider network contract;

(3) the third party accessing the provider network contract agrees to comply with all of the original contract's terms, including the contracted fee schedule and obligations concerning patient steerage;

(4) the provider, issuer, or other contracting entity provides in writing to the dentist the names of all third parties with access to the provider network in existence as of the date the contract is entered into;

(5) the provider, issuer, or other contracting entity identifies all current third parties with access to the provider network on its Internet website with a list updated at least once every 90 days;

(6) the provider, issuer, or other contracting entity requires a third party with access to the provider network to identify the source of any discount on all remittance advices or explanations of payment under which a discount is taken, provided that this subsection does not apply to electronic transactions mandated by the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191);

(7) the provider, issuer, or other contracting entity provides written or electronic notice to network dentists that a third party will lease, acquire, or obtain access to the provider network at least 30 days before the lease or access takes effect;

(8) the provider, issuer, or other contracting entity provides written or electronic notice to network dentists of the termination of the provider network contract at least 30 days before the termination date;

(9) a third party's right to a dentist's discounted rate ceases as of the termination date of the provider network contract; and

(10) the provider, issuer, or other contracting entity makes available a copy of the provider network contract relied on in the adjudication of a claim to a network dentist not later than the 30th day after the date the dentist requests a copy of that contract.

(c) Provides that Subsections (b)(7) and (8) do not apply to a contracting entity that only organizes and leases networks but does not engage in the business of insurance.

(d) Prohibits a person from binding or requiring a dentist to perform dental care services under a provider network contract that has been sold, leased, or assigned to a third party or for which a third party has otherwise obtained provider network access in violation of this section.

(e) Provides that this section does not apply:

(1) if access to a provider network contract is granted to:

(A) a third party operating in accordance with the same brand licensee program as the employee benefit plan provider, health insurance policy issuer, or other contracting entity selling or leasing the provider network contract, provided that the third party accessing the provider network contract agrees to comply with all of the original contract's terms, including the contracted fee schedule and obligations concerning patient steerage; or

(B) an entity that is an affiliate of the employee benefit plan provider, health insurance policy issuer, or other contracting entity selling or leasing the provider network contract, provided that:

(i) the provider, issuer, or entity publicly discloses the names of the affiliates on its Internet website; and

(ii) the affiliate accessing the provider network contract agrees to comply with all of the original contract's terms, including the contracted fee schedule and obligations concerning patient steerage;

(2) to the child health plan program under Chapter 62 (Child Health Plan for Certain Low-Income Children), Health and Safety Code, or the health benefits plan for children under Chapter 63 (Health Benefits Plan for Certain Children), Health and Safety Code; or

(3) to a Medicaid managed care program operated under Chapter 533 (Medicaid Managed Care Program), Government Code, or a Medicaid program operated under Chapter 32 (Medical Assistance Program), Human Resources Code.

SECTION 4. Provides that the changes in law made by this Act apply only to an employee benefit plan for a plan year that commences on or after January 1, 2024, or a health insurance policy delivered, issued for delivery, or renewed on or after January 1, 2024, and any provider network contract entered into on or after the effective date of this Act in connection with one of those plans or policies. Provides that an employee benefit plan for a plan year that commenced before January 1, 2024, or a health insurance policy delivered, issued for delivery, or renewed before January 1, 2024, and any provider network contract entered into before, on, or after the effective date of this Act in connection with one of those plans or policies 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 5. Effective date: September 1, 2023.