By: Zaffirini S.B. No. 1981

A BILL TO BE ENTITLED

AN ACT

relating to the relationship between dentists and certain employee benefit plans and health insurers.

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

SECTION 1. Section 1451.206, Insurance Code, is amended by adding Subsections (d) and (e) to read as follows:

(d) An employee benefit plan or health insurance policy provider or issuer may not recover 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) An employee benefit plan or health insurance policy provider or issuer shall 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. The procedures must allow the dentist to access the claims information in dispute.

SECTION 2. Section 1451.2065, Insurance Code, is amended to read as follows:

Sec. 1451.2065. CONTRACTS WITH DENTISTS. (a) In this section:

(1) "Covered [~~, "covered~~] service" means a dental care service for which reimbursement is available under a patient's employee benefit plan or health insurance policy, or for which reimbursement is available subject to a contractual limitation, including:

(A) [~~(1)~~] a deductible;

(B) [~~(2)~~] a copayment;

(C) [~~(3)~~] coinsurance;

(D) [~~(4)~~] a waiting period;

(E) [~~(5)~~] an annual or lifetime maximum limit;

(F) [~~(6)~~] a frequency limitation; or

(G) [~~(7)~~] an alternative benefit payment.

(2) "Insurer" means a provider or issuer of an employee benefit plan or health insurance policy.

(b) A contract between an insurer and a dentist may not:

(1) limit the fee the dentist may charge for a service that is not a covered service; or

(2) include a provision that:

(A) allows the insurer to deny payment to the

dentist for a covered service provided to a patient; and

(B) prohibits the dentist from billing for and collecting the amount owed for the service from the patient.

SECTION 3. Subchapter E, Chapter 1451, Insurance Code, is amended by adding Section 1451.209 to read as follows:

Sec. 1451.209. REQUIREMENTS FOR THIRD PARTY ACCESS TO PROVIDER NETWORKS. (a) 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, an employee benefit plan or health insurance policy provider or issuer shall 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. 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) 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, may 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 may 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 may 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) 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) A person may not bind or require 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) 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, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or

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

SECTION 4. 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. 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. This Act takes effect September 1, 2023.