Session of 2020

HOUSE BILL No. 2633

By Committee on Health and Human Services

2-11

AN ACT concerning insurance; relating to health benefit plans that provide dental services; health insurers that directly offer dental services; establishing requirements relating to information disclosure, claims processing and reimbursement.

Be it enacted by the Legislature of the State of Kansas:

Section 1. (a) As used in this section:

(1) "Health benefit plan" means the same as defined in K.S.A. 40-4602, and amendments thereto. "Health benefit plan" also includes any individual health insurance policy, any individual or group dental insurance policy and a nonprofit dental services corporation as such term is used in K.S.A. 40-19a01 et seq., and amendments thereto.

(2) "Health insurer" means the same as defined in K.S.A. 40-4602, and amendments thereto. "Health insurer" also includes a nonprofit dental service corporation as such term is used in K.S.A. 40-19a01 et seq., and amendments thereto.

(3) "Insured" means the same as defined in K.S.A. 40-4602, and amendments thereto. "Insured" includes a subscriber to a subscription agreement issued by a nonprofit dental service corporation as such term is used in K.S.A. 40-19a01 et seq., and amendments thereto.

(4) "Participating provider" means the same as defined in K.S.A. 40-4602, and amendments thereto. "Participating provider" includes any dentist who has entered into a participation agreement with a nonprofit dental service corporation as such term is used in K.S.A. 40-19a01 et seq., and amendments thereto.

(5) "Prior authorization" means a written and verifiable determination that one or more specific dental care services are covered under the insured's health benefit plan and are payable and reimbursable in a specific stated amount, subject to applicable coinsurance and deductible amounts.

(b) Every health benefit plan that provides dental care services and that is delivered, issued for delivery, amended or renewed on or after January 1, 2021, shall:

(1) Upon request, provide information regarding an insured's dental benefit coverage and benefit maximum payment schedules available to such insured or to a dentist designated by such insured;

(2) accept claims submitted from a dentist that are formatted or

transmitted in any manner authorized by law; and

(3) provide one or more methods of payment or reimbursement that provide the dentist with 100% 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.

(c) A health insurer providing a health benefit plan that offers dental care services or a health insurer that directly offers dental care services shall establish a website to provide resources and information to dentists and insureds. The health insurer shall make accessible on such website sufficient information about the plan or policy for dentists and insureds such that a dentist, with permission of the insured, may determine the type of dental care services covered by the insured's plan or policy, and prepare an estimate of the amount of the payment or reimbursement available for the dental care services under the plan or policy. The health insurer shall not charge a fee to insureds or dentists for access to the website.

(d) A health insurer providing a health benefit plan that offers dental care services or a health insurer that directly offers dental care services shall not:

(1) Reduce an insured's benefit payment amount as a result of an error relating to any other insured's benefits or transaction by the health insurer or their contracted vendor; or

(2) 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.

(e) (1) For dental services for which prior authorization is required, a health insurer providing a health benefit plan that offers dental services or a health insurer that directly offers dental services shall provide the treating dentist with a prior authorization within 30 days of the date that the treating dentist submits a request for such prior authorization.

(2) A prior authorization shall include a specific benefit payment or reimbursement amount. Except as provided in subsection (f), the health insurer that provided the prior authorization shall not pay or reimburse the dentist a sum that is less than the amount stated in the prior authorization.

(f) A health insurer that provides a prior authorization for a dental care service under subsection (e) may deny a claim for such 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 insured's health benefit plan limitations, including an annual maximum or frequency of treatment limitation and the insured 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 it was prior authorized;

(3) the prior authorized 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 insured's health benefit plan in effect at the time the dental care service was prior authorized because of a change in the insured's condition or because the insured received additional dental care services after the date the prior authorization was provided;

(4) an insurer other than the health insurer that provided the prior authorization is responsible for the payment of the claim;

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

(6) the claim is fraudulent;

(7) the prior authorization was based wholly or in part on material error in information provided to the health insurer that provided the prior authorization or to such health insurer's agents or employees; or

(8) the insured was otherwise ineligible for the dental care service under the insured's health benefit plan and the health insurer did not know and could not reasonably have known that the patient was ineligible for the dental care service on the date the health insurer preauthorized the dental care service.

(g) The provisions of this section shall not be waived by contract and any contractual clause in conflict with the provisions of this section or that purports to waive any requirements of this section is void.

Sec. 2. This act shall take effect and be in force from and after its publication in the statute book.