CHAPTER 48

(HB 370)

AN ACT relating to health care trade practices.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

➔SECTION 1. A NEW SECTION OF SUBTITLE 17C OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

As used in Sections 1 to 5 of this Act:

(1) "Covered person" means an individual who is covered by a dental benefit plan;

(2) "Dental benefit plan" means a limited health service benefit plan that provides coverage for dental services;

(3) "Dental carrier" means a health insurer that provides coverage for dental services;

(4) "Dental services":

(a) Means services for the diagnosis, prevention, treatment, or cure of a dental condition, illness, injury, or disease; and

(b) Does not include services delivered by a provider that are billed as medical expenses under a health insurance plan;

(5) "Dentist" means any dentist licensed or otherwise authorized in this state to furnish dental services;

(6) "Health insurer" means any insurance company, health maintenance organization, self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA, provider-sponsored integrated health delivery network, self-insured employer-organized association, nonprofit hospital, medical-surgical, dental, and health service corporation, or limited health service organization authorized to transact health insurance business in Kentucky; and

(7) "Provider":

(a) Means an individual or entity, acting within the scope of the individual or entity's licensure or certification, that provides dental services or supplies defined by the dental benefit plan; and

(b) Does not include a physician organization or physician hospital organization that leases or rents its network to a third party.

➔SECTION 2. A NEW SECTION OF SUBTITLE 17C OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section:

(a) "Contracting entity" means a dental carrier, a third-party administrator, or any other person that enters into direct contracts with providers for the delivery of dental services in the ordinary course of business;

(b) "Provider network contract" means a contract between a contracting entity and a provider that:

1. Specifies the rights and responsibilities of the contracting entity; and

2. Provides for the delivery and payment of dental services to a covered person; and

(c) "Third party":

1. Means an individual or entity that enters into a contract with a contracting entity or with another person to gain access to the dental services or contractual discounts of a provider network contract; and

2. Does not include an employer or other group for whom the dental carrier or contracting entity provides administrative services.

(2) A contracting entity may 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:

(a) At the time the provider network contract is entered into or renewed, or when there are material modifications to the provider network contract relevant to granting a third party access to a provider network contract, the dental carrier allows any provider which is part of the dental carrier's provider network to choose to:

1. Not participate in third-party access to the provider network contract; or

2. Enter into a provider network contract directly with the health insurer that acquired the provider network;

(b) The provider network contract includes the following third-party access provisions:

1. That the contracting entity may enter into an agreement with third parties allowing the third parties to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity; and

2. When the contracting entity is a dental carrier:

a. That the provider network contract grants third-party access to the provider network;

b. The provider chose to participate in third-party access at the time the provider network contract was entered into or renewed; and

c. The provider has the right to choose not to participate in third-party access;

(c) The third party accessing the provider network contract agrees to comply with all of the contract's terms;

(d) The contracting entity:

1. Identifies all third parties in existence in a list on its Internet Web site, which shall be updated at least once every sixty (60) days;

2. Except for electronic transactions required by the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, requires the third party to identify the source of the discount on all remittance advices or explanations of payment under which a discount is taken; and

3. Makes available a copy of the provider network contract relied on in the adjudication of a claim to a participating provider within thirty (30) days of a request from the provider; and

(e) The third party's right to a provider's discounted rate ceases as of the termination date of the provider network contract with the exception of covered dental services that are in progress.

(3) A dental carrier:

(a) Shall not cancel or otherwise end a contractual relationship with a provider as a result of the provider opting out of third-party access in accordance with subsection (2)(a) of this section; and

(b) When initially contracting with a provider, shall accept a qualified provider even if the provider opts out of a third-party access provision.

(4) A provider shall not be bound by, or required to provide dental services under, a provider network contract that has been granted to a third party in violation of this section.

(5) This section shall not apply:

(a) If access to a provider network contract is granted to:

1. A dental carrier or any other entity operating in accordance with the same brand licensee program as the contracting entity; or

2. An entity that is an affiliate of the contracting entity. A contracting entity shall make a list of its affiliates available to providers on its Internet Web site; or

(b) To a provider network contract for dental services provided to beneficiaries of state-sponsored public medical assistance programs, including Medicaid and the Kentucky Children's Health Insurance Program.

➔SECTION 3. A NEW SECTION OF SUBTITLE 17C OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section, "prior authorization" means any written communication that:

(a) Indicates that a specific procedure is, or multiple procedures are, covered under the covered person's dental benefit plan and reimbursable at a specific amount, subject to applicable cost sharing; and

(b) Is issued in response to a request submitted by a dentist using a format prescribed by the dental carrier.

(2) A dental benefit plan shall not deny any claim subsequently submitted by a dentist for procedures specifically included in a prior authorization unless at least one (1) of the following circumstances applies for each procedure denied:

(a) Benefit limitations, which may include annual maximums and frequency limitations, not applicable at the time of prior authorization are reached due to utilization subsequent to issuance of the prior authorization;

(b) Documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;

(c) In accordance with the dental benefit plan, the service:

1. Is not considered medically necessary; or

2. Does not meet any other terms or conditions for coverage that were in effect at the time the prior authorization was issued;

(d) Another payer is responsible for payment;

(e) The dentist has already been paid for procedures identified on the claim;

(f) The covered person was not eligible to receive the procedure on the date of service and the dental carrier did not know, and with the exercise of reasonable care could not have known, of the covered person's eligibility status; or

(g) The prior authorization was based upon fraudulent, materially inaccurate, or misrepresented information submitted by the covered person or dentist.

➔SECTION 4. A NEW SECTION OF SUBTITLE 17C OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section:

(a) "Credit card payment":

1. Means a type of electronic funds transfer in which a dental benefit plan or its contracted vendor issues a single-use series of numbers associated with the payment of dental services:

a. Performed by a dentist and chargeable to a predetermined dollar amount; and

b. For which the dentist is responsible for processing the payment by a credit card terminal or Internet portal; and

2. Shall include virtual or online credit card payments for which no physical credit card is presented to the dentist and the single-use credit card expires upon payment processing;

(b) "Dentist agent" means a person that establishes an agency relationship contract with a dentist to process bills for services provided by the dentist under terms and conditions established between the agent and dentist. Such contracts may permit the dentist agent to submit bills, request reconsideration, and receive reimbursement; and

(c) "Electronic funds transfer payment":

1. Means a payment by any method of electronic funds transfer other than health care electronic fund transfer and remittance advice transactions under 45 C.F.R. secs. 162.1601 and 162.1602; and

2. Shall include virtual credit card payments.

(2) A dental benefit plan shall not contain restrictions on methods of payment from the dental benefit plan or its vendors to the dentist in which the only acceptable payment method is a credit card payment.

(3) When initiating or changing payments to a dentist using electronic funds transfer payments, a dental benefit plan or its vendors shall:

(a) Notify the dentist if any fees are associated with a particular payment method;

(b) Advise the dentist of the available methods of payment; and

(c) Provide clear instructions to the dentist as to how to select an alternative payment method.

(4) (a) A dental benefit plan or its vendor that initiates or changes payments to a dentist for health care electronic fund transfer and remittance advice transactions under 45 C.F.R. secs. 162.1601 and 162.1602 shall not charge a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee.

(b) When transmitting health care electronic fund transfer and remittance advice transactions under 45 C.F.R. secs. 162.1601 and 162.1602, a dentist agent may charge reasonable fees for payments related to transaction management, data management, portal services, and other value-added services in addition to the bank transmittal.

➔SECTION 5. A NEW SECTION OF SUBTITLE 17C OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

The provisions of Sections 1 to 5 of this Act shall not be waived by contract. Any contractual arrangement in conflict with this section or that purports to waive any requirement of this section of shall be null and void.

➔Section 6. KRS 304.17C-085 is amended to read as follows:

(1) As used in this section:

(a) "Contractual discount" means a percentage reduction from a provider's usual and customary rate for covered services and material required under a participating provider agreement; and

(b) "Covered services" means services and materials for which:

1. Reimbursement from a plan is provided by the enrollee's plan contract; or

2. Reimbursement would be available but for the application of the enrollee's contractual limitations of deductibles, copayments, coinsurance, or frequency limitations.

(2) A participating provider agreement shall not require a participating provider to provide services to an ***enrollee***~~[enrolled participant]~~ at a fee set by or subject to the approval of the limited health service benefit plan unless the services are covered services under the provider agreement.

(3) A provider shall not charge more for services and materials that are noncovered services under a limited health service benefit plan than the provider's rate for the services and materials.

(4) The amount of a contractual discount shall not result in a fee that is less than the limited health service benefit plan would pay for covered services but for the application an enrollee's contractual limitations of deductibles, copayments, coinsurance, or frequency limitations.

(5) Reimbursement paid by the limited health service benefit plan for covered services:

(a) Shall be reasonable; and

(b) Shall not provide nominal reimbursement in order to claim that services and materials are covered services.

➔Section 7. Pursuant to KRS 304.2-110, the commissioner of insurance may promulgate administrative regulations to aid in the effectuation of the provisions of this Act.

➔Section 8. Sections 1 to 6 of this Act shall apply to contracts issued, delivered, entered, extended, or renewed on or after the effective date of this Act.

Signed by Governor March 29, 2022.