

## HOUSE BILL No. 2633

By Committee on Health and Human Services

2-11

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

5  
6 *Be it enacted by the Legislature of the State of Kansas:*

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

8 (1) "Health benefit plan" means the same as defined in K.S.A. 40-  
9 4602, and amendments thereto. "Health benefit plan" also includes any  
10 individual health insurance policy, any individual or group dental  
11 insurance policy and a nonprofit dental services corporation as such term  
12 is used in K.S.A. 40-19a01 et seq., and amendments thereto.

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

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

21 (4) "Participating provider" means the same as defined in K.S.A. 40-  
22 4602, and amendments thereto. "Participating provider" includes any  
23 dentist who has entered into a participation agreement with a nonprofit  
24 dental service corporation as such term is used in K.S.A. 40-19a01 et seq.,  
25 and amendments thereto.

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

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

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

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

1 transmitted in any manner authorized by law; and

2 (3) provide one or more methods of payment or reimbursement that  
3 provide the dentist with 100% of the contracted amount of the payment or  
4 reimbursement and that do not require the dentist to incur a fee to access  
5 the payment or reimbursement.

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

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

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

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

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

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

34 (f) A health insurer that provides a prior authorization for a dental  
35 care service under subsection (e) may deny a claim for such dental care  
36 service or reduce payment or reimbursement to the dentist for the service  
37 only if:

38 (1) The denial or reduction is in accordance with the insured's health  
39 benefit plan limitations, including an annual maximum or frequency of  
40 treatment limitation and the insured met the benefit limitation after the  
41 date the prior authorization was issued;

42 (2) the documentation for the claim fails to reasonably support the  
43 claim as it was prior authorized;

1 (3) the prior authorized dental care service was not medically  
2 necessary based on the prevailing standard of care on the date of the  
3 service or is subject to denial under the conditions for coverage under the  
4 insured's health benefit plan in effect at the time the dental care service  
5 was prior authorized because of a change in the insured's condition or  
6 because the insured received additional dental care services after the date  
7 the prior authorization was provided;

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

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

12 (6) the claim is fraudulent;

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

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

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

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