Dental Insurance Reform
State Legislation 2021

Third-Party Payer Coverage and Administration

Several dental insurance reform bills are filed each year. Some measures have a direct impact on dental benefits while others propose indirect changes. The following pages provide a snapshot of the pertinent reform legislation in the states. Listed by topic, each table includes a brief summary of a state's bill along with the bill numbers and links to the respective state's websites. Legislative proposals can change often as lawmakers consider the various facts and opinions impacting the bills; therefore, this document is updated quarterly. For more information and resources on dental benefits, visit ADA.org/dentalinsurance.

DENTAL BENEFIT ISSUES TRENDING IN STATE LEGISLATIVE SESSIONS

The information in this document is current as of September 2021. Click on a topic below to go to topic overview within the document.

OTHER DENTAL BENEFITS-RELATED ISSUES

 Updated: 10/4/2021

Dental Insurance Reform
State Legislation 2021

All Payer Claims Database	
ARKANSAS HB 1064	Would allow state to collect, validate, analyze, and present health data, including claims data. Would require the state to release and publish on the State Insurance Department's website reimbursement rate information collected under this subchapter.
INDIANA HB 1402	Amends the definition of "health payer" to except some policies of accident and sickness insurance. Establishes requirements for the development and administration of the all payer claims database. Establishes the all payer claims data base advisory board. Provides that individuals appointed to the board must have certain professional qualifications or experience or must represent certain types of employers, organizations, or interests. Provides that six of the 12 initial appointees to the board will be appointed to terms of only two years. Specifies the duties of the board.
NEVADA SB 40	Requires the Department of Health and Human Services to establish an all-payer claims database of information relating to health insurance claims resulting from medical, dental or pharmacy benefits provided.
TEXAS HB 2090	The department shall collaborate with the center under this subchapter to aid in the center's establishment of the database. The center shall leverage the existing resources and infrastructure of the center to establish the database to collect, process, analyze, and store data relating to medical, dental, pharmaceutical, and other relevant health care claims and encounters, enrollment, and benefit information for the purposes of increasing transparency of health care costs, utilization, and access and improving the affordability, availability, and quality of health care in this state, including by improving population health in this state.

Back to Top

Any Willing Provider	
MASSACHUSETTS H 1173 SB 236	Would prohibit insurer from denying a dentist the right to participate as a contracting provider under the plan or policy if the dentist is licensed to provide the dental care services the plan or policy offers.

Back to Top

Assignment of Benefits	
ARIZONA HB 2119	If an insured assigns to a dentist payment for benefits under a carrier's contract, payment may be made only to the health care provider to whom payment has been assigned.

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MASSACHUSETTS H 1173 SB 236	Would require assignment of benefits.
MASSACHUSETTS H 1171 S 714	Would require insurers to allow patients to direct that payment for covered benefits be paid directly to a dental care provider who has not contracted with the insurer. When patients direct the insurer to do so, the insuring entity must pay the benefits directly to the patient's dentist. Any efforts to modify the amount of benefits paid directly to the dentist under this section may include a reduction in benefits paid of no more than 5% less than the usual and customary rates paid to participating dentists.
MASSACHUSETTS H 1181	Requires dental insurers to allow enrollees to direct that reimbursable benefits for covered dental services be paid directly to the treating dentist irrespective of whether the dentist has contracted with the carrier. Insurers would have the right to review the records of the dentist receiving such payment that relate exclusively to the claim for payment to determine that the service in question is rendered. The paying carrier shall not pay the non-par dentist a different rate or fee than a dentist who has contracted with the carrier for the same services rendered.

Back to Top

Associated Medical Costs – Required Coverage

MASSACHUSETTS H 1093	Requires insurers to provide coverage for the hospital or ambulatory center charges and administration of general anesthesia for dental procedures performed on a covered person who is: (i) a child seven years of age or younger who is determined by a licensed dentist to be unable to receive dental treatment in an outpatient setting; (ii) a child 12 years of age or younger with documented phobias or a documented mental illness whose dental needs are complex and urgent that delaying treatment may result in infection or loss of teeth; for whom a successful result cannot be expected from dental care provider under local anesthesia; and for whom a superior result can be expected from dental care provided under general anesthesia; or (iii) a person who has exceptional medical circumstances or a development disability, as determined by a licensed physician which places the person at serious risk.

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NEW JERSEY A 4996	Requires insurance carriers offering dental benefit plans to provide certain level of coverage and reimbursement. Insurers would have to provide coverage that is actuarially equivalent to full actuarial value of the benefits provided under a benchmark plan selected by the state's Commissioner of Banking and Insurance.
NEW YORK S 1173	Would require dental insurance plans to automatically annually carry over any unused benefit amount of such plan in an amount up to at least 25% of the enrollee's benefit amount and which shall be added to the enrollee's benefit amount for the succeeding year.
NEW YORK S 1174	Would require employers to offer dental insurance coverage, which is effective immediately upon the starting date of employment.
NEW YORK A 1455	Relates to requiring insurance policies and contracts, which provide reimbursement for dental restorations, including but not limited to, reimbursement for dental bridgework, to also provide no less than the same level of reimbursement towards the payment of a dental implant.

Back to Top

Claims Generally

ILLINOIS SB 493	Creates the Uniform Electronic Transactions in Dental Care Billing Act. Requires all dental plan carriers and dental care providers to exchange claims and eligibility information electronically using the standard electronic data interchange transactions for claims submissions, payments, and verification of benefits required under the Health Insurance Portability and Accountability Act in order to be compensable by the dental plan carrier. Provides that no dental plan carrier or dental care provider may add to or modify the uniform electronic claims and eligibility requirements adopted by the Department. Provides that the Act applies to all dental plan carriers. Grants the Director of Insurance the right to investigate complaints filed under the Act. Sets forth criteria for complaints filed under the Act.

Back to Top

 Updated: 10/4/2021

Dental Insurance Reform
State Legislation 2021

Claims Review	
GEORGIA SB 80	Requires a private review agent or utilization review entity to ensure that all appeals are reviewed by an appropriate healthcare provider with a current and valid non-restricted license, who is in active practice in the same or similar specialty and who typically manages the medical condition or disease. The entity must be knowledgeable of, and have experience providing, the healthcare service under appeal and not directly involved in making the adverse determination. It must consider all known clinical aspects of the healthcare service under review, including, but not limited to, a review of all pertinent medical or other records provided to the private review agent or utilization review entity by the covered person's healthcare provider, any relevant records provided to such agent or entity by a facility, and any medical or other literature provided to such agent or entity by the healthcare provider.
LOUISIANA SB 82	Would add dental insurance plans to the existing state law making them subject to provisions of the Health Insurance Issuer External Review Act.

Back to Top

Direct Primary Care Agreements (In-Office Plans)	
MASSACHUSETTS HD 3304 H 322	Would establish laws supporting direct dental care agreements.
MONTANA SB 101	Prohibits provider from submitting claim for services in direct patient care agreement. Allows for the direct fee and any additional fees to be paid by a third party. Exempts direct patient care agreements from state insurance authority oversight. Insurers may not prohibit, interfere with, initiate a legal or administrative proceeding against, or impose a fine or penalty against a health care provider solely because the provider provides direct patient care solely because the person pays a direct fee for direct patient care.

Back to Top

Disallow Clause Prohibition	
NEW JERSEY S 2853 A 4820	Prohibits a carrier from including in an agreement between the carrier and a participating dentist a provision that allows the carrier to deny payment to a participating dentist for a procedure performed or for a service provided on behalf of a covered person and prohibits the dentist from collecting the amount owed from the covered person for that procedure or service.

Back to Top

 Updated: 10/4/2021

Downcoding – Prohibit or Limit	
UTAH HB 359	The bill would prohibit insurers from using downcoding in a manner that prevents a dentist from collecting a fee for the service performed from either the plan or the patient. The bill also would prohibit bundling in a manner where a procedure code is labeled as non-billable to the patient unless it is for a procedure that may be provided in conjunction with another procedure. Explanation of benefits would have to include the reason for any downcoding or bundling.

Back to Top

Equal Insurance Payment for Non-Par Dentist	
MASSACHUSETTS H 1173 SB 236	Payment or reimbursement for a noncontracting provider dentist shall be the same or greater as payment or reimbursement for a contracting provider dentist.

Back to Top

Joint Contract Negotiations – Provider and Insurer	
NEW YORK A3378	It is the intention of the legislature to authorize independent physicians and dentists to jointly negotiate with carriers and to qualify such joint negotiations and related joint activities for the state action exemption to the federal antitrust laws through the articulated state policy and active supervision provided under this article.

Back to Top

Medical Loss Ratio – Required Expenditure of Premium Revenues for Care	
ARIZONA SB 1824 HB 2896	The department shall prepare an annual report on the medical loss ratio for each dental insurer doing business in this state. In calculating the medical loss ratio, the department shall use data submitted by dental insurers in existing required regulatory filings.
MASSACHUSETTS HD 640 SD 1479 H 1182	Would establish requirements relative to medical loss ratio reporting for dental benefits corporations.

Back to Top

Non-Covered Services	
NEW YORK A 2392	Would prevent an insurance or managed care company from including in any insurance or managed care contract any provisions that require a dentist to provide services to a covered person at a fee set by or at a fee subject to the approval of the insurer or managed care entity unless such services are covered under the person's dental plan.
OHIO HB 344	Prohibits insurers from requiring dentists charge discounted fee for non-covered services, but does allow for option to only charge discounted fee for non-covered services. No contract may be contingent on whether or not the dentist agrees to accept discounted fees for non-covered services. The bill would allow insurers to communicate to its enrollees which dentists will charge the insurer's discounted fee and which will charge their normal fee for non-covered services. A dentist who does not agree to limit their charge for non-covered services must provide to the patient the insurer's fee for the non-covered service, an estimated fee the dentist charges for the non-covered service, the amount the dentist expects to be reimbursed by the contracting entity for the non-covered service, and the estimated pricing and reimbursement information for any expected covered services. A dentist who does not agree to limit their charge for non-covered services must post a notice stating the following: "IMPORTANT: This dental care provider does not accept the fee schedule set by your insurer for dental care services that are not covered benefits under your plan and instead charges his or her normal fee for those services. This dental care provider will provide you with an estimated cost for each non-covered service."
VERMONT HB 294 (Amended into SB 88)	Would prohibit dental insurance plans from imposing fee schedules on dentists for dental services that are not otherwise covered under the plan.

Back to Top

Notification of Contract Changes	
UTAH HB 359	Under the bill, a dental insurer would have to post its current dental plan policies and procedures online and mail them to dentists upon request. This notification would have to include a summary of all material changes made to the dental plan since the policies and procedures were last updated.

Back to Top

Patient Identification and ERISA Notifications	
NORTH CAROLINA SB 248 HB 391	Would require insurance identification cards to include an indication of whether the health benefit plan is a fully insured or self-funded plan. Plans that are fully insured shall be noted by using the phrase “NCDOI” [North Carolina Department of Insurance] to indicate to the consumer that the Department is able to provide assistance regarding the regulation of the plan.

Back to Top

Patient Protections – Equal Pay, Freedom of Choice, Preexisting Conditions	
LOUISIANA SB 65	Repeals law that requires dental referral plans register with the states. Dental referral plans are defined as contractual plans that provide a list of dental care providers who have agreed to render treatment to enrollees at specific discounted fees. The plans may collect fees from enrollees, employers, insurers, or health maintenance organizations. The plans are not deemed insurance, except as otherwise indicated by law.
MASSACHUSETTS H 1173 SB 236	Prohibits plan from interfering with patient selection of dentist, as long as the dentist hold a state license. (Freedom of Choice)

Back to Top

PPE and COVID-19 Expenses Coverage	
CALIFORNIA S 242	Would require dental insurers to reimburse dentists or provide supplemental payments to dentists a reasonable rate to protect against the spread of diseases causing public health emergencies, including COVID-19. These medically necessary business expenses include PPE, infection control supplies or materials, medical or diagnostic equipment including testing supplies, test processing, the cost of transporting specimens, information technology systems for tracking infections and processing testing, or other related information technology expenses.
CALIFORNIA A454	Requires health care service plans, including a specialized health care service plans and health care service plans that contract for dental services, to provide supplemental provider reimbursements and other nonmonetary support for the duration of specified terms such as public health emergencies. For the duration of the declared emergency and for at least 60 days after it ends insurers must provide specified payments based on payment history, grants, loans, rates increases and nonmonetary support to cover new business costs incurred because of the emergency, including PPE, infection control supplies or materials, medical or diagnostic equipment, and information technology systems.

NEW JERSEY S 2890 A 4508	Dentists would be allowed to charge patients an additional fee to cover PPE costs during the pandemic. The fee would be limited to the direct per-unit cost of PPE used for patient care as determined by the state Division of Consumer Affairs and exclude administrative staff or other personnel not directly involved in dental care.

Back to Top

Premium Refunds

NEW JERSEY A 4538 S 3131	Would require carriers to provide credits for reduced usage during the coronavirus disease 2019 pandemic. Qualifying carriers would have to issue a credit to subscribers reflecting the actuarial value of the carrier's reduced risk exposure resulting from reduced application of dental procedures during the public health emergency. It can be a direct refund, or credit toward future premiums.

Back to Top

Prior Authorization

GEORGIA SB 80	Prior authorization of a covered healthcare service shall be a guarantee of payment to the provider if such services are performed unless there is a billing error, fraud, material misrepresentation, or loss of coverage. An insurer shall make any current prior authorization requirements and restrictions readily accessible on its website to healthcare providers.
ILLINOIS HB 711	Prohibits health insurance issuers from revoking or further limiting, conditioning, or restricting a previously issued prior authorization approval while it remains valid. When a claim is properly coded and submitted timely to an insurer, the insurer must make payment according to the terms of coverage on claims for health care services for which prior authorization was required and approval received before the rendering of health care services, unless one of the specified allowances occurs such as fraud or eligibility issues. (Section 55)
MASSACHUSETTS H 1173 SB 236	An insurer that provides a written predetermination of benefits that includes a specific benefit payment or reimbursement amount may not reimburse the dentist less than the amount set forth in the predetermination.
NEVADA SB 269	A health carrier who provides dental coverage or an administrator of a health benefit plan that includes dental coverage shall not refuse to pay a claim for dental care for which the health carrier or administrator, as applicable, has granted prior authorization unless certain conditions are met such as the patient's condition changing substantially between the authorization and delivery of services.

NORTH DAKOTA HB 1154	Prohibits dental benefit plan from denying a claim subsequently submitted by a dentist for procedures specifically included in a prior authorization, unless the denial is based on specified reasonable situations such as change in patient's condition.

Back to Top

Provider Network Leasing

CONNECTICUT HB 6589	Concerns third-party access to participating dental provider contracts. Specifies the circumstances in which a health carrier, or a health carrier's contractor or subcontractor, may enter into a contract with a third party for the purpose of providing the third party with access to a participating dental provider contract. Includes opt-out clause for dentists.
IDAHO SB 1124	When extending a provider network to other entities, insurers would have to provide dentists full disclosure of the agreement, including any variations in obligations and fee schedule from the original contract. The insurer must provide at least two weeks for contracted dentists to confirm or decline participation.
LOUISIANA HB 387	Would only allow a contracting entity to lease a provider network contract may be leased, dentists are allowed to opt-out, the third party accessing the contract complies with the original contract, a listing of all third parties in existence as of the date of the contract or renewal is provided. Further requires the contracting entity to post all third parties in existence on its website, updated every 90 days. Prohibits a contracting entity from canceling or otherwise ending a contractual relationship if a provider opts out of a lease arrangement. Would also require a contracting entity to accept a qualified provider even if they reject a network lease option. Provides exemption for leasing companies.
NORTH DAKOTA HB 1154	Would prohibit insurers from granting to a third party access to a provider network contract unless the contract allows the participating dentist to choose to or not to participate in third-party access. Requires notification of lease option in contract.
SOUTH DAKOTA HB 1073	Any assignment or other contractual term in an agreement between an insurer and a dentist that purports to share, transfer, or assign contractual discounts to a third-party insurer or entity, without relinquishing the insurer's rights, is severable and voidable at the dentist's option. For purposes of this section, a third-party insurer or entity does not include an insurer or entity operating under the same brand licensee program as the contracting insurer.

UTAH HB 359	Establishes transparency and limitations on insurers' network leasing programs. Generally, the bills require clear and up-to-date notifications on insurers' lease arrangements with third parties. The bills also require insurers to provide the option for dentists to reject proposed lease arrangements.

Back to Top

Retroactive Denials and Overpayment Recovery

MASSACHUSETTS H 1173 SB 236	Same Patient and Overpayment Recovery – Would prohibit retroactive denials unless the deduction is drawn from a claim payment that is for a service provided to the same patient for which the overpayment occurred by the same dentist receiving the overpayment.
NEVADA SB 269	A health carrier who provides dental coverage or an administrator who recovers overpayments under a health benefit plan that includes dental coverage shall not attempt to recover an overpayment more than 12 months after the date of the overpayment.
NORTH DAKOTA HB 1154	A dental carrier may not initiate overpayment recovery efforts more than twelve months after the original payment for the claim was made.

Back to Top

Telemedicine – Requires Coverage for Services

COLORADO SB 139	The bill requires each dental plan issued, amended, or renewed to cover services offered to a covered person that are appropriately provided via telehealth.
PENNSYLVANIA SB 705	Insurers (including dental) must provide coverage for telemedicine delivered by a participating network provider who provides a covered service via telemedicine consistent with the insurer's medical policies. Would prohibit insurers from excluding a coverage for and payment of health care service solely because it is provided through telemedicine. Payment for a covered service provided via telemedicine by any participating network provider shall be negotiated between the health care provider and health insurer.
TEXAS HB 2056	Adds teledentistry and coverage requirements for teledentistry to existing state law that requires insurers to provide coverage for a covered health care service or procedure delivered by a preferred or contracted health professional to a covered patient as a telemedicine medical service or telehealth service on the same basis and to the same extent that the plan provides coverage for the service or procedure in an in-person setting.

Back to Top

Transparency Issues

MASSACHUSETTS H 1173 SB 236	Would require full transparency on claim payment details including whether the plan pays using the Least Expensive Alternative Treatment (LEAT) and exact payment for procedures. Would require an insurer, employer, or employee organization to establish an Internet website to provide resources and accurate information to dentists, insureds, participants, employees, and members. The insurer must also post information about the plan sufficient for patients and dentists to determine the type of dental care services covered by the plan or policy and the amount of the payment or reimbursement available for those services under the plan or policy. The insurer must also post information about the plan sufficient for patients and dentists to determine the type of dental care services covered by the plan or policy and the amount of the payment or reimbursement available for those services under the plan or policy.

Back to Top

Virtual Credit Cards – Claim Payment

IDAHO SB 1124	Would require insurers to provide one or more methods of payment or reimbursement that provides the dentist 100% of the contracted amount of the payment or reimbursement without the dentist incurring a fee to access the payment or reimbursement.
INDIANA HB 1079	Prohibits a health insurance plan from requiring a dental provider to accept virtual credit card payment methodology. Requires that before insurers' first payment using an electronic funds transfer (EFT) payment, including a virtual claim payment, or before modifying the method of payment, they must notify the dentist of any fees associated with EFT payment other than the fees imposed by the dental provider's financial institution and advise the dental provider of the methods of payment available under the health insurance plan. Insurers also must provide clear instructions to the dentist on how to select an alternate payment method.
MASSACHUSETTS H 1173 SB 236	Would require one or more methods of claim payment that does not require a fee to release and disclose the fees, if any, associated with the methods of payment or reimbursement available under the plan or policy.
VERMONT HB 294 (Amended into SB 88)	Bill would prohibit these plans from placing restrictions on allowable methods of payment in their contracts with dentists such that the only acceptable method is a credit card payment.

Back to Top

OTHER DENTAL BENEFITS-RELATED ISSUES

MULTI-TOPICAL BILLS	
IDAHO SB 1124	• Network Leasing. • Virtual Credit Cards.
MASSACHUSETTS H 1173 SB 236	• **Transparency** – Would require full transparency on claim payment details including whether the plan pays using LEAT and exact payment for procedures. Would require an insurer or employer or employee organization to establish an Internet website to provide resources and accurate information to dentists, insureds, participants, employees, and members. • **Equal Payment** – Would require insurers to pay non-par dentists equal or more than par dentists. • **Assignment of Payment** – Would require insurers to allow for assignment of benefit. • **Virtual Credit Cards** – Would require one or more methods of claim payment that does not require a fee to release and disclose the fees, if any, associated with the methods of payment or reimbursement available under the plan or policy. • **Freedom of Choice** – Prohibits plan from interfering with patient selection of dentist, as long as the dentist hold a state license. • **Any Willing Provider** – Would prohibit insurer from denying a dentist the right to participate as a contracting provider under the plan or policy if the dentist is licensed to provide the dental care services the plan or policy offers. • **Same Patient and Overpayment Recovery** – Would prohibit insurers from deducting the amount of an overpayment of a claim from a payment or reimbursement of another claim unless both claims were for dental services provided to the same patient by the same dentist. • **X-Ray Requirement** – Would prohibit an insurer from requiring a dentist to make or obtain a dental x-ray or other diagnostic aid in providing dental care services • **Prior Authorization** – An insurer that provides a written predetermination of benefits that includes a specific benefit payment or reimbursement amount may not reimburse the dentist less than the amount set forth in the predetermination.
NORTH DAKOTA HB 1154	• Fairness in network leasing. • Requires insurer adherence to prior authorizations. • Retroactive denial limitations.

UTAH HB 359	• Network leasing. • Downcoding and bundling. • Explanation of benefits. • Notice of contract change. Transparency.
VERMONT HB 294 (Amended into SB 88)	• Non-covered services. • Virtual credit cards.

Back to Top