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Sixty-seventh
Legislative Assembly
of North Dakota

HOUSE BILL NO. 1154

Introduced by

Representative Keiser

Senators Klein, Vedaa

A BILL ~~for an Act to create and enact chapter 26.1-36.8 of the North Dakota Century Code, relating to transparency in dental benefits contracting; and to provide a penalty.~~for an Act to create and enact chapter 26.1-36.9 and sections 26.1-47-02.2 and 26.1-47-02.3 of the North Dakota Century Code, relating to prior authorization of dental services, dental networks, and payment of dental claims.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

~~**SECTION 1.** Chapter 26.1-36.8 of the North Dakota Century Code is created and enacted as follows:~~

~~**26.1-36.8-01. Definitions.**~~

~~1. "Contracting entity" means a person that enters a direct contract with a provider for the delivery of dental services in the ordinary course of business. The term includes a third-party administrator and a dental carrier.~~

~~2. "Credit card payment" means a type of electronic funds transfer in which a dental benefit plan or a dental benefits plan's contracted vendor issues a single-use series of numbers associated with the payment of dental services performed by a dentist and chargeable to a predetermined dollar amount, through which the dentist is responsible for processing the payment by a credit card terminal or internet portal. The term includes virtual or online credit card payments under which a physical credit card is not presented to the dentist and the single-use credit card expires upon payment processing.~~

~~3. "Dental benefit plan" means a benefits plan that pays or provides dental expense benefits for covered dental services and is delivered or issued for delivery by or through a dental carrier on a stand-alone basis.~~

4. "Dental carrier" means a dental insurance company, dental service corporation, dental plan organization authorized to provide dental benefits, or a health benefits plan that includes coverage for dental services.

5. "Dental services" means services for the diagnosis, prevention, treatment, or cure of a dental condition, illness, injury, or disease. The term does not include services delivered by a provider which are billed as medical expenses under a health benefits plan.

6. "Dental Service Contractor" means a person that accepts a prepayment from or for the benefit of any other person or group of persons as consideration for providing to such person or group of persons the opportunity to receive dental services at such times in the future as such services may be appropriate or required. The term does not includeservice basis for providing specific dental services to an individual patient for whom such services have been prediagnosed.

7. "Dentist" means a dentist licensed or otherwise authorized in this state to furnish dental services.

8. "Dentist's agent" means a person that contracts with a dentist establishing an agency relationship to process bills for services provided by the dentist under the terms and conditions of a contract between the agent and dentist. Such contracts may permit the agent to submit bills, request reconsideration, and receive reimbursement.

9. "Electronic funds transfer payment" means a payment by a method of electronic funds transfer other than through the automated clearing house network, as codified in title 45, Code of Federal Regulations, sections 162.1601 and 162.1602.

10. "Health insurance plan" means a hospital or medical insurance policy or certificate; qualified higher deductible health plan; health maintenance organization subscriber contract; contract providing benefits for dental care whether such contract is pursuant to a medical insurance policy or certificate; or stand-alone dental plan, health maintenance provider contract, or managed health care plan.

11. "Health insurer" means a person that issues health insurance plans.

12. "Prior authorization" means communication indicating a specific procedure is, or multiple procedures are, covered under the patient's dental plan and reimbursable at a

specific amount, subject to applicable coinsurance and deductibles, and issued in response to a request submitted by a dentist using a format prescribed by the insurer.

13. "Provider" means a person that, acting within the scope of licensure or certification, provides dental services or supplies defined by the health benefits or dental benefit plan. The term does not include a physician organization or physician hospital organization that leases or rents the physician organization's or physician hospital organization's network to a third party.

14. "Provider network contract" means a contract between a contracting entity and a provider which specifies the rights and responsibilities of the contracting entity and provides for the delivery and payment of dental services to an enrollee.

15. "Third party" means a person that enters a contract with a contracting entity or with another third party to gain access to the dental services or contractual discounts of a provider network contract. The term does not include an employer or other group for which the dental carrier or contracting entity provides administrative services.

26.1-36.8-02. Responsible leasing requirements if leasing networks.

1. 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 the requirements of subsections 2 and 3 are met.

2. At the time the contract is entered, sold, leased, or renewed, or at the time there are material modifications to a contract relevant to granting access to a provider network contract to a third party, the dental carrier allows any provider that is part of the carrier's provider network to choose not to participate in third-party access to the contract or to enter a contract directly with the health insurer that acquired the provider network. Opting out of lease arrangements may not require dentists to cancel or otherwise end a contractual relationship with the original carrier that leases its network.

3. 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 all of the following are met:

a. The contract specifically states the contracting entity may enter 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 if the contracting entity is a dental carrier, the provider chose to participate in third-party access at the time the provider network contract was entered or renewed. The third-party access provision of a provider contract must be clearly identified in the provider contract including notice the contract grants third-party access to the provider network and that the dentist has the right to choose not to participate in third-party access.~~

~~b. The third party accessing the contract agrees to comply with all the contract's terms, including third party's obligation concerning patient steerage.~~

~~c. The contracting entity identifies, in writing or electronic form to the provider, all third parties in existence as of the date the contract is entered, sold, leased, or renewed.~~

~~d. The contracting entity identifies all third parties in existence in a list on the contracting party's internet website which is updated at least once every ninety days.~~

~~e. The contracting entity requires a third party to identify the source of the discount on all remittance advices or explanations of payment under which a discount is taken. This subdivision does not apply to electronic transactions mandated by the federal Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191].~~

~~f. The contracting entity notifies the third party of the termination of a provider network contract no later than thirty days from the termination date with the contracting entity.~~

~~g. A third party's right to a provider's discounted rate ceases as of the termination date of the provider network contract.~~

~~h. The contracting entity makes available a copy of the provider network contract relied on in the adjudication of a claim to a participating provider within thirty days of a request from the provider.~~

~~4. A provider is not bound by or required to perform dental treatment or services under a provider network contract that has been granted to a third party in violation of this Act.~~

~~**26.1-36.8-03. Exceptions.**~~

~~1. Section 26.1-36.8-02 does not apply if access to a provider network contract is granted to a dental carrier or an entity operating in accordance with the same brand licensee program as the contracting entity or to an entity that is an affiliate of the contracting entity. A list of the contracting entity's affiliates must be made available to a provider on the contracting entity's website; or~~

~~2. Section 26.1-36.8-02 does not apply to a provider network contract for dental services provided to beneficiaries of the state sponsored health programs, such as Medicaid and the children's health insurance program.~~

~~**26.1-36.8-04. Authorized services - Claim denial prohibited - Exceptions.**~~

~~A dental benefit plan may not deny a claim subsequently submitted by a dentist for procedures specifically included in a prior authorization, unless at least one of the following circumstances applies for each procedure denied:~~

~~1. Benefit limitations, such as annual maximums and frequency limitations not applicable at the time of the prior authorization, are reached due to utilization after issuance of the prior authorization;~~

~~2. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;~~

~~3. If, after the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care;~~

~~4. If, after the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would at that time required disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was used; or~~

~~5. The denial of the dental service contractor was due to one of the following:~~

~~a. Another payor is responsible for payment;~~

~~b. The dentist has been paid for the procedures identified on the claim;~~

c. The claim was submitted fraudulently, or the prior authorization was based in whole or material part on erroneous information provided to the dental service contractor by the dentist, patient, or other person not related to the carrier; or

d. The individual receiving the procedure was not eligible to receive the procedure on the date of service and the dental service contractor did not know, and with the exercise of reasonable care could not have known, of the individual's eligibility status.

26.1-36.8-05. Postpayment of claim - Payment recovery limitations.

1. Other than recovery for duplicate payments, a dental carrier, if engaging in overpayment recovery efforts, shall provide written notice to the dentist which identifies the error made in the processing or payment of the claim and justifies the overpayment recovery.

2. A dental carrier shall provide a dentist with the opportunity to challenge an overpayment recovery, including the sharing of claims information, and shall establish written policies and procedures for a dentist to follow to challenge an overpayment recovery.

3. A dental carrier may not initiate overpayment recovery efforts more than sixteen months after the original payment for the claim was made. This time limit does not apply to overpayment recovery efforts that are:

a. Based on reasonable belief of fraud, abuse, or other intentional misconduct;

b. Required by, or initiated at the request of, a self-insured plan; or

c. Required by a state or federal government plan.

26.1-36.8-06. Method of payment option.

1. A dental benefit plan may not contain restrictions on methods of payment from the dental benefit plans or the plan's vendor or the health maintenance organization to the dentist in which the only acceptable payment method is a credit card payment.

2. If initiating or changing payments to a dentist using electronic funds transfer payments, including virtual credit card payments, a dental benefit plan or the plan's contracted vendor or health maintenance organization 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 provide clear instructions to the dentist as to how to select an alternative payment method; and~~

~~c. Notify the dentist if the dental benefit plan is sharing a part of the profit of the fee charged by the credit card company to pay the claim.~~

~~3. A dental benefit plan, or the plan's contracted vendor or health maintenance organization, which initiates or changes payments to a dentist through the automated clearing house network, under title 45, Code of Federal Regulations, sections 162.1601 and 162.1602, may not charge a fee solely to transmit the payment to a dentist unless the dentist has consented to the fee. A dentist's agent may charge reasonable fees if transmitting an automated clearing house network payment related to transaction management, data management, portal services, and other value-added services in addition to the bank transmittal.~~

~~**26.1-36.8-07. Terms of contracts - Enforcement - Penalty.**~~

~~1. The requirements of this chapter may not be waived by contract. A contractual clause in conflict with this chapter or which purports to waive a requirement of this chapter is void.~~

~~2. The insurance commissioner shall enforce this chapter.~~

~~3. A violation of this chapter is a class B misdemeanor.~~

SECTION 1. Chapter 26.1-36.9 of the North Dakota Century Code is created and enacted as follows:

26.1-36.9-01. Definitions.

As used in this chapter:

1. "Dental benefit plan" means a benefits plan that pays or provides dental expense benefits for covered dental services and is delivered through a dental insurer.
2. "Dental insurer" means a dental insurance company, dental service corporation, or dental plan organization authorized to provide dental benefits.
3. "Dental provider" means a licensed provider of dental services in this state.
4. "Dental services" means services for the diagnosis, prevention, treatment, or cure of a dental condition, illness, injury, or disease.
5. "Prior authorization" means confirmation by the covered individual's dental benefit plan that the services sought to be provided by the dental provider meet the criteria for

coverage under the covered individual's dental benefit plan as defined by the covered individual's dental benefit plan.

26.1-36.9-02. Dental benefit plans - Prior authorization.

A dental benefit plan may not deny a claim subsequently submitted by a dental provider for procedures specifically included in a prior authorization, unless at least one of the following circumstances applies for each procedure denied:

1. Benefit limitations, such as annual maximums and frequency limitations not applicable at the time of the prior authorization, are reached due to utilization after issuance of the prior authorization.
2. The documentation for the claim provided by the dental provider submitting the claim clearly fails to support the claim as originally authorized.
3. If, after the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care.
4. If, after the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would at that time require disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was used.
5. The denial of the payment was due to one of the following:
   a. Another payor is responsible for payment.
   b. The dental provider already has been paid for the procedures identified on the claim.
   c. The claim was submitted fraudulently.
   d. The individual receiving the procedure was not eligible to receive the procedure on the date of service.

SECTION 2. Section 26.1-47-02.2 of the North Dakota Century Code is created and enacted as follows:

26.1-47-02.2. Dental networks.

1. As used in this section:

a. "Affiliate" means a person that directly or indirectly through one or more intermediaries controls, or is under the control of, or is under common control with, the person specified.

b. "Contracting entity" means a person that enters a direct contract with a dental provider for the delivery of dental services.

c. "Network" means a group of preferred dental providers providing services under a network plan.

d. "Network plan" means a dental benefit plan that requires a covered individual to use, or creates incentives, including financial incentives, for a covered individual to use a dental provider managed by, owned by, under contract with, or employed by the dental insurer.

e. "Third party" means an entity that is not a party to a contracting entity's dental provider network.

2. A contracting entity may grant a third party access to a dental provider network contract, or a provider's dental services or contractual discounts provided pursuant to a dental provider network contract, if all of the following are met:

a. The contract specifically states the contracting entity may enter an agreement with a third party allowing the third party to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity.

b. If the contracting entity is a dental insurer, the dental provider may opt out of the third-party access at the time the dental provider network contract was entered or renewed.

c. The contracting entity identifies, in writing or electronic form to the dental provider, all third parties in existence as of the date the contract is entered or renewed.

d. The contracting entity notifies dental network providers that a new third party is leasing or purchasing the network at least thirty days in advance of the relationship taking effect.

e. The contracting entity makes available a copy of the dental provider network contract relied on in the adjudication of a claim to a participating dental provider within thirty days of a request from the dental provider.

3. A dental provider's refusal to agree in writing to the third-party access to the dental provider network does not permit the contracting entity to end the contractual relationship with the dental provider.

4. The provisions of this section do not apply if access to a provider network contract is granted to a dental carrier or an entity operating in accordance with the same brand licensee program as the contracting entity or to an entity that is an affiliate of the contracting entity.

SECTION 3. Section 26.1-47-02.3 of the North Dakota Century Code is created and enacted as follows:

26.1-47-02.3. Postpayment of dental claims - Payment recovery limitations.

1. As used in this section, "dental care provider" means a licensed provider of dental care services in this state.

2. Other than recovery for duplicate payments, a dental insurer, if engaging in overpayment recovery efforts, shall provide written notice to the dental care provider which identifies the error made in the processing or payment of the claim and justifies the overpayment recovery.

3. A dental insurer shall provide a dental care provider with the opportunity to challenge an overpayment recovery, including the sharing of claims information, and shall establish written policies and procedures for a dental care provider to follow to challenge an overpayment recovery.

4. A dental insurer may not initiate overpayment recovery efforts more than twelve months after the original payment for the claim was made. This time limit does not apply to overpayment recovery efforts that are:

   a. Based on reasonable belief of fraud, abuse, or other intentional misconduct;

   b. Required by, or initiated at the request of, a self-insured plan; or

   c. Required by a state or federal government plan.