2021 HOUSE INDUSTRY, BUSINESS AND LABOR

HB 1154

2021 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

HB 1154
2/3/2021

Dental Benefits contracting.

(9:01) Chairman Lefor called the hearing to order.

Representatives	Attendance
Chairman Lefor	P
Vice Chairman Keiser	P
Rep Hagert	P
Rep Jim Kasper	P
Rep Scott Louser	P
Rep Nehring	P
Rep O'Brien	P
Rep Ostlie	P
Rep Ruby	P
Rep Schauer	P
Rep Stemen	P
Rep Thomas	P
Rep Adams	P
Rep P Anderson	P

Discussion Topics:

- Transparency in contracts with dental insurance networks.

Vice Chairman Keiser introduces the bill. Attachment #5174.

William Sherwin~Executive Director-ND Dental Association. Attachments #5159 & 5158.

Chrystal Bartuska~ND Insurance Dept. Testified in opposition.

Chairman Lefor closes the hearing.

Additional written testimony: Attachment # 5201.

(9:49) End time.

Ellen LeTang, Committee Clerk

21.0417.01005

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.

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 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 include a dentist or professional dental corporation that accepts prepayment on a fee-for-service basis for providing specific dental services to an individual patient for whom such services have been prediagnosed.

6. "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~~health care provider. 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 written 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~~If a provider opts out of a lease arrangement, this does not permit the

contracting entity to cancel or otherwise end a contractual relationship with the provider. At the time initially contracting with a provider, a contracting entity shall accept a qualified provider even if a provider rejects a network lease provision. This subsection does not apply to a contracting entity that is not a health insurer or dental carrier.

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~~If the contracting entity is an insurer, the third-party access provision of a provider contract also specifically must state the contract grants third-party access to the provider network and, for contracts with dental carriers, that the dentist has the right to chose 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 notifies network providers that a new third party is leasing or purchasing the network at least thirty days in advance of the relationship taking effect;

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

~~h.~~i. 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~~section.

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 already 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~~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.

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; and

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~~an infraction.

26.1-36.8-08. Rulemaking.

The commissioner may adopt rules consistent with this chapter and the laws of this state.

Testimony on HB 1154
William R. Sherwin
North Dakota Dental Association
House Industry, Business and Labor Committee
February 3, 2020

Good Morning Chairman Lefor and members of the House Industry, Business and Labor Committee, my name is William Sherwin, Executive Director of the North Dakota Dental Association. I would like to thank you all for your time today to speak on HB 1154 our "Dental Care Bill of Rights." This legislation was adopted from the national model at NCOIL piloted by our very own Representative Keiser who is our sponsor here in North Dakota as well. Our Dental Care Bill of Rights includes four sections/issues that I will walk through with you briefly:

1. Network Leasing – Fair and Transparent Network Contracting

Insurance companies can "sell/lease" dentists off to different insurance networks without the dentist's knowledge or consent, significantly impacting the insurance benefits available to their patients. This erodes patient/dentist trust, which can lead to assumptions in treatment plans and costs based on a false understanding of patient coverage.

In a typical insurance network arrangement, dentists are fully engaged as they choose to join a network, allowing dentists to understand and discuss the terms of their agreement with patients as needed. In states that allow network leasing to proceed without adequate protections, the insurance network may transfer the rights to a dentist's contract to another insurance company without seeking the dentist's knowledge or consent. As a result, dentists may not be able to adequately advise patients on financial planning around dental services.

The North Dakota Dental Association is advocating for network leasing laws that would expand transparency and provide an opportunity for dentists to accept or refuse these contracts, establishing basic fairness while reducing occurrences of unexpected bills following a procedure.

2. Prior Authorization – Claim Payments Guarantee

To the typical patient, an insurer's authorization means, barring unusual circumstances, payment for the service(s) authorized prior to treatment will be made by the benefit carrier.

Unfortunately, an emerging trend among payers has been to deny a claim for a service that was authorized by the benefit carrier. Patients and their dentists rely upon this promise to pay and are caught off-guard when payment is denied.

In submitting an authorization request, dentists are making a good-faith effort to explain the treatment plan so insurers may determine, prior to the service, if the plan raises any concerns with regard to payment. Once authorization is established, patients and dentists feel assured insurers' coverage will be delivered. When the promise to pay is altered after care is delivered, patients and doctors are left in an unexpected financial bind.

Carriers should be compelled to comply with their promise to pay that is included in preauthorization communications. The intent of proposed legislation is to ensure carriers honor their commitment provided in prior authorizations when there are no extenuating circumstances.

3. Retroactive Denial – Fairness in Claim Payment Refund Requests

Dental plans have the ability to review claims after payment has been delivered and request claims payment refunds under certain circumstances. The profession is interested in laws that restrict the timeframe allowed to request such a refund. Laws in this category restrict refund requests to six months to a year after payment.

Dental benefit plans have become more complex as they adjust to competition and related market pressures. One such adjustment is a greater emphasis on plans auditing claims after payments are made as a means to control their expenditures. While it is appropriate for plans to audit payments for errors and adjust accordingly, it is unreasonable to ask dentists to refund payments several years after plans have made erroneous payments and discover it. The NDDA recognizes the value of public policy that limits the amount of time dental carriers may request a refund for an erroneous claim payment. Such laws establish a reasonable statute of limitations on insurers' refund requests, similar to the existing statute of limitations for providers to file claims for covered services.

As small business owners and employers, dentists are careful in establishing their practice budgets. They must plan carefully, especially as carrier payments for covered services are usually

less than dentists' regular fees. It places an undue burden on the practice to repay carriers for a mistake carriers made in paying claims many years after the mistake was made.

Dentists participating in insurers' networks have a limited amount of time to file claims for covered services, usually less than a year. After that, insurers can refuse to pay anything. This time limit ensures the claim process remains efficient and avoids having to retrace the history of services many years later. The same logic should apply to carriers requesting a refund many years after they send a payment, where carriers ask dentists to refund a claim payment. Just as dentists are limited in claiming payment for covered services, plans should be similarly limited in the time they have to claim a refund on a payment they made by mistake.

4. Virtual Credit Card – Fairness in Claim Payment/Transaction Fees

Unless prohibited, insurance carriers can require dentists to accept claims payment using a credit or debit card equivalent rather than a paper check or direct deposit. Typically, the transaction involves no physical card, but rather a series of numbers the dentist enters into a website or credit card terminal in order to complete the claims payment transaction. If the insurance carrier offers no other alternative for paying its claims, it can become expensive, cumbersome and even impossible for some dentists to be paid.

The virtual credit card payment method includes a per transaction fee of as much as 5% paid by dentists. So, in order to collect for the services they have rendered to a patient/subscriber of the insurance carrier, dentists have to pay a fee for each transaction. This does nothing to improve patients' care and dentists not given an alternative option are left to pay a fee to receive claims payment, that's assuming they are equipped to collect credit card payments.

For these reasons and the reasons outlined in your handouts, I would ask the committee to please support HB 1154, give the bill a due pass recommendations and follow the direction of both NCOIL and so many states across our country on fair and transparent contracting processes in the dental insurance market.

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Dental Care Bill of Rights

HB 1154 – Dental Insurance Reform

1. Retroactive Denial – Fairness in Claim Payment Refund Requests

- Dental insurers audit their claim payment/adjudication activities before and after payments are made to dentists to ensure accuracy and efficiency. Sometimes, insurers require dentists to repay claim payments when the insurers discover they paid a claim mistakenly. While it is appropriate for plans to audit payments for errors and adjust accordingly, it is unreasonable to ask dentists to refund payments several years after plans make erroneous payments.

- The value of *Retroactive Denial* laws is that they establish a reasonable statute of limitations on insurers' refund requests, similar to the existing time limitations for dentists to file claims for covered services they have provided.

- Under existing *Retroactive Denial* laws, dental insurers are limited to a reasonable time period (typically 6 - 12 months) where they can request refunds from dentists when they have paid claims in error.

2. Prior Authorization – Claim Payments Guarantee

- Insurers occasionally issue a "prior authorization" that details for both the patient and the dentist how much the insurer will pay for a treatment plan, which helps reduce confusion and helps patients know what to expect financially.

- Insurers sometimes deny payment for the care they authorized, or reduce the amount they promised to pay for the services. When authorized care is denied, this can result in an emergency financial situation for the patient and doctor, increasing stress and throwing up an unnecessary barrier to future care due to lack of trust in the insurance carriers.

- *Prior Authorization* laws hold dental insurers to paying what they promised in the authorization.

3. Virtual Credit Card – Fairness in Claim Payment/Transaction Fees

- There is a growing trend for insurance carriers to pay a claim by issuing a credit or debit card rather than a paper check or direct deposit. Typically, the transaction involves no physical card, but rather a series of numbers the dentist enters into a website or terminal in order to complete the claims payment transaction.

Continued→

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- The virtual credit card payment method includes a per transaction fee of as much as 5% - to be paid *by* dentists in order to collect the claim payment. In some cases, the insurance carrier offers no other alternative for paying its claims, and may even share in the revenue generated from the fees the dentists must pay to receive the funds.

- The value of *Virtual Credit Card* laws is that they do not prohibit this payment method, but simply inform dentists of other payment options and allow dentists to opt for a different payment method.

4. Network Leasing - Fair and Transparent Network Contracting

- Dental insurers occasionally lease or rent the "in-network" relationship they have established with a dentist to another entity. This can happen without the dentist's consent or knowledge. As the contract a dentist signs with a carrier is leased to other entities, which can happen years after the initial contract is signed, it can obligate the dentist to deeply discounted fees for a larger patient base than anticipated. This behind-the-scenes approach to building networks erodes patient and dentist trust.

- *Network Leasing* laws expand transparency before networks are leased and provide an opportunity for dentists to accept or refuse the contracts to which they would be obliged.

5. Medical Loss Ratio (MLR) – Transparency of Patient Premiums in Dental Care

- The federal government requires major medical plans pay certain percentages of the collected premiums for medical care vs. administrative costs. For example, large group plans must spend at least 85% of their collected premiums on care delivered to patients and no more than 15% can be spent on administrative costs and profit.

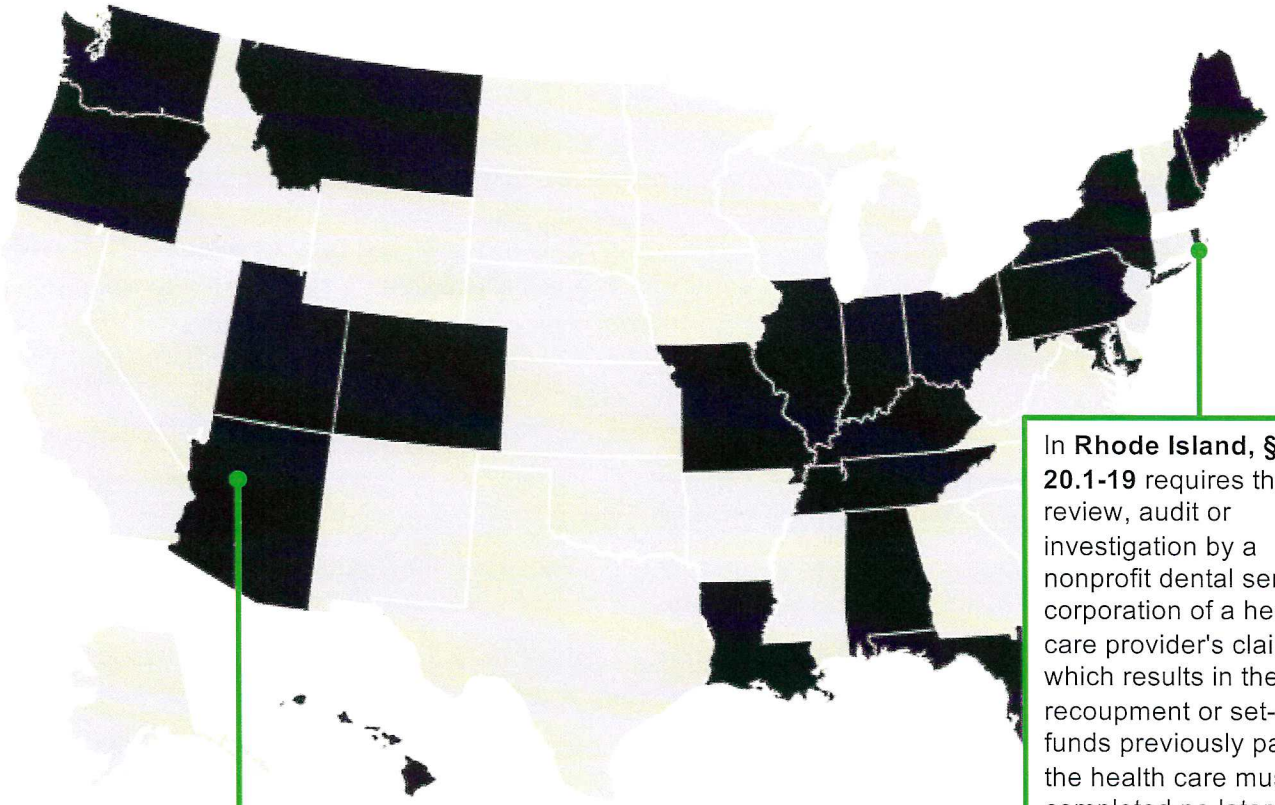
- No such requirement exists for dental plans which are considered "excepted benefits."

- Patients seeking to maximize the value of the coverage they purchase would benefit from knowing how much of the carriers' premiums are invested in the care they receive. State laws establishing a reporting requirement will ensure that dental plans are more transparent to the people they serve.

Retroactive Denial Legislation – Taking Root Across America

PASSED IN

24 states



In **Arizona, A.R.S. § 20-3102 (I)** prohibits insurers from adjusting or requesting adjustment of the payment or denial of a claim more than one year after payment or denial.

In **Rhode Island, § 27-20.1-19** requires that any review, audit or investigation by a nonprofit dental service corporation of a health care provider's claims which results in the recoupment or set-off of funds previously paid to the health care must be completed no later than 18 months after the completed claims were initially paid.

To learn more about Retroactive Denial Legislation in North Dakota, please contact the North Dakota Dental Association at 701-223-8870 or by email at wsherwin@smilenorthdakota.org.

Restricting Retroactive Denial to Prevent Surprise Billing and Protect Patients

Retroactive denial allows insurance companies to require dentists to repay claims already paid to them when insurers discover they paid a claim mistakenly, even if the claim was processed years ago. This results in surprise billing – at the expense of patients.

Patient Concerns

Retroactive denials often result in an unexpected bill for the patient and erodes trust between patients and their dentists, creating uncertainty that can keep patients from seeking care in the future. Patients and dentists alike should be able to expect timely, accurate billing settlements when working with insurers.

Solution

The North Dakota Dental Association is working to pass reforms to limit the time frame within which an insurer may demand a refund on a claim they have already paid out. As a result, "surprise bills" are limited within a reasonable amount of time, typically 6 or 12 months.

What Are the Benefits of Retroactive Denial Laws?

- Adopts a statute-of-limitations approach, establishing a reasonable timeline to conclude health care coverage transactions.
- Establishes accountability and responsibility on the part of insurers in managing their processes and administration of benefits, ultimately helping to keep overall health care costs down.
- Careful management of claims payment administration reduces unexpected health care costs that add to the cost of care in the long run.

Proposed Retroactive Denial Laws in North Dakota

Dental Care Bill of Rights

HB 1154 – Dental Insurance Reform

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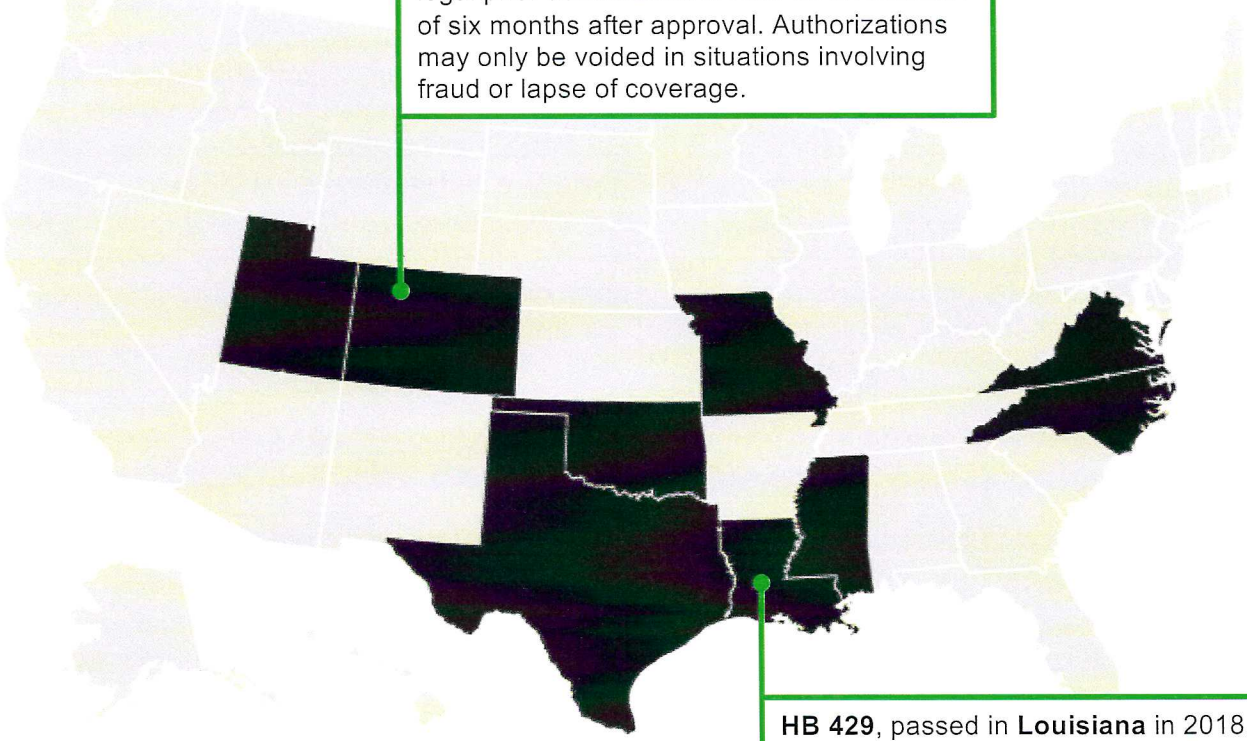
Prior Authorization Legislation is Gathering National, Bipartisan Support

PASSED IN

9 states

HB 1211, passed in **Colorado** with overwhelming support in 2019, renders all legal prior authorizations valid for a minimum of six months after approval. Authorizations may only be voided in situations involving fraud or lapse of coverage.



HB 429, passed in **Louisiana** in 2018, prohibits dental carriers from denying any claims approved in prior authorization, barring circumstances involving exhausted/inadequate coverage or fraud.

To learn more about Prior Authorization Legislation in North Dakota, please contact the North Dakota Dental Association at 701-223-8870 or by email at wsherwin@smilenorthdakota.org.

Protecting Patients by Holding Insurers Accountable for Prior Authorizations

An insurer's authorization means they agree to make payment for the service(s) being sought prior to treatment. However, an increasing number of insurers are denying claims for services previously authorized, reversing their agreement with both patients and dentists.

Patient Concerns

In submitting an authorization request, dentists are making a good-faith effort to explain the treatment plan so insurers may determine, prior to the service, whether coverage is granted and what costs patients will need to pay. Once authorization is granted, patients should have a right to be assured that their procedure will be covered. When the promise to pay is reversed after care is delivered, patients and dentists are left in an unexpected and unfair financial bind, effectively disrupting treatment planning.

Solution

The North Dakota Dental Association is advocating for legislation to hold insurance companies accountable to their promise to pay. "Promise to Pay" legislation ensures that patients have all the information they need so that they can plan for all health care costs. In the last two years, five states have enacted laws to address this unfair practice, demonstrating the state law can and should require insurance companies to stand by their commitment to pay.

What Are the Benefits of Prior Authorization Laws?

- Avoiding surprise costs preserves the trust between patients and their providers, preventing confusion for all parties.
- Patients are far more likely to seek care if they can rely on their insurance carrier's commitment to pay, fully understand which portions of treatment will be covered, and are accurately informed of out-of-pocket costs.

Proposed Prior Authorization Laws in North Dakota

Dental Care Bill of Rights

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Regulating Network Leasing to Preserve Patient Benefits

Insurance companies can pawn dentists off to a different insurance network without the dentist's knowledge or consent, significantly impacting the insurance benefits available to their patients.

Patient Concerns

Without network leasing laws, heath care transparency suffers. Patients and providers should be fully informed about the costs of care as early as possible in any health care transaction. Leased networks often have the opposite effect. Because leased networks operate "silently", the provider and patients are unable to determine coverages and discounts. This erodes patient/dentist trust, which can lead to assumptions in treatment plans and costs based on a false understanding of patient coverage.

Without protections in law, the PPO contracting entities can include dentists in an agreement without their knowledge, consideration or consent. Likewise, there are no protections for dentists from having to comply with various terms, conditions and fee schedules to which they had no opportunity to consider, negotiate or accept/reject.

Solution

The North Dakota Dental Association is advocating for network leasing laws that would expand transparency and provide an opportunity for dentists to accept or refuse these contracts, enforcing basic fairness while reducing occurrences of unexpected bills following a procedure. One third of states currently employ such legislation.

What Are the Benefits of Network Leasing Laws?

- Dentists are fully engaged as they choose to join a network, allowing dentists to understand and negotiate the terms of their agreement.
- As a result, dentists and patients are informed partners as they discuss financial planning around future procedures.

Proposed Network Leasing Laws in North Dakota

Dental Care Bill of Rights

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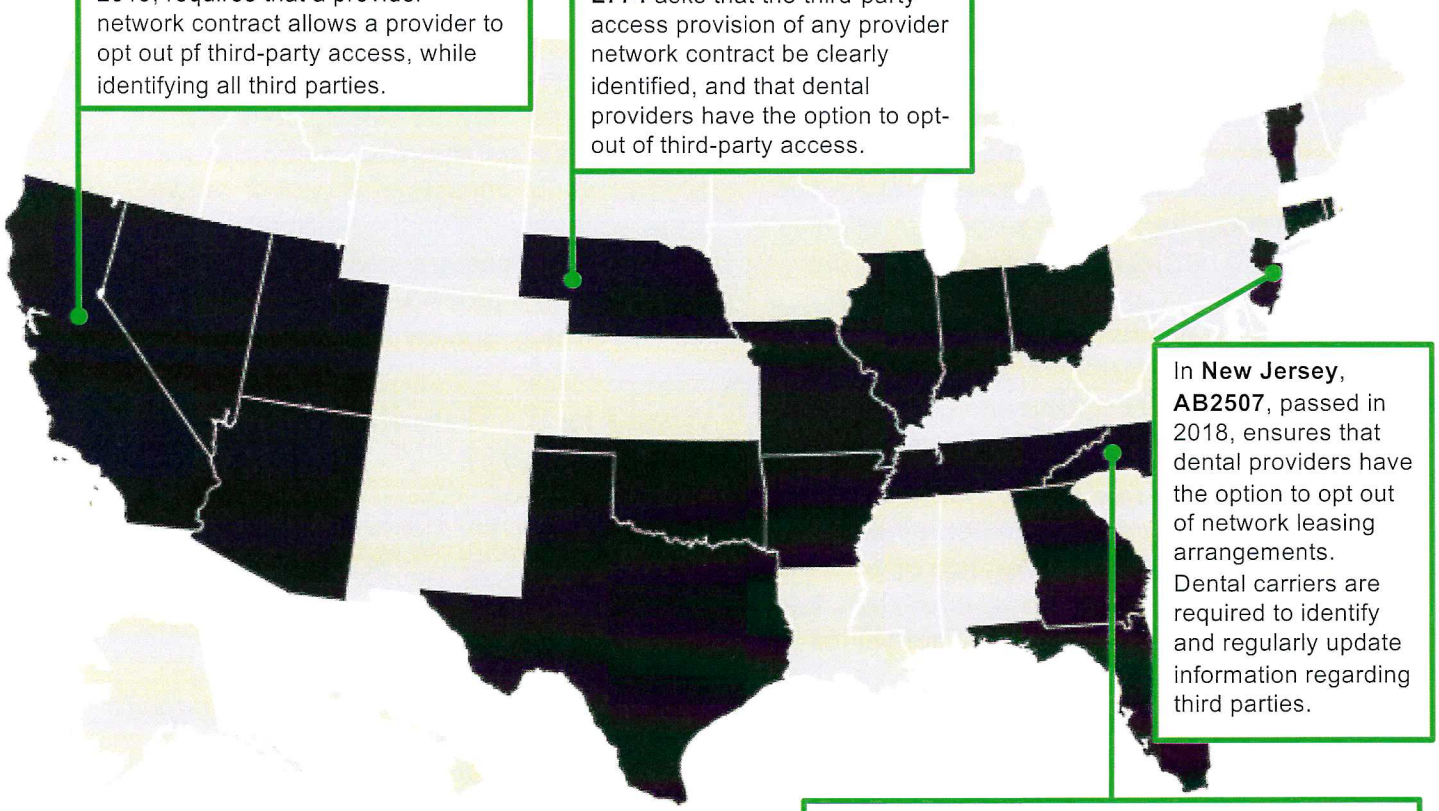
Provider Network Leasing Legislation is Gaining Momentum Across the Nation

PASSED IN

20 states

In **California, AB954**, passed in 2019, requires that a provider network contract allows a provider to opt out pf third-party access, while identifying all third parties.

Passed in 2020, **Nebraska's L774** asks that the third-party access provision of any provider network contract be clearly identified, and that dental providers have the option to opt-out of third-party access.



In **New Jersey, AB2507**, passed in 2018, ensures that dental providers have the option to opt out of network leasing arrangements. Dental carriers are required to identify and regularly update information regarding third parties.

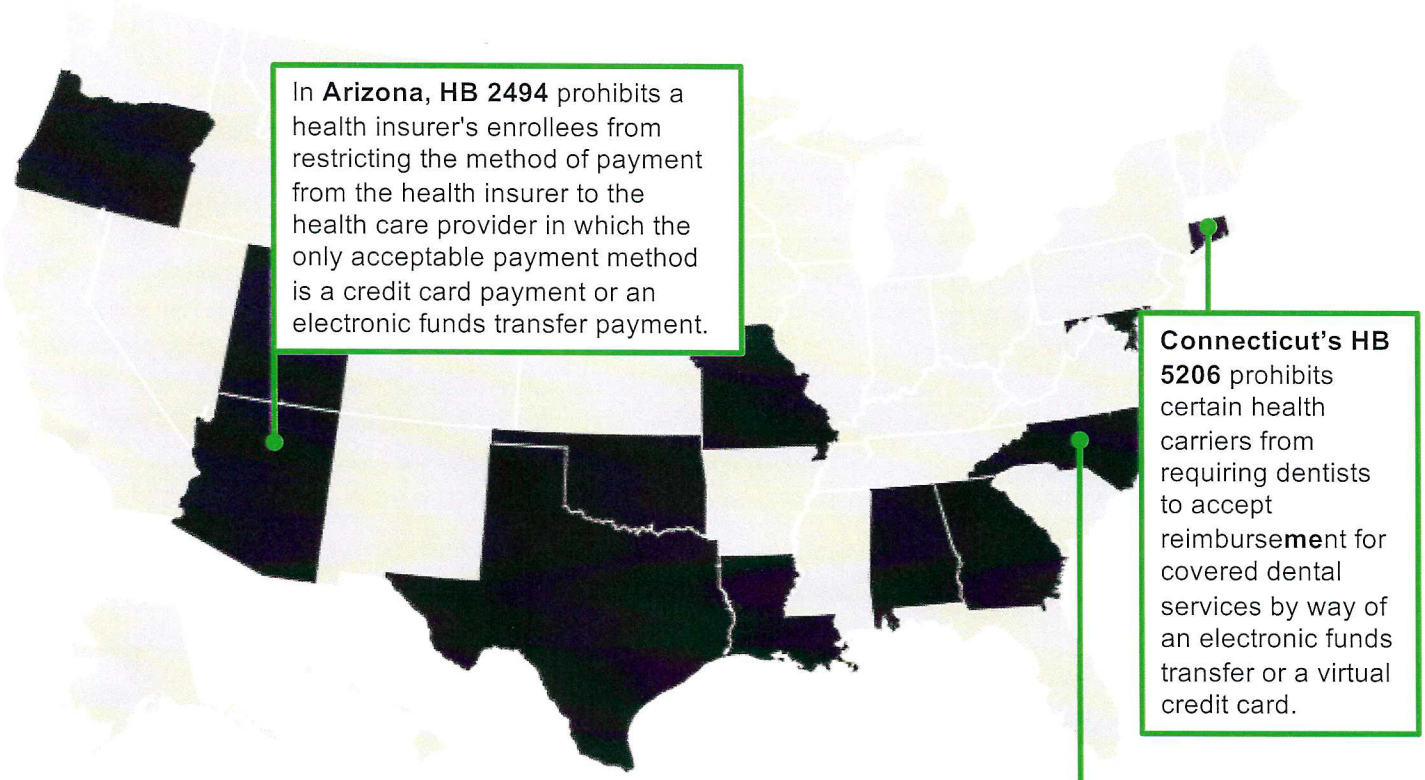
North Carolina's SB252, passed in 2019, requires that insurers proactively identify all third parties with network access, and that such third parties are in compliance with the network contract's terms. Providers can choose not to participate in third-party access to the provider network contract.

To learn more about Network Leasing Legislation in North Dakota, please contact the North Dakota Dental Association at 701-223-8870 or by email at wsherwin@smilenorthdakota.org

Bipartisan Success for Virtual Credit Card Legislation

PASSED IN

12 states



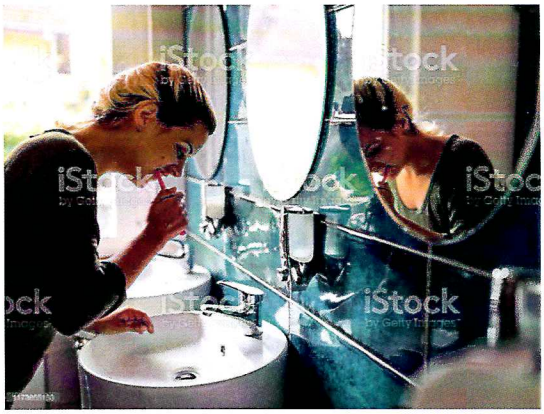
In **Arizona, HB 2494** prohibits a health insurer's enrollees from restricting the method of payment from the health insurer to the health care provider in which the only acceptable payment method is a credit card payment or an electronic funds transfer payment.

Connecticut's HB 5206 prohibits certain health carriers from requiring dentists to accept reimbursement for covered dental services by way of an electronic funds transfer or a virtual credit card.

In **North Carolina, SB 252** prohibits restrictions on methods of claim payment in which the only acceptable payment method from the insurer or entity to the provider of the dental services is a credit card payment.

To learn more about Virtual Credit Card Legislation in North Dakota, please contact the North Dakota Dental Association at 701-223-8870 or by email at wsherwin@smilenorthdakota.org.

Reducing Costly Administrative Barriers through Virtual Credit Card Legislation



Increasingly, insurance companies require dentists to accept claim payment through a virtual credit card, which can include a per-transaction fee of as much as 5%. In some cases, insurance companies even share in the revenue generated from these fees.

Patient Concerns

Efficiencies gained by the insurance company shouldn't come at the expense of patients. Adding an extra expense in the form of transactional fees does not lower health care costs and limiting payment options does not allow for informed decision making. Dentists can best serve patients when they have options on how to accept payment, with or without fees, that all parties can knowingly agree to from the outset.

Solution

The North Dakota Dental Association supports legislation that would prohibit insurance companies from forcing dentists to be paid only through high-fee virtual credit cards. Virtual credit card reforms do not prohibit this payment method but require that providers be informed of other payment options and be given the opportunity to opt into a different payment method. In the last five years, legislation addressing this problem passed with bipartisan support.

What Are the Benefits of Virtual Credit Card Laws?

- Providers are able to explore a variety of fee-free claim payment methods that ultimately reduce overall costs for their patients and practice.
- Dental practices, which are often small businesses, are no longer forced to solely accept a payment method which may come with a fee of as much as 5%.

Proposed Virtual Credit Card Laws in North Dakota

Dental Care Bill of Rights

HB 1154 – Dental Insurance Reform

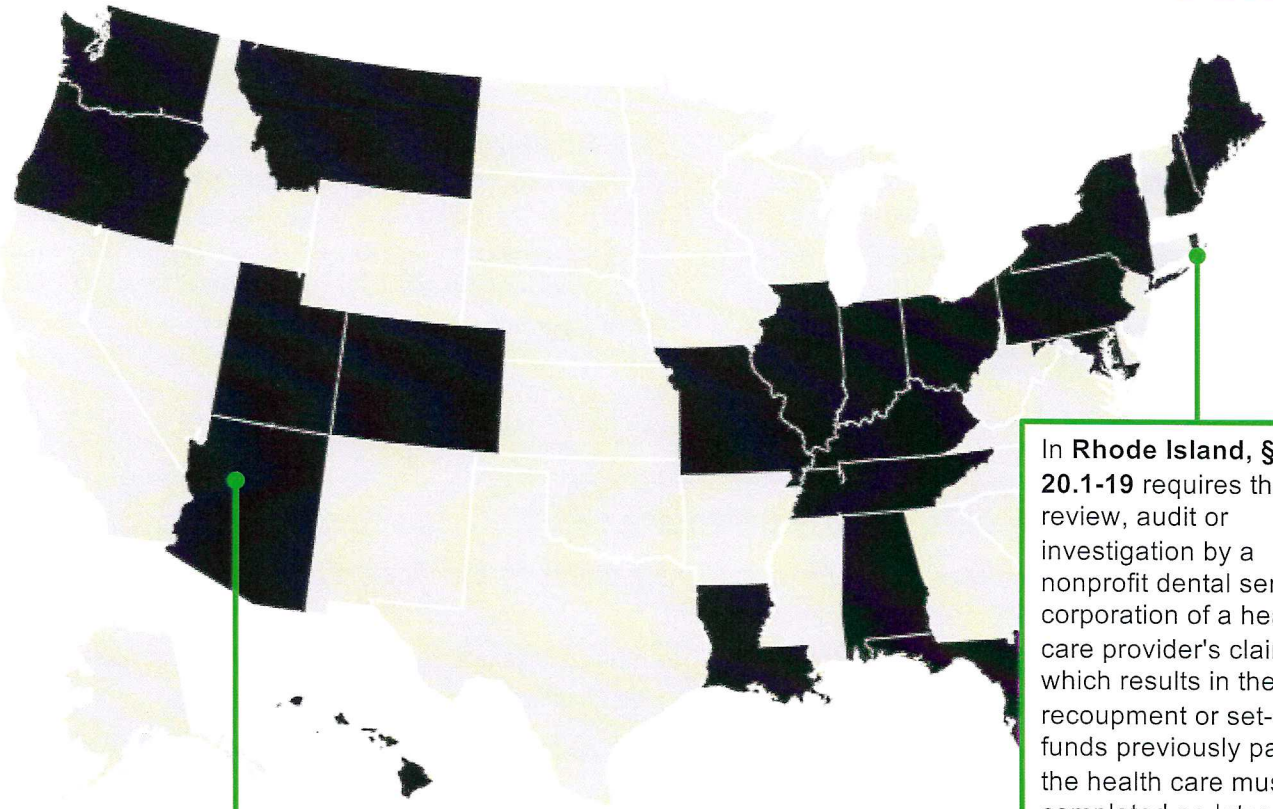
North Dakota DENTAL ASSOCIATION

Physical Address: 1720 Burnt Boat Drive, Suite 201
Mailing Address: P.O. Box 1332, Bismarck, ND 58502-1332
T: 701.223.8870

Retroactive Denial Legislation – Taking Root Across America

PASSED IN

24 states



In **Arizona, A.R.S. § 20-3102 (I)** prohibits insurers from adjusting or requesting adjustment of the payment or denial of a claim more than one year after payment or denial.

In **Rhode Island, § 27-20.1-19** requires that any review, audit or investigation by a nonprofit dental service corporation of a health care provider's claims which results in the recoupment or set-off of funds previously paid to the health care must be completed no later than 18 months after the completed claims were initially paid.

To learn more about Retroactive Denial Legislation in North Dakota, please contact the North Dakota Dental Association at 701-223-8870 or by email at wsherwin@smilenorthdakota.org.

Restricting Retroactive Denial to Prevent Surprise Billing and Protect Patients

Retroactive denial allows insurance companies to require dentists to repay claims already paid to them when insurers discover they paid a claim mistakenly, even if the claim was processed years ago. This results in surprise billing – at the expense of patients.

Patient Concerns

Retroactive denials often result in an unexpected bill for the patient and erodes trust between patients and their dentists, creating uncertainty that can keep patients from seeking care in the future. Patients and dentists alike should be able to expect timely, accurate billing settlements when working with insurers.

Solution

The North Dakota Dental Association is working to pass reforms to limit the time frame within which an insurer may demand a refund on a claim they have already paid out. As a result, "surprise bills" are limited within a reasonable amount of time, typically 6 or 12 months.

What Are the Benefits of Retroactive Denial Laws?

- Adopts a statute-of-limitations approach, establishing a reasonable timeline to conclude health care coverage transactions.
- Establishes accountability and responsibility on the part of insurers in managing their processes and administration of benefits, ultimately helping to keep overall health care costs down.
- Careful management of claims payment administration reduces unexpected health care costs that add to the cost of care in the long run.

Proposed Retroactive Denial Laws in North Dakota

Dental Care Bill of Rights

HB 1154 – Dental Insurance Reform

North Dakota DENTAL ASSOCIATION
Physical Address: 1720 Burnt Boat Drive, Suite 201
Mailing Address: P.O. Box 1332, Bismarck, ND 58502-1332
T: 701.223.8870

House Industry, Business and Labor Committee
HB 1154
Megan Houn, BCBSND
February 3, 2021

On behalf of Blue Cross Blue Shield of North Dakota and our over 350,000 members we respectfully oppose HB 1154. We have serious concerns that this bill closely resembles a version of any willing provider legislation for dentists. The freedom to contract and establish provider networks are components central to the business of insurance and keeping health care costs low. Requiring carriers to contract with any willing provider and eliminating our ability to terminate existing contracts removes our ability to eliminate providers from our network that might not have the best interests of our members in mind. Examples of reasons we might terminate an existing contract include fraud, embezzlement, and malpractice, but also can includes things like breach of contract, charging members in full at the time of service and then refunding the money after payment from BCBSND, billing high charges or collecting too much cost-sharing. None of these are pro-consumer.

Every insurer has credentialing requirements (and perhaps other written "qualifications" but credentialing being the standard), but there could be an instance – even if it's once in a blue moon - when the credentialing requirements are satisfied but the insurer nonetheless does not want to extend a participation agreement. The amended language requires that an insurer contract with the provider as long as the provider has met the insurer's "qualifications." In other words, the insurer's discretion is gone.

If an insurer's position is that it will always, forever and with no exceptions extend a participation agreement to any provider that satisfies the insurer's qualifications, then the revised language is fine. However, if the insurer wants to retain control of its network and discretion not to contract with a provider even if the provider otherwise satisfies the insurer's credentialing and qualifications, the language is bad.

Worse yet, if the language is enacted and an insurer attempts to use discretion in a one-off situation, the provider could have a cause of action against the insurer and the insurer could be subject to regulatory and criminal penalties. We simply don't see how the language is not an any willing provider mandate. If the provider satisfies the insurer's credentialing/qualifications, an insurer MUST contract with the provider. The insurer loses control over the network and has no discretion.

It is worth mentioning that we are unclear what problem this bill solves for BCBSND members. Rather, we feel it provides special treatment for the dentists in the state as opposed to their patients. North Dakotans enter into hundreds of contracts throughout their lifetimes whether it be movie rental agreements, terms of use posted on internet websites, product return rights for e-tailers such Amazon and eBay, license provisions on the back of sporting and concert tickets, apartment leases, car purchases, extended warranties on appliances, and home mortgages. Contracts are a part of life. Like most states, North Dakota has an entire title of law that governs contracts (Title 9, N.D.C.C.), and state and federal courts are highly-adept at reviewing and resolving contractual disputes that arise. Dentists, in the performance of their profession, are no different than other North Dakotans in so far as contracts being a part of their lives; however, their contracts relate to the operation of a dental business. HB 1154

requires that dentists receive special treatment and protections above and beyond the Title 9 provisions of North Dakota law that are generally applicable to North Dakotans. Such special treatment is an unnecessary government intrusion into the long-standing tenet of freedom to contract, and dentists are certainly not a class of North Dakotans needing special protections.

Dentists are highly-educated professionals who engage in an array of contracts every year as part of their normal business operations, so it is fair to assume that they fully understand contracts or have the ability to obtain the professional assistance of an attorney or accountant for those services. Just like all other North Dakotans, dentists have an obligation to read and understand their contracts before signing, and the Legislative Assembly should not pass legislation that gives dentists special treatment when entering into contracts.

HB 1154 is also problematic because it will necessarily create a host of additional operational and administrative requirements that cause expense, and those expenses will ultimately be borne by dental insurance members in the form of increased premiums. BCBSND also inquired with the North Dakota Department of Insurance to see if there were any complaints or inquiries on dental insurance and there were not any. Additionally, BCBSND has a Dental Advisory Board, and we have not heard from the dentists, nor the North Dakota Dental Association on this issue. HB 1154 is a solution for dentists, not consumers, that should be handled directly rather creating an unnecessary special section of code to protect dentists from the contracts they deal with every day.

Due to the concerns raised above, BCBSND opposes 1154.

Megan Houn
Director, Government Relations
Blue Cross Blue Shield of North Dakota

2021 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

HB 1154
2/16/2021

Dental Benefits contracting.

(10:33) Chairman Lefor called the hearing to order.

Representatives	Attendance
Chairman Lefor	P
Vice Chairman Keiser	P
Rep Hagert	P
Rep Jim Kasper	P
Rep Scott Louser	P
Rep Nehring	P
Rep O'Brien	P
Rep Ostlie	P
Rep Ruby	P
Rep Schauer	P
Rep Stemen	P
Rep Thomas	P
Rep Adams	P
Rep P Anderson	P

Discussion Topics:

- Transparency in contracts with dental insurance networks.

Jon Godfread~ND Insurance Commissioner. Attachment #6745.

William Sherwin~ND Dental Association. Answered questions & in favor of the amendment.

Chairman Lefor closes the hearing. The bill will be held.

(10:51) End time.

Ellen LeTang, Committee Clerk

#6745

HB 1154
Amendments proposed
by Insurance Dept. Feb 16 '21.

CHAPTER 26.1-47 PREFERRED PROVIDER ORGANIZATIONS

~~Definitions – Dental~~

1. ~~"Dental benefit plan" mean a benefits plan that pays or provides dental expense benefits for covered dental services and is delivered through a dental carrier.~~
2. ~~"Dental carrier" means a dental insurance company, dental service corporation, dental plan organization authorized to provide dental benefits, or a health benefit plan that includes coverage for dental services.~~
3. ~~"Dental network plan" means a dental benefit plan that requires a covered person to use, or creates incentives, for a covered person to use dental providers managed by, owned by, under contract with, or employed by the dental care insurer.~~
4. ~~"Dental provider" means a licensed provider of dental care services in this state.~~
5. ~~"Dental provider network" means a group of dental providers providing dental services under a dental network plan.~~
6. ~~"Dental services" means services for the diagnosis, prevention, treatment, or cure of a dental condition, illness, injury, or disease.~~
7. ~~"Dentist" means an individual who has a license to practice in this state.~~

26.1-47-02.2 Dental networks.

For the purpose of this section, "network" means a group of preferred dental providers providing services under a network plan. A "network plan" means a dental benefit plan that requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use a dental providers managed by, owned by, under contract with, or employed by the dental insurer.

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1. As used in this section, "contracting entity" means a person or entity that enters into direct contracts with dental providers for the delivery of dental services ~~in the ordinary course of business, including a health care service plan or third-party administrator.~~
2. As used in the section, "third party" means an entity that is not party to contracting entity's dental provider network.

~~A contracting entity may grant third-party access to a dental provider network. If a dental provider opts out of a leasing arrangement, this does not permit the contracting entity to end the contractual relationship with the provider.~~

3. ~~if~~

~~a. The third-party agrees to comply with the dental provider network contract terms;~~

~~b. The contracting entity identifies, in writing or electronic form to the providers, third parties in existence as of the date the contract is entered or renewed;~~

~~c. At the time the contracting entity grants access to the third party, it allows the dental provider not to participate in the third party access;~~

~~d.~~a. ~~If a dental provider opts out of a leasing arrangement, this does not permit the contracting entity to end the contractual relationship with the provider.~~

4. 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 third parties allowing the third parties to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity.

b. ~~, and if~~If the contracting entity is a dental insurer~~carrier~~, the dental provider must choose ~~chose~~ to participate by opting in or out of the ~~in~~ third-party access at the time the dental provider network contract was entered or renewed.

~~a. If the contracting entity is an insurer, the third-party access provision of a provider contract also specifically must state the contract grants third-party access to the provider network and, for contracts with dental carriers, 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.~~

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 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.~~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.

~~f. 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].~~

~~g. 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.~~

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

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.

~~f. A contracting entity may grant third-party access to a dental provider network if the dental provider agrees in writing of the leasing arrangement.~~

~~5.~~ If the A dental provider's refusal to ~~does does not~~ agree in writing to the third party access to the dental provider network ~~in writing this~~ does not permit the contracting entity to end the contractual relationship with the dental provider.

~~i.~~a.

~~5. 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 section.~~

26.1-47-02.34 Post payment of Dental claims – payment recovery limitations.

1. For the purposes of this section, dental care provider means licensed providers of dental care services in this state.

~~1.~~2. Other than recovery for duplicate payments, a dental insurer~~carrier~~, 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.

~~2.~~3. A dental insurer ~~carrier~~ 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.

Commented [BCA1]: No authority

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~~3.~~4. A dental insurer ~~carrier~~ 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.

~~26.1-47-02.5 Method of payment.~~

~~1. As used in this section, "dental provider's agent" means a person that contracts with a dental provider establishing an agency relationship to process bills and reimbursements for services provided by the dental provider under the terms and conditions of a contract between the agent and the dental provider.~~

~~2. A dental benefit plan may not contain restrictions on methods of payment from the dental benefit plan or the plan's vendor or the health maintenance organization to the dental provider in which the only acceptable payment method is a credit card payment.~~

~~3. If initiating or changing payments to a dental provider 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 dental provider if any fees are associated with a particular payment method; and~~

~~b. Advise the dental provider of the available methods of payment and provide clear instructions to the dental provider as to how to select an alternative payment method.~~

~~4. A dental benefit plan, or the plan's contracted vendor or health maintenance organization, which initiates or changes payments to a dental provider 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 dental provider unless the dental provider has consented to the fee. A dental provider'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.~~

Section 1. Chapter 26.1-~~36.649~~ of the North Dakota Century Code is created and enacted as follows:

Definitions – Dental

1. "Dental benefit plan" mean a benefits plan that pays or provides dental expense benefits for covered dental services and is delivered through a ~~-~~dental insurer~~carrier~~.
2. "Dental insurer~~carrier~~" means a dental insurance company, dental service corporation, dental plan organization authorized to provide dental benefits~~, or a health benefit plan that includes coverage for dental services.~~
3. "Dental network plan" means a dental benefit plan that requires a covered person to use, or creates incentives, for a covered person to use dental providers managed by, owned by, under contract with, or employed by the dental ~~care~~ insurer.
4. "Dental provider" means a licensed provider of dental care services in this state.
5. "Dental provider network" means a group of dental providers providing dental care services under a dental network plan.
6. "Dental services" means services for the diagnosis, prevention, treatment, or cure of a dental condition, illness, injury, or disease.
7. "Dentist" means an individual who has a license to practice in this state.
8. "Prior authorization" means confirmation by the covered person's dental benefit plan that the services sought to be provided by the dental provider meet the criteria for coverage under the covered person's dental benefit plan as defined by the covered person's dental benefit plan.

26.1-49 Prior authorizations - Claim denial prohibited - Exceptions.

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 ~~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.
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~~, or the prior authorization was based in whole or material part on erroneous information provided by the dental provider, patient, or other person not related to the carrier.~~
    ~~d.~~ The individual receiving the procedure was not eligible to receive the procedure on the date of service ~~and the dental provider did not know, and with the exercise of reasonable care could not have known, of the individual's eligibility status.~~
    d.

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2021 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

HB 1154
2/17/2021

Dental Benefits contracting.

(9:00) Chairman Lefor called the hearing to order.

Representatives	Attendance
Chairman Lefor	P
Vice Chairman Keiser	P
Rep Hagert	P
Rep Jim Kasper	A
Rep Scott Louser	P
Rep Nehring	P
Rep O'Brien	P
Rep Ostlie	P
Rep Ruby	P
Rep Schauer	P
Rep Stemen	P
Rep Thomas	P
Rep Adams	P
Rep P Anderson	P

Discussion Topics:

- Transparency in contracts with dental insurance networks.

Jennifer Clark~Legislative Council amendment 21.0417.01008. Attachment #6797 & 6796.

Jon Godfreid~Insurance Commissioner explained the amendment.

Crystal Bartuska~ND Insurance Department explained a different part of the amendment. Lisa Feldner-ND Dental Association. Testified in favor.

Levi Andres~Representing American Council of Life Insurers. Testified in neutral.

Vice Chairman Keiser moved the amendment 21.0417.01008.

Rep Schauer second.

Voice vote Motion carried.

Rep P Anderson moved a Do Pass as Amended.

Rep D Ruby second.

Representatives	Vote
Chairman Lefor	Y
Vice Chairman Keiser	Y
Rep Hagert	Y
Rep Jim Kasper	A
Rep Scott Louser	Y
Rep Nehring	Y
Rep O'Brien	Y
Rep Ostlie	Y
Rep Ruby	Y
Rep Schauer	Y
Rep Stemen	Y
Rep Thomas	Y
Rep Adams	Y
Rep P Anderson	Y

Vote roll call taken Motion carried 13-0-1 & Keiser is the carrier.

(9:14) End time.

Ellen LeTang, Committee Clerk

DP 2/17/21
1 of 3

21.0417.01008
Title.02000

Prepared by the Legislative Council staff for
Representative Keiser
February 16, 2021

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1154

Page 1, line 1, after "A BILL" replace the remainder of the bill with "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 26.1-36.9 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."

Renumber accordingly

REPORT OF STANDING COMMITTEE

HB 1154: Industry, Business and Labor Committee (Rep. Lefor, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (13 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). HB 1154 was placed on the Sixth order on the calendar.

Page 1, line 1, after "A BILL" replace the remainder of the bill with "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 26.1-36.9 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."

Renumber accordingly

21.0417.01008
Title.

Prepared by the Legislative Council staff for
Representative Keiser
February 16, 2021

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1154

Page 1, line 1, after "A BILL" replace the remainder of the bill with "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 26.1-36.9 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."

Renumber accordingly

21.0417.01008

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.

2021 SENATE HUMAN SERVICES

HB 1154

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

HB 1154
3/9/2021

A BILL 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.

Madam Chair Lee opened the hearing on HB 1154 at 9:13 a.m. Members present: Lee, K. Roers, Hogan, Anderson, Clemens, O. Larsen.

Discussion Topics:

- Third party contracts
- Insurance department operation impacts
- Prior authorization process
- Network changes
- Self-insured patients

[9:13] Representative George Keiser, District 47. Introduced HB 1154.

[9:23] William Sherwin, Executive Director, North Dakota Dental Association. Provided testimony #8236 in favor.

[9:53] Chrystal Bartuska, Director, Life and Health Division, ND Insurance Department. Provided neutral oral testimony.

Additional written testimony: (1)

Teresa Cagnolatti, Director, Government and Regulatory Affairs, National Association of Dental Plans (NADP). Provided written testimony #8180 in opposition.

Madam Chair Lee closed the hearing on HB 1154 at 9:58 a.m.

Justin Velez, Committee Clerk

Testimony on HB 1154
William R. Sherwin
North Dakota Dental Association
Senate Human Services Committee
March 9, 2020

Good Morning Chairman Lee and members of the Senate Human Services Committee, my name is William Sherwin, Executive Director of the North Dakota Dental Association. I would like to thank you all for your time today to speak on HB 1154 our "Dental Care Bill of Rights." This legislation was adopted from the national model at NCOIL piloted by our very own Representative Keiser who is our sponsor here in North Dakota as well. Our Dental Care Bill of Rights includes three sections/issues that I will walk through with you briefly:

1. Network Leasing – Fair and Transparent Network Contracting

Insurance companies can "sell/lease" dentists off to different insurance networks without the dentist's knowledge or consent, significantly impacting the insurance benefits available to their patients. This erodes patient/dentist trust, which can lead to assumptions in treatment plans and costs based on a false understanding of patient coverage.

In a typical insurance network arrangement, dentists are fully engaged as they choose to join a network, allowing dentists to understand and discuss the terms of their agreement with patients as needed. In states that allow network leasing to proceed without adequate protections, the insurance network may transfer the rights to a dentist's contract to another insurance company without seeking the dentist's knowledge or consent. As a result, dentists may not be able to adequately advise patients on financial planning around dental services.

The North Dakota Dental Association is advocating for network leasing laws that would expand transparency and provide an opportunity for dentists to accept or refuse these contracts, establishing basic fairness while reducing occurrences of unexpected bills following a procedure.

2. Prior Authorization – Claim Payments Guarantee

To the typical patient, an insurer's authorization means, barring unusual circumstances, payment for the service(s) authorized prior to treatment will be made by the benefit carrier.

Unfortunately, an emerging trend among payers has been to deny a claim for a service that was authorized by the benefit carrier. Patients and their dentists rely upon this promise to pay and are caught off-guard when payment is denied.

In submitting an authorization request, dentists are making a good-faith effort to explain the treatment plan so insurers may determine, prior to the service, if the plan raises any concerns with regard to payment. Once authorization is established, patients and dentists feel assured insurers' coverage will be delivered. When the promise to pay is altered after care is delivered, patients and doctors are left in an unexpected financial bind.

Carriers should be compelled to comply with their promise to pay that is included in preauthorization communications. The intent of proposed legislation is to ensure carriers honor their commitment provided in prior authorizations when there are no extenuating circumstances.

3. Retroactive Denial – Fairness in Claim Payment Refund Requests

Dental plans have the ability to review claims after payment has been delivered and request claims payment refunds under certain circumstances. The profession is interested in laws that restrict the timeframe allowed to request such a refund. Laws in this category restrict refund requests to six months to a year after payment.

Dental benefit plans have become more complex as they adjust to competition and related market pressures. One such adjustment is a greater emphasis on plans auditing claims after payments are made as a means to control their expenditures. While it is appropriate for plans to audit payments for errors and adjust accordingly, it is unreasonable to ask dentists to refund payments several years after plans have made erroneous payments and discover it. The NDDA recognizes the value of public policy that limits the amount of time dental carriers may request a refund for an erroneous claim payment. Such laws establish a reasonable statute of limitations on insurers' refund requests, similar to the existing statute of limitations for providers to file claims for covered services.

As small business owners and employers, dentists are careful in establishing their practice budgets. They must plan carefully, especially as carrier payments for covered services are usually

less than dentists' regular fees. It places an undue burden on the practice to repay carriers for a mistake carriers made in paying claims many years after the mistake was made.

Dentists participating in insurers' networks have a limited amount of time to file claims for covered services, usually less than a year. After that, insurers can refuse to pay anything. This time limit ensures the claim process remains efficient and avoids having to retrace the history of services many years later. The same logic should apply to carriers requesting a refund many years after they send a payment, where carriers ask dentists to refund a claim payment. Just as dentists are limited in claiming payment for covered services, plans should be similarly limited in the time they have to claim a refund on a payment they made by mistake.

For these reasons and the reasons outlined in your handouts, I would ask the committee to please support HB 1154, give the bill a due pass recommendations and follow the direction of the North Dakota House, NCOIL and so many states across our country on fair and transparent contracting processes in the dental insurance market.

North Dakota
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Dental Care Bill of Rights

HB 1154 – Dental Insurance Reform

1. Retroactive Denial – Fairness in Claim Payment Refund Requests

- Dental insurers audit their claim payment/adjudication activities before and after payments are made to dentists to ensure accuracy and efficiency. Sometimes, insurers require dentists to repay claim payments when the insurers discover they paid a claim mistakenly. While it is appropriate for plans to audit payments for errors and adjust accordingly, it is unreasonable to ask dentists to refund payments several years after plans make erroneous payments.

- The value of *Retroactive Denial* laws is that they establish a reasonable statute of limitations on insurers' refund requests, similar to the existing time limitations for dentists to file claims for covered services they have provided.

- Under existing *Retroactive Denial* laws, dental insurers are limited to a reasonable time period (typically 6 - 12 months) where they can request refunds from dentists when they have paid claims in error.

2. Prior Authorization – Claim Payments Guarantee

- Insurers occasionally issue a "prior authorization" that details for both the patient and the dentist how much the insurer will pay for a treatment plan, which helps reduce confusion and helps patients know what to expect financially.

- Insurers sometimes deny payment for the care they authorized, or reduce the amount they promised to pay for the services. When authorized care is denied, this can result in an emergency financial situation for the patient and doctor, increasing stress and throwing up an unnecessary barrier to future care due to lack of trust in the insurance carriers.

- *Prior Authorization* laws hold dental insurers to paying what they promised in the authorization.

3. Virtual Credit Card – Fairness in Claim Payment/Transaction Fees

- There is a growing trend for insurance carriers to pay a claim by issuing a credit or debit card rather than a paper check or direct deposit. Typically, the transaction involves no physical card, but rather a series of numbers the dentist enters into a website or terminal in order to complete the claims payment transaction.

Continued→

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- The virtual credit card payment method includes a per transaction fee of as much as 5% - to be paid *by* dentists in order to collect the claim payment. In some cases, the insurance carrier offers no other alternative for paying its claims, and may even share in the revenue generated from the fees the dentists must pay to receive the funds.

- The value of *Virtual Credit Card* laws is that they do not prohibit this payment method, but simply inform dentists of other payment options and allow dentists to opt for a different payment method.

4. Network Leasing - Fair and Transparent Network Contracting

- Dental insurers occasionally lease or rent the "in-network" relationship they have established with a dentist to another entity. This can happen without the dentist's consent or knowledge. As the contract a dentist signs with a carrier is leased to other entities, which can happen years after the initial contract is signed, it can obligate the dentist to deeply discounted fees for a larger patient base than anticipated. This behind-the-scenes approach to building networks erodes patient and dentist trust.

- *Network Leasing* laws expand transparency before networks are leased and provide an opportunity for dentists to accept or refuse the contracts to which they would be obliged.

5. Medical Loss Ratio (MLR) – Transparency of Patient Premiums in Dental Care

- The federal government requires major medical plans pay certain percentages of the collected premiums for medical care vs. administrative costs. For example, large group plans must spend at least 85% of their collected premiums on care delivered to patients and no more than 15% can be spent on administrative costs and profit.

- No such requirement exists for dental plans which are considered "excepted benefits."

- Patients seeking to maximize the value of the coverage they purchase would benefit from knowing how much of the carriers' premiums are invested in the care they receive. State laws establishing a reporting requirement will ensure that dental plans are more transparent to the people they serve.

Regulating Network Leasing to Preserve Patient Benefits

Insurance companies can pawn dentists off to a different insurance network without the dentist's knowledge or consent, significantly impacting the insurance benefits available to their patients.

Patient Concerns

Without network leasing laws, heath care transparency suffers. Patients and providers should be fully informed about the costs of care as early as possible in any health care transaction. Leased networks often have the opposite effect. Because leased networks operate "silently", the provider and patients are unable to determine coverages and discounts. This erodes patient/dentist trust, which can lead to assumptions in treatment plans and costs based on a false understanding of patient coverage.

Without protections in law, the PPO contracting entities can include dentists in an agreement without their knowledge, consideration or consent. Likewise, there are no protections for dentists from having to comply with various terms, conditions and fee schedules to which they had no opportunity to consider, negotiate or accept/reject.

Solution

The North Dakota Dental Association is advocating for network leasing laws that would expand transparency and provide an opportunity for dentists to accept or refuse these contracts, enforcing basic fairness while reducing occurrences of unexpected bills following a procedure. One third of states currently employ such legislation.

What Are the Benefits of Network Leasing Laws?

- Dentists are fully engaged as they choose to join a network, allowing dentists to understand and negotiate the terms of their agreement.
- As a result, dentists and patients are informed partners as they discuss financial planning around future procedures.

Proposed Network Leasing Laws in North Dakota

Dental Care Bill of Rights

HB 1154 – Dental Insurance Reform

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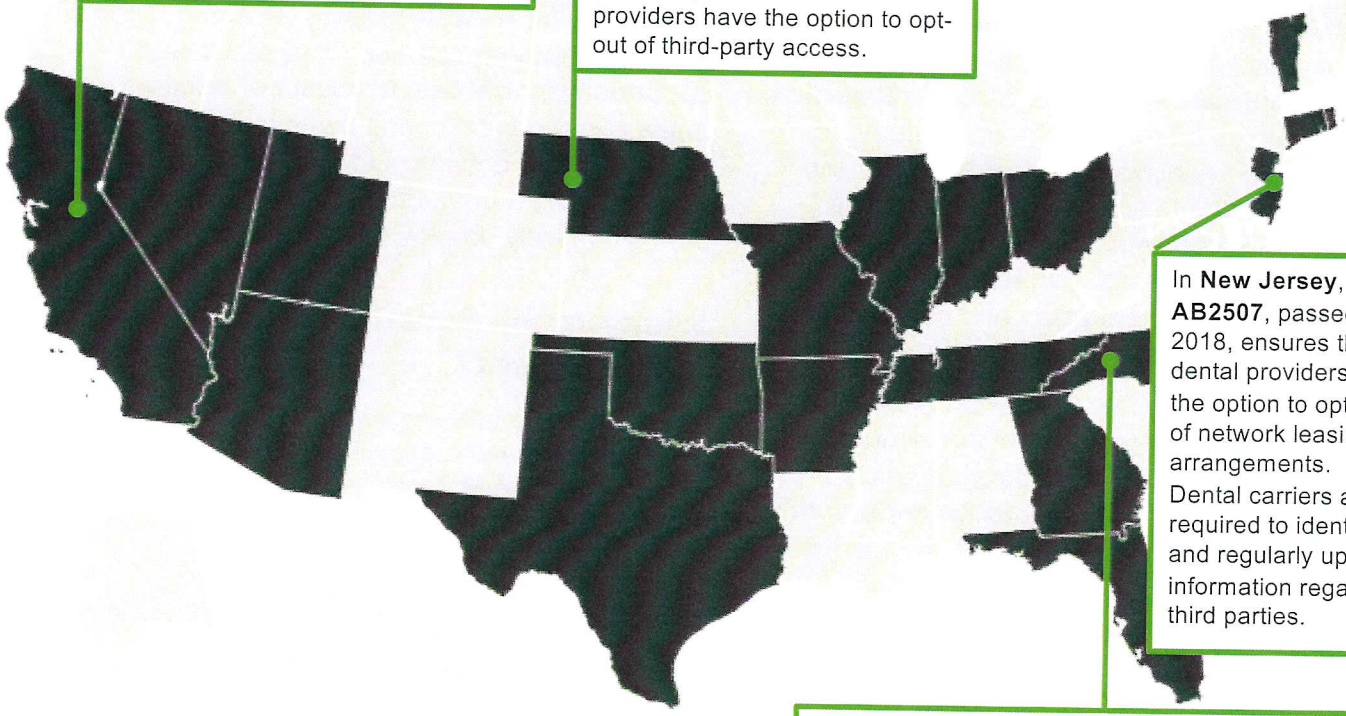
Provider Network Leasing Legislation is Gaining Momentum Across the Nation

PASSED IN

20 states

In **California, AB954**, passed in 2019, requires that a provider network contract allows a provider to opt out pf third-party access, while identifying all third parties.

Passed in 2020, **Nebraska's L774** asks that the third-party access provision of any provider network contract be clearly identified, and that dental providers have the option to opt-out of third-party access.



In **New Jersey, AB2507**, passed in 2018, ensures that dental providers have the option to opt out of network leasing arrangements. Dental carriers are required to identify and regularly update information regarding third parties.

North Carolina's SB252, passed in 2019, requires that insurers proactively identify all third parties with network access, and that such third parties are in compliance with the network contract's terms. Providers can choose not to participate in third-party access to the provider network contract.

To learn more about Network Leasing Legislation in North Dakota, please contact the North Dakota Dental Association at 701-223-8870 or by email at wsherwin@smilenorthdakota.org

Protecting Patients by Holding Insurers Accountable for Prior Authorizations

An insurer's authorization means they agree to make payment for the service(s) being sought prior to treatment. However, an increasing number of insurers are denying claims for services previously authorized, reversing their agreement with both patients and dentists.

Patient Concerns

In submitting an authorization request, dentists are making a good-faith effort to explain the treatment plan so insurers may determine, prior to the service, whether coverage is granted and what costs patients will need to pay. Once authorization is granted, patients should have a right to be assured that their procedure will be covered. When the promise to pay is reversed after care is delivered, patients and dentists are left in an unexpected and unfair financial bind, effectively disrupting treatment planning.

Solution

The North Dakota Dental Association is advocating for legislation to hold insurance companies accountable to their promise to pay. "Promise to Pay" legislation ensures that patients have all the information they need so that they can plan for all health care costs. In the last two years, five states have enacted laws to address this unfair practice, demonstrating the state law can and should require insurance companies to stand by their commitment to pay.

What Are the Benefits of Prior Authorization Laws?

- Avoiding surprise costs preserves the trust between patients and their providers, preventing confusion for all parties.
- Patients are far more likely to seek care if they can rely on their insurance carrier's commitment to pay, fully understand which portions of treatment will be covered, and are accurately informed of out-of-pocket costs.

Proposed Prior Authorization Laws in North Dakota

Dental Care Bill of Rights

HB 1154 – Dental Insurance Reform

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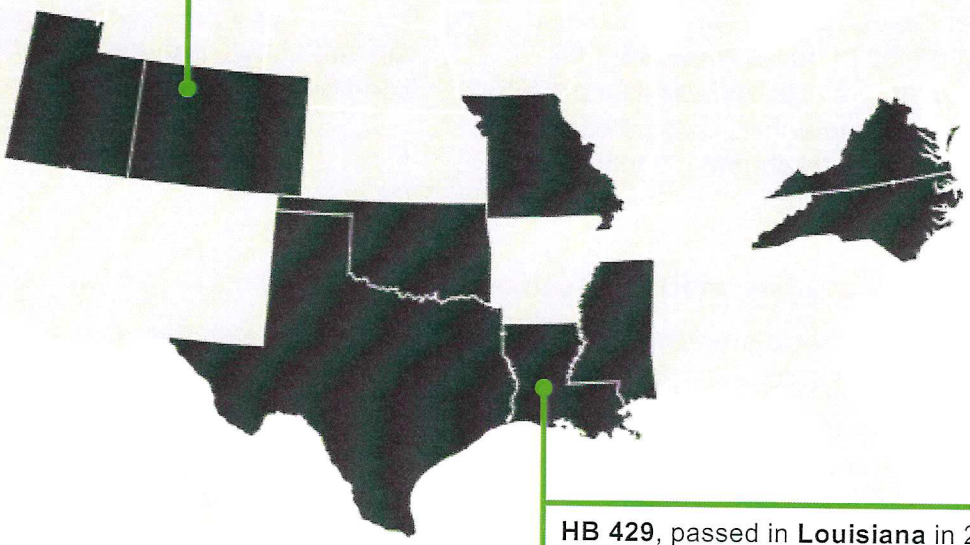
Prior Authorization Legislation is Gathering National, Bipartisan Support

PASSED IN

9 states

HB 1211, passed in **Colorado** with overwhelming support in 2019, renders all legal prior authorizations valid for a minimum of six months after approval. Authorizations may only be voided in situations involving fraud or lapse of coverage.



HB 429, passed in **Louisiana** in 2018, prohibits dental carriers from denying any claims approved in prior authorization, barring circumstances involving exhausted/inadequate coverage or fraud.

To learn more about Prior Authorization Legislation in North Dakota, please contact the North Dakota Dental Association at 701-223-8870 or by email at wsherwin@smilenorthdakota.org.

Restricting Retroactive Denial to Prevent Surprise Billing and Protect Patients

Retroactive denial allows insurance companies to require dentists to repay claims already paid to them when insurers discover they paid a claim mistakenly, even if the claim was processed years ago. This results in surprise billing – at the expense of patients.

Patient Concerns

Retroactive denials often result in an unexpected bill for the patient and erodes trust between patients and their dentists, creating uncertainty that can keep patients from seeking care in the future. Patients and dentists alike should be able to expect timely, accurate billing settlements when working with insurers.

Solution

The North Dakota Dental Association is working to pass reforms to limit the time frame within which an insurer may demand a refund on a claim they have already paid out. As a result, "surprise bills" are limited within a reasonable amount of time, typically 6 or 12 months.

What Are the Benefits of Retroactive Denial Laws?

- Adopts a statute-of-limitations approach, establishing a reasonable timeline to conclude health care coverage transactions.
- Establishes accountability and responsibility on the part of insurers in managing their processes and administration of benefits, ultimately helping to keep overall health care costs down.
- Careful management of claims payment administration reduces unexpected health care costs that add to the cost of care in the long run.

Proposed Retroactive Denial Laws in North Dakota

Dental Care Bill of Rights

HB 1154 – Dental Insurance Reform

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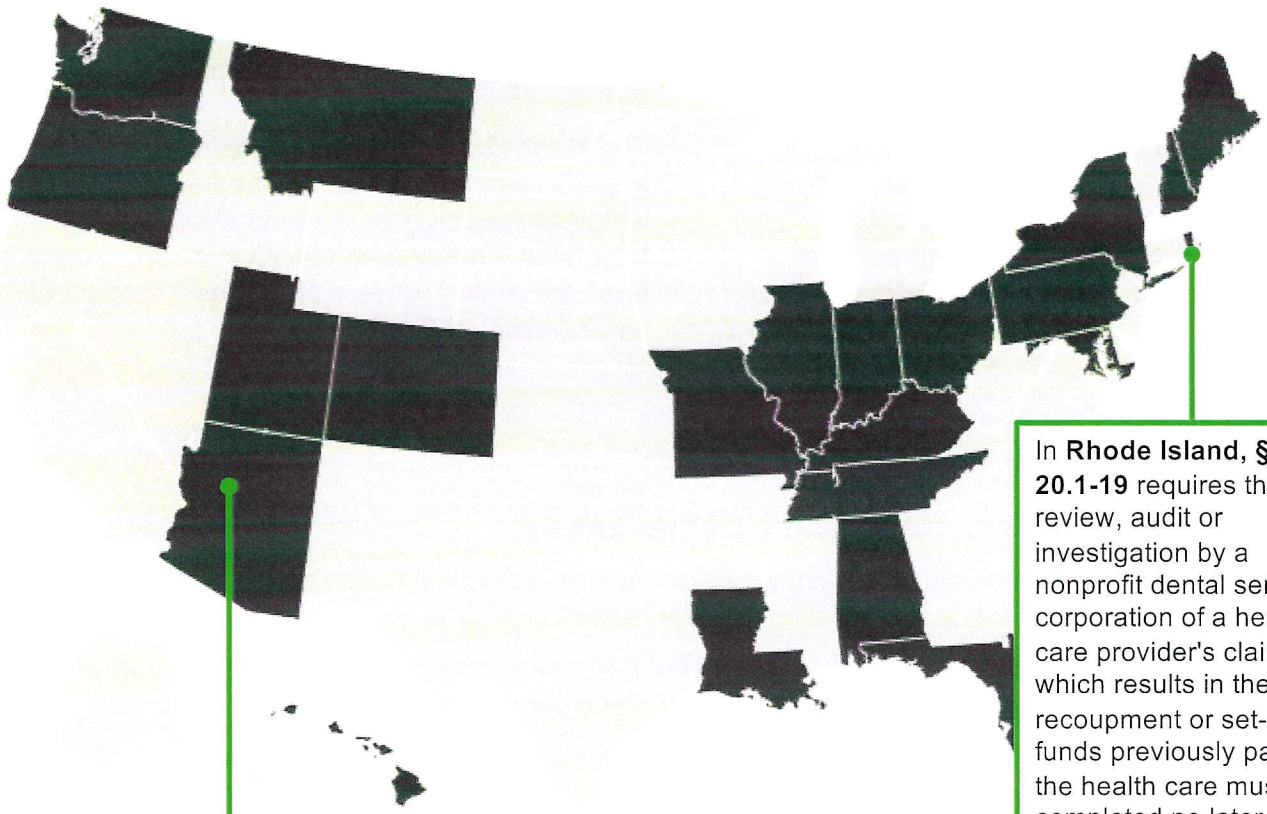
Retroactive Denial Legislation – Taking Root Across America

PASSED IN

24 states



In **Rhode Island, § 27-20.1-19** requires that any review, audit or investigation by a nonprofit dental service corporation of a health care provider's claims which results in the recoupment or set-off of funds previously paid to the health care must be completed no later than 18 months after the completed claims were initially paid.

In **Arizona, A.R.S. § 20-3102 (I)** prohibits insurers from adjusting or requesting adjustment of the payment or denial of a claim more than one year after payment or denial.

To learn more about Retroactive Denial Legislation in North Dakota, please contact the North Dakota Dental Association at 701-223-8870 or by email at wsherwin@smilenorthdakota.org.

National Association of Dental Plans

March 9, 2021

The Honorable Judy Lee
North Dakota Senate Human Services Committee
600 East Boulevard
Bismarck, ND 58505-0360

Dear Chairwoman Lee and Members of the Senate Human Services Committee:

On behalf of the National Association of Dental plans, the leading national representative of dental benefits provided to over 200 million Americans, and on behalf of approximately 375,000 North Dakotans who have dental benefits, we respectfully oppose HB 1154.

We appreciate that HB 1154 recognizes that network leasing is an important practice that creates value for employers, providers, and consumers by expanding carriers' networks. Through leasing arrangements, dentists receive access to new market segments and new patients. Consumers receive the benefits of broader provider networks, including increased access to care and choice of provider. Broader networks, from or made possible by leasing, result in lower costs for consumers, both for premiums and cost sharing on dental care services. NADP supports provider choice with regard to participation in a carrier's leasable network. We also believe providers should be well-informed about leasing arrangements in which they participate with carriers or leasing companies, and we support efforts to enhance communication between providers and these entities.

However, we recognize that HB1154 also contains additional provisions unrelated to network leasing. Some of these provisions, like regulations on prior authorization, have been enacted by a handful of states in recent years. While NADP appreciates the sponsor's efforts to help patients and their dentists anticipate the costs of dental services before such services are rendered, **this legislation fails to recognize the fundamental differences between a prior authorization and other communications about benefits coverage which occur frequently between dental carriers and dental providers,** such as pre-treatment estimates.

National Association of Dental Plans
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972.458.6998

The failure to accurately define a prior authorization in a way that is commonly understood and used by dental carriers and to distinguish the term from other, voluntary, benefit determination processes will ultimately lead to confusion among North Dakota's dentists and patients.

The definition of prior authorization in HB 1154, as currently drafted, is flawed in the following ways:

- HB 1154 does not recognize that a prior authorization, as used elsewhere in North Dakota Code[1], as defined in other state statutes[2], and as commonly understood by insurance carriers,[3] is a process whereby a provider, typically on behalf of a patient, requests approval or authorization from the insurance carrier before delivering a treatment or service. **A communication is considered prior authorization only if there is a requirement by the carrier or plan that services be authorized, prior to being rendered, in order to be covered.** This is typically a process that is required if a patient needs a complex treatment.
- HB 1154 does not recognize that **a prior authorization is distinct from non-binding, voluntary communications between a dentists and insurance carriers, such as a pre-treatment estimate**. A pre-treatment estimate is an optional process whereby providers and plan members can request information about benefit coverage and costs and receive an estimate. A pre-treatment estimate is neither a guaranty of payment nor a determination of the necessity for the service.
- HB 1154 does not specify that **prior authorizations are written communications which are issued in response to requests submitted by a dentist using a format prescribed by the insurer**. The failure to specify the manner in which prior authorizations are obtained may lead dental providers and patients to mistakenly believe that phone calls or claims tools used to help a patient or dentist determine what the plan could cover and pay for are prior authorizations. These voluntary services may not check the patient's eligibility (until the date of service), incentive levels, maximum or deductible, or any additional coverage that may apply; they are not a guaranty of payment.

We strongly urge you prevent this unnecessary confusion by adding language to this bill plainly stating that a prior authorization does not include a voluntary, non-binding request for a projection of dental benefits or payment that does not require authorization. This approach mirrors legislation enacted last year in the state of North Carolina[4] and introduced in Texas[5].

[1] N.D.C.C. § 50-24.6-01
[2] Ind. Code § 27-1-37.5-7
[3] https://www.ahip.org/wp-content/uploads/Prior-Authorization-FAQs.pdf
[4] North Carolina G.S. 58-3-200(c)
[5] Texas HB 2486

Further, we urge this Committee to clarify that a prior authorization must be written and submitted in format prescribed by the insurer.

NADP respectfully submits the following amendment language for this Committee's consideration:

"Prior authorization" means written confirmation by the covered person's dental benefit plan that the services sought to be provided by the dental provider meet the criteria for coverage under the covered person's dental benefit plan ~~as defined~~ and are 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 covered person's dental benefit plan. For purposes of this section, a prior authorization does not include a voluntary, non-binding request for a projection of dental benefits or payment that does not require authorization."

Thank you for your time and consideration of these important issues. We remain committed to working with you and with the dental provider community in North Dakota to address this matter in a way that is beneficial to the patients that we all serve.

Sincerely,

Teresa Cagnolatti
Director of Government and Regulatory Affairs

NADP Description:
NADP is the largest non-profit trade association focused exclusively on the dental benefits industry. NADP's members provide dental HMO, dental PPO, dental indemnity, and discount dental products to more than 200 million Americans with dental benefits. Our members include the entire spectrum of dental carriers: companies that provide both medical and dental coverage, companies that provide only dental coverage, major national carriers, regional, and single state companies, as well as companies organized as non-profit plans.

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

HB 1154
3/15/2021

A BILL 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.

Madam Chair Lee opened the discussion on HB 1154 at 3:48 p.m. Members present: Lee, K. Roers, Hogan, Anderson, Clemens, O. Larsen.

Discussion Topics:

- Dental benefit plans
- Title 9
- Network leasing

[3:49] William Sherwin, Executive Director, ND Dental Association. Provided clarification to the committee on Sanford Health and Blue Cross and Blue Shield dental plans.

Senator Anderson moves **DO PASS.**
Senator Hogan seconded.

Senators	Vote
Senator Judy Lee	Y
Senator Kristin Roers	Y
Senator Howard C. Anderson, Jr.	Y
Senator David A. Clemens	Y
Senator Kathy Hogan	Y
Senator Oley Larsen	N

The motion passed 5-1-0
Senator Lee will carry HB 1154.

Additional written testimony: N/A

Madam Chair Lee closed the discussion on HB 1154 at 4:01 p.m.

Justin Velez, Committee Clerk

REPORT OF STANDING COMMITTEE

HB 1154, as engrossed: Human Services Committee (Sen. Lee, Chairman) recommends **DO PASS** (5 YEAS, 1 NAY, 0 ABSENT AND NOT VOTING). Engrossed HB 1154 was placed on the Fourteenth order on the calendar.