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2024 – Enacted Dental Benefit State Legislation

23 New Laws in 14 States

Arizona *(3 Issues-2 Bills);* **Florida** *(2 Issues-1 Bill)*; **Indiana** *(2 Issues-1 Bill)*; **Iowa** *(2 Issues-1 Bill)*; **Louisiana** *(1 issue-1 Bill);* **Illinois** *(2 Issues-2 Bills);* **Maryland** *(1 Issue-1 Bill)*; **Missouri** *(2 Issues-1 Bill);* **Ohio** *(1 Issue-1 Bill);* **Pennsylvania** *(1 issue-1 bill);* **Rhode Island** *(1 Issue-1 Bill);* **Tennessee** *(2 Issues-1 Bill);* **Virginia** *(2 Issues-1 Bill);* **Wisconsin** *(1 Issue-1 Bill)*

Assignment of Benefits (Back to Top)	
Indiana SB 132	If a covered individual assigns the rights of the covered individual to benefits for dental services to the provider of the dental services, the covered individual's dental carrier shall pay the benefits assigned by the covered individual to the provider of the dental services.
Missouri (*Prompt Payment in AoB*) SB 1359	Impact of law is that existing prompt claim payment laws apply to payments under assignment of benefits.
Wisconsin AB 62	If the right to receive reimbursement for dental care and related services is assigned to a provider of dental care or related services, the insurer shall directly pay the provider the amount of any claim under the same criteria and payment schedule under which the insurer would have reimbursed the insured.

Claims Review (Back to Top)	
Arizona HB 2444	(Includes provision on VCC as seen in SB 1070 below) Adds prompt payment concerns to list of allowable grievances; grievances are any written complaints subject to resolution through the insurer's system. Requires state to post a report on a publicly accessible websites that includes the information such as: 1. The total number of grievances received; 2. The average time to resolve a grievance; 3. The percentage of grievances where a health care insurer's decision was overturned; and, a summary of all records of health care provider grievances received during the prior six months.
Maryland SB 791	New law requires insurance carriers to provide contact information for each entity involved in their claims process along with detailed explanations for any coverage denials when requested. It strengthens requirements for emergency review of grievances reviews under emergency situations. For non-emergency adverse decisions, the law requires explanation of the reasoning used to determine care was not medically necessary. It sets time limits on responses from insurers. Additionally, the law requires private review agents to attest to applying specific criteria in making decisions which include making decisions that are objective, based on peer-reviewed science, sufficiently flexible for deviations in care as needed and accountable for atypical diagnoses.

Disallow Clause Prohibition (Back to Top)	
Arizona HB 2444	New law clarifies that there is no preclusion on a health care provider, with written informed consent of the patient, from collecting monies for a service that is either:1. Not covered under the insurance policy; or 2. Medically necessary and a payment on the claim was not made due to a denial on the basis of frequency or a disallowance on the basis of frequency. For the purposes of this paragraph, a provider is limited to the rates prescribed by that provider's fee schedule.

Downcoding & Bundling – Prohibit/Limit (Back to Top)	
Tennessee HB 677	Prohibits dental insurers from maintaining a plan that uses downcoding in a manner that prevents a provider from collecting the fee for actual services performed either from the dental benefit plan or the patient or uses bundling in a manner where a procedure code is labeled as nonbillable to the patient unless, under generally accepted practice standards, the procedure code is for a procedure that may be provided in conjunction with another procedure. Requires that an explanation of benefits for a dental benefit plan includes the reason for any downcoding or bundling result.

Medical Loss Ratio (Back to Top)	
Louisiana SB 463	Establishes that: Numerator is: clinical dental service costs (defined by commissioner), quality improvement (defined by commissioner) not to exceed 5% of net revenue. Overhead and administrative costs (defined by commissioner) may not be in numerator. Dental insurers to file MLR report with insurance department that includes additional data: 1. The number of enrollees, 2. The plan cost-sharing and deductible amounts, 3. The annual maximum coverage limit, and 4. The number of enrollees who meet or exceed the annual coverage limit. Info is posted on website that allows public to allow public to search carriers by plan type.
Rhode Island SB 2873 SB 7944	Requires insurers to file with the commissioner an actuarial memorandum disclosing its incurred claims and earned premiums for the preceding calendar reporting year, together with such additional information as may be required. Requires study of MLR.
Virginia HB 1132	Requires posting of dental insurers' MLR. The legislation will also convene a work group of stakeholders including representatives of the VDA and dental carriers to evaluate the need for changes regarding ethics and fairness in dental carrier business practices.

Non-Covered Services (Back to Top)	
Ohio SB 40	Limits insurer ability to set fees on covered services: "Covered dental services" means dental care services for which reimbursement is available under an

	enrollee's health care contract, or for which a reimbursement would be available but for the application of contractual limitations, such as a deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation, alternative benefit payment, or any other limitation.

Prior Authorization (Back to Top)	
Florida **SB 892**	Prohibits insurers from denying claims for procedures included in a prior authorization unless certain situations are present such as patient has exceeded annual maximum or condition has changed considerably since authorization.
Illinois **HB 4789**	Prohibits dental insurers from denying claims for procedures specifically included in a prior authorization unless certain circumstances apply. Provides that a dental service contractor shall not recoup a claim solely due to a loss of coverage for a patient or ineligibility if, at the time of treatment, the dental service contractor erroneously confirmed coverage and eligibility, but had sufficient information available to the dental service contractor indicating that the patient was no longer covered or was ineligible for coverage.

Provider Network Leasing (Back to Top)	
Indiana **SB 132**	Any provider that is a party to the provider network contract must be allowed to choose not to participate in the third party access [lease]. Ensures provider has a right to choose not to participate in the third party access [lease]. Dentists choosing to not participate in lease shall not have their rights or status altered under the provider network contract because of the provider's choice not to participate in third party access. The third party being granted access to dental insurance networks must agree to comply with all terms of the provider network contract. Additional protections in lease arrangements in law.
Iowa **HF 2400**	Lease limitations with opt-out and requirement that 3rd party accessing network adhere to the contract leased. Contacting entity may not cancel, terminate, or refuse to form a contractual relationship with a provider that chooses to not participate in third-party access.

Required Coverage (Back to Top)	
Illinois **SB 3305**	Requires coverage for medically necessary care and treatment to address a major injury to the jaw either through an accident or disease. Coverage under this Section may impose the same deductibles, coinsurance, or other cost-sharing limitations that are imposed on other related benefits under the policy.

Virtual Credit Card-Payment (Back to Top)	
Arizona SB 1070	If a health care provider opts out of a method of payment, that decision remains in effect until the health care provider opts back into the prior method payment or a new contract is executed.
Florida SB 892	Prohibits a contract between a health insurer and a dentist from containing certain restrictions on payment methods. Prohibits a health insurer from charging a fee to transmit a payment to a dentist through ACH transfer unless the dentist has consented to such fee and prohibits a contract between a prepaid limited health service organization and a dentist from containing certain restrictions on payment methods.
Iowa HF 2400	Insurer paying with VCC must notify the provider of any fees associated with each payment method, inform the provider of the available options for methods of payment, and provide clear instructions to the provider for the selection of an alternative payment method. A dentist agent that transmits payments through the national automated clearinghouse may charge a reasonable fee related to bank transmittal, transaction management, data management, portal services, and other value-added services.
Missouri SB 1359	Dentists' VCC election notice will remain in effect for the duration of the contract unless the health care provider requests otherwise. All payments made by the health carrier to the health care provider after receipt of the notice declining to be reimbursed with a payment method cannot require the health care provider to pay a fee, discount the amount of the provider's claim for reimbursement, or remit any other form of remuneration in order to redeem the amount of the provider's claim for reimbursement.
Pennsylvania HB 1664	Prohibits insurers from restricting claim payment methods to a participating health care provider so that the exclusive payment method is a credit card payment. Requires insurers to, when changing or initiating payment methods, a health insurer must advise the health care provider of all available payment methods and notify the health care provider that fees imposed by the health insurer or its contracted vendor may apply to electronic funds transfer payments, including credit card payments, and provide instructions and contact information so that the health care provider may obtain the exact amount of the fees. Fees charged by a financial institution or merchant servicer chosen by the health care provider shall not be included for the purposes of this law. Law includes fines for non-compliance.
Tennessee SB 677	A dental benefit plan must not contain restrictions on methods of payment from the dental benefit plan or its vendors to the dentist in which the only acceptable payment method is a credit card payment

Insurer Business Practices in Review (Back to Top)	
Virginia HB 1132	The legislation will also convene a work group of stakeholders including representatives of the VDA and dental carriers to evaluate the need for changes regarding ethics and fairness in dental carrier business practices.