Dental Transparency Legislation

1. Medical/Dental Loss Ratio (MLR)

MLR laws require insurers to report the percentage of premium revenue that is spent on actual care, as compared to administrative costs. Some proposals may require rebates if plans under-spend on dental care.

2. Explanation of Benefit-Required Format

Commissioner approves explanation of benefits forms, definitions and terms. Sets minimum standards for the format, terms, and definitions for explanation of benefits forms. Commissioner must approve explanation of benefits forms and the standard definitions or terms used on forms to prevent confusing, inconsistent, or misleading information.

3. All Payer Claims Database

Requires insurers and to an extent health care providers to submit certain claims data to the state for collection and reporting purposes.

4. Uniform Benefits and Coverage Disclosure Matrix

Requires carriers to utilize a uniform benefits and coverage disclosure matrix to offer patients a consistent format for determining plans' designs. The matrix could include: deductible, benefit limit, coverage info for basic-preventive-diagnostic-major & orthodontia services, dental plan reimbursement levels/estimated enrollee cost share for services, waiting periods, examples to illustrate coverage and estimated enrollee costs of commonly used benefits.

5. Insurance Identification Card – ERISA Notification

Front desk personnel who see the insurance cards never know if a patient's plan must adhere to state laws such as non-covered services or assignment of benefits regulations. Some laws require notification on insurance cards indicating "fully insured" which clarify that state laws apply to this transaction.

6. Independent Claims Review

Provides a requirement that dental plans include a method for independent claims review for patients wishing to have denied claims reviewed after the plan has exhausted internal reviews.

7. Coordination of Benefits (CoB)

When two dental plans cover the same procedure, laws typically determine how to identify primary and secondary plans (who pays first and second). Significant provisions of CoB laws are those that require the secondary plan to pay a benefit and/or prohibit secondary plans from refusing to pay a benefit.

8. Downcoding Limitations

Prohibition/limitations on dental plans using procedure codes different from the one submitted by the dentist in order to determine a benefit in an amount less than that which would be allowed for the submitted code.

9. Notification of Contract Changes

Insurers' contracts with dentists may include a provision that changes may occur without notice. Some changes can be substantive. These laws require plans to provide early notice of planned substantive contract changes well in advance. Legislative approaches may include opt-in or opt-out options for dentists when contract changes are proposed.

10.Equal Payment

Requires dental plans to pay the same benefit for a covered individual whether the rendering dentist is participating or non-participating in the dental plan

11.Disallow Clause Prohibition

This law would prohibit any contract provision that prevents a dentist from charging a covered person for a covered procedure not paid for by the benefit plan. The law would prohibit contract provisions saying no payment will be made for a covered service by the dental plan AND the participating dentist may not collect payment from the covered person for the covered service disallowed by the dental plan

12.Credentialing Improvements

Requires a health care entity or health plan to issue a decision regarding the credentialing of a health care provider within XX calendar days of receiving a complete credentialing application.

13.Fee Reduction Regulation

Insurers would be prohibited from reducing reimbursement paid to health care providers by more than XX% for more than a certain number of consecutive years, and prohibits further reductions without approval of state authority.

14.Provider Rating Systems

Some benefit plans may use a rating systems such as stars to rate dentists based on costs/charges. To help ensure proper profiling of dentists, health care entities may be required to employ rating designations that are fair and accurate based on reliable, diverse and approved data collection methods; these rating entities would have to provide dentists the right to challenge and correct erroneous designations, data, and methodologies.

15.All-Product Clauses - Providers' Right to Choose Act

Would prohibit health insurers from requiring a health care provider to participate in all health plans offered by the health insurer, or to participate in all the insurer's provider network arrangements. It prohibits the health insurer from terminating any contractual relationship with a health care provider for not agreeing to participate in a provider network arrangement.