GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

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HOUSE BILL 704
PROPOSED COMMITTEE SUBSTITUTE H704-PCS10608-BP-6

Short Title: Dental Bill of Rights. (Public)

Sponsors:

Referred to:

April 11, 2019

A BILL TO BE ENTITLED

AN ACT TO CLARIFY CERTAIN PROVIDER AND PATIENT RIGHTS REGARDING HEALTH BENEFIT PLAN CONTRACTS FOR THE PROVISION OF DENTAL SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-80-290 reads as rewritten:

"**§ 58-50-290. Health benefit plans or insurers contracting for provision of dental services; no limitation on fees for noncovered ~~services.~~services or on methods of claims payment.**

(a) No agreement between an insurer or an entity that writes stand-alone dental insurance and a dentist for the provision of dental services on a preferred or in-network basis to plan members or insurance subscribers in connection with coverage under a stand-alone dental plan, but not in connection with or incidental to coverage under a medical plan or health insurance policy, may require that a dentist provide services at a fee limited or set by the plan or insurer, unless the services are reimbursed as covered services under the contract.

(b) For purposes of this section, "covered services" means a service for which reimbursement is available under an insurer's policy, without regard to contractual limitations by a deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation, alternative benefit payment, or other limitation.

(c) No agreement between an insurer or another entity contracting for the provision of dental services and a provider of dental services shall contain 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."

SECTION 2. Article 50 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-50-292. Dental provider networks; confidential business information.**

(a) The following definitions apply in this section:

(1) Provider network contract. – A contract between an insurer and a dental services provider specifying the rights and responsibilities of the insurer and the provider for the delivery of and payment for dental services.

(2) Insurer. – As defined in G.S. 58-3-225(a).

(3) Third party. – A person or entity that enters into a contract with an insurer or with another entity to gain access to a dental provider network contract. Third party does not include an employer group or other group for which the insurer provides administrative services, including payment of claims.

(b) An insurer may grant access to its provider network contract to a third party if:

(1) At the time the provider network contract is entered into and at the time the provider network contract is renewed, the insurer allows any provider who is part of the carrier's provider network to choose not to participate in third party-access to the provider network contract. The third party access provision of any provider network contract shall be clearly identified in the provider network contract. An insurer shall not grant third party access to the provider network contract of any provider who does not participate in third party access.

(2) The insurer includes on its Web site a listing identifying all third parties who have been granted such access.

(3) The third party accessing the provider network contract agrees to comply with all of the provider network contract's terms.

(c) This section shall not apply to the assignment of or access to a provider network contract to an entity operating under the same brand licensee program as the contracting entity or any affiliates of the contracting entity."

SECTION 3. G.S. 58-3-200(c) reads as rewritten:

"(c) Coverage Determinations. – If an insurer or its authorized representative determines that services, supplies, or other items are covered under its health benefit ~~plan,~~ plan or dental plan, including any determination under G.S. 58-50-61, the insurer shall not subsequently retract its determination after the services, supplies, or other items have been provided, or reduce payments for a service, supply, or other item furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about the insured's health condition that was knowingly made by the insured or the provider of the service, supply, or other item. For purposes of this subsection, a pretreatment estimate means a voluntary request for a projection of dental benefits or payment that does not require authorization, and a pretreatment estimate for dental services shall not be considered a coverage determination."

SECTION 4. This act becomes effective January 1, 2020, and applies to health benefit contracts issued, renewed, or amended on or after that date.