SUBJECT: Requiring certain disclosure and prior authorization of dental care benefits

COMMITTEE: Insurance — committee substitute recommended

VOTE: 8 ayes — Lucio, Oliverson, S. Davis, Julie Johnson, Lambert, Paul, C. Turner, Vo

0 nays

1 absent — G. Bonnen

WITNESSES: For — Matt Roberts, Texas Dental Association (*Registered, but did not testify*: David Mintz, Texas Academy of General Dentistry; Tracy Morehead, Texas Academy of Pediatric Dentistry; Bruce Scott, Texas Society of Oral and Maxillofacial Surgeons; Sandy Dunn)

Against — None

On — (*Registered, but did not testify*: Doug Danzeiser, Texas Department of Insurance)

BACKGROUND: Interested parties suggest that dental patients and dentists need timely and accurate information about benefits in order to verify patients' enrollment, eligibility, and scope of benefits. Observers suggest that providing this information on a website could address inefficiencies in eligibility verification and claims processing for both dentists and patients.

DIGEST: CSHB 2486 would require disclosure of dental care benefits on a website and prior authorization of benefits and would create certain requirements for plans and policies offering dental care.

Website. CSHB 2486 would require a person or entity providing an employee benefit plan or health insurance policy for dental care services to establish a website to provide resources to dentists, insureds, participants, employees, and members.

The website would have to contain information about the plan or policy sufficient for patients and dentists to determine the type of dental care services covered by the plan or policy, the percentage of the allowed charges for a covered service that would be reimbursed, and an estimate of the amount of the payment or reimbursement available for a contracting provider's services.

The bill would require the website to be accessible at no charge to patients and dentists.

Prior Authorization. CSHB 2486 would require the provider of an employee benefit plan or health insurance policy to provide to a dentist a written prior authorization of benefits for a dental care service for a patient on request of a patient or treating dentist.

"Prior authorization" would mean a written and verifiable determination that one or more specific dental care services were covered under a plan or policy and were payable and reimbursable in a specific stated amount. The term would include preauthorization but not a predetermination of benefits.

The plan or policy provider could not deny a claim for dental care service or pay a dentist an amount less than the amount stated in the prior authorization except in certain circumstances. The plan or policy provider may deny a claim or reduce reimbursement only if:

- the denial or reduction was in accordance with the patient's benefit limitations, including an annual maximum or frequency of treatment limitation, and the patient met the limitation after the prior authorization was issued;
- the documentation for the claim failed to reasonably support the claim as preauthorized;
- the preauthorized service was not medically necessary or was subject to denial under the conditions for coverage because of a change in the patient's condition or because the patient received additional dental care services; and

- other circumstances listed in the bill transpired.

Methods of payment. CSHB 2486 would require an employee benefit plan or health insurance policy providing dental care to provide one or more methods of payment or reimbursement providing the dentist 100 percent of the contracted amount. The methods of payment could not require the dentist to incur a fee to access the payment or reimbursement.

A plan or policy also would have to disclose on the website required by this bill any fees associated with the available methods of payment or reimbursement, on the request of a dentist or party to or beneficiary of the plan or policy.

Overpayment of a claim. The bill would prohibit an employee benefit plan or health insurance policy providing dental care from deducting the amount of an overpayment of a claim from a payment or reimbursement for a service provided by a dentist who did not receive the overpayment.

Predetermination of benefits. The bill would define "predetermination of benefits" as an estimate by the patient's plan or policy provider of:

- the patient's eligibility for benefits or covered services;
- the amount of the patient's deductible, copayment, or coinsurance related to benefits or covered services; and
- the maximum benefit limits for benefits or covered services.

The bill would take effect September 1, 2019, and would apply to an employee benefit plan or health insurance policy providing dental care that was issued on or after that date.