Amendment No. 1 to SB0677

Bailey
Signature of Sponsor

AMEND Senate Bill No. 677* House Bill No. 949

by deleting all language after the enacting clause and substituting:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 10, is amended by adding the following as a new section:

(a) As used in this section:

(1) "Bundling" means the practice of combining distinct dental procedures into one (1) procedure for billing purposes;

(2) "Covered person" means an individual who is covered by a dental benefit plan;

(3) "Covered services" means dental services for which a reimbursement is available under the enrollee's plan contract, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefits payments, or any other limitation;

(4) "Credit card payment":

(A) Means a type of electronic funds transfer in which a dental benefit plan or its contracted vendor issues a single-use series of numbers associated with the payment of dental services:

(i) Performed by a dentist and chargeable to a predetermined dollar amount; and

(ii) For which the dentist is responsible for processing the payment by a credit card terminal or internet portal; and

(B) Includes virtual or online credit card payments for which no physical credit card is presented to the dentist and the single-use credit card expires upon payment processing;

(5) "Dental benefit plan" means a limited health service benefit plan that provides coverage for dental services;

(6) "Dental carrier" means a health insurance entity that provides coverage for dental services;

(7) "Dental services":

(A) Means services for the diagnosis, prevention, treatment, or cure of a dental condition, illness, injury, or disease; and

(B) Does not include services delivered by a provider that are billed as medical expenses under a health insurance plan;

(8) "Dentist" means a dentist licensed or otherwise authorized in this state to furnish dental services;

(9) "Dentist agent" means a person who establishes an agency relationship contract with a dentist to process bills for services provided by the dentist under terms and conditions established between the agent and dentist. Such contracts may permit the dentist agent to submit bills, request reconsideration, and receive reimbursement;

(10) "Downcoding" means the adjustment of a claim submitted to a dental benefit plan to a less complex or lower cost procedure code;

(11) "Electronic funds transfer payment" means a payment by any method of electronic funds transfer other than healthcare electronic funds transfer and remittance advice transactions under 45 CFR 162.1601 and 162.1602;

(12) "Health insurance entity" means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner of commerce and insurance, that contracts or offers to contract to provide health insurance coverage, including, but not limited to, an insurance company, a health maintenance organization, and a nonprofit hospital and medical service corporation;

(13) "Material change" means a change to:

(A) A dental benefit plan's rules, guidelines, policies, or procedures concerning payment for dental services;

(B) The general practices of the dental benefit plan that decrease reimbursements paid to providers; or

(C) How a dental benefit plan adjudicates and pays claims for services if the change would:

(i) Require a provider to change how the provider submits claims to the plan; or

(ii) Increase the provider's administrative expense; and

(14) "Participating provider" or "provider" means a dentist licensed to practice dentistry in this state, who provides dental services to an enrollee at a fee set by or at a fee subject to the approval of an insurer, dental services plan, third-party administrator, or another party that contracts to provide dental services.

(b) 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.

(c)

(1) When initiating or changing payments to a dentist using electronic funds transfer payments, including virtual credit card payments, a dental benefit plan or its vendors 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

(C) Provide clear instructions to the dentist as to how to select an alternative payment method.

(2) A dental benefit plan or its vendor that initiates or changes payments to a dentist for healthcare electronic funds transfer and remittance advice transactions under 45 CFR 162.1601 and 162.1602 shall not charge a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee.

(3) When transmitting healthcare electronic funds transfer and remittance advice transactions under 45 CFR 162.1601 and 162.1602, a dentist agent may charge reasonable fees for payments related to transaction management, data management, portal services, and other value-added services in addition to the bank transmittal.

(d)

(1) A dental carrier that contracts or renews a contract with a provider shall:

(A) Make the dental carrier's current dental benefit plan policies or guidelines available online; and

(B) If requested by a provider, send a copy of the policies to the provider through mail or electronic mail.

(2) A dental benefit plan contract as described in subdivision (d)(1) must furnish to providers:

(A) A summary of all material changes made to a dental benefit plan no less than thirty (30) days prior to the date the material change takes effect;

(B) The downcoding and bundling policies that the dental carrier reasonably expects to be applied to the provider's services as a matter of policy; and

(C) A description of the dental benefit plan's utilization review procedures, including, but not limited to:

(i) A procedure for a covered person to obtain a review of an adverse determination; and

(ii) A statement of a provider's rights and responsibilities regarding the procedure described in subdivision (d)(2)(C)(i).

(3) A dental carrier shall not offer or maintain in this state a dental benefit plan that:

(A) Based on the provider's contracted fee for covered services, 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

(B) 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.

(4) A dental carrier shall ensure that an explanation of benefits for a dental benefit plan includes the reason for any downcoding or bundling result.

(e) A violation of this section may subject the dental carrier, dental service plan, third-party administrator, or other party that covers any dental services to the sanctions described in § 56-2-305.

(f) This section does not apply to the TennCare program or a successor program provided for in the Medical Assistance Act of 1968, compiled in title 71, chapter 5, or to the CoverKids Act of 2006, compiled in title 71, chapter 3, part 11, or a successor program.

SECTION 2. Tennessee Code Annotated, Section 56-7-1017, is amended by adding the following as a new subsection:

(e) A violation of this section may subject the insurer, dental service plan, third-party administrator, or other party that covers any dental services to the sanctions described in § 56-2-305.

SECTION 3. This act takes effect July 1, 2024, the public welfare requiring it.