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Bill Analysis

Version: As Introduced

Primary Sponsor: Rep. Santucci

Logan Briggs, Attorney

CORRECTED VERSION

SUMMARY

- Requires health plan issuers to notify covered persons that they may incur out-of-pocket expenses for dental care services that are not covered services.
- Prohibits, beginning January 1, 2024, a contracting entity from requiring that a dental care provider accept a payment amount set by the contracting entity for dental care services unless those services are covered services.
- Makes a violation of the above provisions an unfair and deceptive act in the business of insurance.
- Requires dental care providers to disclose pricing and certain other information for dental care services that are not covered services.
- Subjects providers who violate the bill's disclosure requirements to professional discipline.

DETAILED ANALYSIS

Overview

The bill modifies the law governing health plan issuers, health care contracts, and dental care providers to include several contract and disclosure requirements related to the provision of dental care services that are not covered by insurance. The bill requires health pan issuers to notify covered persons of potential out-of-pocket costs, prohibits inclusion of certain terms in contracts between contracting entities and dental care providers, and requires certain pricing disclosures by dental care providers. The bill's requirements for dental care services are similar, in some respects, to current law requirements for vision care services. However, unlike vision care, where the requirements apply to both services *and* materials, the bill's dental care requirements apply only to services. The bill does not address insurance contracts that exclusively cover dental care materials.

Health Plan Issuers

Notifications

The bill imposes disclosure requirements on any health care policy, contract, agreement, or plan of a (1) health insuring corporation, (2) sickness and accident insurer, (3) multiple employer welfare arrangement, or (4) public employee benefit plan (collectively, health plan issuers) covering dental care services. The bill requires the following notification to be made to all individuals covered by such a health benefit plan:

> IMPORTANT: If you opt to receive dental care services that are not covered benefits under this plan, a participating dental care provider may charge you his or her normal fee for such services. Prior to providing you with dental care services that are not covered benefits, the dental care provider will provide you with an estimated cost for each service.[1]

Similarly, health plan issuers must explain to covered persons that they may incur out-of-pocket expenses as a result of the purchase of dental care services that are not covered. The explanation must be provided in a manner similar to that in which the health plan issuer provides a covered person with information on a health benefit plan's coverage levels and out-of-pocket expenses.[2]

Unfair and deceptive practice

Under continuing law, a continuous or repeated practice by a health plan issuer of violating notice requirements is an unfair and deceptive practice. This classification also applies to the bill's new requirements related to dental care services.[3] Under continuing law, a person who is found to have committed an unfair and deceptive practice in the business of insurance is subject to any or all of the following sanctions:

- Suspension or revocation of the person's license to engage in the business of insurance;
- Prohibition on an insurance company or insurance agency employing the person or permitting the person to serve the company or agency in any capacity for a period of time;
- Return of any payments received by the person as a result of the violation;
- Fees for attorneys and other costs of any investigation into the violations committed by the person.[4]

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[1] R.C. 1751.85(B)(2) and 3923.86(B)(2); R.C. 1739.05, not in the bill.

[2] R.C. 1751.85(B)(4) and 3923.86(B)(4); R.C. 1739.05, not in the bill.

[3] R.C. 1751.85(C), 3901.21(BB), and 3923.86(C); R.C. 1739.05, not in the bill.

[4] R.C. 3901.22, not in the bill.

Health Care Contracts

Provider contract terms

The bill also prohibits certain terms from being included in health care contracts between a dental care provider and a contracting entity (i.e., any person that has the primary business purpose of contracting with participating providers for the delivery of health care services). Under the bill such contracts must not require, or be made contingent upon, a dental care provider accepting an amount set by the contracting entity as payment for dental care services other than covered services. A dental care provider may choose to accept an amount set by the contracting entity as payment for noncovered dental care services. Furthermore, a covered entity may communicate to covered persons which dental care providers have made such a choice. However, other than noting the provider's decision, the bill requires contracting entities to treat all participating, in-network dental care providers equally in provider directories, locators, and other marketing materials.

In addition, the bill prohibits a contracting entity from requiring a dental care provider to contract with a benefit plan offering supplemental or specialty health care services as a condition of contracting with a plan offering basic health care services.

These provisions apply to contracts entered into, amended, or renewed on or after January 1, 2024.[5]

Dental care provider disclosures

The bill requires a dental care provider that chooses not to accept a payment amount set by a contracting entity for dental services, other than covered services, to provide pricing and reimbursement information for those services. The information must include the estimated fee or discounted price suggested by the contracting entity, the estimated fee charged by the dental care provider, the amount the dental care provider expects to be reimbursed by the contracting entity, and estimated pricing and reimbursement information for any covered services that are also expected to be provided during the covered person's visit. Furthermore, the dental care provider must post, in a conspicuous place, a notice stating the following:

> IMPORTANT: This dental care provider does not accept the fee schedule set by your insurer for dental care services that are not covered benefits under your plan and instead charges his or her normal fee for those services. This dental care provider will provide you with an estimated cost for each noncovered service.[6]

Meaning of provisions

The bill specifies that its health care contract provisions are not to be construed as doing any of the following:

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[5] R.C. 3963.01 (E) and (G) and 3963.02(F)(1).

[6] R.C. 3963.02(F)(2).

- Restricting or limiting a contracting entity's ability to enter into an agreement with another contracting entity or an affiliate of another contracting entity;
- Restricting or limiting a health care plan's ability to enter into an agreement with a dental care plan to deliver routine dental care services that are covered under a covered person's plan;
- Restricting or limiting a dental care plan network from acting as a network for a health care plan;
- Prohibiting a participating dental care provider from accepting as payment an amount that is the same as the amount set by the contracting entity for dental care services that are not covered dental services.[7]

Furthermore, the bill specifies that continuing law's requirements relating to the termination of health care contracts are not to be construed as authorizing the Superintendent of Insurance to exercise regulatory authority over dental care providers.[8]

Enforcement

Health Care Contract Law

The health care contract provisions described above are part of Ohio's Health Care Contract Law. Continuing law authorizes the Superintendent of Insurance to conduct a market investigation of any person regulated by the Department of Insurance under Ohio's Insurance Law or Ohio's Corporation and Partnership Law to determine whether any violation of the Health Care Contract Law has occurred. When conducting such an examination, the Superintendent can assess the costs of the examination against the person examined.

The Superintendent may enter into a consent agreement to impose any administrative assessment or fine for conduct discovered that may be a violation of the Health Care Contract Law. In addition, a series of violations of the Health Care Contract Law by any person regulated by the Department of Insurance that, taken together, constitute a pattern or practice of violating that Law may constitute an unfair and deceptive insurance practice.[9]

The bill also specifies that a violation of its dental care services provisions is an unfair or deceptive practice in the business of insurance (see "**Unfair and deceptive practice**" above for a description of possible sanctions).[10]

[7] R.C. 3963.02(F)(3).

[8] R.C. 3963.02(G)(5).

[9] R.C. 3963.09, not in the bill.

[10] R.C. 3901.21(BB).

Professional licensing law

In addition, the bill subjects a dental care provider that engages in a pattern of continuous or repeated violations of the bill's disclosure, pricing, and notice requirements to discipline by the State Dental Board. Such discipline may include suspension or revocation of the provider's license to practice dentistry, formal censure, or other corrective actions.[11]

Definitions

The bill makes the following definitions:

"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.

"Dental care provider" means a dentist licensed by the State Dental Board. "Dental care provider" does not include a dental hygienist.[12]

HISTORY

Action	Date
Introduced	04-26-23

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[11] R.C. 4715.30(A)(19) and (C).

[12] R.C. 3963.01(E) and (G).