

SENATE BILL NO. 172

INTRODUCED BY E. WALKER

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A BILL FOR AN ACT ENTITLED: "AN ACT PROHIBITING A DENTAL INSURANCE PLAN FROM REQUIRING A PARTICIPATING DENTIST TO ACCEPT A FEE SET BY THE PLAN FOR ANY SERVICES EXCEPT COVERED SERVICES; PROHIBITING NETWORKS FROM SETTING DENTAL FEES OTHER THAN FOR COVERED SERVICES; PROVIDING A PENALTY; AND PROVIDING AN EFFECTIVE DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. Section 1. Provider agreement limited to covered services -- dental network constraints -- penalty -- definitions. (1) A provider agreement entered into or renewed on or after July 1, 2013, between dentists licensed under Title 37, chapter 4, and an issuer that offers an excepted benefits plan for limited-scope dental benefits or a health benefit plan that includes covered services may not:

(a) require the dentist to provide dental services to an individual covered under the excepted benefits plan or health benefit plan at a fee set by or subject to the approval of the issuer unless the dental services are covered services; or

(b) prohibit the dentist from offering or providing to an individual covered under the excepted benefits plan or health benefit plan any dental services that are not covered services. The fee for the noncovered services may be determined only under terms or conditions set by the dentist or negotiated by the dentist with the individual covered under the excepted benefits plan or health benefit plan.

(c) provide minimal coverage for covered services under the provider agreement for the sole purpose of avoiding the requirements of this section.

(2) A business entity that owns a network of health care providers and markets access to that network may not circumvent the terms of this section by making available to an issuer of an excepted benefits plan for limited-scope dental benefits or a health benefit plan that includes covered services any dentists in that network if the business entity sets dental services fees in its network for any services except covered services.

(3) An issuer of an excepted benefits plan for limited-scope dental benefits or a health benefit plan that includes covered services is subject to a fine as provided in 33-1-317 for a violation of this section.

(4) For the purposes of this section, the following definitions apply:



1 (a) "Covered services" means dental care services provided under a plan for limited-scope dental
2 benefits or a health benefit plan for which a payment is available subject to the application of contractual terms,
3 including but not limited to annual or lifetime maximums, deductibles, copayments, coinsurance, waiting periods,
4 frequency limitations, or alternative benefit reimbursement.

5 (b) "Issuer" includes an insurer, a health service corporation, or a third-party administrator that offers or
6 administers an excepted benefits plan for limited-scope dental benefits or a health benefit plan that includes
7 covered services.

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9 **NEW SECTION. Section 2. Codification instruction.** [Section 1] is intended to be codified as an
10 integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [section 1].

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12 **NEW SECTION. Section 3. Effective date.** [This act] is effective July 1, 2013.

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