Dental Benefits Legislation

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AB 1048: Consumer Protections and Rate Review (2023)
Enacts stronger regulatory oversight and consumer protections in dental plans by: 1) Prohibiting plans from denying claims related to a patient's pre-existing dental conditions; 2) prohibiting plans in the large group market from imposing waiting periods before patients can access their full benefits; 3) requiring state regulatory review of the premiums charged by dental plans to help protect consumers from unreasonable or unjustified rates. Dental plans lack much of the oversight and protections that come with medical insurance, and AB 1048 addresses some of the key disparities.

AB 952: ERISA Disclosure Transparency (2023)
Provides greater transparency by requiring dental plans to clearly disclose, at the time of determining coverage, whether a patient's plan is state or federally regulated. An estimated 40% of Californians are enrolled in self-insured plans that are exempt from California's laws and regulated instead under the federal Employee Retirement Income Security Act (ERISA). This has often led to confusion about a patient's coverage until the billing process has been completed and the plan has denied coverage or cited a billing exemption for services already rendered. AB 952 requires dental plans to disclose through their online patient portal or upon a dental office's request whether the patient's plan is state regulated, along with including the phrase "state regulated" on the patient's electronic or physical insurance identification card. The improved disclosure will also be helpful when a conflict occurs with a plan, making it easier to identify which regulatory entity to contact.

SB 242: Health Care Provider Reimbursements (2021)
Requires insurance plans to reimburse health care providers for increased costs of critical PPE during future public health emergencies. With the increased economic burden of safely operating during a pandemic, there is a risk of patients losing access to care amid a constriction of the dental provider network. The state will need a regulatory structure that can respond to future public health emergencies. By requiring insurance plans to provide financial assistance for PPE, SB 242 helps ensure that provider networks remain intact and prevent future disruptions in access to care.

AB 954: Dental Plan Network Leasing (2019)
Requires dental benefit plans to be more transparent about leasing access to a network of contracted dentists from another dental benefit plan. Lack of transparency in network leasing can cause confusion for patients and dentists, making it difficult for providers to educate patients about treatment options and the cost of care. AB 954 makes several changes, including: 1) requiring dental plans to clearly identify a contract clause allowing network leasing; 2) maintaining an up-to-date website list of all third parties that have access to a provider network contract; and 3) giving dentists the ability to opt out.

SB 1008: Dental Plan Transparency (2018)
Requires all dental plans to use a uniform matrix to disclose their benefits, similar to the one used by medical plans. The matrix will provide plan beneficiaries with a summary of plan details, including covered services, reimbursement levels, estimated enrollee cost share, limitations, and exceptions. SB 1008 will hold plans accountable to comparable standards as medical plans. The law is a direct result of data gathered from AB 1962. Click here for a list of dental loss ratios from 2014-2022.

AB 1962: Dental Plan Reporting & Accountability (2014)
Requires dental plans to file an annual Medical Loss Ratio report that will inform Californians as to the value of their dental insurance plans and receive the same protections that apply to medical plans under the Affordable Care Act. AB 1962 created a standardized reporting system for dental plans to uniformly disclose how they spend premium revenue.

AB 2252: Required plan notification of changes to coverage and fees (2012)
Requires dental benefit plans to notify contracted dentists whenever a plan changes the coverage of a plan the dentist is in network for, when the fee schedule or the manner in which treatment is reimbursed changes, and any claim adjudication system conversion may delay claims processing and payments.

AB 2275: Non-covered procedures (2010)
Prohibits dental benefit plans from capping fees charged for procedures that a plan doesn't cover and never pays for.

AB 895: Coordination of benefits (2008)
Establishes payment responsibility of dental benefit plans that are secondary for a patient with dual coverage. AB 895 prohibits "non-duplication of benefit policies."

SB 1387: Refund demand requirements (2008)
Clarifies requirements on plans when seeking to recover alleged overpayments from dental practices. This legislative requirement gives the provider 30 working days to respond to a refund demand, either in paying the refund, or in formally appealing the refund demand.