

Senate Bill 813 Written Testimony.pdf

Uploaded by: Antonio Hayes

Position: FAV

ANTONIO HAYES

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Legislative District 40



THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

Bill: Senate Bill 813

Title: *Health Insurance and Dental Plan Organizations - Dentists - Assignment of Benefits and Reimbursement of Nonpreferred Providers*

Committee: Finance

Sponsor: Senator Antonio Hayes

Good afternoon, Chair, Vice Chair, and members of the Finance Committee,

For the record, I am Senator Antonio Hayes, and I am here to present **Senate Bill 813**. This legislation seeks to improve patient access to dental care and reduce financial administrative burdens for Maryland families by modernizing how dental insurance benefits are processed.

Currently, unlike in medical insurance, many dental plans prohibit patients from "assigning benefits" to a dentist if that dentist is out-of-network (nonpreferred). This means that even if a patient has insurance coverage, they are often required to pay the full cost of the procedure upfront, wait for the insurance company to send a check to their home, and then settle the account. Alternatively, the insurance check is mailed to the patient, who may not realize it needs to be turned over to the provider, leading to confusion and collections issues.

The Solution: Assignment of Benefits

SB 813 extends the same rights patients currently have with physicians to their dental care.

- **Direct Reimbursement:** The bill prohibits insurers and dental plan organizations from refusing to directly reimburse a nonpreferred dentist when a patient has assigned their benefits.
- **Parity:** This simply adds "dentist" to the existing statute that already protects this right for physicians.

Crucially, this bill includes robust consumer protections to ensure patients are fully informed before they receive care. To accept an assignment of benefits, a nonpreferred dentist must provide the patient with a clear disclosure before performing the service, including:

- A statement that the dentist is a nonpreferred provider;
- A notification that the patient may be balance billed for covered services or charged for noncovered services;
- An estimate of the cost of services; and
- Specific terms regarding payment and interest

The bill provides reasonable exceptions where an insurer is not required to honor the assignment, such as if the patient paid the full amount at the time of service or if the assignment was withdrawn.

Senate Bill 813 streamlines the payment process, reduces out-of-pocket friction for patients, and ensures transparency regarding costs. The Act will take effect on January 1, 2027.

I respectfully request a favorable report on Senate Bill 813.

Position: Favorable

Testimony in support of SB 813.pdf

Uploaded by: Daniel Doherty

Position: FAV



SB 813 – Health Insurance and Dental Plan Organizations – Dentists – Assignment of Benefits and Reimbursement of Nonpreferred Providers

Testimony by Daniel T. Doherty, Jr. on behalf of The Maryland State Dental Association (MSDA) and The Maryland Society of Oral & Maxillofacial Surgeons (MSOMS) in Support of SB 813

SB 813 corrects an inequity that has existed for some time. While insurers have been required to honor a properly completed assignment of covered benefits directly to a nonpreferred physician, this has not been the case in dentistry. The purpose of SB 813 is to require all insurers and dental plan organizations to allow an enrollee/patient to direct that payment of the benefits provided for a dental service be made directly to a treating nonpreferred dentist.

Pursuant to the provisions of SB 813, the assignment of benefits is voluntary, but before a patient agrees to the assignment the dentist is obligated to:

- a) inform the patient that the dentist is a nonpreferred dentist;
- b) inform the patient that they may be billed for noncovered services;
- c) inform them that the dentist may charge the patient for the balance owed for covered services;
- d) provide an estimate of the cost for the services to be provided;
- e) provide the terms of payment that may apply; and
- f) disclose the amount of interest, if any, that will be charged by the dentist.

The dentist then must submit a Disclosure Form developed by the Commissioner to the insurer to document the assignment of benefits. The insurer may not refuse to directly reimburse a nonpreferred dentist except in three (3) circumstances. First, if the insurer receives notice of the assignment of benefits after it has paid the enrollee. Second, the enrollee withdraws the assignment before the insurer has paid the benefits. Finally, the enrollee paid the dentist the full amount at the time of service.

SB 813 benefits both the patient and the nonpreferred dentist. It assures the dentist that she or he will be paid the covered amount. It saves the patient from having to pay the covered amount upfront. Finally, it facilitates the continuation of a dentist/patient relationship that could have been interrupted by changes relating to the patient's insurance coverage.

The MSDA and the MSOMS respectfully request that SB 813 receive a Favorable Report.

Daniel T. Doherty, Jr.
March 4, 2026

SB813 AOB Reimbursement SIC Final.pdf

Uploaded by: Irnise Williams

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Deputy Unit Director

March 2, 2026

To: The Honorable Pamela Beidle, Chair
Finance Committee

From: Irnise F. Williams, Deputy Director, Health Education and Advocacy Unit

Re: Senate Bill 0813 - Health Insurance and Dental Plan Organizations - Dentists -
Assignment of Benefits and Reimbursement of Nonpreferred Providers –
SUPPORT IN CONCEPT

The Office of the Attorney General’s Health Education and Advocacy Unit (HEAU) supports the aim of SB813. SB813 prohibits certain health insurers and dental plan organizations (“carriers”) from blocking assignment of benefits to dentists—allowing insured individuals to direct payment to the provider, even if they are out-of-network. Current law requires direct payment to out-of-network physicians¹ under an assignment of benefits (AOB), but requires the physician to inform the patient of their non-preferred status, that they may charge for noncovered services, that they may balance bill the patient, provide an estimate of potential charges, outline payment terms and applicable interest rates, and submit the disclosure form to the carrier with the claim. If benefits are assigned, carriers must pay the provider directly. When benefits are not assigned, carrier payments to the insured must instruct the patient to remit payment to the physician in the event payment has not been made by the patient.

This bill mirrors the physician assignment of benefit provisions for dentists. This bill provides meaningful consumer benefits, including:

- Improved access to dental care, particularly for individuals who prefer or must see out-of-network dentists.
- Reduced financial and administrative burden, as consumers can direct insurers to pay providers directly, avoiding delays and reimbursement complications.

¹ On-call and hospital-based physicians, and HMOs are governed by separate provisions that prohibit balance billing.

- Greater transparency, because the bill requires clear disclosures about potential out-of-pocket costs before treatment.

These provisions are particularly important for patients facing urgent dental needs, those with limited provider options, and those who may not understand complex billing practices.

While we support the bill as parallel of existing protections that already apply to physicians, our office has advocated in the past and continues to believe that when out-of-network providers accept an AOB, they are effectively agreeing to allow the insurer to pay them directly and should accept the insurer's allowed amount as full compensation and *not* balance bill the patient. Consumers who sign an AOB reasonably expect that the insurer's allowed amount, combined with their standard cost-sharing obligations, will fully resolve their liability. For that reason, balance billing should not be permitted in this context.

If, however, the General Assembly chooses to allow balance billing when an AOB is accepted, then meaningful disclosure requirements become essential. We reiterate that position here. The notice must be provided at a time that enables patients to make fully informed decisions about both their care and their financial obligations—not merely “before performing a health care service,” which is the current regulatory standard.

To ensure disclosures are truly meaningful, we recommend adding language requiring that:

- For services scheduled the same day, the disclosure must be provided before services are provided.
- For services scheduled at least three days in advance, the disclosure must be provided no later than one business day after scheduling; and
- For services scheduled at least ten business days in advance, the disclosure must be provided no later than three business days after scheduling.

These timing requirements better align with the transparency goals and ensure that patients are not placed in the untenable position of learning about the providers' network status and potential balance billing only when it is too late to choose differently.

We also wanted to bring to your attention a drafting error on Page 4, line 27. The reference should be to the enrollee's responsibility, not the plan's responsibility. There is also an error on page 2, lines 21-22. It appears that the two new references to “OR DENTIST” should be struck, and replaced with a reference to “OR DENTIST” after the word “physician” on line 21.

Thank you for taking this information into consideration as you consider SB813.

cc: Senator Antonio Hayes