

The logo for SKYGEN, featuring the word "SKYGEN" in a bold, white, sans-serif font. The letter "G" is stylized with a double outline and a horizontal bar extending from its center to the right. A registered trademark symbol (®) is located at the bottom right of the "N".

SKYGEN®

THE TRUSTED SOLUTION FOR DENTAL & VISION

Regulatory Updates April 2026

AGENDA

- Passed Bills
- Passed bills that still need Gov. signature
- Bills To Watch
 - State Medicaid
 - Commercial
- Dead Bills

PASSED: IN HB 1271, RECOUPMENT

- Commercial, Dental and Vision
- Passed 3/4/26
- Effective 7/1/26
 - An insurer may not, more than 180 days (down from 2 years) after the date on which an overpayment was made to a provider by the insurer:
 - Request that the provider repay the overpayment; or
 - Adjust a subsequent claim filed by the provider as a method of obtaining reimbursement of the overpayment from the provider
 - An insurer may not recoup a paid claim more than 180 days after the date on which the claim was initially paid
 - An insurer may not retroactively audit a paid claim more than 3 years after the initial payment date
- Action items: Dave has already communicated to several teams, but want to assign owners and start tracking more closely, discuss client notification with CE

PASSED: MS HB 1117, DLR REPORTING

- Commercial, Dental
- Passed 3/17/26
- First reporting 6/30/26, and annually thereafter
- Provides DLR calculation formula, included in larger summary
 - All carriers shall file a DLR annual report for the preceding calendar year with the commissioner no later than June 30, 2026, and annually thereafter.
 - The annual report shall:
 - Be organized by market and product type;
 - Contain the same information as required by the 2013 federal Centers for Medicare & Medicaid Services Medical Loss Ratio Annual Reporting Form (CMS-10418); and
 - Provide the number of enrollees, the plan cost-sharing, deductible amounts, the annual maximum coverage limit, and the number of enrollees who meet or exceed the annual coverage limit.
 - If the commissioner requires additional information, the carrier shall have 30 days from receipt of notice.
- Action items: Communicate to reporting team, assign as owners, discuss with CE if client notification is needed

PASSED: WV HB 4335, CREDENTIALING

- Medicaid, Dental, Vision
- Passed 3/2/26
- Effective 7/1/26
- Credentialing completed within 60 calendar days of receipt of complete application (one-time extension of up to 30 days with written justification to department and notice to applicant)
- By 7/1/26, Commissioner shall prescribe CAQH form as credentialing application form
- Enrollment and credentialing applications, renewals, documents, and supporting materials submitted by providers or a managed care plan shall be submitted electronically
- Action items: Communicate with credentialing team, discuss with CE if client notification is needed

PASSED: CMS-0053-F ELECTRONIC CLAIMS ATTACHMENTS

- Effective 5/26/26, compliance beginning 5/26/28
- I believe this applies across the board, to all HIPAA-covered entities
- Establishes HIPAA-adopted standards for transmission of health care claims attachments
- Eliminates manual processes such as faxing and mailing, and enables electronic submission of clinical data for attachment information
- Establishes Health Care Claims Attachments Standards (X12, HL7)
- Establishes verified electronic signature standards
- These standards apply to claims attachments, not prior authorization attachments (“**Prior authorization attachment standards were not finalized at this time.** The Department of Health and Human Services (HHS) will continue evaluating alternative standards for prior authorization attachments currently being tested by the industry.”)

- Definitions

- “Attachment information” means documentation that enables the health plan to make a decision about health care that is not included in a health care claims or equivalent encounter information transaction, as described in § 162.1101.
- A “health care claims attachments transaction” is the transmission of either of the following:
 - Attachment information from a health care provider to a health plan in support of a health care claims or equivalent encounter transaction, as described in § 162.1101.
 - A request from a health plan to a health care provider for attachment information.
- § 162.1101 Health care claims or equivalent encounter information transaction.
- The “health care claims or equivalent encounter information transaction” is the transmission of either of the following:
 - A request to obtain payment, and the necessary accompanying information from a health care provider to a health plan, for health care.
 - If there is no direct claim, because the reimbursement contract is based on a mechanism other than charges or reimbursement rates for specific services, the transaction is the transmission of encounter information for the purpose of reporting health care.

- Sent to Governor 4/1/26, effective upon passage/approval
- Cost-sharing requirements (eligibility requirements, excluded services)
 - Beginning 10/1/28, the cost-sharing established under this section shall be in the form of a copayment requirement equal to \$5
 - The total aggregate amount of costsharing imposed under this section for all individuals in a family shall not exceed 5% of the family's income on a monthly or quarterly basis (determined by secretary)
- Eligibility
 - Community engagement requirement for Medicaid enrollees
 - Each MCO shall at least monthly make all reasonable efforts to identify any individual who is:
 - Enrolled in KY Medicaid
 - Served by, enrolled with, or assigned to the MCO; and
 - Covered by, insured by, or enrolled with the MCO, its parent company, or any subsidiary
 - Each MCO shall promptly notify the Cabinet of any identified individuals; and
 - On a monthly basis, report to the Dept. efforts undertaken to comply with this section

- Sent to Governor 4/1/26, effective upon passage/approval
- Website requirements
 - Each MCO website shall include:
 - Name, individual email address, and individual telephone number for each of the MCO's provider relations representatives for:
 - Behavioral health
 - Physical health
 - Provider contract changes; and
 - A detailed explanation, in plain and simple language, of the MCO's process for:
 - Internal appeals; and
 - Providers to request an external, independent review
 - Information required to be accessible on the website shall be kept current and updated within 30 days of any changes

- Sent to Governor 4/1/26, effective upon passage/approval
- Grievance/appeal timeline
 - Extends timeline for providers to file grievance/appeal related to reduction or denial of a claim to 120 days
 - Following an appeal resulting in a determination that payment is owed to a provider, payment must be made in full within 30 days of resolution
 - Provider audits:
 - Allow at least 30 calendar days for provider to provide requested records
 - Complete audit within 180 calendar days of initiation
 - Only recoup denied payments upon final disposition

- Sent to Governor 4/1/26, effective upon passage/approval
- Timely authorizations
 - Expedited: 24 hours (used to be 72) (14 day extension available)
 - Standard: 5 calendar days (used to be 2 business days) (extension available)
- Monthly reporting
 - Each MCO shall report monthly to the department:
 - Number/dollar amount of claims denied/approved
 - Number of auth requests and number approved/denied
 - Number of internal appeals/grievances, total dollar amount for denials being appeals, time of resolution, type of service, etc.

- Sent to Governor 4/1/26, effective upon passage/approval
- Dental Services Model
 - Administration of Medicaid-covered dental services shall transition to an ASO model by January 1, 2029.
 - "Administrative service organization" or "ASO" means the entity contracted by the department in accordance with this section to perform specified administrative functions related to the administration of Medicaid-covered dental services without assuming a financial or insurance risk
 - The duties of the ASO contracted pursuant to this section shall be limited to the following administrative services:
 - Assisting with and facilitating the transition of all Medicaid beneficiaries from MCO coverage into ASO coverage for dental services
 - Processing and paying Medicaid-covered dental service claims
 - Employing utilization control strategies established by the department and managing all prior auth requests for Medicaid-covered dental services
 - Providing coordination of care with a Medicaid beneficiary's MCO
 - Providing customer service and support to beneficiaries and dental providers; and
 - Any other administrative duties contractually assigned to the ASO

- Commercial, Dental
- Delivered to Governor 4/1/26, effective upon passage
- “Covered services” means services and materials for which 1) reimbursement from a plan is provided by the enrollee’s plan contract; or 2) reimbursement would be available but for the application of the enrollee’s contractual limitations of deductibles, copayments, coinsurance, or frequency limitations; **and**
 - **Does not include services and materials for which reimbursement would be available but for the application of the enrollee’s contractual limitation of an annual maximum benefit.**
- A participating provider agreement shall not require the provider to provide services at a fee set by/subject to the approval of the limited health services benefit plan unless the services are covered under the **participating** provider agreement
- Impact: Moving to billing members for balances exceeding annual maximum

- Medicaid, Dental, Vision
- Delivered to Governor 4/1/26
- Various effective dates: 1/1/27 and 1/1/28
- Every insurer must offer a gold card program which shall:
 - A provider may receive a prior authorization exemption for a particular service if, during the evaluation period, the provider met program terms
 - Not condition an exemption upon the provider exceeding a 93% approval rate for a particular service for an evaluation period
 - Require the insurer to annual evaluate whether a participating provider qualifies for an exemption
 - Require notification to the provider of exemption qualification within 30 days of annual review, including a list of services for which the provider is eligible
 - Require an insurer to make available to a provider during the contracting process the gold card program requirements

- Commercial, Dental, Vision
- Presented to Governor 4/2/26, no effective date given
- An insurer that offers a health insurance policy may not require a health care provider to accept payments under the health insurance policy via virtual credit card payment.
- An insurer shall inform a health care provider of the fees associated with any available payment methods and how to select a payment method other than virtual credit card payments before providing a payment via virtual credit card payment.
- If an insurer transmits a payment to a health care provider in accordance with certain federal standards for transmitting electronic funds, the insurer may not charge a fee solely for the transmission, unless the provider has consented to the fee

- Commercial, Vision
- Introduced 2/12/26, no movement since then
- Vision benefit manager/insurer requirements for website, telephone number, mailing address, email account, contracts with vision providers
- Do we have MD vision clients?

TO WATCH, COMMERCIAL: OH SB 162, RECOUPMENT

- Commercial, Dental, Vision
- Introduced 4/2/25, no movement since then
- Changes the time period allowed for recoupment from two years to “a time period, beginning on the date payment is made and ending on the date that occurs after the same number of days the health plan issuer grants for the filing of provider claims”
- No third-party payer shall change its payment, audit, or review timelines during the contract period
- A third-party payer may recover an overpaid amount if the process is initiated within the period of time described above
- A third-party payer shall give the provider an opportunity to appeal the overpayment determination and shall not charge the provider for an appeal

- Commercial, Dental
- Introduced 3/4/26, effective 1/1/27 if passed
- Insurer shall pay benefits directly to provider upon receipt of executed written direction

- Commercial, Dental, Vision
- Introduced 2/6/26, house committee favorably reported 2/24/26
- Requires that when an insurer denies coverage based on medical necessity, a Georgia-licensed clinical peer with training in a related specialty must affirmatively agree to the denial. Current law allows insurers to deny care after a discussion with a clinical peer; new law requires clinical peer to **sign off on the decision**. The bill also requires reviewers to attempt to contact the treating provider before issuing a denial.

- Commercial, Dental, Vision
- Introduced 2/18/26, House Committee favorably reported by substitute 2/25/26
- Sets a 45-day deadline for commercial health insurers to complete credentialing of a provider after receiving a complete application and directs the Department of Insurance to create a standardized credentialing form aligned with Georgia Medicaid's existing credentialing system.

- Commercial, Dental
- Introduced 4/2/26
- Dental plan may not initiate/change to payment method including fee, including VCC payment, unless:
 - Informs dentist of all available payment methods
 - Provides clear and accessible instructions for selection of alternative method
 - Ensures dentist may select without restrictions
 - Provider elects, through express acceptance, to accept credit card or EFT payment

- Medicaid
- Introduced 2/11/26, house withdrawn, recommitted 3/4/26
- Prohibits Medicaid applicants and recipients from using self-attestation to verify income, residency, or identity and requires ongoing cross-checks of enrollees against multiple state and federal data sources.
- Reduces retroactive Medicaid coverage from three months to two months,

- Medicaid, Dental
- GA House of Reps Fiscal Year 2027 Budget includes significant investments in Medicaid provider rates, specifically dental care. Increases reimbursement rates for essential dental codes.
- Senate is now addressing, and we will watch whether the Medicaid package is changed

- GA Medicare for All program
- Introduced 3/4/26
- Introduced to establish a single-payer health program
- Proposes to repeal restrictions on Medicaid expansion and establish a trust fund for universal healthcare

DEAD BILLS: FL HB 1015, PRIOR AUTHORIZATION

- Reviewed in February 2026 Regulatory Meeting
- Significant prior authorization requirements
- Died in subcommittee 3/13/26