HOUSE BILL REPORT
HB 1002

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to prohibiting unfair and deceptive dental insurance practices.

Brief Description: Prohibiting unfair and deceptive dental insurance practices.

Sponsors: Representative DeBolt.

Brief History:
Committee Activity:
Health Care & Wellness: 2/4/15, 2/13/15 [DPS].

Brief Summary of Substitute Bill

- Prohibits dental-only plans from denying coverage for emergency dental conditions on the basis that they are provided on the same day the patient was examined and diagnosed for the conditions.
- Requires dental-only plans to submit certain information to the Office of the Insurance Commissioner.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 15 members: Representatives Cody, Chair; Riccelli, Vice Chair; Schmick, Ranking Minority Member; Harris, Assistant Ranking Minority Member; Caldier, Clibborn, DeBolt, Jinkins, Johnson, Moeller, Robinson, Rodne, Short, Tharinger and Van De Wege.

Staff: Jim Morishima (786-7191).

Background:

Health carriers enter into contracts with health care providers under which the providers agree to accept a specified reimbursement rate for their services. Health carriers require prior authorization for certain health procedures. Prior authorization is the requirement that a health care provider seek approval of a drug, procedure, or test before seeking reimbursement from an insurer.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

A health carrier offering a health benefit plan must annually submit certain data to the Office of the Insurance Commissioner (OIC), including:

- the total number of members;
- the total amount of hospital and medical payments;
- the medical loss ratio;
- the average amount of premiums per member per month;
- the percentage change in the average premium per member per month;
- the total amount of claim adjustment expenses;
- the total amount of general administrative expenses;
- the amount of reserves for unpaid claims;
- the total net underwriting gain or loss;
- the carrier's net income after taxes;
- dividends to stockholders;
- the net change in capital and surplus from the prior year; and
- the total amount of the capital and surplus from the prior year.

The OIC must make this information available to the public through a searchable public website.

Summary of Substitute Bill:

Emergency Dental Conditions.

A health carrier offering a dental-only plan may not deny coverage for treatment of an emergency dental condition that would otherwise be considered a covered service of an existing benefit contract on the basis that the service was provided on the same day the covered person was examined and diagnosed for the emergency dental condition.

An emergency dental condition is a dental condition manifesting itself by acute symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and dentistry could reasonably expect the absence of immediate dental attention to result in:

- placing the patient, or her unborn child, in serious jeopardy;
- serious impairment of bodily functions; or
- serious dysfunction of any bodily organ or part.

Dental Only Plan Reporting.

A health carrier offering a dental-only plan must annually submit the following data to the OIC on an aggregate level:

- the total number of dental members;
- the total amount of dental revenue;
- the total amount of dental payments;
- the dental loss ratio;
- the average amount of premiums per month; and

- the percentage change in the average premium per member per month measured from the previous year.

The OIC must make this information available to the public through a searchable public website.

Substitute Bill Compared to Original Bill:

The substitute bill:

- removes provisions in the underlying bill relating to payment rates, contracting practices, non-participating providers, medical loss ratios, the Patient Protection and Affordable Care Act, and protections for dentists who attempt to enforce their rights or the rights of their patients; and
- requires dental-only plans to submit certain information to the OIC.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Substitute Bill: The bill takes effect on January 1, 2017.

Staff Summary of Public Testimony:

(In support of substitute bill) This is a patient advocacy bill. Patients care about every benefit dollar and can struggle when care is not covered. In emergencies, dentists assess the patient first. If definitive care is provided the same day, insurance carriers often deny reimbursement. Dentists often absorb the costs of this care. This bill will require dental-only carriers to disclose their medical loss ratios. This bill has been negotiated among the stakeholders.

(In support with concerns on substitute bill) A dental-only carrier's medical loss ratio should be reported company-wide, not by line of business.

(Opposed) None.

Persons Testifying: (In support of substitute bill) Representative DeBolt, prime sponsor; Amy Cook; Bracken Killpack, Washington State Dental Association; Sean Pickard, Delta Dental of Washington; and Melissa Johnson, Willamette Dental Group.

(In support with concerns on substitute bill) Len Sorrin, Premera Blue Cross; and Chris Bandoli, Regence Blue Shield.

Persons Signed In To Testify But Not Testifying: None.