SENATE BILL REPORT
SHB 1002

As of March 20, 2015

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

Brief Description: Prohibiting unfair and deceptive dental insurance practices.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representative DeBolt).

Brief History: Passed House: 3/02/15, 97-0.
Committee Activity: Health Care: 3/16/15.

SENATE COMMITTEE ON HEALTH CARE

Staff: Mich'l Needham (786-7442)

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. Emergency medical services are not subject to prior authorization and coverage must include services necessary to screen and stabilize a covered person.

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

- 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

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- the total amount of the capital and surplus from the prior year.

OIC must make this information available to the public through a searchable public website. No similar information is available on dental-only plans.

Summary of Bill: 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 the following:

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

A health carrier offering a dental-only plan must annually submit the following data to 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.

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

Appropriation: None.

Fiscal Note: Available on proposed substitute.

Committee/Commission/Task Force Created: No.

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

Staff Summary of Public Testimony: PRO: This bill started with many consumer concerns, with the main focus on emergency dental care. The first version was a bit heavy handed but we have created a compromise bill that ensures emergency dental procedures will be covered. This version is broadly supported by the dental alliance and dental insurance providers.

Persons Testifying: PRO: Representative DeBolt, prime sponsor; Amy Cook, private dentist, Alliance of WA Dentists PAC; Melissa Johnson, Willamette Dental Group.

Persons Signed in to Testify But Not Testifying: No one.