Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 1316

Brief Description: Addressing fair dental insurance practices.

Sponsors: Representatives Caldier, Cody, Jinkins, Wylie, Bergquist, Harris, Clibborn, Rodne, Griffey and Appleton.

Brief Summary of Bill

- Applies statutes related to utilization review, prior authorization, grievance and adverse benefit determination review processes, and independent review organizations to dental-only plans.
- Prohibits a carrier offering a dental-only plan from retaliating against a provider for disputing the carrier's determination about a dental service.
- Prohibits a carrier offering a dental-only plan from denying a claim for a covered dental service provided by a treating dentist to a covered person.

Hearing Date: 1/27/17

Staff: Alexa Silver (786-7190).

Background:

A "health plan" is defined as any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care services. Certain types of coverage are excluded from the definition of "health plan," including dental-only coverage and limited health care services offered by limited health care service contractors.

Utilization review: Carriers offering a health plan are required to maintain a documented utilization review program description and written utilization review criteria based on reasonable medical evidence. Carriers must make their clinical protocols, medical management standards, and other review criteria available to participating providers. By rule, they are prohibited from penalizing or threatening a provider or facility with a reduction in future payment or termination

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of participating provider or facility status because the provider or facility disputes the carrier's determination regarding coverage or payment.

Prior authorization: A carrier offering a health plan may not retrospectively deny coverage for care that had prior authorization under the plan's written policies at the time the care was rendered.

Grievances and review of adverse benefit determinations: Carriers and health plans must have comprehensive and effective processes for grievances and review of adverse benefit determinations, and the processes must be consistent with requirements in statute. For example, the statute requires that the carrier and plan provide written notice to an enrollee, his or her designated representative, and his or her provider of its decision to deny, modify, reduce, or terminate payment, coverage, or authorization for services or benefits. By rule, carriers and health plans are prohibited from taking or threatening to take punitive action against a provider acting on behalf of or in support of an enrollee as part of a review of an adverse benefit determination.

Review by independent review organizations: An enrollee in a health plan may seek review by a certified independent review organization (IRO) if: (1) a carrier denies, modifies, reduces, or terminates coverage of, or payment for, a health care service; and (2) the enrollee has exhausted the carrier's grievance process or the carrier has exceeded timelines for grievances. Reviewers for the IRO make determinations regarding the medical necessity or appropriateness of, and the application of plan provisions to, health care services for an enrollee. An IRO determination must be consistent with the plan unless it is unreasonable or inconsistent with evidence-based medical practice. Only contract specialists may make determinations about application of plan provisions and only clinical reviewers may determine medical necessity and appropriateness. An IRO is required to notify the enrollee and the carrier of the result and rationale for the determination within 15 days of receiving all necessary information or 20 days after receiving the request (or 25 days in exceptional circumstances), whichever is earlier. The carrier must timely implement the determination and pay the IRO's fees.

Summary of Bill:

A "health plan" includes a dental-only plan offered after December 31, 2017, for purposes of the statutes regulating utilization review programs, prior authorization, grievances and review of adverse benefit determinations, and review by independent review organizations.

A health carrier offering a dental-only plan may not take or threaten to take punitive action against a provider acting on behalf of or in support of a covered person because the provider disputes the carrier's determination regarding coverage or payment for a dental service.

A health carrier offering a dental-only plan may not deny a claim for a covered dental service provided by a treating dentist to a covered person. If the carrier denies such a claim, the carrier may not advertise that the carrier covers the service in promotional materials or an explanation of benefits sent to prospective or current members.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.