HOUSE BILL REPORT
2ESHB 1316

As Passed House:
February 12, 2018

Title: An act relating to fair dental insurance practices.

Brief Description: Addressing fair dental insurance practices.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Caldier, Cody, Jinkins, Wylie, Bergquist, Harris, Clibborn, Rodne, Griffey and Appleton).

Brief History:
Committee Activity:
Health Care & Wellness: 1/27/17, 2/17/17 [DPS].
Floor Activity:
Passed House: 3/8/17, 97-0.
Floor Activity:
Passed House: 2/12/18, 98-0.

Brief Summary of Second Engrossed Substitute Bill

- Applies statutes related to utilization review programs and retrospective denial of coverage to dental plans.
- Prohibits dental plans from subjecting a provider to additional oversight because the provider files an appeal on behalf of a patient.
- Requires the Office of the Insurance Commissioner to convene a work group to examine stand-alone dental plans' explanations of benefits.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 17 members: Representatives Cody, Chair; Macri, Vice Chair; Schmick, Ranking Minority Member; Graves, Assistant Ranking Minority Member; Caldier, Clibborn, DeBolt, Harris, Jinkins, MacEwen, Maycumber, Riccelli, Robinson, Rodne, Slatter, Stonier and Tharinger.

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.

Staff: Jim Morishima (786-7191).

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 Programs and Retrospective Dental Coverage.
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 of participating provider or facility status because the provider or facility disputes the carrier's determination regarding coverage or payment.

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.

Dental Plan Coverage.
A carrier offering a dental-only plan may not deny coverage for treatment of emergency dental conditions because the services were provided on the same day the covered person was examined and diagnosed for the emergency dental condition.

Summary of Second Engrossed Substitute Bill:

Utilization Review Programs and Retrospective Denial of Coverage.
A carrier that offers a dental plan must maintain a utilization review program description and written criteria based on prevention of dental disease and chronic disease implications. Carriers offering a health plan must make any of the following (rather than all of the following) available upon request to participating providers: clinical protocols, medical management standards, or other review criteria.

A carrier that offers a dental plan may not retrospectively deny coverage for care that had prior authorization.

Rules adopted by the Office of the Insurance Commissioner (OIC) related to utilization review programs and retrospective denials must consider relevant standards adopted by either (rather than both) national managed care accreditation organizations or state agencies that purchase managed health care services.

Dental Plan Coverage.
A carrier offering a dental plan may not subject a provider to an additional level of oversight under the carrier's provider agreement solely because the provider files an appeal or grievance on behalf of a patient.

The prohibition on denying coverage for treatment of emergency dental conditions on the basis that the service was provided the same day as examination and diagnosis applies to dental plans (rather than dental-only plans).

Fully capitated dental plans are exempt from the provisions related to additional levels of oversight and coverage of emergency conditions.

Appropriation: None.

Fiscal Note: Available.

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

Staff Summary of Public Testimony:

(In support) When the Patient Bill of Rights was passed in 2000, dental benefits were omitted, so when a dental provider or patient appeals a claim, the insurance company determines whether to pay it. If a provider continues appealing, the insurance company threatens to put the dentist on focused review status. This bill allows for reviews by independent review organizations and prohibits insurance companies from punishing providers for advocating for patients. It is about treating consumers and dentists fairly. It will force insurance companies to follow the standard of care. If an insurance company denies a claim because what they do is different from dentists, the company should not be able to advertise that benefit. It is the exception that a dentist would over-treat a patient.

(Opposed) This bill would increase the cost of dental benefits to customers. Dental plans were exempted in 2000 because that bill was designed to curb consumer concerns about medical plan coverage. Some elements make sense (such as utilization review programs, retrospective denials, and an appeals process), but many provisions have no application to dental plans. The average dental claim is much lower in value than medical claims, so using the independent review process could exceed the cost of the claim. The National Association of Insurance Commissioners Model Act and most states have exempted dental-only plans.

Carriers provide pre-estimates for dentists and have a thorough appeals process involving review by dental consultants. Carriers try to preserve the network, but some dentists are put on focused review because of suspicious treatment patterns. Certain criteria must be met for procedures, especially those with a higher likelihood of abuse. With respect to advertising, carriers are advertising on behalf of purchasers.

(Other) The model at issue here is fee-for-service. Fully capitated dental plans already do some of the things required by the bill, and other parts are not applicable. Employee dentists design treatment plans with patients. There is a peer review process to ensure quality of care. There is no processing of claims, but there is a process for grievances and appeals. This bill would have undue costs for dental plans.

Adding rights under the Patient Bill of Rights to people using dental care makes sense. There are a variety of reasons why a carrier may not cover a claim, like frequency limits.

There is concern about the explanation of benefits with respect to how plans may advertise denied procedures.

Persons Testifying: (In support) Representative Caldier, prime sponsor; Amy Cook, Cook Family Dentistry; and Brady McDonald, McDonald Dentistry.

(Opposed) Sean Pickard and Cindy Snyder, Delta Dental of Washington.

(Other) Melissa Johnson, Willamette Dental Group; Lonnie Johns-Brown, Office of the Insurance Commissioner; and Steve Gano, Premera Blue Cross.

Persons Signed In To Testify But Not Testifying: None.