ENGROSSED SUBSTITUTE HOUSE BILL 1316

State of Washington 65th Legislature 2017 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Caldier, Cody, Jinkins, Wylie, Bergquist, Harris, Clibborn, Rodne, Griffey, and Appleton)

READ FIRST TIME 02/17/17.

AN ACT Relating to fair dental insurance practices; amending RCW 48.43.520, 48.43.525, and 48.43.740; creating a new section; and providing an expiration date.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 48.43.520 and 2000 c 5 s 8 are each amended to read as follows:

(1) Carriers that offer a health plan shall maintain a documented utilization review program description and written utilization review criteria based on reasonable medical evidence. The program must include a method for reviewing and updating criteria. Carriers shall make clinical protocols, medical management standards, ((~~and~~)) or other review criteria available upon request to participating providers.

(2) A carrier that offers a dental plan shall maintain a documented utilization review program description and written utilization criteria based on prevention of dental disease and chronic disease implications.

(3) The commissioner shall adopt, in rule, standards for this section after considering relevant standards adopted by national managed care accreditation organizations ((~~and~~)) or state agencies that purchase managed health care services.

((~~(3)~~)) (4) A carrier that offers a health plan shall not be required to use medical evidence or standards in its utilization review of religious nonmedical treatment or religious nonmedical nursing care.

Sec. 2. RCW 48.43.525 and 2000 c 5 s 9 are each amended to read as follows:

(1) A health carrier that offers a health plan or a dental plan shall not retrospectively deny coverage for emergency and nonemergency care that had prior authorization under the plan's written policies at the time the care was rendered.

(2) The commissioner shall adopt, in rule, standards for this section after considering relevant standards adopted by national managed care accreditation organizations ((~~and~~)) or state agencies that purchase managed health care services.

Sec. 3. RCW 48.43.740 and 2015 c 9 s 1 are each amended to read as follows:

(1) A health carrier offering a dental ((~~only~~)) plan may not:

(a) Deny coverage for treatment of emergency dental conditions that would otherwise be considered a covered service of an existing benefit contract on the basis that the services were provided on the same day the covered person was examined and diagnosed for the emergency dental condition; or

(b) Subject a provider to an additional level of oversight under the health carrier's provider agreement solely because the provider, on behalf of a patient, files an appeal or grievance.

(2) This section does not apply to a fully capitated dental plan.

(3) For purposes of this section:

(a) "Emergency dental condition" means a dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain or infection such that a prudent layperson, who possesses an average knowledge of health and dentistry, could reasonably expect the absence of immediate dental attention to result in:

(i) Placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part.

(b) "Health carrier," in addition to the definition in RCW 48.43.005, also includes health care service contractors, limited health care service contractors, and disability insurers offering dental ((~~only~~)) coverage.

NEW SECTION. **Sec. 4.** (1) The office of the insurance commissioner shall convene a work group of interested stakeholders, including carriers that offer stand-alone dental plans, to examine current carrier practices related to the contents of stand-alone dental plans' explanations of benefits sent to covered persons. By December 15, 2017, the insurance commissioner must provide the legislature with a summary of the stakeholder feedback on explanations of benefits for stand-alone dental plans.

(2) This section expires January 1, 2018.

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