H-4832.1

SECOND SUBSTITUTE HOUSE BILL 1018

State of Washington 66th Legislature 2020 Regular Session

By House Appropriations (originally sponsored by Representatives Caldier, Cody, Jinkins, Santos, and Appleton)

READ FIRST TIME 02/11/20.

AN ACT Relating to fair dental insurance practices; amending RCW 48.43.740; adding new sections to chapter 48.43 RCW; and providing an expiration date.

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

NEW SECTION. **Sec. 1.** A new section is added to chapter 48.43 RCW to read as follows:

(1) Health benefit plans, health care service contractors, or health carriers offering dental benefits may not deny or limit coverage based on an individual's oral health condition, including situations in which a tooth is missing at the time coverage starts with the carrier.

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

NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43 RCW to read as follows:

Carriers that offer dental only coverage must maintain a documented utilization review program description and written utilization review criteria based on reasonable dental evidence. The program must include a method for reviewing and updating criteria. Carriers must make available electronically or online all clinical protocols, dental management standards, and other review criteria to

participating providers before the provider is subject to the protocols, standards, and criteria. Upon the request of a participating provider, a health carrier must provide paper copies of all clinical protocols, dental management standards, and other review criteria.

NEW SECTION. **Sec. 3.** A new section is added to chapter 48.43 RCW to read as follows:

A carrier that offers dental only coverage must not retrospectively deny coverage for emergency and nonemergency dental care that had prior authorization under the carrier's written policies at the time the dental care was rendered.

NEW SECTION. **Sec. 4.** A new section is added to chapter 48.43 RCW to read as follows:

(1) Each carrier offering dental only coverage and each dental only plan must have fully operational, comprehensive grievance and appeal processes that comply with the requirements of this section and any rules adopted by the commissioner to implement this section. For the purposes of this section, the commissioner must consider applicable grievance and appeal, or review of adverse benefit determination process standards, adopted by national managed care accreditation organizations applicable to dental only coverage and state agencies that purchase managed dental care services. In the case of dental only coverage offered in connection with a group dental only plan, if either the carrier offering dental only coverage or the group dental only plan complies with the requirements of this section, and complies with the requirements of the pilot program established under section 5 of this act from January 1, 2022, through the termination of the pilot program, then the obligation to comply is satisfied for both the carrier offering dental only coverage and the dental only plan with respect to the dental coverage.

(2) Each carrier offering dental only coverage and each dental only plan must process as a grievance an enrollee's expression of dissatisfaction about customer service or the quality or availability of a dental service. Each carrier must implement procedures for registering and responding to oral and written grievances in a timely and thorough manner.

(3) Each carrier offering dental only coverage and each dental only plan must provide written notice, as described in subsection (6)

of this section, to an enrollee or the enrollee's designated representative, and the enrollee's provider, of its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of dental services or benefits.

(4) An enrollee's written or oral request that a carrier reconsider its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of dental services or benefits must be processed as follows:

(a) The dental only plan and the carrier offering dental only coverage must process it as a review of an adverse benefit determination; and

(b) Neither a carrier offering dental only coverage nor a dental only plan may require that an enrollee file a complaint or grievance prior to seeking appeal of a decision or review of an adverse benefit determination under this subsection.

(5) To process an appeal, each dental only plan and each carrier offering that dental only coverage plan must:

(a) Provide written notice to the enrollee when the appeal is received;

(b) Assist the enrollee with the appeal process;

(c) Make its decision regarding the appeal within thirty days of the date the appeal is received. An appeal must be expedited if the enrollee's provider or the carrier's dental director reasonably determines that following the appeal process response timelines could seriously jeopardize the enrollee's life, health, or ability to regain maximum function. The decision regarding an expedited appeal must be made within seventy-two hours of the date the appeal is received;

(d) Cooperate with a representative authorized in writing by the enrollee;

(e) Consider information submitted by the enrollee;

(f) Investigate and resolve the appeal; and

(g) Provide written notice of its resolution of the appeal to the enrollee and, with the permission of the enrollee, to the enrollee's dental providers. The written notice must explain the decision of the carrier offering dental only coverage and the dental only plan, and the supporting coverage or clinical reasons; and, from January 1, 2022, through the termination of the pilot program established under section 5 of this act, if the claim involves specified dental services as defined in section 5 of this act, the right of the

enrollee's dental provider to aggregate the claim with other similar claims and request independent review of the carrier's decisions under section 5 of this act.

(6) The written notice required by subsection (3) of this section must explain:

(a) The decision of the carrier offering dental only coverage and the dental only plan, and the supporting coverage or clinical reasons; and

(b) The appeal process of the carrier offering dental only coverage or, for dental only plans, the adverse benefit determination review process, including information, as appropriate, about how the enrollee can exercise the enrollee's rights to obtain a second opinion, and how to continue receiving services as provided in this section.

(7) When an enrollee requests that the carrier offering dental only coverage or the dental only plan reconsider its decision to modify, reduce, or terminate an otherwise covered dental service that an enrollee is receiving through the dental only plan, and the decision of the carrier offering dental only coverage and the dental only plan is based upon a finding that the dental service, or level of dental service, is no longer medically necessary or appropriate, the carrier offering dental only coverage and the dental only plan must continue to provide that dental service until the appeal is resolved. If the resolution of the appeal or any review sought by a dentist under section 5 of this act from January 1, 2022, through termination of the pilot program created in section 5 of this act, affirms the decision of the carrier offering dental only coverage or the dental only plan, the enrollee may be responsible for the cost of this continued dental service.

(8) Each carrier offering dental only coverage and each dental only plan must provide a clear explanation of the grievance and appeal process upon enrollment to new enrollees, and annually to enrollees and subcontractors.

(9) Each carrier offering dental only coverage and each dental only plan must ensure that each grievance and appeal process is accessible to enrollees who are limited English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file a grievance or appeal.

(10) Each dental only plan and the carrier that offers it must: Track each appeal until final resolution; maintain, and make

accessible to the commissioner for a period of three years, a log of all appeals; and identify and evaluate trends in appeals.

(11) In complying with this section, dental only plans and the carriers offering them must treat a rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at that time, and any decision to deny coverage in an initial eligibility determination, as an adverse benefit determination.

NEW SECTION. **Sec. 5.** A new section is added to chapter 48.43 RCW to read as follows:

(1) The commissioner must establish a pilot program to use an external review process for fair consideration of disputes relating to clinical decisions by carriers offering dental only coverage to deny, modify, reduce, or terminate coverage of or payment of claims submitted by dentists for specified dental services provided to enrollees. The pilot program must commence January 1, 2022, and continue through July 1, 2024, unless terminated earlier as provided in subsection (6) of this section.

(2) The commissioner must work with carriers offering dental only coverage, dentists, and others in the dental industry to develop and implement the pilot program in accordance with the requirements of this section.

(3) The commissioner must establish and use a rotational registry system for the assignment of a certified independent review organization to each dispute. The system must be flexible enough to ensure that an independent review organization has the expertise necessary to review the particular dental condition or service at issue in the dispute, and that any approved independent review organization does not have a conflict of interest that will influence its independence. To the extent possible, all independent review organizations must use licensed dentists that have not served on the board of, or be currently or previously employed by, Delta Dental, Washington dental service, or the Washington state dental association.

(4) The pilot program is subject to the following requirements:

(a) Treating dentists may seek review by a certified independent review organization of decisions of a carrier offering dental only coverage to deny, modify, reduce, or terminate coverage of or payment of claims for specified dental services, after exhausting the carrier's grievance process and receiving decisions that are

unfavorable to the enrollee or the treating dentist, or after a carrier offering dental only coverage has exceeded the timelines for grievances provided in section 4 of this act, without good cause and without reaching decisions.

(b) Only aggregated claims for specified dental services for which the aggregated amount billed is two thousand five hundred dollars or greater are subject to review. A treating dentist must aggregate claims for specified dental services based on dates of service occurring within a consecutive three-month period to meet the aggregated claims amount of two thousand five hundred dollars or greater. A treating dentist may seek review of additional claims for specified dental services with dates of service occurring within the same consecutive three-month period as previously submitted claims only if: (i) The additional billed claims when aggregated with other claims for specified dental services not previously submitted for review are equal to or greater than two thousand five hundred dollars; and (ii) the aggregated claims in the subsequent submission have dates of service occurring within a consecutive three-month period.

(c) Carriers must provide to the appropriate certified independent review organization, not later than the third business day after the date the carrier receives a request for review, a copy of:

(i) Any dental records of the enrollee that are relevant to the review;

(ii) Any documents used by the carrier in making the determination to be reviewed by the certified independent review organization;

(iii) Any documentation and written information submitted to the carrier in support of the appeal; and

(iv) A list of each dentist or dental provider who has provided care to the enrollee and who may have dental records relevant to the appeal. Health information or other confidential or proprietary information in the custody of a carrier may be provided to an independent review organization, subject to rules adopted by the commissioner.

(d) Treating dentists must be provided with at least five business days to submit to the independent review organization in writing additional information that the independent review organization must consider when conducting the external review. The

independent review organization must forward any additional information submitted by an enrollee to the plan or carrier within one business day of receipt by the independent review organization.

(e) Each enrollee receiving specified dental services included in the aggregated claims submitted for review must provide consent, although specific written consent, is not necessary, to the treating dentist submitting the aggregated claims, permitting the disclosure of health care information as defined in RCW 70.02.010 to the independent review organization, before an independent review organization is engaged to conduct the review.

(f) Independent review organizations must make determinations regarding the medical necessity or appropriateness of, and the application of the dental only plan coverage provisions to, specified dental services for each of the aggregated claims submitted by a treating dentist. The independent review organizations' determinations must be based upon their expert dental judgment, after consideration of relevant dental, scientific, and cost-effectiveness evidence, and dental standards of practice in the state of Washington. The independent review organizations must ensure that determinations are consistent with the scope of covered benefits as outlined in the dental coverage agreement and the processing policies established by the carrier offering dental only coverage. In making any determination, dental reviewers must comply with the processing policies of the carrier offering dental only coverage and are not authorized to revise the processing policies of carriers.

(g) If an independent review organization's determination overturns the carrier's decision that gave rise to a disputed claim, the carrier must promptly readjudicate each such claim in accordance with the independent review organization's determination. Such claims adjudication may result in changes in allocation of financial responsibility among the carrier, the enrollee, and the treating dentist for the payment of the claim for specified dental services.

(h) The independent review organization's charges for the review of the aggregated claims will be allocated on a pro rata basis among the aggregated claims submitted by a treating dentist for review. The allocated charges plus the reasonable preparation costs of review incurred by the substantially prevailing party for each claim must be paid by the nonprevailing party for each separate claim determination made by a dental reviewer.

(i) If a treating dentist is the nonprevailing party and is responsible for paying seventy-five percent or more of the dental reviewer's charges for aggregated claims submitted three times during any twelve-month period, such dentist is not permitted to seek review by a dental reviewer under this section for one year from the date of the issuance of the dental reviewer's decision that results in the third instance of the dentist being the nonprevailing party responsible for seventy-five percent or more of the dental reviewer's charges.

(5) On or before December 31, 2023, the commissioner must submit a report to the legislature assessing the effectiveness of the pilot program established by this section based on the findings of an independent third party selected by the commissioner. The findings must include the percentage of the total independent review organization charges paid by dentists under subsection (4)(g) of this section and the percentage of total independent review organization charges paid by carriers offering dental only plans under subsection (4)(g) of this section. The independent review organization must report review data requested by the commissioner as necessary to facilitate the report.

(6) If the report submitted under subsection (5) of this section finds the percentage of total independent review organizations' charges paid by dentists is equal to or greater than seventy-five percent of the total charges paid to independent review organizations, the pilot program established in this section terminates upon the submission of the report to the legislature.

(7) For the purposes of this section, "specified dental services" means core buildups as defined under the American dental association code D2950 and periodontal scaling/root planing as defined under the American dental association codes D4341/4342.

(8) Unless terminated earlier as provided under subsection (6) of this section, the pilot program established in this section terminates July 1, 2024.

(9) This section expires July 1, 2024.

Sec. 6. 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 ((~~deny~~)):

(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;

(b) Take or threaten to take punitive action including, but not limited to, reducing future payments or terminating participating provider or facility status, against a provider acting on behalf of or in support of a covered person because the provider disputes the carrier's determination with respect to coverage or payment for a dental service; or

(c) Subject or threaten to subject a provider to an additional level of oversight including, but not limited to, audits or focused review of the provider or facility solely because the provider, on behalf of a patient, files an appeal or grievance.

(2) 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.

--- END ---