SENATE BILL REPORT
ESHB 1316

As of March 20, 2017

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: Passed House: 3/08/17, 97-0.
Committee Activity: Health Care: 3/20/17.

Brief Summary of 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 workgroup to examine stand-alone dental plans' explanations of benefits.

SENATE COMMITTEE ON HEALTH CARE

Staff: Mich'l Needham (786-7442)

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

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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 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: (1) clinical protocols, (2) medical management standards, or (3) 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.

OIC Workgroup. OIC must convene a workgroup of interested stakeholders, including carriers that offer stand-alone dental plans, to examine current practices related to the contents of stand-alone dental plans' explanation of benefits. By December 15, 2017, the OIC must provide the Legislature with a summary of the stakeholder feedback.

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: When the patient bill of rights was passed in 2000, the dental plans were excluded, so when a dental provider appeals a claim, it is solely up to the insurance company to determine whether to pay. If the provider continues

appealing, the plan puts the dentist on a focused review status. This adds language into the utilization review requirements for health plans and prohibits the focused reviews. It also creates a workgroup on the explanation of benefits dental plans use. They display the network savings when a claim is denied and they are confusing. The workgroup can decide what is fair and transparent.

Persons Testifying: PRO: Representative Michelle Caldier, Prime Sponsor.

Persons Signed In To Testify But Not Testifying: No one.