H-0631.1

HOUSE BILL 1316

State of Washington 65th Legislature 2017 Regular Session

By Representatives Caldier, Cody, Jinkins, Wylie, Bergquist, Harris, Clibborn, Rodne, Griffey, and Appleton

Read first time 01/17/17. Referred to Committee on Health Care & Wellness.

AN ACT Relating to fair dental insurance practices; amending RCW 48.43.005 and 48.43.740; and creating a new section.

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

NEW SECTION. **Sec. 1.** (1) In 2000, the patient bill of rights was enacted to ensure that health insurers use appropriate medical personnel to make health care decisions and that enrollees have access to an impartial process for appealing an insurer's decisions. To that end, the legislation required insurers to have a utilization review program, prohibited insurers from denying coverage for care that had prior authorization, required insurers to have a comprehensive grievance process, and established an independent review process for resolving disputes. The patient bill of rights has been successful in protecting consumers by establishing fair health insurance practices.

(2) The requirements of the patient bill of rights do not apply to health plans that provide dental only coverage. Insurers offering dental only coverage have engaged in unfair practices that have harmed consumers, and consumers have not had the necessary tools to challenge these practices. Consumers deserve the same protections when accessing dental care as when accessing medical care.

(3) The legislature, therefore, intends to curb abuses by dental plans by extending the protections of the patient bill of rights to health plans that offer dental only coverage, protecting health care providers who advocate on behalf of their dental patients, and prohibiting other unfair dental insurance practices.

Sec. 2. RCW 48.43.005 and 2016 c 65 s 2 are each amended to read as follows:

Unless otherwise specifically provided, the definitions in this section apply throughout this chapter.

(1) "Adjusted community rate" means the rating method used to establish the premium for health plans adjusted to reflect actuarially demonstrated differences in utilization or cost attributable to geographic region, age, family size, and use of wellness activities.

(2) "Adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination, or failure to provide or make payment that is based on a determination of an enrollee's or applicant's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(3) "Applicant" means a person who applies for enrollment in an individual health plan as the subscriber or an enrollee, or the dependent or spouse of a subscriber or enrollee.

(4) "Basic health plan" means the plan described under chapter 70.47 RCW, as revised from time to time.

(5) "Basic health plan model plan" means a health plan as required in RCW 70.47.060(2)(e).

(6) "Basic health plan services" means that schedule of covered health services, including the description of how those benefits are to be administered, that are required to be delivered to an enrollee under the basic health plan, as revised from time to time.

(7) "Board" means the governing board of the Washington health benefit exchange established in chapter 43.71 RCW.

(8)(a) For grandfathered health benefit plans issued before January 1, 2014, and renewed thereafter, "catastrophic health plan" means:

(i) In the case of a contract, agreement, or policy covering a single enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, one thousand seven hundred fifty dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least three thousand five hundred dollars, both amounts to be adjusted annually by the insurance commissioner; and

(ii) In the case of a contract, agreement, or policy covering more than one enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, three thousand five hundred dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least six thousand dollars, both amounts to be adjusted annually by the insurance commissioner.

(b) In July 2008, and in each July thereafter, the insurance commissioner shall adjust the minimum deductible and out-of-pocket expense required for a plan to qualify as a catastrophic plan to reflect the percentage change in the consumer price index for medical care for a preceding twelve months, as determined by the United States department of labor. For a plan year beginning in 2014, the out-of-pocket limits must be adjusted as specified in section 1302(c)(1) of P.L. 111-148 of 2010, as amended. The adjusted amount shall apply on the following January 1st.

(c) For health benefit plans issued on or after January 1, 2014, "catastrophic health plan" means:

(i) A health benefit plan that meets the definition of catastrophic plan set forth in section 1302(e) of P.L. 111-148 of 2010, as amended; or

(ii) A health benefit plan offered outside the exchange marketplace that requires a calendar year deductible or out-of-pocket expenses under the plan, other than for premiums, for covered benefits, that meets or exceeds the commissioner's annual adjustment under (b) of this subsection.

(9) "Certification" means a determination by a review organization that an admission, extension of stay, or other health care service or procedure has been reviewed and, based on the information provided, meets the clinical requirements for medical

necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

(10) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

(11) "Covered person" or "enrollee" means a person covered by a health plan including an enrollee, subscriber, policyholder, beneficiary of a group plan, or individual covered by any other health plan.

(12) "Dependent" means, at a minimum, the enrollee's legal spouse and dependent children who qualify for coverage under the enrollee's health benefit plan.

(13) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition (a) 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, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

(14) "Emergency services" means a medical screening examination, as required under section 1867 of the social security act (42 U.S.C. 1395dd), that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the social security act (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the social security act (42 U.S.C. 1395dd(e)(3)).

(15) "Employee" has the same meaning given to the term, as of January 1, 2008, under section 3(6) of the federal employee retirement income security act of 1974.

(16) "Enrollee point-of-service cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

(17) "Exchange" means the Washington health benefit exchange established under chapter 43.71 RCW.

(18) "Final external review decision" means a determination by an independent review organization at the conclusion of an external review.

(19) "Final internal adverse benefit determination" means an adverse benefit determination that has been upheld by a health plan or carrier at the completion of the internal appeals process, or an adverse benefit determination with respect to which the internal appeals process has been exhausted under the exhaustion rules described in RCW 48.43.530 and 48.43.535.

(20) "Grandfathered health plan" means a group health plan or an individual health plan that under section 1251 of the patient protection and affordable care act, P.L. 111-148 (2010) and as amended by the health care and education reconciliation act, P.L. 111-152 (2010) is not subject to subtitles A or C of the act as amended.

(21) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

(22) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 RCW, drug and alcohol treatment facilities licensed under chapter 70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision or instrumentality of the state and such other facilities as required by federal law and implementing regulations.

(23) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(24) "Health care service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

(25) "Health carrier" or "carrier" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020, and includes "issuers" as that term is used in the patient protection and affordable care act (P.L. 111-148).

(26)(a) Except as provided in (b) of this subsection, "health plan" or "health benefit plan" means any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care services except the following:

((~~(a)~~)) (i) Long-term care insurance governed by chapter 48.84 or 48.83 RCW;

((~~(b)~~)) (ii) Medicare supplemental health insurance governed by chapter 48.66 RCW;

((~~(c)~~)) (iii) Coverage supplemental to the coverage provided under chapter 55, Title 10, United States Code;

((~~(d)~~)) (iv) Limited health care services offered by limited health care service contractors in accordance with RCW 48.44.035;

((~~(e)~~)) (v) Disability income;

((~~(f)~~)) (vi) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

((~~(g)~~)) (vii) Workers' compensation coverage;

((~~(h)~~)) (viii) Accident only coverage;

((~~(i)~~)) (ix) Specified disease or illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance offered as an independent, noncoordinated benefit;

((~~(j)~~)) (x) Employer-sponsored self-funded health plans;

((~~(k)~~)) (xi) Dental only and vision only coverage;

((~~(l)~~)) (xii) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only

plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner; and

((~~(m)~~)) (xiii) Civilian health and medical program for the veterans affairs administration (CHAMPVA).

(b) For purposes of RCW 48.43.520, 48.43.525, 48.43.530, and 48.43.535, "health plan" or "health benefit plan" also includes a dental only plan offered after December 31, 2017.

(27) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(28) "Material modification" means a change in the actuarial value of the health plan as modified of more than five percent but less than fifteen percent.

(29) "Open enrollment" means a period of time as defined in rule to be held at the same time each year, during which applicants may enroll in a carrier's individual health benefit plan without being subject to health screening or otherwise required to provide evidence of insurability as a condition for enrollment.

(30) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

(31) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

(32) "Review organization" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, health care service contractor as defined in RCW 48.44.010, or health maintenance organization as defined in RCW 48.46.020, and entities affiliated with, under contract with, or acting on behalf of a health carrier to perform a utilization review.

(33) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in

business that employed an average of at least one but no more than fifty employees, during the previous calendar year and employed at least one employee on the first day of the plan year, is not formed primarily for purposes of buying health insurance, and in which a bona fide employer-employee relationship exists. In determining the number of employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. A self-employed individual or sole proprietor who is covered as a group of one must also: (a) Have been employed by the same small employer or small group for at least twelve months prior to application for small group coverage, and (b) verify that he or she derived at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year, except a self-employed individual or sole proprietor in an agricultural trade or business, must have derived at least fifty-one percent of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year.

(34) "Special enrollment" means a defined period of time of not less than thirty-one days, triggered by a specific qualifying event experienced by the applicant, during which applicants may enroll in the carrier's individual health benefit plan without being subject to health screening or otherwise required to provide evidence of insurability as a condition for enrollment.

(35) "Standard health questionnaire" means the standard health questionnaire designated under chapter 48.41 RCW.

(36) "Utilization review" means the prospective, concurrent, or retrospective assessment of the necessity and appropriateness of the allocation of health care resources and services of a provider or

facility, given or proposed to be given to an enrollee or group of enrollees.

(37) "Wellness activity" means an explicit program of an activity consistent with department of health guidelines, such as, smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education for the purpose of improving enrollee health status and reducing health service costs.

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;

(b) 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 with respect to coverage or payment for a dental service; or

(c) Deny a claim for a covered dental service provided by a treating dentist to a covered person. If the carrier denies a claim for such a service, the carrier may not advertise in promotional materials or an explanation of benefits sent to prospective or current members that the carrier covers the dental service.

(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 ---