HOUSE BILL REPORT
HB 1018

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to fair dental insurance practices.

Brief Description: Concerning fair dental insurance practices.

Sponsors: Representatives Caldier, Cody, Jinkins, Santos and Appleton.

Brief History:
Committee Activity:
Health Care & Wellness: 1/22/19, 2/6/19 [DPS].

Brief Summary of Substitute Bill

- Applies statutes related to utilization review, prior authorization, grievance and adverse benefit determination review processes, and independent review organizations to dental-only plans.
- Prohibits a carrier offering a dental-only plan from retaliating against a provider for disputing the carrier's determination about a dental service or denying a claim for a covered dental service provided by a treating dentist to a covered person.
- Requires health carriers offering dental only plans to submit explanation of benefits forms to the Insurance Commissioner for approval.
- Prohibits health benefit plans, health care service contractors, or health carriers offering dental benefits from denying or limiting coverage based on an individual's oral health at the time coverage begins.
- Exempts fully capitated dental plans from the provisions of the bill.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 12 members: Representatives Cody, Chair; Macri, Vice Chair; Caldier, Assistant Ranking Minority Member; Chambers, Davis, DeBolt, Jinkins, Riccelli, Robinson, Stonier, Thai 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.

Minority Report: Do not pass. Signed by 2 members: Representatives Schmick, Ranking Minority Member; Maycumber.

Minority Report: Without recommendation. Signed by 1 member: Representative Harris.

Staff: Kim Weidenaar (786-7120).

Background:

Regulation of Health Plans.
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. 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.

Prior Authorization. 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.

Grievances and Review of Adverse Benefit Determinations. Carriers and health plans must have comprehensive and effective processes for grievances and review of adverse benefit determinations, and the processes must be consistent with requirements in statute. For example, the statute requires that the carrier and plan provide written notice to an enrollee, his or her designated representative, and his or her provider of its decision to deny, modify, reduce, or terminate payment, coverage, or authorization for services or benefits. By rule, carriers and health plans are prohibited from taking or threatening to take punitive action against a provider acting on behalf of or in support of an enrollee as part of a review of an adverse benefit determination.

Review by Independent Review Organizations. An enrollee in a health plan may seek review by a certified independent review organization (IRO) if: (1) a carrier denies, modifies, reduces, or terminates coverage of, or payment for, a health care service; and (2) the enrollee has exhausted the carrier's grievance process or the carrier has exceeded timelines for grievances. Reviewers for the IRO make determinations regarding the medical necessity or appropriateness of, and the application of plan provisions to, health care services for an enrollee. An IRO determination must be consistent with the plan unless it is unreasonable or inconsistent with evidence-based medical practice. Only contract specialists may make determinations about application of plan provisions and only clinical reviewers may determine medical necessity and appropriateness. An IRO is required to notify the enrollee and the carrier of the result and rationale for the determination within 15 days of receiving all

necessary information or 20 days after receiving the request (or 25 days in exceptional circumstances), whichever is earlier. The carrier must timely implement the determination and pay the IRO's fees.

Explanation of Benefits.
An explanation of benefits (EOB) is a statement used by a health carrier to inform an enrollee of how the carrier reimbursed a provider for services rendered on the enrollee's behalf. An EOB may include information on the service provided, the amount charged by the provider, the amount reimbursed by the health plan, and the enrollee's responsibility. Health carriers must submit their rates and forms to the Insurance Commissioner (Commissioner) for approval. The Commissioner may disapprove of an insurance contract if:

- it contains inconsistent, ambiguous, or misleading content;
- the carrier is soliciting purchase of the product through deceptive advertising;
- it contains unreasonable restrictions on the treatment of patients; or
- the benefits are unreasonable in relation to the amount charged.

Health carriers do not submit EOBs to the Commissioner for approval.

Dental Care and Preexisting Conditions.
Under the federal Affordable Care Act (ACA), dental care for adults is not an essential health benefit, but is covered as an essential health benefit for children under 18. Under the ACA, health carriers may not deny someone a policy because they have a preexisting condition, refuse to cover services necessary to treat a preexisting condition, or charge a higher premium based on a person's health status.

Summary of Substitute Bill:

Regulation of Dental-Only Plans.
A "health plan" includes a dental-only plan offered after December 31, 2019, for purposes of the statutes regulating utilization review programs, prior authorization, grievances and review of adverse benefit determinations, and review by independent review organizations.

A health carrier offering a dental-only plan may not 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 regarding coverage or payment for a dental service.

A health carrier offering a dental-only plan may not deny a claim for a covered dental service provided by a treating dentist to a covered person. If the carrier denies such a claim, the carrier may not advertise that the carrier covers the service in promotional materials or an explanation of benefits sent to prospective or current members.

Explanation of Benefits.
Beginning October 1, 2019, a health carrier offering a dental-only plan must annually submit to the Insurance Commissioner (Commissioner) the Explanation of Benefits (EOB) form the carrier plans to use for the upcoming plan year. The submission must include a list of standard definitions and terms the carriers will use and an example of a completed form.

No later than July 1, 2020, the Commissioner must utilize the EOB forms received in 2019 to adopt rules setting minimum standards for the format, terms, and definitions for EOB forms used by dental-only plans. The rules must include a model EOB form, model terms, and model definitions. Beginning in plan year 2021, a health carrier offering a dental-only plan may not use an EOB form, or the standard definitions or terms used on the form, if the Commissioner has disapproved of the form, definitions, or terms. The Commissioner may disapprove of an EOB form, or the definitions or terms used on the form, if he or she finds the form, definitions, or terms are confusing, inconsistent, or misleading. The Commissioner may not disapprove a form, definitions, or terms that are substantially identical to the model form, definitions, and terms. The EOB requirements do not apply to fully capitated dental plans.

Preexisting Conditions.
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, including a missing tooth, at the time coverage begins.

Fully capitated dental plans are exempted from the provisions of the bill.

Substitute Bill Compared to Original Bill:

The substitute bill exempts fully capitated dental plans from the provision of the bill.

Appropriation: None.

Fiscal Note: Available.

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

Staff Summary of Public Testimony:

(In support) This bill adds dental patients to the Patient's Bill of Rights. It is a resurrection of three bills from last year and we are currently working with stakeholders to come to agreement and compromise. The elements of the bill are significant to dentists. There is commitment to reach an agreement on language and this process is strongly supported.

(Opposed) There are a number of elements in this bill that certain dental companies already comply with such as not retroactively denying claims and having grievance and appeals processes. However, some of the elements would have serious implications for dental plans. For example, the cost of conducting an independent review would often exceed the costs of the actual claims. Additional, the explanation of benefit requirements only apply to dental plans and do not apply to medical.

(Other) It is a worthwhile pursuit to create some form of remedies for dental patients, and the sponsor has done a lot of work in the past on these issues, which is appreciated. However, regulating fully capitated dental plans in this way is not appropriate as they are not claims based models and many of these requirements do not apply. For example, the cost of requiring independent review organizations would likely exceed the benefit, and there is no financial incentive for dentists in fully capitated plans to offer services that are not warranted. In these plans the patient and the provider set a treatment plan so there is no need for utilization management.

There is also a concern that the language of the bill prohibits plans from denying certain dental care practices or treatments. This bill attempts to put dental patients into the Patient's Bill of Rights. While this sounds simple, it causes a number of issues and so it is suggested that there should be a new statute created for dental patients.

Finally, adding dental plans to the definition of health plans also causes a number of inconsistencies. For example, there are requirements related to adoption of national standards that exist for the practice of medicine, but do not exist for dental practice.

Persons Testifying: (In support) Representative Caldier, prime sponsor; and Trent House, Washington State Dental Association.

(Opposed) Sean Pickard, Delta Dental of Washington.

(Other) Melissa Johnson, Willamette Dental Group; Lonnie Johns-Brown, Office of the Insurance Commissioner; Amber Ulvenes, Kaiser Permanente Northwest; and Meg Jones, Association of Washington Healthcare Plans.

Persons Signed In To Testify But Not Testifying: None.