SENATE BILL REPORT
SB 6218

As of January 24, 2024

Title: An act relating to dental only plans.

Brief Description: Concerning dental only plans.

Sponsors: Senators Van De Wege, King, Kuderer, Lovick, Nobles and Valdez.

Brief History:
Committee Activity: Health & Long Term Care: 1/25/24.

Brief Summary of Bill

- Requires health carriers to submit information related to dental loss ratio for dental-only plans to the Office of the Insurance Commissioner.
- Requires the Insurance Commissioner to disapprove dental-only plan rates under certain circumstances.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Staff: Greg Attanasio (786-7410)

Background: The Affordable Care Act (ACA) requires fully-insured commercial market health carriers to pay a minimum amount of the premium collected towards medical care or quality improvement initiatives. In the individual and small group markets, this threshold is 80 percent and in the large group market it is 85 percent. This percentage is known as the medical loss ratio. If expenses and profit exceed these thresholds, the difference must be returned to customers as refunds or rebates.

Health carriers offering dental-only plans must submit annual data on the plans, including the total number of members, the total revenue, the total amount of payments, and the dental loss ratio. There is not a minimum dental loss ratio threshold for dental-only plans,

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however, the Office of the Insurance Commissioner (OIC) does publish data on the dental loss ratios for carriers that operate in Washington State.

OIC reviews health plan rates for all individual and small-group health plans to determine if the rate change is reasonable in relation to the plan's benefits. If OIC determines the rate request is justified, state law requires OIC to approve the increase. If OIC determines the rate increase is not justified, it will be denied. The carrier can then revise its rate-increase request or it can request a hearing. OIC also reviews and approves pediatric dental-only plans offered as an essential health benefit on the individual and small group plan markets.

Summary of Bill: Health carriers offering dental-only plans must submit information to OIC related to the projected dental loss ratio for the plans and the components of projected administrative expenses. Administrative expenses include:

- financial administration expenses;
- marketing and sales expenses;
- distribution expenses;
- claims operations expenses;
- medical administration expenses, such as disease management, care management, utilization review, and medical management activities;
- network operations expenses;
- charitable expenses;
- board, bureau, or association fees;
- state and federal tax expenses, including assessments; and
- payroll expenses.

Health carriers must file their dental-only plan rates and any changes to group rating factors that will be effective January 1st of the following year by a date determined by OIC. OIC shall disapprove of any plan rate that is excessive, inadequate, or unreasonable in relation to the benefits and shall disapprove of any group rating factor that is discriminatory or not actuarially sound.

A rate must be presumptively disapproved if:

- the administrative expense component increases from the previous year's rate filing by more than the most recent calendar year's increase in the dental services consumer price index;
- reported contribution to surplus exceeds 1.9 percent of total revenue; or
- dental loss ratio for the plan is less than 83 percent.

If OIC disapproves a rate or group rating factor change, OIC must notify the carrier no less than 45 days before the effect date of the rate or group rating factor. A carrier may request a hearing within ten days of the notice from OIC and a hearing must be held within 15 days of the request. OIC must issue a decision within 30 days after the hearing.

If a plan rate is presumptively disapproved OIC must hold a public hearing and the carrier

must notify all employers and individuals covered by the plan.

If the dental loss ratio of a plan is less than 83 percent, the carrier must refund the excess premium to those covered by the plan. OIC may authorize a waiver or adjustment of the refund requirements if it is determined that issuing refunds would result in financial impairment for the carrier.

When submitting required data on the the total number of members, the total revenue, the total amount of payments, and the dental loss ratio of dental-only plans, carriers may only include data from Washington.

Appropriation: None.

Fiscal Note: Requested on January 15, 2024.

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

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