Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 1535

Brief Description: Ensuring patient choice and access to care by prohibiting unfair and deceptive dental insurance practices.

Sponsors: Representatives Thai, Marshall, Parshley, Caldier, Nance, Richards, Walen, Connors, Davis, Rule, Reeves, Morgan, Ramel, Abbarno, Stonier, Doglio, Tharinger, Lekanoff, Leavitt, Reed, Gregerson, Kloba, Salahuddin, Zahn, Ormsby, Scott, Hill and Simmons.

Brief Summary of Bill

- Prohibits certain stand-alone dental plans from overriding the decisions of the treating dentist and the patient.
- Prohibits certain stand-alone dental plans from reducing reimbursement rates during the term of the contract without the dentist's consent.
- Limits the circumstances under which a dentist may be required to accept payment via a credit card or electronic funds transfer.
- Requires noncontracting dentists to be paid the same as contracting dentists, under certain circumstances.
- Imposes a minimum dental loss ratio on stand-alone dental plans.
- Subjects stand-alone dental plans to rate review.

Hearing Date: 1/29/25

Staff: Jim Morishima (786-7191).

Background:

Dental Insurance.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

Dental benefits are provided to enrollees in a variety of forms. For example, some comprehensive health plans offer dental benefits. Dental benefits are also offered by stand-alone dental plans, which may be offered by limited health service contractors or fully licensed carriers offering only dental benefits.

Relationships Between Dental Insurers and Dental Providers.
Disability insurers and health care service contractors offering dental benefits may not:

- set or limit the fee a dentist charges for noncovered services; or
- prohibit a dentist from providing noncovered services.

Medical Loss Ratio.
The federal Affordable Care Act requires health insurers to spend a minimum percentage of premiums on health care, known as the medical loss ratio. For large group plans, the minimum medical loss ratio is 85 percent and for individual and small group market plans, the minimum medical loss ratio is 80 percent. If a carrier does not meet the minimum ratio, it must provide a rebate to its enrollees.

State law requires each stand-alone dental insurer to provide a supplemental data statement to the Office of the Insurance Commissioner (OIC) that includes information about the carrier's dental loss ratio. The dental loss ratio is calculated by dividing the total amount of dental payments by the total amount of dental revenue.

Rate Review.
Health carriers are required to file their rates with the OIC. The OIC reviews and approves insurance rates in both the individual and small group markets, as well as for pediatric dental coverage offered by stand-alone dental carriers. Rates that are unreasonable in relation to the benefits in the agreement are subject to disapproval.

Summary of Bill:

Relationships Between Dental Insurers and Dental Providers.
A limited health care service contractor offering dental benefits must allow a treating dentist, in consultation with the enrollee, to make all decisions on dental services, rather than making such decisions through contracts or agreements between the dentist and limited health care service contractor. The decisions must be based on accepted dental practices. Consistent with this requirement the limited health service contractor is prohibited from:

- deny coverage for service provided by the dentist based on an independent diagnosis made by the limited health service contractor or an employee or agent of the limited health care service contractor; or
- deny coverage for procedures on the basis that the procedures were performed on the same day.

The limited health care service contractor may not modify reimbursement rates paid to a contracting dentist during the term of the contract, unless the contracting dentist agrees to the

modification in writing.

A dental insurer (defined as an "insurer that offers a policy or certificate of insurance or other contract that provides only a dental benefit"), the dental insurer's contracted vendor, or a third-party administrator may pay a claim using a credit card or electronic funds transfer payment that imposes a processing charge if:

- the dental insurer notifies the provider, in advance, of the potential charges;
- the dental insurer offers the provider an alternative payment method that does not impose similar charges; and
- the provider or a designee of the provider elects to accept a payment of the claim in this manner.

An "employee benefit plan" or "health insurance policy" must provide that payment or reimbursement for a non-contracting provider dentist is no less than the payment or reimbursement for a contracting provider dentist.

Dental Loss Ratio.
Carriers offering stand-alone dental plans must submit information to the Office of the Insurance Commissioner (OIC), including the current and projected dental loss ratio for stand-alone dental plans and the components of projected administrative expenses. The dental loss ratio must be computed by dividing the total dental payments by the total revenue for the plan. Unless otherwise determined by the OIC, administrative expenses include:

- financial administrative expenses;
- marketing and sales expenses;
- distribution expenses;
- claims operation expenses;
- medical administration expenses;
- network operations expenses;
- charitable expenses involving a nonprofit associated with an insurance company;
- board, bureau, or association fees; and
- state and federal tax expenses.

If the dental loss ratio is less than 85 percent, the carrier must refund the excess premium to its covered individuals and covered groups. The carrier must notify individuals and groups that qualify for a refund. The total of all refunds must equal the amount of the carrier's earned premium that exceeds the amount necessary to achieve a "medical loss ratio" of 85 percent, calculated using data reported by the carrier as prescribed in rules adopted by the OIC. The OIC may authorize a waiver or adjustment of the refund requirements if it is determined that issuing refunds would result in the financial impairment of the carrier.

Rate Review.
A carrier offering a stand-alone dental plan must file with the OIC its plan rates and any changes to group rating factors that are effective January 1 the following year. The OIC must disapprove of any proposed rate that is excessive, inadequate, or unreasonable in relation to the benefits

charged and must disapprove of any change to group rating factors that are discriminatory or not actuarily 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;
- the reported contribution to surplus exceeds 1.9 percent of total revenue; or
- the dental loss ratio for the plan is less than 85 percent.

If a rate is presumptively disapproved, the OIC must hold a public hearing. The carrier must notify all employers and individuals covered by the plan of the presumptive disapproval and that the disapproval is subject to a public hearing.

For all other disapprovals, the OIC must notify the carrier no later than 45 days before the effective date of the rate or group rating factor. The carrier may request a hearing within 10 days of receiving the disapproval. The OIC must conduct the hearing within 15 days of the request and issue a decision within 30 days after the hearing. The carrier may not implement the disapproved rate or group rating factor unless the disapproval is reversed.

Data Statement.
Data submitted to the OIC by carriers offering stand-alone dental plans must be based only on Washington data.

Appropriation: None.

Fiscal Note: Requested on January 24, 2025.

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