SENATE BILL REPORT
SB 5351

As of January 28, 2025

Title: An act relating to ensuring patient choice and access to care by prohibiting unfair and deceptive dental insurance practices.

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

Sponsors: Senators King, Chapman, Cleveland, Muzzall, Orwall, Christian, Nobles, Harris, Salomon, Conway, Frame, Hasegawa, Holy, Shewmake and Trudeau.

Brief History:
Committee Activity: Health & Long-Term Care: 1/30/25.

Brief Summary of Bill

- Requires limited health care service contractors to permit a dentist, in consultation with the patient, to make all decisions on dental services provided to the patient.
- Provides circumstances in which an insurer may include a processing fee or similar charge when paying a claim to a provider.
- Requires insurers to reimburse noncontracting dentists at the same rate as contracting dentists.
- Directs the Office of the Insurance Commissioner to review and approve dental-only plan rates and sets a minimum dental loss ratio.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Staff: Greg Attanasio (786-7410)

Background: The Affordable Care Act requires fully-insured commercial market health

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carriers to pay a minimum amount of the premium collected toward 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, 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.

"Limited health care service contractor" means a health care service contractor that offers one and only one limited health care service, including dental care services, vision care services, mental health services, chemical dependency services, pharmaceutical services, podiatric care services, and such other services determined by OIC.

Summary of Bill: Limited Health Care Service Contractors. A limited health care service contractor (contractor) that offers coverage for dental care services shall permit a treating dentist, in consultation with the covered person, to make all decisions on dental services provided to the covered person, rather than making such decisions through contracts or agreements between the dentist and the contractor. The decisions made by the dentist, in consultation with the covered person, must be based on accepted dental practices.

A contractor may not:

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

A contractor may not modify the reimbursement rates paid to a contracting dentist during the term of the contract, unless the contracting dentist agrees to the modification in writing.

Claims Payment. A dental insurer or third-party administrator, or vendor contracted with the insurer or third-party administrator, may pay a claim for reimbursement made by a dental care provider using a credit card or electronic funds transfer payment method that imposes on the provider a fee or similar charge to process the payment if:

- the insurer or vendor notifies the provider in advance of the potential fees or charges;
- the insurer or vendor offers the provider an alternative payment method that does not impose a fee; and
- the provider or a designee elects to accept payment using a credit card or electronic funds transfer.

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

Rate Filing and Dental Loss Ratio. Health carriers offering dental only plans must submit to OIC current and projected dental loss ratio for dental only plans, calculated by dividing the total dental payments by the total revenue for the plan, and the components of projected administrative expenses. Unless otherwise determined by OIC, the following items shall be deemed to be an administrative expense for the purposes of calculating and reporting the dental loss ratio:

- financial administration expenses;
- marketing and sales expenses;
- distribution expenses;
- claims operations expenses;
- medical administration expenses;
- network operations expenses;
- charitable expenses;
- board, bureau, or association fees; and
- state and federal tax expenses, including assessments.

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 85 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 annual dental loss ratio for a dental only plan offered by a carrier is less than 85 percent, the carrier shall refund the excess premium to its covered individuals and covered groups. The total of all refunds issued shall equal the amount of a 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 by OIC in rule. OIC may authorize a waiver or adjustment of the refund requirements in this section only if it is determined that issuing refunds would result in financial impairment for the carrier.

Data submitted to OIC on dental only plan membership, revenue, payments, dental loss ratio, and premiums must be based on Washington data and may not include data from any other state.

Appropriation: None.

Fiscal Note: Requested on January 21, 2025.

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

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