
HOUSE BILL 1316

State of Washington

65th Legislature

2017 Regular Session

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

1 AN ACT Relating to fair dental insurance practices; amending RCW
2 48.43.005 and 48.43.740; and creating a new section.

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

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

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

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

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

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

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

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

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

30 (4) "Basic health plan" means the plan described under chapter
31 70.47 RCW, as revised from time to time.

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

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

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

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

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

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

18 (b) In July 2008, and in each July thereafter, the insurance
19 commissioner shall adjust the minimum deductible and out-of-pocket
20 expense required for a plan to qualify as a catastrophic plan to
21 reflect the percentage change in the consumer price index for medical
22 care for a preceding twelve months, as determined by the United
23 States department of labor. For a plan year beginning in 2014, the
24 out-of-pocket limits must be adjusted as specified in section
25 1302(c)(1) of P.L. 111-148 of 2010, as amended. The adjusted amount
26 shall apply on the following January 1st.

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

29 (i) A health benefit plan that meets the definition of
30 catastrophic plan set forth in section 1302(e) of P.L. 111-148 of
31 2010, as amended; or

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

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

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

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

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

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

12 (13) "Emergency medical condition" means a medical condition
13 manifesting itself by acute symptoms of sufficient severity,
14 including severe pain, such that a prudent layperson, who possesses
15 an average knowledge of health and medicine, could reasonably expect
16 the absence of immediate medical attention to result in a condition
17 (a) placing the health of the individual, or with respect to a
18 pregnant woman, the health of the woman or her unborn child, in
19 serious jeopardy, (b) serious impairment to bodily functions, or (c)
20 serious dysfunction of any bodily organ or part.

21 (14) "Emergency services" means a medical screening examination,
22 as required under section 1867 of the social security act (42 U.S.C.
23 1395dd), that is within the capability of the emergency department of
24 a hospital, including ancillary services routinely available to the
25 emergency department to evaluate that emergency medical condition,
26 and further medical examination and treatment, to the extent they are
27 within the capabilities of the staff and facilities available at the
28 hospital, as are required under section 1867 of the social security
29 act (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with
30 respect to an emergency medical condition, has the meaning given in
31 section 1867(e)(3) of the social security act (42 U.S.C.
32 1395dd(e)(3)).

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

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

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

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

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

12 (20) "Grandfathered health plan" means a group health plan or an
13 individual health plan that under section 1251 of the patient
14 protection and affordable care act, P.L. 111-148 (2010) and as
15 amended by the health care and education reconciliation act, P.L.
16 111-152 (2010) is not subject to subtitles A or C of the act as
17 amended.

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

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

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

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

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

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

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

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

19 ~~((a))~~ (i) Long-term care insurance governed by chapter 48.84 or
20 48.83 RCW;

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

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

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

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

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

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

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

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

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

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

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

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

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

8 (b) For purposes of RCW 48.43.520, 48.43.525, 48.43.530, and
9 48.43.535, "health plan" or "health benefit plan" also includes a
10 dental only plan offered after December 31, 2017.

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

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

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

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

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

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

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

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

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

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

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

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

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

10 **Sec. 3.** RCW 48.43.740 and 2015 c 9 s 1 are each amended to read
11 as follows:

12 (1) A health carrier offering a dental only plan may not:

13 (a) Deny coverage for treatment of emergency dental conditions
14 that would otherwise be considered a covered service of an existing
15 benefit contract on the basis that the services were provided on the
16 same day the covered person was examined and diagnosed for the
17 emergency dental condition;

18 (b) Take or threaten to take punitive action against a provider
19 acting on behalf of or in support of a covered person because the
20 provider disputes the carrier's determination with respect to
21 coverage or payment for a dental service; or

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

27 (2) For purposes of this section:

28 (a) "Emergency dental condition" means a dental condition
29 manifesting itself by acute symptoms of sufficient severity,
30 including severe pain or infection such that a prudent layperson, who
31 possesses an average knowledge of health and dentistry, could
32 reasonably expect the absence of immediate dental attention to result
33 in:

34 (i) Placing the health of the individual, or with respect to a
35 pregnant woman the health of the woman or her unborn child, in
36 serious jeopardy;

37 (ii) Serious impairment to bodily functions; or

38 (iii) Serious dysfunction of any bodily organ or part.

1 (b) "Health carrier," in addition to the definition in RCW
2 48.43.005, also includes health care service contractors, limited
3 health care service contractors, and disability insurers offering
4 dental only coverage.

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