S-3954.1

SENATE BILL 6218

State of Washington 68th Legislature 2024 Regular Session

By Senators Van De Wege, King, Kuderer, and Lovick

AN ACT Relating to dental only plans; amending RCW 48.43.743; and adding new sections to chapter 48.43 RCW.

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

NEW SECTION. **Sec. 1.** A new section is added to chapter 48.43 RCW to read as follows:

(1) The commissioner shall require health carriers, as defined in RCW 48.43.743, offering dental only plans to submit information as required by the commissioner, which shall include the current and projected dental loss ratio for dental only plans and the components of projected administrative expenses.

(2) Unless otherwise determined by the commissioner, the following items shall be deemed to be an administrative expense for the purposes of calculating and reporting the dental loss ratio:

(a) Financial administration expenses;

(b) Marketing and sales expenses;

(c) Distribution expenses;

(d) Claims operations expenses;

(e) Medical administration expenses, such as disease management, care management, utilization review, and medical management activities;

(f) Network operations expenses;

(g) Charitable expenses;

(h) Board, bureau, or association fees;

(i) State and federal tax expenses, including assessments; and

(j) Payroll expenses.

(3) The dental loss ratio shall be computed by dividing the total dental payments by the total revenue for the plan.

NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43 RCW to read as follows:

(1) Health carriers, as defined in RCW 48.43.743, offering dental only plans shall file their plan rates and any changes to group rating factors that will be effective January 1st of the following year by a date determined by the commissioner.

(2) The commissioner shall disapprove any proposed plan rates that are excessive, inadequate, or unreasonable in relation to the benefits charged, and shall disapprove any change to group rating factors that are discriminatory or not actuarially sound.

(3) A rate shall be presumptively disapproved as excessive by the commissioner if a carrier files a rate change and:

(a) The administrative expense component, not including taxes and assessments, 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;

(b) The reported contribution to surplus exceeds 1.9 percent of total revenue; or

(c) The dental loss ratio for the plan is less than 83 percent.

(4)(a)(i) If the commissioner disapproves of a rate or group rating factor submitted by a carrier under subsection (2) of this section, the commissioner shall notify the carrier no later than 45 days before the proposed effective date of the rate or group rating factor.

(ii) A carrier may request a hearing within 10 days of receiving notice of the disapproval. If a carrier requests a hearing, the commissioner shall hold a hearing within 15 days of the request and issue a decision within 30 days after the hearing. A carrier may not implement the disapproved rate or group rating factor unless the commissioner reverses the decision after the hearing.

(b)(i) If a plan rate is presumptively disapproved under subsection (3) of this section, the commissioner shall hold a public hearing.

(ii) A carrier shall notify all employers and individuals covered by the plan of the presumptive disapproval and that the disapproval is subject to a public hearing.

(5)(a) If the annual dental loss ratio for a dental only plan offered by a carrier is less than 83 percent, the carrier shall refund the excess premium to its covered individuals and covered groups.

(b) A carrier shall communicate to all individuals and groups that were covered under plans during the relevant 12-month period that such individuals and groups qualify for a refund on the premium, or, if the individual or groups are still covered by the carrier, that the individual or groups are eligible for a credit on the premium for the subsequent 12-month period.

(c) 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 83 percent, calculated using data reported by the carrier as prescribed by the commissioner in rule.

(d) The commissioner 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.

Sec. 3. RCW 48.43.743 and 2015 c 9 s 2 are each amended to read as follows:

(1) Each health carrier offering a dental only plan shall submit to the commissioner on or before April 1st of each year as part of the additional data statement or as a supplemental data statement the following information for the preceding year that is derived from the carrier's annual statement, including the exhibit of premiums, enrollments, and utilization for the company at an aggregate level and the additional data to the annual statement, which must be based on Washington data and may not include data from other states:

(a) The total number of dental members;

(b) The total amount of dental revenue;

(c) The total amount of dental payments;

(d) The dental loss ratio that is computed ((~~by dividing the total amount of dental payments by the total amount of dental revenues~~)) as required in section 1 of this act;

(e) The average amount of premiums per member per month; and

(f) The percentage change in the average premium per member per month, measured from the previous year.

(2) A carrier shall electronically submit the information described in subsection (1) of this section in a format and according to instructions prescribed by the commissioner.

(3) The commissioner shall make the information reported under this section available to the public in a format that allows comparison among carriers through a searchable public website on the internet.

(4) For the purposes of licensed disability insurers and health care service contractors, the commissioner shall work collaboratively with insurers to develop an additional or supplemental data statement that utilizes to the maximum extent possible information from the annual statement forms that are currently filed by these entities.

(5) For purposes of this section, "health carrier," in addition to the definition in RCW 48.43.005, also includes health care service contractors, limited health care service contractors, and disability insurers offering dental only coverage.

(6) Nothing in this section is intended to establish a minimum dental loss ratio.

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