Multiple Agency Fiscal Note Summary

Bill Number: 6218 SB	**Title:** Dental only plans

Estimated Cash Receipts

NONE

Estimated Operating Expenditures

Agency Name	2023-25				2025-27				2027-29			
	FTEs	GF-State	NGF-Outlook	Total	FTEs	GF-State	NGF-Outlook	Total	FTEs	GF-State	NGF-Outlook	Total
Washington State Health Care Authority	Non-zero but indeterminate cost and/or savings. Please see discussion.											
Office of Insurance Commissioner	1.9	0	0	794,854	3.6	0	0	1,504,946	3.6	0	0	1,504,946
Total $	**1.9**	**0**	**0**	**794,854**	**3.6**	**0**	**0**	**1,504,946**	**3.6**	**0**	**0**	**1,504,946**

Estimated Capital Budget Expenditures

Agency Name	2023-25			2025-27			2027-29		
	FTEs	Bonds	Total	FTEs	Bonds	Total	FTEs	Bonds	Total
Washington State Health Care Authority	.0	0	0	.0	0	0	.0	0	0
Office of Insurance Commissioner	.0	0	0	.0	0	0	.0	0	0
Total $	**0.0**	**0**	**0**	**0.0**	**0**	**0**	**0.0**	**0**	**0**

Estimated Capital Budget Breakout

Prepared by: Jason Brown, OFM	**Phone:** (360) 742-7277	**Date Published:** Final 1/31/2024

FNPID 70091

FNS029 Multi Agency rollup

Individual State Agency Fiscal Note

Bill Number: 6218 SB	**Title:** Dental only plans	**Agency:** 107-Washington State Health Care Authority

Part I: Estimates

☐ **No Fiscal Impact**

Estimated Cash Receipts to:

NONE

Estimated Operating Expenditures from:

Non-zero but indeterminate cost and/or savings. Please see discussion.

Estimated Capital Budget Impact:

NONE

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

☒ If fiscal impact is greater than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.

☐ If fiscal impact is less than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).

☐ Capital budget impact, complete Part IV.

☐ Requires new rule making, complete Part V.

Legislative Contact:	Greg Attanasio	Phone: 360-786-7410	Date: 01/15/2024
Agency Preparation:	Sara Whitley	Phone: 360-725-0944	Date: 01/19/2024
Agency Approval:	Tanya Deuel	Phone: 360-725-0908	Date: 01/19/2024
OFM Review:	Marcus Ehrlander	Phone: (360) 489-4327	Date: 01/26/2024

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Significant provisions of the bill and any related workload or policy assumptions that have revenue or expenditure impact on the responding agency by section number.

See attached narrative.

II. B - Cash receipts Impact

Cash receipts impact of the legislation on the responding agency with the cash receipts provisions identified by section number and when appropriate, the detail of the revenue sources. Description of the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explanation of how workload assumptions translate into estimates. Distinguished between one time and ongoing functions.

See attached narrative.

II. C - Expenditures

Agency expenditures necessary to implement this legislation (or savings resulting from this legislation), with the provisions of the legislation that result in the expenditures (or savings) identified by section number. Description of the factual basis of the assumptions and the method by which the expenditure impact is derived. Explanation of how workload assumptions translate into cost estimates. Distinguished between one time and ongoing functions.

See attached narrative.

Part III: Expenditure Detail

III. A - Operating Budget Expenditures

Non-zero but indeterminate cost and/or savings. Please see discussion.

III. B - Expenditures by Object Or Purpose

Non-zero but indeterminate cost and/or savings. Please see discussion.

III. C - Operating FTE Detail: *FTEs listed by classification and corresponding annual compensation. Totals agree with total FTEs in Part I and Part IIIA.*

NONE

III. D - Expenditures By Program (optional)

NONE

Part IV: Capital Budget Impact

IV. A - Capital Budget Expenditures

NONE

IV. B - Expenditures by Object Or Purpose

NONE

IV. C - Capital Budget Breakout

Acquisition and construction costs not reflected elsewhere on the fiscal note and description of potential financing methods.

NONE

IV. D - Capital FTE Detail: *FTEs listed by classification and corresponding annual compensation. Totals agree with total FTEs in Part IVB.*

NONE

See attached narrative

Part V: New Rule Making Required

Provisions of the bill that require the agency to adopt new administrative rules or repeal/revise existing rules.

HCA Fiscal Note

Bill Number: SB 6218 HCA Request #: 24-061 Title: **Dental only coverage**

Part I: Estimates

☐ No Fiscal Impact

Estimated Cash Receipts to:

NONE

Estimated Operating Expenditures from:

Indeterminate fiscal impact

Estimated Capital Budget Impact:
NONE

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

☒ If fiscal impact is greater than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.

☐ If fiscal impact is less than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).

☐ Capital budget impact, complete Part IV.

☐ Requires new rule making, complete Part V.

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Section 1 adds a new section to RCW 48.43 (Health Insurance Reform) requiring health plans offering dental only coverage to submit Dental Loss Ratio (DLR) information to the Insurance Commissioner, including all assumed administrative expenses as defined under section 1(2).

Section 1(3) defines the DLR as total dental payments divided by the total revenue for the dental only plan.

Section 2 adds a new section to RCW 48.43 requiring plans to file their rates to be approved by the Insurance Commissioner, who will determine if the rates submitted are excessive, inadequate or unreasonable in relation to the benefits charged to the plans. Rates will be automatically considered excessive if the following provisions are met:

- The administrative expenses reported for the rates submitted have increase over and above the previous years' rate filing by more than the most recent year's increase in the dental services consumer price index (CPI);
- The reported contribution to surplus exceed 1.9 percent (1.9%) of total reported plan revenue; or if,
- The reported DLR for the plan is less than 83 percent (83%)

Section 2(5)(a) requires dental only health plans with a reported DLR of less than 83 percent (83%) to refund the excess premium to individuals covered by the plan. The refund can be provided in the form of:

- A credit to premiums for the subsequent twelve-month period of coverage for members who maintain enrollment from the previous plan year, or
- A full refund of premiums.

Section 3 amends RCW 48.43.743 (Dental only plans – annual data statement) requiring all data submitted to the Office of the Insurance Commissioner (OIC) regarding the plan's annual financial statements, exhibit of premiums, enrollment and plan utilization to be based on Washington only data, not to include data from other states.

Section 3(1)(d) clarifies the calculation of the dental loss ratio, as referenced in Section 1(3) of this bill.

II. B - Cash Receipts Impact

II. C – Expenditures

<u>Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) programs</u>

Indeterminate fiscal impact.

This bill establishes new requirements and standards of reporting for dental only plans, to include: establishing a minimum 83 percent (83%) dental loss ratio (DLR) threshold, new definitions for what can be determined administrative fees and new data reporting standards for dental only plans.

Delta Dental of Washington (the third-party administrator for the self-insured Uniform Dental Plan (UDP) and fully insured carrier for the DeltaCare plan offering) and fully insured carrier Willamette Dental administer the PEBB and SEBB dental offerings. Both carriers note the potential for impacts to internal operations and plan

economics that could require increases in claims expenses, provider compensation and benefit enhancements resulting from this legislation. While both carriers are unable to quantify the potential impacts to PEBB and SEBB dental premiums, they note the potential for cost impacts.

Because dental-only premiums for active employees are 100 percent employer paid, any change to premiums for dental-only coverage will impact the state benefit contribution level, resulting in an increase to state expenditures for dental benefits. Employer Groups (Political Subdivisions), subscribers enrolled in COBRA, early retirees and Medicare enrollees who select a dental plan do not receive a state contribution toward dental premiums; therefore, any change to dental premiums would impact the self-pay premium contributions paid by these members.

As drafted, the bill is not assumed to impact requirements on the self-insured Uniform Dental Plan (UDP) established and governed by RCW 41.05 (Health care authority), which is offered in both the PEBB and SEBB programs. However, given Delta Dental of Washington's feedback related to provider fee schedules, it is assumed that any changes to the provider fee schedule for Delta's book-of-business could result in an impact to claims liability in the UDP, thereby impacting the plan's premium. Furthermore, any changes in the underlying administration of the plan which result in impacts to administrative costs that could further impact potential future UDP premiums.

Part III: Expenditure Detail

III. A - Operating Budget Expenditure

Indeterminate

III. B - Expenditures by Object Or Purpose

Indeterminate

III. C - Operating FTE Detail: FTEs listed by classification and corresponding annual compensation. Totals agree with total FTEs in Part I and Part IIIA.

NONE

III. D - Expenditures By Program (optional)

NONE

Part IV: Capital Budget Impact

IV. A - Capital Budget Expenditures

NONE

IV. B - Expenditures by Object Or Purpose

NONE

IV. C - Capital Budget Breakout: Acquisition and construction costs not reflected elsewhere on the fiscal note and description of potential financing methods.

NONE

IV. D - Capital FTE Detail: FTEs listed by classification and corresponding annual compensation. Totals agree with total FTEs in Part IVB.

NONE

Part V: New Rule Making Required

Provisions of the bill that require the agency to adopt new administrative rules or repeal/revise existing rules.

NONE

Individual State Agency Fiscal Note

Bill Number: 6218 SB	**Title:** Dental only plans	**Agency:** 160-Office of Insurance Commissioner

Part I: Estimates

☐ **No Fiscal Impact**

Estimated Cash Receipts to:

NONE

Estimated Operating Expenditures from:

	FY 2024	FY 2025	2023-25	2025-27	2027-29
FTE Staff Years	0.0	3.9	1.9	3.6	3.6
Account					
Insurance Commissioners Regulatory Account-State 138-1	0	794,854	794,854	1,504,946	1,504,946
Total $	0	794,854	794,854	1,504,946	1,504,946

Estimated Capital Budget Impact:

NONE

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

☒ If fiscal impact is greater than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.

☐ If fiscal impact is less than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).

☐ Capital budget impact, complete Part IV.

☒ Requires new rule making, complete Part V.

Legislative Contact:	Greg Attanasio	Phone: 360-786-7410	Date: 01/15/2024
Agency Preparation:	Sydney Rogalla	Phone: 360-725-7042	Date: 01/25/2024
Agency Approval:	Michael Wood	Phone: 360-725-7007	Date: 01/25/2024
OFM Review:	Jason Brown	Phone: (360) 742-7277	Date: 01/25/2024

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Significant provisions of the bill and any related workload or policy assumptions that have revenue or expenditure impact on the responding agency by section number.

Section 1(1) requires health carriers, offering dental only plans, to submit information as require by the Office of Insurance Commissioner (OIC), which must include the current projected dental loss ratio for dental only plan and the components of projected administrate expenses.

Section 2(1) requires health carriers, offering dental only plans, to 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 OIC.

Section 2(2) requires the OIC to 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.

Section 2(3) provides criteria for the presumptive disapproval of rates which is if there is a rate change filed and either administrative expenses increased more than the most recent calendar year increase in the dental services consumer price index, the reported contribution to surplus is more than 1.9% of total revenue, or if the dental loss ratio for the plan is less than 83%.

Section 2(4)(a) requires the OIC to notify the carrier not later than 45 days before the proposed effective date of the rate or group rating factor, allows the carrier to request a hearing within 10 days of receiving the disapproval notice, and requires the OIC to hold a hearing within 15 days of receiving the request and issue a decision within 30 days after the hearing. It also notes that carriers may not implement disapproved rates or rating factors unless the disapproval is reversed at hearing.

Section 2(4)(b) requires the OIC to hold a public hearing if a plan rate is presumptively disapproved and requires the carrier to notify all employers and individuals covered by the plan of the presumptive disapproval and upcoming hearing.

Section 2(5) requires the refunding of excess premiums by the carrier if the dental loss ratio is less than 83% for a plan, including communicating to all individuals and groups affected, and ensuring refunds would total an amount that would bring the dental loss ratio to 83% as prescribed by the OIC in rule. There is one waiver or adjustment to the refunds which is if they would result in the financial impairment of the carrier.

Section 3 amends RCW 48.43.743 to adjust the dental loss ratio reporting to Washington only data.

II. B - Cash receipts Impact

Cash receipts impact of the legislation on the responding agency with the cash receipts provisions identified by section number and when appropriate, the detail of the revenue sources. Description of the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explanation of how workload assumptions translate into estimates. Distinguished between one time and ongoing functions.

II. C - Expenditures

Agency expenditures necessary to implement this legislation (or savings resulting from this legislation), with the provisions of the legislation that result in the expenditures (or savings) identified by section number. Description of the factual basis of the assumptions and the method by which the expenditure impact is derived. Explanation of how workload assumptions translate into cost estimates. Distinguished between one time and ongoing functions.

Section 1(1) requires health carriers, offering dental only plans, to submit information as require by the Office of Insurance Commissioner (OIC), which must include the current projected dental loss ratio for dental only plan and the components of projected administrate expenses.

Section 2(1) requires health carriers, offering dental only plans, to 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 OIC.

Section 2(2) requires the OIC to 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.

Section 2(3) provides criteria for the presumptive disapproval of rates which is if there is a rate change filed and either administrative expenses increased more than the most recent calendar year increase in the dental services consumer price index, the reported contribution to surplus is more than 1.9% of total revenue, or if the dental loss ratio for the plan is less than 83%.

Section 2(4)(a) requires the OIC to notify the carrier not later than 45 days before the proposed effective date of the rate or group rating factor, allows the carrier to request a hearing within 10 days of receiving the disapproval notice, and requires the OIC to hold a hearing within 15 days of receiving the request and issue a decision within 30 days after the hearing. It also notes that carriers may not implement disapproved rates or rating factors unless the disapproval is reversed at hearing.

Section 2(4)(b) requires the OIC to hold a public hearing if a plan rate is presumptively disapproved and requires the carrier to notify all employers and individuals covered by the plan of the presumptive disapproval and upcoming hearing.

Section 2(5) requires the refunding of excess premiums by the carrier if the dental loss ratio is less than 83% for a plan, including communicating to all individuals and groups affected, and ensuring refunds would total an amount that would bring the dental loss ratio to 83% as prescribed by the OIC in rule. There is one waiver or adjustment to the refunds which is if they would result in the financial impairment of the carrier.

Section 3 amends RCW 48.43.743 to adjust the dental loss ratio reporting to Washington only data.

For purposes of this fiscal note, the OIC assumes that the bill applies to individual and small group pooled dental rate filings and large group dental only rate filings. The OIC anticipates conducting additional hearings when the OIC disapproves rates or group rating factors. In 2023, the OIC received 43 individual and small group dental only pooled rate filings and an estimated 1,754 large group dental only rate filings. Assuming 20% of the individual and small group pooled dental rate filings and 5% of the large group dental only rate filings will be disapproved and subject to a hearing, the OIC assume there will be 97 additional hearings each year and that each hearing will require an average of 60 hours per hearing requiring 970 hours (97 hearings x 10 hours) of a Presiding Officer, 1,940 hours (97 hearings x 20 hours) of an Actuary 3, and 2,910 hours (97 hearings x 30 hours) of an Insurance Attorney each year beginning in FY2025.

Sections 1 through 3 will also lead to an increase in enforcement actions, including the potential for enforcement in situations in which a carrier does not comply with the requirements and definitions within the bill. OIC anticipates an average of an additional 3 enforcement cases in FY2025 and 1 enforcement case in FY2026 and beyond to address compliance issues. For purposes of this fiscal note, it is assumed that enforcement actions will require the equivalent of approximately 40 hours per case requiring 120 hours (3 cases x 40 hours) in FY2025 and 40 hours (1 case x 40 hours) in FY2026 and thereafter of an Insurance Attorney.

This bill will require 'normal' rulemaking, in FY2025, to amend and adopt new sections of WAC. The OIC could expect a dental only carriers and other health plan carriers to be involved in the rulemaking.

Ongoing Costs:
Salary, benefits and associated costs for 1.83 FTE Insurance Attorney, 1.2 FTE Actuary 3, and .6 FTE Presiding Officer.

Part III: Expenditure Detail

III. A - Operating Budget Expenditures

Account	Account Title	Type	FY 2024	FY 2025	2023-25	2025-27	2027-29
138-1	Insurance Commissioners Regulatory Account	State	0	794,854	794,854	1,504,946	1,504,946
		Total $	0	794,854	794,854	1,504,946	1,504,946

III. B - Expenditures by Object Or Purpose

	FY 2024	FY 2025	2023-25	2025-27	2027-29
FTE Staff Years		3.9	1.9	3.6	3.6
A-Salaries and Wages		493,720	493,720	935,644	935,644
B-Employee Benefits		142,163	142,163	268,312	268,312
C-Professional Service Contracts					
E-Goods and Other Services		158,971	158,971	300,990	300,990
G-Travel					
J-Capital Outlays					
M-Inter Agency/Fund Transfers					
N-Grants, Benefits & Client Services					
P-Debt Service					
S-Interagency Reimbursements					
T-Intra-Agency Reimbursements					
9-					
Total $	0	794,854	794,854	1,504,946	1,504,946

III. C - Operating FTE Detail: *List FTEs by classification and corresponding annual compensation. Totals need to agree with total FTEs in Part I and Part IIIA*

Job Classification	Salary	FY 2024	FY 2025	2023-25	2025-27	2027-29
Actuary 3	176,496		1.2	0.6	1.2	1.2
Functional Program Analyst 4	86,712		0.1	0.0		
Insurance Attorney	103,500		1.9	0.9	1.8	1.8
Presiding Officer	111,036		0.6	0.3	0.6	0.6
Senior Policy Analyst	116,148		0.2	0.1		
Total FTEs			3.9	2.0	3.6	3.6

III. D - Expenditures By Program (optional)

NONE

Part IV: Capital Budget Impact

IV. A - Capital Budget Expenditures

NONE

IV. B - Expenditures by Object Or Purpose

NONE

IV. C - Capital Budget Breakout

Acquisition and construction costs not reflected elsewhere on the fiscal note and description of potential financing methods.

NONE

IV. D - Capital FTE Detail: *FTEs listed by classification and corresponding annual compensation. Totals agree with total FTEs in Part IVB.*

NONE

Part V: New Rule Making Required

Provisions of the bill that require the agency to adopt new administrative rules or repeal/revise existing rules.

This bill will require 'normal' rulemaking, in FY2025, to amend and adopt new sections of WAC. The OIC could expect a dental only carriers and other health plan carriers to be involved in the rulemaking.

- Sec 1(2) - Will require rulemaking to identify all administrative expenses not clearly defined in this section.
- Sec 2(2) – Does not specify a date. A date of required filing will need to be established by rule.
- Sec 2(5)(c) – Explicitly stated that the dental loss ratio data used in the calculation needs to be prescribed by the commissioner in rule.

Additionally, WAC 284-43-0200, WAC 284-43-5720, WAC 284-43-5760, and WAC 284-43-6500 et seq. need to be reviewed and properly changed where needed to comply with this bill.