S-0509.1

SENATE BILL 5351

State of Washington 69th Legislature 2025 Regular Session

By Senators King, Chapman, Cleveland, Muzzall, Orwall, Christian, Nobles, Harris, and Salomon

AN ACT Relating to ensuring patient choice and access to care by prohibiting unfair and deceptive dental insurance practices; amending RCW 48.44.035, 48.44.495, and 48.43.743; adding new sections to chapter 48.44 RCW; adding new sections to chapter 48.43 RCW; and creating new sections.

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

NEW SECTION. **Sec. 1.** The legislature finds that the dental benefits system in Washington is failing both patients and dental professionals, as it primarily benefits corporate insurance companies rather than those it is meant to serve. Insurance executives, whose bonuses increase when payouts to patients decrease, dominate the system, leaving patients and providers struggling to navigate a system that prioritizes profits over care.

Therefore, the legislature seeks to reform this broken system by putting patients at the center, ensuring the system works for all stakeholders, especially those in need. The goal of this act is to bring equity, transparency, and fairness to the dental insurance market. By aligning dental insurance protections with those already established for medical insurance, it ensures patients have the same rights and protections. The focus is on making dental benefits work for people, not corporations. A key element of the reform is

protecting patient choice. Patients should be able to choose a trusted dentist and receive the full benefits they pay for, regardless of network restrictions. Therefore, the legislature intends to eliminate corporate restrictions that limit care and undermine the patient-provider relationship.

Additionally, the legislature intends to mandate that at least 85 percent of premium dollars be spent directly on care, ensuring that patients get value for what they pay. The legislature further intends for patients to request an independent review of denied claims, empowering them to receive necessary care, as well as tackling additional actions by insurance companies taking advantage of patients and providers. This act addresses inequities in the dental benefits system, especially for vulnerable populations, by creating a fairer, more transparent market that improves access to care and reduces out-of-pocket costs for all Washington residents.

NEW SECTION. **Sec. 2.** A new section is added to chapter 48.44 RCW to read as follows:

(1)(a) A limited health care service 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 limited health care service contractor.

(b) Consistent with (a) of this subsection, the limited health care service contractor may not:

(i) Deny coverage for services provided by the dentist based on an independent diagnosis made by the limited health care service contractor or an employee or agent of the limited health care service contractor; or

(ii) Deny coverage for procedures on the basis that the procedures were performed on the same day.

(c) The decisions made by the dentist, in consultation with the covered person, under (a) of this subsection must be based on accepted dental practices.

(2) A limited health care service contractor that offers coverage for dental care services 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.

(3) For purposes of this section, "limited health care service contractor" has the same meaning as in RCW 48.44.035.

Sec. 3. RCW 48.44.035 and 1997 c 212 s 1 are each amended to read as follows:

(1) For purposes of this section ((~~only~~)) and section 2 of this act, "limited health care service" means dental care services, vision care services, mental health services, chemical dependency services, pharmaceutical services, podiatric care services, and such other services as may be determined by the commissioner to be limited health services, but does not include hospital, medical, surgical, emergency, or out-of-area services except as those services are provided incidentally to the limited health services set forth in this subsection.

(2) For purposes of this section ((~~only~~)) and section 2 of this act, a "limited health care service contractor" means a health care service contractor that offers one and only one limited health care service.

(3) Except as provided in subsection (4) of this section, every limited health care service contractor must have and maintain a minimum net worth of three hundred thousand dollars.

(4) A limited health care service contractor registered before July 27, 1997, that, on July 27, 1997, has a minimum net worth equal to or greater than that required by subsection (3) of this section must continue to have and maintain the minimum net worth required by subsection (3) of this section. A limited health care service contractor registered before July 27, 1997, that, on July 27, 1997, does not have the minimum net worth required by subsection (3) of this section must have and maintain a minimum net worth of:

(a) Thirty-five percent of the amount required by subsection (3) of this section by December 31, 1997;

(b) Seventy percent of the amount required by subsection (3) of this section by December 31, 1998; and

(c) One hundred percent of the amount required by subsection (3) of this section by December 31, 1999.

(5) For all limited health care service contractors that have had a certificate of registration for less than three years, their uncovered expenditures shall be either insured or guaranteed by a foreign or domestic carrier admitted in the state of Washington or by another carrier acceptable to the commissioner. All such contractors

shall also deposit with the commissioner one-half of one percent of their projected premium for the next year in cash, approved surety bond, securities, or other form acceptable to the commissioner.

(6) For all limited health care service contractors that have had a certificate of registration for three years or more, their uncovered expenditures shall be assured by depositing with the insurance commissioner twenty-five percent of their last year's uncovered expenditures as reported to the commissioner and adjusted to reflect any anticipated increases or decreases during the ensuing year plus an amount for unearned prepayments; in cash, approved surety bond, securities, or other form acceptable to the commissioner. Compliance with subsection (5) of this section shall also constitute compliance with this requirement.

(7) Limited health service contractors need not comply with RCW 48.44.030 or 48.44.037.

NEW SECTION. **Sec. 4.** A new section is added to chapter 48.44 RCW to read as follows:

(1) A dental 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:

(a) The dental insurer notifies the provider, in advance, of the potential fees or other charges associated with the use of the credit card or electronic funds transfer payment method;

(b) The dental insurer offers the provider an alternative payment method that does not impose fees or similar charges on the provider; and

(c) The provider or a designee of the provider elects to accept a payment of the claim using the credit card or electronic funds transfer payment method.

(2) If a dental insurer contracts with a vendor to process payments of dental providers' claims, the dental insurer shall require the vendor to comply with the provisions of subsection (1)(a) of this section.

(3) As used in this section, "dental insurer" means an insurer that offers a policy or certificate of insurance or other contract, that provides only a dental benefit.

NEW SECTION. **Sec. 5.** The insurance commissioner may adopt any rules necessary to implement sections 2 through 4 of this act.

Sec. 6. RCW 48.44.495 and 2010 c 228 s 3 are each amended to read as follows:

(1) Notwithstanding any other provisions of law, no contract of any health care service contractor subject to the jurisdiction of the state of Washington that covers any dental services, and no contract or participating provider agreement with a dentist may:

(a) Require, directly or indirectly, that a dentist who is a participating provider provide services to an enrolled participant at a fee set by, or at a fee subject to the approval of, the health care service contractor unless the dental services are covered services, including services that would be reimbursable but for the application of contractual limitations such as benefit maximums, deductibles, coinsurance, waiting periods, or frequency limitations, under the applicable group contract or individual contract; nor

(b) Prohibit, directly or indirectly, a dentist who is a participating provider from offering or providing to an enrolled participant dental services that are not covered services on any terms or conditions acceptable to the dentist and the enrolled participant.

(2) 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.

(3) For the purposes of this section, "covered services" means dental services that are reimbursable under the applicable subscriber agreement or would be reimbursable but for the application of contractual limitations such as benefit maximums, deductibles, coinsurance, waiting periods, or frequency limitations.

NEW SECTION. **Sec. 7.** 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 when the expense involves a nonprofit affiliated with an insurance company;

(h) Board, bureau, or association fees; and

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

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

NEW SECTION. **Sec. 8.** 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 85 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 85 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 85 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. 9. 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 7 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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