
HOUSE BILL 1535

State of Washington

69th Legislature

2025 Regular Session

By Representatives Thai, Marshall, Parshley, Caldier, Nance, Richards, Walen, Connors, Davis, Rule, Reeves, Morgan, Ramel, Abbarno, Stonier, Doglio, Tharinger, Lekanoff, Leavitt, Reed, Gregerson, Kloba, Salahuddin, Zahn, Ormsby, Scott, Hill, and Simmons

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

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

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

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

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

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

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

18 (1)(a) A limited health care service contractor that offers
19 coverage for dental care services shall permit a treating dentist, in
20 consultation with the covered person, to make all decisions on dental
21 services provided to the covered person, rather than making such
22 decisions through contracts or agreements between the dentist and the
23 limited health care service contractor.

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

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

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

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

35 (2) A limited health care service contractor that offers coverage
36 for dental care services may not modify the reimbursement rates paid
37 to a contracting dentist during the term of the contract, unless the
38 contracting dentist agrees to the modification in writing.

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

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

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

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

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

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

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

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

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

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

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

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

14 (7) Limited health service contractors need not comply with RCW
15 48.44.030 or 48.44.037.

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

18 (1) A dental insurer or third-party administrator may pay a claim
19 for reimbursement made by a dental care provider using a credit card
20 or electronic funds transfer payment method that imposes on the
21 provider a fee or similar charge to process the payment if:

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

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

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

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

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

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

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

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

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

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

22 (2) An employee benefit plan or health insurance policy must
23 provide that payment or reimbursement for a noncontracting provider
24 dentist is no less than the payment or reimbursement for a
25 contracting provider dentist.

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

31 NEW SECTION. **Sec. 7.** A new section is added to chapter 48.43
32 RCW to read as follows:

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

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

4 (a) Financial administration expenses;

5 (b) Marketing and sales expenses;

6 (c) Distribution expenses;

7 (d) Claims operations expenses;

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

11 (f) Network operations expenses;

12 (g) Charitable expenses when the expense involves a nonprofit
13 affiliated with an insurance company;

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

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

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

18 NEW SECTION. **Sec. 8.** A new section is added to chapter 48.43
19 RCW to read as follows:

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

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

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

30 (a) The administrative expense component, not including taxes and
31 assessments, increases from the previous year's rate filing by more
32 than the most recent calendar year's increase in the dental services
33 consumer price index;

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

36 (c) The dental loss ratio for the plan is less than 85 percent.

37 (4) (a) (i) If the commissioner disapproves of a rate or group
38 rating factor submitted by a carrier under subsection (2) of this
39 section, the commissioner shall notify the carrier no later than 45

1 days before the proposed effective date of the rate or group rating
2 factor.

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

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

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

15 (5) (a) If the annual dental loss ratio for a dental only plan
16 offered by a carrier is less than 85 percent, the carrier shall
17 refund the excess premium to its covered individuals and covered
18 groups.

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

25 (c) The total of all refunds issued shall equal the amount of a
26 carrier's earned premium that exceeds the amount necessary to achieve
27 a medical loss ratio of 85 percent, calculated using data reported by
28 the carrier as prescribed by the commissioner in rule.

29 (d) The commissioner may authorize a waiver or adjustment of the
30 refund requirements in this section only if it is determined that
31 issuing refunds would result in financial impairment for the carrier.

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

34 (1) Each health carrier offering a dental only plan shall submit
35 to the commissioner on or before April 1st of each year as part of
36 the additional data statement or as a supplemental data statement the
37 following information for the preceding year that is derived from the
38 carrier's annual statement, including the exhibit of premiums,
39 enrollments, and utilization for the company at an aggregate level

1 and the additional data to the annual statement, which must be based
2 on Washington data and may not include data from other states:

3 (a) The total number of dental members;

4 (b) The total amount of dental revenue;

5 (c) The total amount of dental payments;

6 (d) The dental loss ratio that is computed (~~by dividing the~~
7 ~~total amount of dental payments by the total amount of dental~~
8 ~~revenues~~) as required in section 7 of this act;

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

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

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

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

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

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

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

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