HOUSE BILL REPORT
HB 1505

As Reported by House Committee On:
Consumer Protection & Business

Title: An act relating to correcting obsolete or erroneous references in statutes administered by the insurance commissioner, by repealing defunct statutes and reports, aligning policy with federal law and current interpretations, making timeline adjustments, protecting patient data, and making technical corrections.

Brief Description: Correcting obsolete or erroneous references in statutes administered by the insurance commissioner.

Sponsors: Representatives Walen, Berry, Lekanoff, Reed, Ormsby, Tharinger, Macri, Hill and Scott; by request of Insurance Commissioner.

Brief History:
Committee Activity:
Consumer Protection & Business: 2/7/25, 2/14/25 [DPS].

Brief Summary of Substitute Bill

- Makes revisions to or repeals statutes in the Insurance Code related to public records, tax refunds, reporting requirements, motor vehicle insurance, health insurance, dental plans, charitable gift annuity businesses, accounts, and other provisions.

HOUSE COMMITTEE ON CONSUMER PROTECTION & BUSINESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 9 members: Representatives Walen, Chair; Berry, Donaghy, Fosse, Kloba, Morgan, Reeves, Ryu and Santos.

Minority Report: Do not pass. Signed by 4 members: Representatives Dufault, Assistant Ranking Minority Member; Abbarno, Corry and Steele.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

Minority Report: Without recommendation. Signed by 1 member: Representative McClintock, Ranking Minority Member.

Staff: Peter Clodfelter (786-7127).

Background:

Public Records Act.
The Public Records Act includes exemptions from disclosure for different types of information relating to insurance and financial institutions.

Tax Refunds from the Insurance Commissioner.
If a person has paid to the Insurance Commissioner (Commissioner) any tax, license fee, or other charge in error or in excess of that which they are lawfully obligated to pay, upon a written request, the Commissioner must make a refund. A person may only request a refund of taxes within six years from the date the taxes were paid. To facilitate refunds, the Commissioner may establish a revolving fund out of funds appropriated by the Legislature.

Reporting Requirements.
The Commissioner was required to report to the Legislature in 2020 on any credits or discounts provided on insurance premiums for fire alarms and smoke detection devices installed in dwelling units.

The Commissioner was also required to report to the Legislature on the adoption of certain rules related to market conduct actions, under a 2007 law related to procedures and documents being substantially similar to the National Association of Insurance Commissioners (NAIC) work products.

The Commissioner, in consultation with the Health Care Authority and the Department of Health, is required to to issue a report to the Legislature biannually on geographic access to gender-affirming treatment across Washington.

The Commissioner must collect information from insurers offering fixed payment insurance products and annually report aggregated data for each calendar year to the Legislature.

Health care provider direct practices must submit annual statements to the Commissioner specifying the number of providers in each practice, the total number of patients being served, the average direct fee being charged, providers' names, and the business address for each direct practice. The form and content for the annual statement must be developed in a manner prescribed by the Commissioner.

The Commissioner must annually prepare aggregate statistical summaries of closed claims based on data submitted to the Commissioner from insuring entities or self-insurers that provide medical malpractice insurance to any facility or provider in Washington. The

Commissioner must also prepare an annual report that summarizes and analyzes the closed claim reports for medical malpractice filed with the Commissioner and the annual financial reports filed by authorized insurers writing medical malpractice insurance in Washington. The report is due by June 30, unless the Commissioner notifies legislative committees by June 1 that data are not available and informs the committees when the summaries will be completed.

Motor Vehicle Insurance.
Automobile liability and physical damage insurance for which any schedule, rates, or rating plan is submitted to the Commissioner must provide an appropriate reduction in premium charges, except for underinsured motorist coverage, for insured persons who are age 55 or over for two years after the insured person age 55 or over successfully completes a motor vehicle accident prevention course.

Due consideration in making rates for motor vehicle insurance must be given to any anticipated change in losses that may be attributable to the use of:

- properly installed and maintained anti-theft devices in the insured private passenger automobile;
- lights and lighting devices that have been proven effective in increasing the visibility of motor vehicles during daytime or in poor visibility conditions, as well as rear stop lights; and
- seat belts, child restraints, and other lifesaving devices.

Health Carrier Coverage.
A coverage requirement for health carriers provides that coverage for a newly born child must be no less than the coverage of the child's mother for no less than three weeks, even if there are separate hospital admissions.

For nongrandfathered group health plans other than small group health plans, a health carrier must include coverage for hearing instruments, including bone conduction hearing devices. A health carrier must provide coverage for hearing instruments at no less than $3,000 per ear with hearing loss every 36 months.

Dental-Only Plans.
Each health carrier offering a dental-only plan must submit to the Commissioner on or before April 1 of each year, as part of an additional data statement or as a supplemental data statement, specific information for the preceding year that is derived from the carrier's annual statement. The Commissioner must make the information reported available to the public in a format that allows comparison among carriers through a searchable public website.

Charitable Gift Annuity Business Exemption.
A certificate of exemption issued by the Commissioner for charitable gift annuity businesses is available if requirements are met by an insurer or educational, religious,

charitable, or scientific institution conducting a charitable gift annuity business. One of the requirements is for the entity to have and maintain unrestricted net assets of $500,000. Additionally, on or before March 1 of each year, the entity must pay an annual filing fee of $25 plus $5 for each charitable gift annuity contract written for Washington residents during its fiscal year ending on or before December 31 of the previous calendar year.

Fraud Program Funding.
The annual cost of operating the Commissioner's fraud program is funded from the Commissioner's Regulatory Fraud Account subject to appropriation by the Legislature.

Guaranteed Asset Protection Waiver—Account.
The application fee for registration to market, offer for sale, or sell a guaranteed asset protection waiver is deposited to the Guaranteed Asset Protection Waiver Account. A guaranteed asset protection waiver is a contractual agreement wherein a creditor agrees for a separate charge to cancel or waive all or part of the amounts due to that creditor on a borrower's finance agreement with that creditor in the event of a total physical damage loss or unrecovered theft of the motor vehicle. The agreement must be part of, or a separate addendum to, the finance agreement.

Summary of Substitute Bill:

Public Records Act and Data Aggregation.
A Public Records Act exemption is added for documents, materials, or information obtained by the Insurance Commissioner (Commissioner) under requirements for health care providers with direct practices to submit annual reports to the Commissioner specifying the number of providers in each practice, the total number of patients being served, the average direct fee being charged, providers' names, and the business address for each direct practice.

It is specified that the report the Commissioner submits annually to the Legislature on health care provider direct practices including participation trends, complaints received, and voluntary data reported, must be in aggregate form that does not permit the identification of individual direct practices.

Tax Refunds from the Insurance Commissioner.
The authorization for a person to request a refund of taxes paid to the Commissioner in excess of what they were legally obligated to pay is modified so a person may only request a refund of taxes within six years of the end of the calendar year for which the taxes are owed, instead of within six years from the date the taxes were paid.

The authority for the Commissioner is removed to establish a revolving fund out of funds appropriated by the Legislature for the use of facilitating cash refunds of taxes, license fees, or other charges in error or excess of what a person is lawfully obligated to pay.

Modifying or Removing Reporting Requirements.
A requirement is removed for the Commissioner to report to the Legislature on any credits or discounts provided on insurance premiums for fire alarms and smoke detection devices installed in dwelling units, related to a report published in 2020.

Another requirement is removed for the Commissioner to report to the Legislature on the adoption of certain rules under a 2007 law related to procedures and documents being substantially similar to the National Association of Insurance Commissioners (NAIC) work products for conducting market conduct actions.

A reporting requirement is changed from biannually to biennially for the Commissioner, in consultation with the Health Care Authority and the Department of Health, to issue a report on geographic access to gender-affirming treatment across Washington.

A requirement is removed for the Commissioner to annually prepare aggregate statistical summaries of closed claims based on data submitted to the Commissioner from insuring entities or self-insurers that provides medical malpractice insurance to any facility or provider in Washington. Requirements for an annual report by the Commissioner that summarizes and analyzes the closed claim reports for medical malpractice are modified to specify that annual financial data filed with the NAIC, instead of annual financial reports filed by authorized insurers, are to be summarized and analyzed. The deadline for the report is changed to September 1, instead of being June 30, unless the Commissioner notifies legislative committees by June 1 that data are not available and informs the committees when the summaries will be completed. References to financial reports are changed to financial data.

Motor Vehicle Insurance.
It is specified that it is "personal" automobile liability and physical damage insurance, instead of automobile liability and physical damage insurance, for which any schedule or rates or rating plan submitted to the Commissioner must provide an appropriate reduction in premium charges, except for underinsured motorist coverage, for those insured persons who are age 55 or over for two years after the insured person age 55 or over successfully completes a motor vehicle accident prevention course.

The requirement is removed for due consideration in making rates for motor vehicle insurance to be given to any anticipated change in losses that may be attributable to the use of:

- properly installed and maintained anti-theft devices in the insured private passenger automobile;
- lights and lighting devices that have been proven effective in increasing the visibility of motor vehicles during daytime or in poor visibility conditions, as well as rear stop lights; and
- seat belts, child restraints, and other lifesaving devices.

Health Carrier Coverage.
Health plans issued or renewed on or after January 1, 2026, are added to plans for which carriers must include coverage for hearing instruments, including bone conduction hearing devices. It is specified that for health plans issued or renewed on or after January 1, 2026, a health carrier must provide coverage for hearing instruments every 36 months per ear with hearing loss and may not establish any lifetime or annual limit on the dollar amount of coverage for services for any individual, whether provided in-network or out-of-network. A health carrier may require prior authorization or adopt other appropriate utilization controls before approving coverage for medically necessary hearing instruments.

Dental-Only Plans.
It is specified that it is a dental-only plan offered in Washington, instead of a dental-only plan offered in general, that requires the carrier offering the plan to annually submit to the Commissioner 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 the aggregate level. It is specified it is Washington-specific data that must be submitted.

The requirement for the Commissioner to make information about health carriers offering dental-only plans available to the public in a format that allows comparison among carriers through a searchable public website is modified to eliminate the requirement that the information be in a format that allows comparison of carriers with searchability.

Charitable Gift Annuity Business Exemption.
The eligibility requirements are revised to be granted a certificate of exemption by the Commissioner for an insurer or educational, religious, charitable, or scientific institution conducting a charitable gift annuity business. A revision specifies a requirement is for the entity to have and maintain minimum net assets without donor restrictions of $500,000, instead of a requirement for the entity to have and maintain unrestricted net assets of $500,000.

Another revision specifies that within 60 days of the end of the fiscal year, instead of on or before March 1 of each year, the entity must pay an annual filing fee of $25 plus $5 for each charitable gift annuity contract written for Washington residents during the preceding fiscal year, instead of during its fiscal year ending on or before December 31 of the previous calendar year.

Fraud Program Funding.
The Commissioner's account funding the annual cost of operating a fraud program is changed from the Commissioner's Regulatory Account to the Commissioner's Fraud Account.

Guaranteed Asset Protection Waiver—Account.
The application fee for registration to market, offer for sale, or sell a guaranteed asset

protection waiver is deposited to the General Fund, instead of to the Guaranteed Asset Protection Waiver Account.

Repealed Statutes.
The following statutes are repealed:

- provisions related to an individual health insurance market stability program from 2017;
- a work group that studied and made recommendations on natural disaster and resiliency activities under a 2019 law with a final report published in 2020;
- a requirement for health carriers offering a health benefit plan to annually submit to the Commissioner specified information from the carrier's annual statement, and a provision requiring the Commissioner to make the information available to the public in a format that allows comparison among carriers through a searchable public website;
- a requirement for the Commissioner to collect information from insurers offering fixed payment insurance products and to annually report aggregated data for each calendar year to the Legislature; and
- the Guaranteed Asset Protection Waiver Account.

Substitute Bill Compared to Original Bill:

The substitute bill restores the current requirement that health carriers providing coverage for maternity services must provide coverage for the newly born child that is no less than the coverage of the child's mother for no less than three weeks, even if there are separate hospital admissions.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Substitute Bill: The bill contains multiple effective dates. Please see the bill.

Staff Summary of Public Testimony:

(In support) This is intended as a clean-up bill. The last time a bill like this updated the Insurance Code was in 2012. Technical changes identified in the years since then were made, including removing provisions from eight one-time work groups or studies, correcting typographical errors, and updating misstated funds. There are several maintenance-type changes as well, including aligning the statute on hearing aids to essential benefit requirements under the Affordable Care Act that take effect on January 1, 2026, and applying similar data protections to direct medical practice data relative to other data protections the Legislature has recently prescribed. Outdated insurance rating discounts are

also removed from rate filing requirements for near universal technology such as lights or seat belts. These were added to the Insurance Code in 1987 as mandatory discounts and are now universally present in cars. Although the outdated language is being removed, it is intended the discounts will continue to be allowed. The bill removes a provision requiring newly born children be automatically enrolled in their parents' health plan, which has caused frustration for parents, families, and insurers, and led to complaints.

(Opposed) None.

Persons Testifying: Representative Amy Walen, prime sponsor; and Rory Paine-Donovan, Office of the Insurance Commissioner.

Persons Signed In To Testify But Not Testifying: None.