Z-0287.2

SENATE BILL 5262

State of Washington 69th Legislature 2025 Regular Session

By Senators Kauffman, J. Wilson, Nobles, Shewmake, and Trudeau; by request of Insurance Commissioner

Read first time 01/14/25. Referred to Committee on Business, Financial Services & Trade.

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; amending RCW 42.56.400, 48.14.070, 48.19.460, 48.19.501, 48.19.540, 48.37.050, 48.38.010, 48.38.012, 48.43.0128, 48.43.115, 48.43.135, 48.43.743, 48.135.030, 48.140.040, 48.140.050, 48.150.100, and 48.160.020; repealing RCW 48.02.230, 48.02.240, 48.19.500, 48.43.049, 48.43.650, 48.140.070, and 48.160.005; and providing an effective date.

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

Sec. 1. RCW 42.56.400 and 2023 c 149 s 12 are each amended to read as follows:

The following information relating to insurance and financial institutions is exempt from disclosure under this chapter:

(1) Records maintained by the board of industrial insurance appeals that are related to appeals of crime victims' compensation claims filed with the board under RCW 7.68.110;

(2) Information obtained and exempted or withheld from public inspection by the health care authority under RCW 41.05.026, whether retained by the authority, transferred to another state purchased

health care program by the authority, or transferred by the authority to a technical review committee created to facilitate the development, acquisition, or implementation of state purchased health care under chapter 41.05 RCW;

(3) The names and individual identification data of either all owners or all insureds, or both, received by the insurance commissioner under chapter 48.102 RCW;

(4) Information provided under RCW 48.30A.045 through 48.30A.060;

(5) Information provided under RCW 48.05.510 through 48.05.535, 48.43.200 through 48.43.225, 48.44.530 through 48.44.555, and 48.46.600 through 48.46.625;

(6) Examination reports and information obtained by the department of financial institutions from banks under RCW 30A.04.075, from savings banks under RCW 32.04.220, from savings and loan associations under RCW 33.04.110, from credit unions under RCW 31.12.565, from check cashers and sellers under RCW 31.45.030(3), and from securities brokers and investment advisers under RCW 21.20.100, information that could reasonably be expected to reveal the identity of a whistleblower under RCW 21.40.090, and information received under RCW 43.320.190, all of which are confidential and privileged information;

(7) Information provided to the insurance commissioner under RCW 48.110.040(3);

(8) Documents, materials, or information obtained by the insurance commissioner under RCW 48.02.065, all of which are confidential and privileged;

(9) Documents, materials, or information obtained or provided by the insurance commissioner under RCW 48.31B.015(2) (l) and (m), 48.31B.025, 48.31B.030, 48.31B.035, and 48.31B.036, all of which are confidential and privileged;

(10) Data filed under RCW 48.140.020, 48.140.030, 48.140.050, and 7.70.140 that, alone or in combination with any other data, may reveal the identity of a claimant, health care provider, health care facility, insuring entity, or self-insurer involved in a particular claim or a collection of claims. For the purposes of this subsection:

(a) "Claimant" has the same meaning as in RCW 48.140.010(2).

(b) "Health care facility" has the same meaning as in RCW 48.140.010(6).

(c) "Health care provider" has the same meaning as in RCW 48.140.010(7).

(d) "Insuring entity" has the same meaning as in RCW 48.140.010(8).

(e) "Self-insurer" has the same meaning as in RCW 48.140.010(11);

(11) Documents, materials, or information obtained by the insurance commissioner under RCW 48.135.060;

(12) Documents, materials, or information obtained by the insurance commissioner under RCW 48.37.060;

(13) Confidential and privileged documents obtained or produced by the insurance commissioner and identified in RCW 48.37.080;

(14) Documents, materials, or information obtained by the insurance commissioner under RCW 48.37.140;

(15) Documents, materials, or information obtained by the insurance commissioner under RCW 48.17.595;

(16) Documents, materials, or information obtained by the insurance commissioner under RCW 48.102.051(1) and 48.102.140 (3) and (7)(a)(ii);

(17) Documents, materials, or information obtained by the insurance commissioner in the commissioner's capacity as receiver under RCW 48.31.025 and 48.99.017, which are records under the jurisdiction and control of the receivership court. The commissioner is not required to search for, log, produce, or otherwise comply with the public records act for any records that the commissioner obtains under chapters 48.31 and 48.99 RCW in the commissioner's capacity as a receiver, except as directed by the receivership court;

(18) Documents, materials, or information obtained by the insurance commissioner under RCW 48.13.151;

(19) Data, information, and documents provided by a carrier pursuant to section 1, chapter 172, Laws of 2010;

(20) Information in a filing of usage-based insurance about the usage-based component of the rate pursuant to RCW 48.19.040(5)(b);

(21) Data, information, and documents that are submitted to the office of the insurance commissioner by an entity providing health care coverage pursuant to RCW 28A.400.275;

(22) Data, information, and documents obtained by the insurance commissioner under RCW 48.29.017;

(23) Information not subject to public inspection or public disclosure under RCW 48.43.730(5);

(24) Documents, materials, or information obtained by the insurance commissioner under chapter 48.05A RCW;

(25) Documents, materials, or information obtained by the insurance commissioner under RCW 48.74.025, 48.74.028, 48.74.100(6), 48.74.110(2) (b) and (c), and 48.74.120 to the extent such documents, materials, or information independently qualify for exemption from disclosure as documents, materials, or information in possession of the commissioner pursuant to a financial conduct examination and exempt from disclosure under RCW 48.02.065;

(26) Nonpublic personal health information obtained by, disclosed to, or in the custody of the insurance commissioner, as provided in RCW 48.02.068;

(27) ((~~Data, information, and documents obtained by the insurance commissioner under RCW 48.02.230;~~

~~(28)~~)) Documents, materials, or other information, including the corporate annual disclosure obtained by the insurance commissioner under RCW 48.195.020;

((~~(29)~~)) (28) Findings and orders disapproving acquisition of a trust institution under RCW 30B.53.100(3);

((~~(30)~~)) (29) All claims data, including health care and financial related data received under RCW 41.05.890, received and held by the health care authority; ((~~and~~

~~(31)~~)) (30) Documents, materials, or information obtained by the insurance commissioner under RCW 48.150.100; and

(31) Contracts not subject to public disclosure under RCW 48.200.040 and 48.43.731.

Sec. 2. RCW 48.14.070 and 2009 c 549 s 7056 are each amended to read as follows:

In event any person has paid to the commissioner any tax, license fee or other charge in error or in excess of that which he or she is lawfully obligated to pay, the commissioner shall upon written request ((~~made to him or her~~)) make a refund thereof. A person may only request a refund of taxes within six years ((~~from the date the taxes were paid~~)) of the end of the calendar year for which the taxes are owed. A person may only request a refund of fees or charges other than taxes within ((~~thirteen~~)) 13 months of the date the fees or charges were paid. Refunds may be made either by crediting the amount toward payment of charges due or to become due from such person, or by making a cash refund. ((~~To facilitate such cash refunds the commissioner may establish a revolving fund out of funds appropriated by the legislature for his use.~~))

Sec. 3. RCW 48.19.460 and 2007 c 258 s 1 are each amended to read as follows:

Any schedule of rates or rating plan for personal automobile liability and physical damage insurance submitted to or filed with the commissioner shall provide for an appropriate reduction in premium charges except for underinsured motorist coverage for those insureds who are ((~~fifty-five~~)) 55 years of age and older, for a two-year period after successfully completing a motor vehicle accident prevention course meeting the criteria of the department of licensing with a minimum of eight hours, or additional hours as determined by rule of the department of licensing. The classroom course may be conducted by a public or private agency approved by the department. An eight-hour course meeting the criteria of the department of licensing may be offered via an alternative delivery method of instruction, which may include internet, video, or other technology-based delivery methods. An agency seeking approval from the department to offer an alternative delivery method course of instruction is not required to conduct classroom courses under this section. The department of licensing may adopt rules to ensure that insureds who seek certification for taking a course offered via an alternative delivery method have completed the course.

Sec. 4. RCW 48.19.501 and 1989 c 11 s 21 are each amended to read as follows:

Due consideration in making rates for motor vehicle insurance shall be given to((~~:~~

~~(1) 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. An exhibit detailing these losses and any credits or discounts resulting from any such changes shall be included in each filing pertaining to private passenger automobile (or motor vehicle) insurance.~~

~~(2) Any anticipated change in losses that may be attributable to the use of lights and lighting devices that have been proven effective in increasing the visibility of motor vehicles during daytime or in poor visibility conditions and to the use of rear stop lights that have been proven effective in reducing rear-end collisions. An exhibit detailing these losses and any credits or discounts resulting from any such changes shall be included in each~~

~~filing pertaining to private passenger automobile (or motor vehicle) insurance.~~

~~(3) Any~~)) any anticipated change in losses per vehicle covered that may be attributable to the fact that the insured has more vehicles covered under the policy than there are insured drivers in the same household. An exhibit detailing these changes and any credits or discounts resulting from any such changes shall be included in each filing pertaining to private passenger automobile (or motor vehicle) insurance.

Sec. 5. RCW 48.19.540 and 2019 c 455 s 4 are each amended to read as follows:

(1) In making rates for the insurance coverage for dwelling units, insurers shall consider the benefits of fire alarms and smoke detection devices in their rate making. If the insurer determines a separate rate factor is valid, then an exhibit supporting these changes and any credits or discounts resulting from any such changes must be included in the initial filing supporting such change. An insurer need not file any exhibits or offer any related discounts if:

(a) No changes are made to the credits or discounts already in effect prior to July 28, 2019;

(b) It determines that there is no material anticipated change in losses due to the use of such equipment; or

(c) Any potential credit or discount is not actuarially supported.

(2) ((~~The commissioner shall report to the appropriate committees of the legislature on any credits or discounts provided on insurance premiums for fire alarms and smoke detection devices installed in dwelling units. By December 31, 2020, and in compliance with RCW 43.01.036, the commissioner must submit a report to the appropriate committees of the legislature that details the use of discounts prior to and after July 28, 2019, and the type of fire alarm or smoke detection device qualifying for a credit or discount.~~

~~(3)~~)) For the purposes of this section:

(a) "Dwelling unit" means a residential dwelling of any type, including a single-family residence, apartment, condominium, or cooperative unit.

(b) "Smoke detection device" or "smoke detection devices" means an assembly incorporating in one unit a device which detects visible or invisible particles of combustion, the control equipment, and the

alarm-sounding device, operated from a power supply either in the unit or obtained at the point of installation.

(c) "Fire alarm" or "fire alarms" means any mechanical, electrical((~~,~~))_,_ or radio-controlled device that is designed to emit a sound or transmit a signal or message when activated or any such device that emits a sound and transmits a signal or message when activated because of smoke, heat((~~,~~))_,_ or fire.

((~~(4)~~)) (3) This section applies to rate filings for coverage for dwelling units filed on or after January 1, 2020.

Sec. 6. RCW 48.37.050 and 2007 c 82 s 7 are each amended to read as follows:

(1) Market conduct actions shall be taken as a result of market analysis and shall focus on the general business practices and compliance activities of insurers, rather than identifying obviously infrequent or unintentional random errors that do not cause significant consumer harm.

(2)(a) The commissioner is authorized to determine the frequency and timing of such market conduct actions. The timing shall depend upon the specific market conduct action to be initiated, unless extraordinary circumstances indicating a risk to consumers require immediate action.

(b) If the commissioner has information that more than one insurer is engaged in common practices that may violate statutes or rules, the commissioner may schedule and coordinate multiple examinations simultaneously.

(3) The insurer shall be given reasonable opportunity to resolve matters that arise as a result of a market analysis to the satisfaction of the commissioner before any additional market conduct actions are taken against the insurer.

(4) The commissioner shall adopt by rule, under chapter 34.05 RCW, procedures and documents that are substantially similar to the NAIC work products defined or referenced in this chapter. Market analysis, market conduct actions, and market conduct examinations shall be performed in accordance with the rule.

((~~(5) At the beginning of the next legislative session after the adoption of the rules adopted under the authority of this section, the commissioner shall report to the appropriate policy committees of the legislature what rules were adopted; what statutory policies these rules were intended to implement; and such other matters as are~~

~~indicated for the legislature's understanding of the role played by the NAIC in regulation of the insurance industry of Washington.~~))

Sec. 7. RCW 48.38.010 and 2012 c 211 s 5 are each amended to read as follows:

The commissioner may grant a certificate of exemption to any insurer or educational, religious, charitable, or scientific institution conducting a charitable gift annuity business that:

(1) ((~~Which is~~)) Is organized and operated exclusively as, or for the purpose of aiding, an educational, religious, charitable, or scientific institution which is organized as a nonprofit organization without profit to any person, firm, partnership, association, corporation, or other entity;

(2) ((~~Which possesses~~)) Possesses a current tax exempt status under the laws of the United States;

(3) ((~~Which serves~~)) Serves such purpose by issuing charitable gift annuity contracts only for the benefit of such educational, religious, charitable, or scientific institution;

(4) ((~~Which appoints~~)) Appoints the insurance commissioner as its true and lawful attorney upon whom may be served lawful process in any action, suit, or proceeding in any court, which appointment is irrevocable, binds the insurer or institution or any successor in interest, remains in effect as long as there is in force in this state any contract made or issued by the insurer or institution, or any obligation arising therefrom, and must be processed in accordance with RCW 48.05.200;

(5) ((~~Which is~~)) Is fully and legally organized and qualified to do business and has been actively doing business under the laws of the state of its domicile for a period of at least three years prior to its application for a certificate of exemption;

(6) ((~~Which has~~)) Has and maintains minimum ((~~unrestricted~~)) net assets without donor restrictions of ((~~five hundred thousand dollars~~)) $500,000. "((~~Unrestricted net~~)) Net assets without donor restrictions" means the excess of total assets over total liabilities that are neither permanently restricted nor temporarily restricted by donor-imposed stipulations;

(7) ((~~Which files~~)) Files with the insurance commissioner its application for a certificate of exemption showing:

(a) Its name, location, and organization date;

(b) The kinds of charitable annuities it proposes to offer;

(c) A statement of the financial condition, management, and affairs of the organization and any affiliate thereof, as that term is defined in RCW 48.31B.005, on a form satisfactory to, or furnished by the insurance commissioner;

(d) Other documents, stipulations, or information as the insurance commissioner may reasonably require to evidence compliance with the provisions of this chapter;

(8) ((~~Which subjects~~)) Subjects itself and any affiliate thereof, as that term is defined in RCW 48.31B.005, to periodic examinations conducted under chapter 48.03 RCW as may be deemed necessary by the insurance commissioner;

(9) ((~~Which files~~)) Files with the insurance commissioner for the commissioner's advance approval a copy of any policy or contract form to be offered or issued to residents of this state. The grounds for disapproval of the policy or contract form are set forth in RCW 48.18.110; and

(10) ((~~Which:~~))(a) Files with the insurance commissioner annually, within ((~~sixty~~)) 60 days of the end of its fiscal year a report of its current financial condition, management, and affairs, on a form and in a manner prescribed by the commissioner, as well as such other financial material as may be requested, including the annual statement or other such financial materials as may be requested relating to any affiliate, as that term is defined in RCW 48.31B.005;

(b) Attaches to the report of its current financial condition the statement of a qualified actuary setting forth the actuary's opinion relating to annuity reserves and other actuarial items for the fiscal year covered by the report. "Qualified actuary" as used in this subsection means a member in good standing of the American academy of actuaries or a person who has otherwise demonstrated actuarial competence to the satisfaction of the insurance regulatory official of the domiciliary state; and

(c) ((~~On or before March 1st of each year~~)) Within 60 days of the end of the fiscal year, pays an annual filing fee of ((~~twenty-five dollars~~)) $25 plus ((~~five dollars~~)) $5 for each charitable gift annuity contract written for residents of this state during ((~~its~~)) the preceding fiscal year ((~~ending on or before December 31st of the previous calendar year~~)).

Sec. 8. RCW 48.38.012 and 1998 c 284 s 7 are each amended to read as follows:

After June 30, 1998, an insurer or institution which does not have the minimum ((~~unrestricted~~)) net assets without donor restrictions required by RCW 48.38.010(6) may not issue any new charitable gift annuities until the insurer or institution has and maintains the minimum ((~~unrestricted~~)) net assets without donor restrictions required by RCW 48.38.010(6).

Sec. 9. RCW 48.43.0128 and 2021 c 280 s 3 are each amended to read as follows:

(1) A health carrier offering a nongrandfathered health plan or a plan deemed by the commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular, full-time undergraduate student at an accredited higher education institution may not:

(a) In its benefit design or implementation of its benefit design, discriminate against individuals because of their age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions; and

(b) With respect to the health plan or plan deemed by the commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular, full-time undergraduate student at an accredited higher education institution, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

(2) Nothing in this section may be construed to prevent a carrier from appropriately utilizing reasonable medical management techniques.

(3) For health plans issued or renewed on or after January 1, 2022:

(a) A health carrier may not deny or limit coverage for gender-affirming treatment when that treatment is prescribed to an individual because of, related to, or consistent with a person's gender expression or identity, as defined in RCW 49.60.040, is medically necessary, and is prescribed in accordance with accepted standards of care.

(b) A health carrier may not apply categorical cosmetic or blanket exclusions to gender-affirming treatment. When prescribed as medically necessary gender-affirming treatment, a health carrier may not exclude as cosmetic services facial feminization surgeries and other facial gender-affirming treatment, such as tracheal shaves, hair electrolysis, and other care such as mastectomies, breast reductions, breast implants, or any combination of gender-affirming procedures, including revisions to prior treatment.

(c) A health carrier may not issue an adverse benefit determination denying or limiting access to gender-affirming services, unless a health care provider with experience prescribing or delivering gender-affirming treatment has reviewed and confirmed the appropriateness of the adverse benefit determination.

(d) Health carriers must comply with all network access rules and requirements established by the commissioner.

(4) For the purposes of this section, "gender-affirming treatment" means a service or product that a health care provider, as defined in RCW 70.02.010, prescribes to an individual to treat any condition related to the individual's gender identity and is prescribed in accordance with generally accepted standards of care. Gender-affirming treatment must be covered in a manner compliant with the federal mental health parity and addiction equity act of 2008 and the federal affordable care act. Gender-affirming treatment can be prescribed to two spirit, transgender, nonbinary, intersex, and other gender diverse individuals.

(5) Nothing in this section may be construed to mandate coverage of a service that is not medically necessary.

(6) By December 1, 2022, the commissioner, in consultation with the health care authority and the department of health, must issue a report on geographic access to gender-affirming treatment across the state. The report must include the number of gender-affirming providers offering care in each county, the carriers and medicaid managed care organizations those providers have active contracts with, and the types of services provided by each provider in each region. The commissioner must update the report ((~~biannually~~)) biennially and post the report on its website.

(7) The commissioner shall adopt any rules necessary to implement subsections (3), (4), and (5) of this section.

(8) Unless preempted by federal law, the commissioner shall adopt any rules necessary to implement subsections (1) and (2) of this

section, consistent with federal rules and guidance in effect on January 1, 2017, implementing the patient protection and affordable care act.

Sec. 10. RCW 48.43.115 and 2020 c 80 s 37 are each amended to read as follows:

(1) The legislature recognizes the role of health care providers as the appropriate authority to determine and establish the delivery of quality health care services to maternity patients and their newly born children. It is the intent of the legislature to recognize patient preference and the clinical sovereignty of providers as they make determinations regarding services provided and the length of time individual patients may need to remain in a health care facility after giving birth. It is not the intent of the legislature to diminish a carrier's ability to utilize managed care strategies but to ensure the clinical judgment of the provider is not undermined by restrictive carrier contracts or utilization review criteria that fail to recognize individual postpartum needs.

(2) Unless otherwise specifically provided, the following definitions apply throughout this section:

(a) "Attending provider" means a provider who: Has clinical hospital privileges consistent with RCW 70.43.020; is included in a provider network of the carrier that is providing coverage; and is a physician licensed under chapter 18.57 or 18.71 RCW, a certified nurse midwife licensed under chapter 18.79 RCW, a midwife licensed under chapter 18.50 RCW, a physician's assistant licensed under chapter 18.71A RCW, or an advanced practice registered nurse ((~~practitioner~~)) licensed under chapter 18.79 RCW.

(b) "Health carrier" or "carrier" means disability insurers regulated under chapter 48.20 or 48.21 RCW, health care services contractors regulated under chapter 48.44 RCW, health maintenance organizations regulated under chapter 48.46 RCW, plans operating under the health care authority under chapter 41.05 RCW, the state health insurance pool operating under chapter 48.41 RCW, and insuring entities regulated under this chapter.

(3)(a) Every health carrier that provides coverage for maternity services must permit the attending provider, in consultation with the mother, to make decisions on the length of inpatient stay, rather than making such decisions through contracts or agreements between

providers, hospitals, and insurers. These decisions must be based on accepted medical practice.

(b) Covered eligible services may not be denied for inpatient, postdelivery care to a mother and her newly born child after a vaginal delivery or a cesarean section delivery for such care as ordered by the attending provider in consultation with the mother.

(c) At the time of discharge, determination of the type and location of follow-up care must be made by the attending provider in consultation with the mother rather than by contract or agreement between the hospital and the insurer. These decisions must be based on accepted medical practice.

(d) Covered eligible services may not be denied for follow-up care, including in-person care, as ordered by the attending provider in consultation with the mother. Coverage for providers of follow-up services must include, but need not be limited to, attending providers as defined in this section, home health agencies licensed under chapter 70.127 RCW, and registered nurses licensed under chapter 18.79 RCW.

(e) This section does not require attending providers to authorize care they believe to be medically unnecessary.

((~~(f) Coverage for the 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.~~))

(4) A carrier that provides coverage for maternity services may not deselect, terminate the services of, require additional documentation from, require additional utilization review of, reduce payments to, or otherwise provide financial disincentives to any attending provider or health care facility solely as a result of the attending provider or health care facility ordering care consistent with this section. This section does not prevent any insurer from reimbursing an attending provider or health care facility on a capitated, case rate, or other financial incentive basis.

(5) Every carrier that provides coverage for maternity services must provide notice to policyholders regarding the coverage required under this section. The notice must be in writing and must be transmitted at the earliest of the next mailing to the policyholder, the yearly summary of benefits sent to the policyholder, or January 1 of the year following June 6, 1996.

(6) This section does not establish a standard of medical care.

(7) This section applies to coverage for maternity services under a contract issued or renewed by a health carrier after June 6, 1996, and applies to plans operating under the health care authority under chapter 41.05 RCW beginning January 1, 1998.

Sec. 11. RCW 48.43.135 and 2023 c 245 s 1 are each amended to read as follows:

(1) For nongrandfathered group health plans other than small group health plans issued or renewed on or after January 1, 2024, and for health plans issued or renewed on or after January 1, 2026, a health carrier shall include coverage for hearing instruments, including bone conduction hearing devices. This section does not include coverage of over-the-counter hearing instruments.

(2) Coverage shall also include the initial assessment, fitting, adjustment, auditory training, and ear molds as necessary to maintain optimal fit. Coverage of the services in this subsection shall include services for enrollees who intend to obtain or have already obtained any hearing instrument, including an over-the-counter hearing instrument.

(3) ((~~A~~))(a) Until the date specified in (b) of this subsection, a health carrier shall provide coverage for hearing instruments as provided in subsection (1) of this section at no less than $3,000 per ear with hearing loss every 36 months.

(b) For health plans issued or renewed on or after January 1, 2026, a health carrier shall provide coverage for hearing instruments as provided in subsection (1) of this section 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 described in subsection (1) or (2) of this section for any individual, whether provided in-network or out-of-network.

(c) A health carrier may require prior authorization or adopt other appropriate utilization controls in approving coverage for medically necessary hearing instruments.

(4) The services and hearing instruments covered under this section are not subject to the enrollee's deductible unless the health plan is offered as a qualifying health plan for a health savings account. For such a qualifying health plan, the carrier may apply a deductible to coverage of the services covered under this section only at the minimum level necessary to preserve the enrollee's ability to claim tax exempt contributions and withdrawals

from the enrollee's health savings account under internal revenue service laws and regulations.

(5) Coverage for a minor under 18 years of age shall be available under this section only after the minor has received medical clearance within the preceding six months from:

(a) An otolaryngologist for an initial evaluation of hearing loss; or

(b) A licensed physician, which indicates there has not been a substantial change in clinical status since the initial evaluation by an otolaryngologist.

(6) For the purposes of this section:

(a) "Hearing instrument" has the same meaning as defined in RCW 18.35.010.

(b) "Over-the-counter hearing instrument" has the same meaning as "over-the-counter hearing aid" in 21 C.F.R. Sec. 800.30 as of December 28, 2022.

Sec. 12. 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 in Washington 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~~)), Washington specific data 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:

(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;

(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~~)) on the commissioner's 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.

Sec. 13. RCW 48.135.030 and 2006 c 284 s 4 are each amended to read as follows:

The annual cost of operating the fraud program is funded from the insurance commissioner's ((~~regulatory~~)) fraud account under RCW 48.02.190 subject to appropriation by the legislature.

Sec. 14. RCW 48.140.040 and 2006 c 8 s 204 are each amended to read as follows:

((~~The commissioner must prepare aggregate statistical summaries of closed claims based on data submitted under RCW 48.140.020.~~

~~(1) At a minimum, the commissioner must summarize data by calendar year and calendar/incident year. The commissioner may also decide to display data in other ways if the commissioner:~~

~~(a) Protects information as required under RCW 48.140.060(2); and~~

~~(b) Exempts from disclosure data described in RCW 42.56.400(11).~~

~~(2) The summaries must be available by April 30th of each year, unless the commissioner notifies legislative committees by March 15th that data are not available and informs the committees when the summaries will be completed.~~

~~(3)~~)) Information included in an individual closed claim report submitted by an insuring entity, self-insurer, provider, or facility under this chapter is confidential and exempt from public disclosure, and the commissioner must not make these data available to the public.

Sec. 15. RCW 48.140.050 and 2006 c 8 s 205 are each amended to read as follows:

((~~Beginning in 2010, the~~)) The commissioner must prepare an annual report that summarizes and analyzes the medical malpractice closed claim ((~~reports for medical malpractice~~)) data filed under RCW 48.140.020 and 7.70.140 and the annual financial ((~~reports~~)) data filed ((~~by authorized insurers~~)) with the national association of insurance commissioners by insuring entities writing medical malpractice insurance in this state. The commissioner must complete the report by ((~~June 30th, unless the commissioner notifies legislative committees by June 1st that data are not available and informs the committees when the summaries will be completed~~)) September 1st.

(1) The report must include:

(a) An analysis of reported closed claims from prior years for which data are collected. The analysis must show:

(i) Trends in the frequency and severity of claim payments;

(ii) A comparison of economic and noneconomic damages;

(iii) A distribution of allocated loss adjustment expenses and other legal expenses;

(iv) The types of medical malpractice for which claims have been paid; and

(v) Any other information the commissioner finds relevant to trends in medical malpractice closed claims if the commissioner:

(A) Protects information as required under RCW 48.140.060(2); and

(B) Exempts from disclosure data described in RCW 42.56.400((~~(11)~~)) (10);

(b) An analysis of the medical malpractice insurance market in Washington state, including:

(i) An analysis of the financial ((~~reports~~)) data of the authorized insurers with a combined market share of at least ((~~ninety~~)) 90 percent of direct written medical malpractice premium in Washington state for the prior calendar year;

(ii) A loss ratio analysis of medical malpractice insurance written in Washington state; and

(iii) A profitability analysis of the authorized insurers with a combined market share of at least ((~~ninety~~)) 90 percent of direct written medical malpractice premium in Washington state for the prior calendar year;

(c) A comparison of loss ratios and the profitability of medical malpractice insurance in Washington state to other states based on financial ((~~reports~~)) data filed with the national association of insurance commissioners and any other source of information the commissioner deems relevant; and

(d) A summary of the rate filings for medical malpractice that have been approved by the commissioner for the prior calendar year, including an analysis of the trend of direct incurred losses as compared to prior years.

(2) The commissioner must post reports required by this section on the internet no later than ((~~thirty~~)) 30 days after they are due.

(3) The commissioner may adopt rules that require insuring entities and self-insurers required to report under RCW 48.140.020 and subsection (1)(a) of this section to report data related to:

(a) The frequency and severity of closed claims for the reporting period; and

(b) Any other closed claim information that helps the commissioner monitor losses and claim development patterns in the Washington state medical malpractice insurance market.

Sec. 16. RCW 48.150.100 and 2007 c 267 s 12 are each amended to read as follows:

(1) Direct practices must submit annual statements, beginning on October 1, 2007, to the office of ((~~[the]~~)) the insurance commissioner specifying the number of providers in each practice, 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 annual statements and the data reported in them are confidential and exempt from public disclosure, and from the requirements of chapter 42.56 RCW.

(2) A health care provider may not act as, or hold himself or herself out to be, a direct practice in this state, nor may a direct agreement be entered into with a direct patient in this state, unless the provider submits the annual statement in subsection (1) of this section to the commissioner.

(3) The commissioner shall report annually to the legislature on direct practices including, but not limited to, participation trends, complaints received, voluntary data reported by the direct practices,

and any necessary modifications to this chapter. The commissioner's report and the data in it shall be in aggregate form that does not permit the identification of individual direct practices. The initial report shall be due December 1, 2009.

Sec. 17. RCW 48.160.020 and 2009 c 334 s 3 are each amended to read as follows:

(1) This chapter applies only to guaranteed asset protection waivers for financing of motor vehicles as defined in this chapter. Any person or entity must register with the commissioner before marketing, offering for sale or selling a guaranteed asset protection waiver, and before acting as an obligor for a guaranteed asset protection waiver, in this state. However, a retail seller of motor vehicles that assigns more than ((~~eighty-five~~)) 85 percent of guaranteed asset protection waiver agreements within ((~~thirty~~)) 30 days of such agreements' effective date, or an insurer authorized to transact such insurance business in this state, are not required to register pursuant to this section. Failure of any retail seller of motor vehicles to assign ((~~one hundred~~)) 100 percent of guaranteed asset protection waiver agreements within ((~~forty-five~~)) 45 days of such agreements' effective date will result in that retail seller being required to comply with the registration requirements of this chapter.

(2) No person may market, offer for sale, or sell a guaranteed asset protection waiver, or act as an obligor on a guaranteed asset protection waiver in this state without a registration as provided in this chapter, except as set forth in subsection (1) of this section.

(3) The application for registration must include the following:

(a) The applicant's name, address, and telephone number;

(b) The identities of the applicant's executive officers or other officers directly responsible for the waiver business;

(c) An application fee of ((~~two hundred fifty dollars~~)) $250, which shall be deposited into the ((~~guaranteed asset protection waiver account~~)) general fund;

(d) A copy filed by the applicant with the commissioner of the waivers the applicant intends to offer in this state;

(e) A list of all unregistered marketers of guaranteed asset protection waivers on which the applicant will be the obligor;

(f) Such additional information as the commissioner may reasonably require.

(4) Once registered, the applicant shall keep the information required for registration current by reporting changes within ((~~thirty~~)) 30 days after the end of the month in which the change occurs.

NEW SECTION. **Sec. 18.** The following acts or parts of acts are each repealed:

(1) RCW 48.02.230 (Health insurance market stability program—Confidentiality—Definitions—Reports—Commissioner's responsibilities) and 2017 3rd sp.s. c 30 s 1;

(2) RCW 48.02.240 (Natural disaster and resiliency work group) and 2019 c 388 s 2;

(3) RCW 48.19.500 (Motor vehicle insurance—Seat belts, etc) and 1989 c 11 s 20 & 1987 c 310 s 1;

(4) RCW 48.43.049 (Health carrier data—Information from annual statement—Format prescribed by commissioner—Public availability) and 2006 c 104 s 2;

(5) RCW 48.43.650 (Fixed payment insurance products—Commissioner's annual report) and 2007 c 296 s 6;

(6) RCW 48.140.070 (Model statistical reporting standards—Report to legislature) and 2006 c 8 s 207; and

(7) RCW 48.160.005 (Guaranteed asset protection waiver account) and 2009 c 334 s 10.

NEW SECTION. **Sec. 19.** Section 7 of this act takes effect January 1, 2026.

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