

Chapter 48.46 RCW

HEALTH MAINTENANCE ORGANIZATIONS

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48.46.010 Legislative declaration—Purpose. In affirmation of the declared principle that health care is a right of every citizen of the state, the legislature expresses its concern that the present high costs of health care in Washington may be preventing or inhibiting a large segment of the people from obtaining access to quality health care services.

The legislature declares that the establishment of qualified prepaid group and individual practice health care delivery systems should be encouraged in order to provide all citizens of the state with the freedom of choice between competitive, alternative health care delivery systems necessary to realize their right to health. It is the purpose and policy of this chapter to provide for the development and registration of prepaid group and individual practice health care plans as health maintenance organizations, which the legislature

declares to be in the interest of the health, safety and welfare of the people. [1975 1st ex.s. c 290 § 2.]

48.46.012 Filings with secretary of state—Copy for commissioner. Health maintenance organizations shall send a copy specifically for the office of the insurance commissioner to the secretary of state of any corporate document required to be filed in the office of the secretary of state, including articles of incorporation and bylaws, and any amendments thereto. The copy specifically provided for the office of the insurance commissioner shall be in addition to the copies required by the secretary of state and shall clearly indicate on the copy that it is for delivery to the office of the insurance commissioner. [1998 c 23 § 17.]

48.46.020 Definitions. As used in this chapter, the terms defined in this section shall have the meanings indicated unless the context indicates otherwise.

(1) "Carrier" means a health maintenance organization, an insurer, a health care services contractor, or other entity responsible for the payment of benefits or provision of services under a group or individual agreement.

(2) "Census date" means the date upon which a health maintenance organization offering coverage to a small employer must base rate calculations. For a small employer applying for a health benefit plan through a health maintenance organization other than its current health maintenance organization, the census date is the date that final group composition is received by the health maintenance organization. For a small employer that is renewing its health benefit plan through its existing health maintenance organization, the census date is ninety days prior to the effective date of the renewal.

(3) "Commissioner" means the insurance commissioner.

(4) "Comprehensive health care services" means basic consultative, diagnostic, and therapeutic services rendered by licensed health professionals together with emergency and preventive care, inpatient hospital, outpatient and physician care, at a minimum, and any additional health care services offered by the health maintenance organization.

(5) "Consumer" means any member, subscriber, enrollee, beneficiary, or other person entitled to health care services under terms of a health maintenance agreement, but not including health professionals, employees of health maintenance organizations, partners, or shareholders of stock corporations licensed as health maintenance organizations.

(6) "Copayment" means an amount specified in a subscriber agreement which is an obligation of an enrolled participant for a specific service which is not fully prepaid.

(7) "Deductible" means the amount an enrolled participant is responsible to pay out-of-pocket before the health maintenance organization begins to pay the costs associated with treatment.

(8) "Department" means the state department of social and health services.

(9) "Enrolled participant" means a person who or group of persons which has entered into a contractual arrangement or on whose behalf a contractual arrangement has been entered into with a health maintenance organization to receive health care services.

(10) "Fully subordinated debt" means those debts that meet the requirements of RCW 48.46.235(3) and are recorded as equity.

(11) "Group practice" means a partnership, association, corporation, or other group of health professionals:

(a) The members of which may be individual health professionals, clinics, or both individuals and clinics who engage in the coordinated practice of their profession; and

(b) The members of which are compensated by a prearranged salary, or by capitation payment or drawing account that is based on the number of enrolled participants.

(12) "Health maintenance agreement" means an agreement for services between a health maintenance organization which is registered pursuant to the provisions of this chapter and enrolled participants of such organization which provides enrolled participants with comprehensive health services rendered to enrolled participants by health professionals, groups, facilities, and other personnel associated with the health maintenance organization.

(13) "Health maintenance organization" means any organization receiving a certificate of registration by the commissioner under this chapter which provides comprehensive health care services to enrolled participants of such organization on a group practice per capita prepayment basis or on a prepaid individual practice plan, except for an enrolled participant's responsibility for copayments and/or deductibles, either directly or through contractual or other arrangements with other institutions, entities, or persons, and which qualifies as a health maintenance organization pursuant to RCW 48.46.030 and 48.46.040.

(14) "Health professionals" means health care practitioners who are regulated by the state of Washington.

(15) "Individual practice health care plan" means an association of health professionals in private practice who associate for the purpose of providing prepaid comprehensive health care services on a fee-for-service or capitation basis.

(16) "Insolvent" or "insolvency" means that the organization has been declared insolvent and is placed under an order of liquidation by a court of competent jurisdiction.

(17) "Meaningful appeal procedure" and "meaningful adverse determination review procedure" means a procedure for investigation of consumer appeals and adverse review determinations in a timely manner aimed at mutual agreement for settlement according to procedures approved by the commissioner, and which may include arbitration procedures.

(18) "Meaningful role in policy making" means a procedure approved by the commissioner which provides consumers or elected representatives of consumers a means of submitting the views and recommendations of such consumers to the governing board of such organization coupled with reasonable assurance that the board will give regard to such views and recommendations.

(19) "Net worth" means the excess of total admitted assets as defined in RCW 48.12.010 over total liabilities but the liabilities shall not include fully subordinated debt.

(20) "Participating provider" means a provider as defined in subsection (21) of this section who contracts with the health maintenance organization or with its contractor or subcontractor and has agreed to provide health care services to enrolled participants with an expectation of receiving pay-

ment, other than copayment or deductible, directly or indirectly, from the health maintenance organization.

(21) "Provider" means any health professional, hospital, or other institution, organization, or person that furnishes any health care services and is licensed or otherwise authorized to furnish such services.

(22) "Replacement coverage" means the benefits provided by a succeeding carrier.

(23) "Uncovered expenditures" means the costs to the health maintenance organization of health care services that are the obligation of the health maintenance organization for which an enrolled participant would also be liable in the event of the health maintenance organization's insolvency and for which no alternative arrangements have been made as provided herein. The term does not include expenditures for covered services when a provider has agreed not to bill the enrolled participant even though the provider is not paid by the health maintenance organization, or for services that are guaranteed, insured, or assumed by a person or organization other than the health maintenance organization. [2012 c 211 § 22. Prior: 2010 c 292 § 5; 1990 c 119 § 1; 1983 c 106 § 1; 1982 c 151 § 1; 1975 1st ex.s. c 290 § 3.]

Additional notes found at www.leg.wa.gov

48.46.023 Insurance producer—Definition—License required—Application, issuance, renewal, fees—Penalties involving license. (1) Insurance producer, as used in this chapter, means any person appointed or authorized by a health maintenance organization to solicit applications for health care service agreements on its behalf.

(2) No person shall act as or hold himself or herself out to be an appointed insurance producer of a health maintenance organization unless licensed as a disability insurance producer by this state and appointed or authorized by the health maintenance organization on whose behalf solicitations are to be made.

(3) Applications, appointments, and qualifications for licenses, the renewal thereof, the fees and issuance of a license, and the renewal thereof shall be in accordance with the provisions of chapter 48.17 RCW that are applicable to a disability insurance producer.

(4) The commissioner may revoke, suspend, or refuse to issue or renew any insurance producer's license, or levy a fine upon the licensee, in accordance with those provisions of chapter 48.17 RCW that are applicable to a disability insurance producer. [2008 c 217 § 54; 1983 c 202 § 8.]

Additional notes found at www.leg.wa.gov

48.46.027 Registration, required—Issuance of securities—Penalty. (1) A person may not in this state, by mail or otherwise, act as or hold himself or herself out to be a health maintenance organization as defined in RCW 48.46.020 without first being registered with the commissioner.

(2) The issuance, sale, or offer for sale in this state of securities of its own issue by any health maintenance organization domiciled in this state other than the memberships and bonds of a nonprofit corporation is subject to the provisions of chapter 48.06 RCW relating to obtaining solicitation permits the same as if health maintenance organizations were domestic insurers.

(3) Any person violating any provision of subsection (2) of this section is guilty of a gross misdemeanor and will, upon conviction, be fined not more than one thousand dollars, or imprisoned for not more than six months, or both, for each violation. [2003 c 250 § 10; 1983 c 202 § 9.]

Additional notes found at www.leg.wa.gov

48.46.030 Eligibility requirements for certificate of registration—Application requirements, information—Provider compensation. Any corporation, cooperative group, partnership, individual, association, or groups of health professionals licensed by the state of Washington, public hospital district, or public institutions of higher education shall be entitled to a certificate of registration from the insurance commissioner as a health maintenance organization if it:

(1) Provides comprehensive health care services to enrolled participants on a group practice per capita prepayment basis or on a prepaid individual practice plan and provides such health services either directly or through arrangements with institutions, entities, and persons which its enrolled population might reasonably require as determined by the health maintenance organization in order to be maintained in good health; and

(2) Is governed by a board elected by enrolled participants, or otherwise provides its enrolled participants with a meaningful role in policy making procedures of such organization, as defined in RCW 48.46.020(18) and 48.46.070; and

(3) Affords enrolled participants with a meaningful appeal procedure aimed at settlement of disputes between such persons and such health maintenance organization, as defined in RCW 48.46.020(17) and 48.46.100; and

(4) Provides enrolled participants, or makes available for inspection at least annually, financial statements pertaining to health maintenance agreements, disclosing income and expenses, assets and liabilities, and the bases for proposed rate adjustments for health maintenance agreements relating to its activity as a health maintenance organization; and

(5) Demonstrates to the satisfaction of the commissioner that its facilities and personnel are reasonably adequate to provide comprehensive health care services to enrolled participants and that it is financially capable of providing such members with, or has made adequate contractual arrangements through insurance or otherwise to provide such members with, such health services; and

(6) Substantially complies with administrative rules and regulations of the commissioner for purposes of this chapter; and

(7) Submits an application for a certificate of registration which shall be verified by an officer or authorized representative of the applicant, being in form as the commissioner prescribes, and setting forth:

(a) A copy of the basic organizational document, if any, of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(b) A copy of the bylaws, rules and regulations, or similar documents, if any, which regulate the conduct of the internal affairs of the applicant, and all amendments thereto;

(c) A list of the names, addresses, members of the board of directors, board of trustees, executive committee, or other

governing board or committee and the principal officers, partners, or members;

(d) A full and complete disclosure of any financial interests held by any officer, or director in any provider associated with the applicant or any provider of the applicant;

(e) A description of the health maintenance organization, its facilities and its personnel, and the applicant's most recent financial statement showing such organization's assets, liabilities, income, and other sources of financial support;

(f) A description of the geographic areas and the population groups to be served and the size and composition of the anticipated enrollee population;

(g) A copy of each type of health maintenance agreement to be issued to enrolled participants;

(h) A schedule of all proposed rates of reimbursement to contracting health care facilities or providers, if any, and a schedule of the proposed charges for enrollee coverage for health care services, accompanied by data relevant to the formulation of such schedules;

(i) A description of the proposed method and schedule for soliciting enrollment in the applicant health maintenance organization and the basis of compensation for such solicitation services;

(j) A copy of the solicitation document to be distributed to all prospective enrolled participants in connection with any solicitation;

(k) A financial projection which sets forth the anticipated results during the initial two years of operation of such organization, accompanied by a summary of the assumptions and relevant data upon which the projection is based. The projection should include the projected expenses, enrollment trends, income, enrollee utilization patterns, and sources of working capital;

(l) A detailed description of the procedures and programs to be implemented to assure that the health care services delivered to enrolled participants will be of professional quality;

(m) A detailed description of procedures to be implemented to meet the requirements to protect against insolvency in RCW 48.46.245;

(n) Documentation that the health maintenance organization has an initial net worth of one million dollars and shall thereafter maintain the minimum net worth required under RCW 48.46.235; and

(o) Such other information as the commissioner shall require by rule or regulation which is reasonably necessary to carry out the provisions of this section.

A health maintenance organization shall, unless otherwise provided for in this chapter, file a notice describing any modification of any of the information required by subsection (7) of this section. Such notice shall be filed with the commissioner. With respect to provider compensation; however, such notice shall be filed in compliance with the requirements regarding provider compensation filing in chapter 48.43 RCW. [2013 c 277 § 4; 2012 c 211 § 23; 1990 c 119 § 2; 1985 c 320 § 1; 1983 c 106 § 2; 1975 1st ex.s. c 290 § 4.]

48.46.033 Unregistered activities—Acts committed in this state—Sanctions. (1) As used in this section, "person" has the same meaning as in RCW 48.01.070.

(2) For the purpose of this section, an act is committed in this state if it is committed, in whole or in part, in the state of Washington, or affects persons or property within the state and relates to or involves a health maintenance agreement.

(3) Any person who knowingly violates RCW 48.46.027(1) is guilty of a class B felony punishable under chapter 9A.20 RCW.

(4) Any criminal penalty imposed under this section is in addition to, and not in lieu of, any other civil or administrative penalty or sanction otherwise authorized under state law.

(5)(a) If the commissioner has cause to believe that any person has violated the provisions of RCW 48.46.027(1), the commissioner may:

(i) Issue and enforce a cease and desist order in accordance with the provisions of RCW 48.02.080; and/or

(ii) Assess a civil penalty of not more than twenty-five thousand dollars for each violation, after providing notice and an opportunity for a hearing in accordance with chapters 34.05 and 48.04 RCW.

(b) Upon failure to pay a civil penalty when due, the attorney general may bring a civil action on behalf of the commissioner to recover the unpaid penalty. Any amounts collected by the commissioner must be paid to the state treasurer for the account of the general fund. [2003 c 250 § 11.]

Additional notes found at www.leg.wa.gov

48.46.040 Certificate of registration—Issuance—Grounds for refusal—Name restrictions—Inspection and review of facilities. The commissioner shall issue a certificate of registration to the applicant within sixty days of such filing unless he or she notifies the applicant within such time that such application is not complete and the reasons therefor; or that he or she is not satisfied that:

(1) The basic organizational document of the applicant permits the applicant to conduct business as a health maintenance organization;

(2) The organization has demonstrated the intent and ability to assure that comprehensive health care services will be provided in a manner to assure both their availability and accessibility;

(3) The organization is financially responsible and may be reasonably expected to meet its obligations to its enrolled participants. In making this determination, the commissioner shall consider among other relevant factors:

(a) Any agreements with an insurer, a medical or hospital service bureau, a government agency or any other organization paying or insuring payment for health care services;

(b) Any arrangements for liability and malpractice insurance coverage; and

(c) Adequate procedures to be implemented to meet the protection against insolvency requirements in RCW 48.46.245;

(4) The procedures for offering health care services and offering or terminating contracts with enrolled participants are reasonable and equitable in comparison with prevailing health insurance subscription practices and health maintenance organization enrollment procedures; and, that

(5) Procedures have been established to:

(a) Monitor the quality of care provided by such organization, including, as a minimum, procedures for internal peer review;

(b) Offer enrolled participants an opportunity to participate in matters of policy and operation in accordance with RCW 48.46.020(18) and 48.46.070.

No person to whom a certificate of registration has not been issued, except a health maintenance organization certified by the secretary of the department of health and human services, pursuant to Public Law 93-222 or its successor, shall use the words "health maintenance organization" or the initials "HMO" in its name, contracts, or literature. Persons who are contracting with, operating in association with, recruiting enrolled participants for, or otherwise authorized by a health maintenance organization possessing a certificate of registration to act on its behalf may use the terms "health maintenance organization" or "HMO" for the limited purpose of denoting or explaining their relationship to such health maintenance organization.

The department of health, at the request of the insurance commissioner, shall inspect and review the facilities of every applicant health maintenance organization to determine that such facilities are reasonably adequate to provide the health care services offered in their contracts. If the commissioner has information to indicate that such facilities fail to continue to be adequate to provide the health care services offered, the department of health, upon request of the insurance commissioner, shall reinspect and review the facilities and report to the insurance commissioner as to their adequacy or inadequacy. [2012 c 211 § 24; 2009 c 549 § 7150; 1990 c 119 § 3; 1989 1st ex.s. c 9 § 223; 1983 c 106 § 3; 1975 1st ex.s. c 290 § 5.]

Additional notes found at www.leg.wa.gov

48.46.045 Catastrophic health plans permitted. Notwithstanding the provisions of this chapter, a health maintenance organization may offer catastrophic health plans as defined in RCW 48.43.005. [2000 c 79 § 27.]

Additional notes found at www.leg.wa.gov

48.46.060 Prepayment agreements—Standards for forms and documents—Grounds for disapproval—Cancellation or failure to renew—Filing of agreement forms.

(1) Any health maintenance organization may enter into agreements with or for the benefit of persons or groups of persons, which require prepayment for health care services by or for such persons in consideration of the health maintenance organization providing health care services to such persons. Such activity is not subject to the laws relating to insurance if the health care services are rendered directly by the health maintenance organization or by any provider which has a contract or other arrangement with the health maintenance organization to render health services to enrolled participants.

(2) All forms of health maintenance agreements issued by the organization to enrolled participants or other marketing documents purporting to describe the organization's comprehensive health care services shall comply with such minimum standards as the commissioner deems reasonable and necessary in order to carry out the purposes and provisions of this chapter, and which fully inform enrolled participants of the health care services to which they are entitled, including any limitations or exclusions thereof, and such other rights,

responsibilities and duties required of the contracting health maintenance organization.

(3) Subject to the right of the health maintenance organization to demand and receive a hearing under chapters 48.04 and 34.05 RCW, the commissioner may disapprove an individual or group agreement form for any of the following grounds:

(a) If it contains or incorporates by reference any inconsistent, ambiguous, or misleading clauses, or exceptions or conditions which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the agreement;

(b) If it has any title, heading, or other indication which is misleading;

(c) If purchase of health care services thereunder is being solicited by deceptive advertising;

(d) If it contains unreasonable restrictions on the treatment of patients;

(e) If it is in any respect in violation of this chapter or if it fails to conform to minimum provisions or standards required by the commissioner by rule under chapter 34.05 RCW; or

(f) If any agreement for health care services with any state agency, division, subdivision, board, or commission or with any political subdivision, municipal corporation, or quasi-municipal corporation fails to comply with state law.

(4) In addition to the grounds listed in subsection (2) of this section, the commissioner may disapprove any agreement if the benefits provided therein are unreasonable in relation to the amount charged for the agreement. Rates, or any modification of rates effective on or after July 1, 2008, for individual health benefit plans may not be used until sixty days after they are filed with the commissioner. If the commissioner does not disapprove a rate filing within sixty days after the health maintenance organization has filed the documents required in RCW 48.46.062(2) and any rules adopted pursuant thereto, the filing shall be deemed approved.

(5) No health maintenance organization authorized under this chapter shall cancel or fail to renew the enrollment on any basis of an enrolled participant or refuse to transfer an enrolled participant from a group to an individual basis for reasons relating solely to age, sex, race, or health status. Nothing contained herein shall prevent cancellation of an agreement with enrolled participants (a) who violate any published policies of the organization which have been approved by the commissioner, or (b) who are entitled to become eligible for medicare benefits and fail to enroll for a medicare supplement plan offered by the health maintenance organization and approved by the commissioner, or (c) for failure of such enrolled participant to pay the approved charge, including cost-sharing, required under such contract, or (d) for a material breach of the health maintenance agreement.

(6) No agreement form or amendment to an approved agreement form shall be used unless it is first filed with the commissioner. [2008 c 303 § 3; 2000 c 79 § 31; 1989 c 10 § 10. Prior: 1985 c 320 § 2; 1985 c 283 § 2; 1983 c 106 § 4; 1975 1st ex.s. c 290 § 7.]

Additional notes found at www.leg.wa.gov

48.46.062 Schedule of rates for individual agreements—Loss ratio—Definitions. (1) The definitions in this

subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Claims" means the cost to the health maintenance organization of health care services, as defined in RCW 48.43.005, provided to an enrollee or paid to or on behalf of the enrollee in accordance with the terms of a health benefit plan, as defined in RCW 48.43.005. This includes capitation payments or other similar payments made to providers for the purpose of paying for health care services for an enrollee.

(b) "Claims reserves" means: (i) The liability for claims which have been reported but not paid; (ii) the liability for claims which have not been reported but which may reasonably be expected; (iii) active life reserves; and (iv) additional claims reserves whether for a specific liability purpose or not.

(c) "Declination rate" for a health maintenance organization means the percentage of the total number of applicants for individual health benefit plans received by that health maintenance organization in the aggregate in the applicable year which are not accepted for enrollment by that health maintenance organization based on the results of the standard health questionnaire administered pursuant to *RCW 48.43.018(2)(a).

(d) "Earned premiums" means premiums, as defined in RCW 48.43.005, plus any rate credits or recoupments less any refunds, for the applicable period, whether received before, during, or after the applicable period.

(e) "Incurred claims expense" means claims paid during the applicable period plus any increase, or less any decrease, in the claims reserves.

(f) "Loss ratio" means incurred claims expense as a percentage of earned premiums.

(g) "Reserves" means: (i) Active life reserves; and (ii) additional reserves whether for a specific liability purpose or not.

(2) A health maintenance organization must file supporting documentation of its method of determining the rates charged for its individual agreements. At a minimum, the health maintenance organization must provide the following supporting documentation:

(a) A description of the health maintenance organization's rate-making methodology;

(b) An actuarially determined estimate of incurred claims which includes the experience data, assumptions, and justifications of the health maintenance organization's projection;

(c) The percentage of premium attributable in aggregate for nonclaims expenses used to determine the adjusted community rates charged; and

(d) A certification by a member of the American academy of actuaries, or other person approved by the commissioner, that the adjusted community rate charged can be reasonably expected to result in a loss ratio that meets or exceeds the loss ratio standard of seventy-four percent, minus the premium tax rate applicable to the carrier's individual health benefit plans under RCW 48.14.0201. [2011 c 314 § 12; 2008 c 303 § 6; 2001 c 196 § 12; 2000 c 79 § 32.]

*Reviser's note: RCW 48.43.018 was repealed by 2019 c 33 § 7.

Additional notes found at www.leg.wa.gov

48.46.063 Calculation of premiums—Members of a purchasing pool—Adjusted community rating method—

(2022 Ed.)

Definitions. (1) Premiums for health benefit plans for individuals who purchase the plan as a member of a purchasing pool:

(a) Consisting of five hundred or more individuals affiliated with a particular industry;

(b) To whom care management services are provided as a benefit of pool membership; and

(c) Which allows contributions from more than one employer to be used towards the purchase of an individual's health benefit plan;

shall be calculated using the adjusted community rating method that spreads financial risk across the entire purchasing pool of which the individual is a member. Such rates are subject to the following provisions:

(i) The health maintenance organization shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(A) Geographic area;

(B) Family size;

(C) Age;

(D) Tenure discounts; and

(E) Wellness activities.

(ii) The adjustment for age in (c)(i)(C) of this subsection may not use age brackets smaller than five-year increments which shall begin with age twenty and end with age sixty-five. Individuals under the age of twenty shall be treated as those age twenty.

(iii) The health maintenance organization shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer, and coverage for which medicare is not the primary payer. Both rates are subject to the requirements of this subsection.

(iv) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(v) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs.

(vi) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(A) Changes to the family composition;

(B) Changes to the health benefit plan requested by the individual; or

(C) Changes in government requirements affecting the health benefit plan.

(vii) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in *RCW 48.43.015.

(viii) A tenure discount for continuous enrollment in the health plan of two years or more may be offered, not to exceed ten percent.

(2) Adjusted community rates established under this section shall not be required to be pooled with the medical expe-

rience of health benefit plans offered to small employers under RCW 48.46.066.

(3) As used in this section and RCW 48.46.066, "health benefit plan," "adjusted community rates," "small employer," and "wellness activities" mean the same as defined in RCW 48.43.005. [2006 c 100 § 6.]

*Reviser's note: RCW 48.43.015 was repealed by 2019 c 33 § 7.

Additional notes found at www.leg.wa.gov

48.46.064 Calculation of premiums—Adjusted community rate—Definitions. (1) Except for health benefit plans covered under RCW 48.46.063, premium rates for health benefit plans for individuals shall be subject to the following provisions:

(a) The health maintenance organization shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

- (i) Geographic area;
- (ii) Family size;
- (iii) Age;
- (iv) Tenure discounts; and
- (v) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments which shall begin with age twenty and end with age sixty-five. Individuals under the age of twenty shall be treated as those age twenty.

(c) The health maintenance organization shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection.

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

- (i) Changes to the family composition;
- (ii) Changes to the health benefit plan requested by the individual; or
- (iii) Changes in government requirements affecting the health benefit plan.

(g) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in *RCW 48.43.015.

(h) A tenure discount for continuous enrollment in the health plan of two years or more may be offered, not to exceed ten percent.

(2) Adjusted community rates established under this section shall pool the medical experience of all individuals pur-

chasing coverage, except individuals purchasing coverage under **RCW 48.46.063, and shall not be required to be pooled with the medical experience of health benefit plans offered to small employers under RCW 48.46.066.

(3) As used in this section and RCW 48.46.066, "health benefit plan," "adjusted community rate," "small employer," and "wellness activities" mean the same as defined in RCW 48.43.005. [2006 c 100 § 5; 2004 c 244 § 8; 2000 c 79 § 33; 1997 c 231 § 209; 1995 c 265 § 17.]

Reviser's note: *(1) RCW 48.43.015 was repealed by 2019 c 33 § 7.

***(2) The reference in 2006 c 100 § 5 to "section 5 of this act" was erroneous. Section 6 of this act, codified as RCW 48.46.063, was apparently intended.

Additional notes found at www.leg.wa.gov

48.46.066 Health plan benefits for small employers—Coverage—Exemption from statutory requirements—Premium rates—Requirements for providing coverage for small employers. (1)(a) A health maintenance organization offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market to the small employer a health benefit plan featuring a limited schedule of covered health care services. Nothing in this subsection shall preclude a health maintenance organization from offering, or a small employer from purchasing, other health benefit plans that may have more comprehensive benefits than those included in the product offered under this subsection. A health maintenance organization offering a health benefit plan under this subsection shall clearly disclose all the covered benefits to the small employer in a brochure filed with the commissioner.

(b) A health benefit plan offered under this subsection shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but is not subject to the requirements of RCW 48.46.275, 48.46.280, 48.46.285, 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, and 48.46.530.

(2) Nothing in this section shall prohibit a health maintenance organization from offering, or a purchaser from seeking, health benefit plans with benefits in excess of the health benefit plan offered under subsection (1) of this section. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.

(3) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

(a) The health maintenance organization shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

- (i) Geographic area;
- (ii) Family size;
- (iii) Age; and
- (iv) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments, which shall begin with age twenty and end with age sixty-

five. Employees under the age of twenty shall be treated as those age twenty.

(c) The health maintenance organization shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection (3).

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs. Up to a twenty percent variance may be allowed for small employers that develop and implement a wellness program or activities that directly improve employee wellness. Employers shall document program activities with the carrier and may, after three years of implementation, request a reduction in premiums based on improved employee health and wellness. While carriers may review the employer's claim history when making a determination regarding whether the employer's wellness program has improved employee health, the carrier may not use maternity or prevention services claims to deny the employer's request. Carriers may consider issues such as improved productivity or a reduction in absenteeism due to illness if submitted by the employer for consideration. Interested employers may also work with the carrier to develop a wellness program and a means to track improved employee health.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

- (i) Changes to the enrollment of the small employer;
- (ii) Changes to the family composition of the employee;
- (iii) Changes to the health benefit plan requested by the small employer; or
- (iv) Changes in government requirements affecting the health benefit plan.

(g) On the census date, as defined in RCW 48.46.020, rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, and differences in census date between new and renewal groups, with the exception of discounts for health improvement programs.

(h) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. A carrier may develop its rates based on claims costs due to network provider reimbursement schedules or type of network. This subsection does not restrict or enhance the portability of benefits as provided in *RCW 48.43.015.

(i) Adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage, including the small group participants in the health insurance partnership established in **RCW 70.47A.030. However, annual rate adjustments for each

small group health benefit plan may vary by up to plus or minus four percentage points from the overall adjustment of a carrier's entire small group pool, such overall adjustment to be approved by the commissioner, upon a showing by the carrier, certified by a member of the American academy of actuaries that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than four percentage points are subject to review by the commissioner, and must be approved or denied within sixty days of submittal. A variation that is not denied within sixty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial within thirty days of the denial.

(j) For health benefit plans purchased through the health insurance partnership established in **chapter 70.47A RCW:

(i) Any surcharge established pursuant to **RCW 70.47A.030(2)(e) shall be applied only to health benefit plans purchased through the health insurance partnership; and

(ii) Risk adjustment or reinsurance mechanisms may be used by the health insurance partnership program to redistribute funds to carriers participating in the health insurance partnership based on differences in risk attributable to individual choice of health plans or other factors unique to health insurance partnership participation. Use of such mechanisms shall be limited to the partnership program and will not affect small group health plans offered outside the partnership.

(k) If the rate developed under this section varies the adjusted community rate for the factors listed in (a) of this subsection, the date for determining those factors must be no more than ninety days prior to the effective date of the health benefit plan.

(4) Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

(5)(a) Except as provided in this subsection and subsection (3)(g) of this section, requirements used by a health maintenance organization in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) A health maintenance organization shall not require a minimum participation level greater than:

- (i) One hundred percent of eligible employees working for groups with three or less employees; and
- (ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) A health maintenance organization may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(e) Minimum participation requirements and employer premium contribution requirements adopted by the health

insurance partnership board under **RCW 70.47A.110 shall apply only to the employers and employees who purchase health benefit plans through the health insurance partnership.

(6) A health maintenance organization must offer coverage to all eligible employees of a small employer and their dependents. A health maintenance organization may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. A health maintenance organization may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan. [2010 c 292 § 6; 2009 c 131 § 3; 2008 c 143 § 8; 2007 c 260 § 9; 2004 c 244 § 9; 1995 c 265 § 18; 1990 c 187 § 4.]

Reviser's note: *(1) RCW 48.43.015 was repealed by 2019 c 33 § 7.

***(2) Chapter 70.47A RCW was repealed in its entirety by 2017 3rd sp.s. c 25 § 9.

Finding—Intent—Severability—1990 c 187: See notes following RCW 48.21.045.

Additional notes found at www.leg.wa.gov

48.46.068 Requirements for plans offered to small employers—Definitions. (1) A health maintenance organization may not offer any health benefit plan to any small employer without complying with RCW 48.46.066(3).

(2) Employers purchasing health plans provided through associations or through member-governed groups formed specifically for the purpose of purchasing health care are not small employers and are not subject to RCW 48.46.066(3).

(3) For purposes of this section, "health benefit plan," "health plan," and "small employer" mean the same as defined in RCW 48.43.005. [2003 c 248 § 16; 1995 c 265 § 24.]

Additional notes found at www.leg.wa.gov

48.46.070 Governing body. (1) The members of the governing body of a health maintenance organization shall be nominated by the voting members or by the enrolled participants and providers, and shall be elected by the enrolled participants or voting members pursuant to the provisions of their bylaws, which shall not be restricted to providers. At least one-third of such body shall consist of consumers who are substantially representative of the enrolled population of such organization: PROVIDED, HOWEVER, That any organization that is a qualified health maintenance organization under P.L. 93-222 (Title XIII, section 1310(d) of the public health services [service] act) is deemed to have satisfied these governing body requirements and the requirements of RCW 48.46.030(2).

(2) For health maintenance organizations formed by public institutions of higher education or public hospital districts, the governing body shall be advised by an advisory board consisting of at least two-thirds consumers who are elected by the voting members or the enrolled participants and are substantially representative of the enrolled population. [1985 c 320 § 3; 1983 c 106 § 5; 1975 1st ex.s. c 290 § 8.]

48.46.080 Annual statement—Filings—Contents—Fee—Penalty for failure to file—Accuracy required. (1)

[Title 48 RCW—page 388]

Every domestic health maintenance organization shall annually, on or before the first day of March, file with the commissioner a statement verified by at least two of the principal officers of the health maintenance organization showing its financial condition as of the last day of the preceding calendar year.

(2) Such annual report shall be in such form as the commissioner shall prescribe and shall include:

(a) A financial statement of such organization, including its balance sheet and receipts and disbursements for the preceding year, which reflects at a minimum;

(i) All prepayments and other payments received for health care services rendered pursuant to health maintenance agreements;

(ii) Expenditures to all categories of health care facilities, providers, insurance companies, or hospital or medical service plan corporations with which such organization has contracted to fulfill obligations to enrolled participants arising out of its health maintenance agreements, together with all other direct expenses including depreciation, enrollment, and commission; and

(iii) Expenditures for capital improvements, or additions thereto, including but not limited to construction, renovation, or purchase of facilities and capital equipment;

(b) The number of participants enrolled and terminated during the report period. Every employer offering health care benefits to their employees through a group contract with a health maintenance organization shall furnish said health maintenance organization with a list of their employees enrolled under such plan;

(c) The number of doctors by type of practice who, under contract with or as an employee of the health maintenance organization, furnished health care services to consumers during the past year;

(d) A report of the names and addresses of all officers, directors, or trustees of the health maintenance organization during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals for services to such organization. For partnership and professional service corporations, a report shall be made for partners or shareholders as to any compensation or expense reimbursement received by them for services, other than for services and expenses relating directly for patient care;

(e) Such other information relating to the performance of the health maintenance organization or the health care facilities or providers with which it has contracted as reasonably necessary to the proper and effective administration of this chapter, in accordance with rules and regulations; and

(f) Disclosure of any financial interests held by officers and directors in any providers associated with the health maintenance organization or any provider of the health maintenance organization.

(3) The commissioner may for good reason allow a reasonable extension of the time within which such annual statement shall be filed.

(4) In addition to the requirements of subsections (1) and (2) of this section, every health maintenance organization that is registered in this state shall annually, on or before March 1st of each year, file with the national association of insurance commissioners a copy of its annual statement, along with those additional schedules as prescribed by the commis-

sioner for the preceding year. The information filed with the national association of insurance commissioners shall be in the same format and scope as that required by the commissioner and shall include the signed jurate page and the actuarial certification. Any amendments and addendums to the annual statement filing subsequently filed with the commissioner shall also be filed with the national association of insurance commissioners.

(5) Coincident with the filing of its annual statement and other schedules, each health maintenance organization shall pay a reasonable fee directly to the national association of insurance commissioners in an amount approved by the commissioner to cover the costs associated with the analysis of the annual statement.

(6) Foreign health maintenance organizations that are domiciled in a state that has a law substantially similar to subsection (4) of this section are considered to be in compliance with this section.

(7) In the absence of actual malice, members of the national association of insurance commissioners, their duly authorized committees, subcommittees, and task forces, their delegates, national association of insurance commissioners employees, and all other persons charged with the responsibility of collecting, reviewing, analyzing, and disseminating the information developed from the filing of the annual statement shall be acting as agents of the commissioner under the authority of this section and shall not be subject to civil liability for libel, slander, or any other cause of action by virtue of their collection, review, analysis, or dissemination of the data and information collected for the filings required under this section.

(8) The commissioner may suspend or revoke the certificate of registration of any health maintenance organization failing to file its annual statement or pay the fees when due or during any extension of time therefor which the commissioner, for good cause, may grant.

(9) No person shall knowingly file with any public official or knowingly make, publish, or disseminate any financial statement of a health maintenance organization which does not accurately state the health maintenance organization's financial condition. [2006 c 25 § 9; 1997 c 212 § 5; 1993 c 492 § 296. Prior: 1983 c 202 § 10; 1983 c 106 § 6; 1975 1st ex.s. c 290 § 9.]

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

Additional notes found at www.leg.wa.gov

48.46.090 Standard of services provided. A health maintenance organization, and the health care facilities and providers with which such organization has entered into contracts to provide health care services to its enrolled participants, shall provide such services in a manner consistent with the dignity of each enrolled participant as a human being. [1975 1st ex.s. c 290 § 10.]

48.46.100 Grievance procedure. A health maintenance organization shall establish and maintain a grievance procedure, approved by the commissioner, to provide reasonable and effective resolution of complaints initiated by enrolled participants concerning any matter relating to the interpretation of any provision of such enrolled participants' health maintenance contracts, including, but not limited to,

claims regarding the scope of coverage for health care services; denials, cancellations, or nonrenewals of enrolled participants' coverage; and the quality of the health care services rendered, and which may include procedures for arbitration. [1975 1st ex.s. c 290 § 11.]

48.46.110 Name restrictions—Discrimination—Recovery of costs of health care services participant not entitled to. (1) No health maintenance organization may refer to itself in its name or advertising with any of the words: "insurance", "casualty", "surety", "mutual", or any other words descriptive of the insurance, casualty, or surety business, or deceptively similar to the name or description of any insurance or surety corporation or health care service contractor or other health maintenance organization doing business in this state.

(2) No health maintenance organization, nor any health care facility or provider with which such organization has contracted to provide health care services, shall discriminate against any person from whom or on whose behalf, payment to meet the required charge is available, with regard to enrollment, disenrollment, or the provision of health care services, on the basis of such person's race, color, sex, religion, place of residence if there is reasonable access to the facility of the health maintenance organization, socioeconomic status, or status as a recipient of medicare under Title XVIII of the Social Security Act, 42 U.S.C. section 1396, et seq.

(3) Where a health maintenance organization determines that an enrolled participant has received health care services to which such enrolled participant is not entitled under the terms of his or her health maintenance agreement, neither such organization, nor any health care facility or provider with which such organization has contracted to provide health care services, shall have recourse against such enrolled participant for any amount above the actual cost of providing such service, if any, specified in such agreement, unless the enrolled participant or a member of his or her family has given or withheld information to the health maintenance organization, the effect of which is to mislead or misinform the health maintenance organization as to the enrolled participant's right to receive such services. [2009 c 549 § 7151; 1983 c 202 § 11; 1975 1st ex.s. c 290 § 12.]

48.46.120 Examination of health maintenance organizations—Duties of organizations, powers of commissioner—Independent audit reports. (1) The commissioner may make an examination of the operations of any health maintenance organization as often as he or she deems necessary in order to carry out the purposes of this chapter.

(2) Every health maintenance organization shall submit its books and records relating its operation for financial condition and market conduct examinations and in every way facilitate them. The quality or appropriateness of medical services or systems shall not be examined except to the extent that such items are incidental to an examination of the financial condition or the market conduct of a health maintenance organization. For the purpose of examinations, the commissioner may issue subpoenas, administer oaths, and examine the officers and principals of the health maintenance organization and the principals of such providers concerning their business.

(3) The commissioner may elect to accept and rely on audit reports made by an independent certified public accountant for the health maintenance organization in the course of that part of the commissioner's examination covering the same general subject matter as the audit. The commissioner may incorporate the audit report in his or her report of the examination. [2009 c 549 § 7152; 2007 c 468 § 2; 1987 c 83 § 1; 1986 c 296 § 9; 1985 c 7 § 115; 1983 c 63 § 2; 1975 1st ex.s. c 290 § 13.]

Additional notes found at www.leg.wa.gov

48.46.130 Investigation of violations—Hearing—Findings—Penalties—Order requiring compliance, etc.—Suspension or revocation of certificate, effect—Application to courts. (1) The commissioner may, consistent with the provisions of the administrative procedure act, chapter 34.05 RCW, initiate proceedings to determine whether a health maintenance organization has:

(a) Operated in a manner that materially violates its organizational documents;

(b) Materially breached its obligation to furnish the health care services specified in its contracts with enrolled participants;

(c) Violated any provision of this chapter, or any rules and regulations promulgated thereunder;

(d) Made any false statement with respect to any report or statement required by this chapter or by the commissioner under this chapter;

(e) Advertised or marketed, or attempted to market, its services in such a manner as to misrepresent its services or capacity for services, or engaged in deceptive, misleading, or unfair practices with respect to advertising or marketing;

(f) Prevented the commissioner from the performance of any duty imposed by this chapter; or

(g) Fraudulently procured or attempted to procure any benefit under this chapter.

(2) After providing written notice and an opportunity for a hearing to be scheduled no sooner than ten days following such notice, the commissioner shall make administrative findings and may, as appropriate:

(a) Impose a penalty of not more than ten thousand dollars for each and every unlawful act committed which materially affects the health services offered or furnished;

(b) Issue an administrative order requiring the health maintenance organization to:

(i) Cease or modify inappropriate conduct or practices by it or any of the personnel employed or associated with it;

(ii) Fulfill its contractual obligations;

(iii) Provide a service which has been improperly denied;

(iv) Take steps to provide or arrange for any service which it has agreed to make available; or

(v) Abide by the terms of an arbitration proceeding, if any;

(c) Suspend or revoke the certificate of authority of the health maintenance organization:

(i) If its certificate of authority is suspended, the organization shall not, during the period of such suspension, enroll any additional participants except newborn children or other newly acquired dependents of existing enrolled participants, and shall not engage in any advertising or solicitation whatsoever;

(ii) If its certificate of authority is revoked, the organization shall proceed under the supervision of the commissioner immediately following the effective date of the order of revocation to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of such affairs: PROVIDED, That the commissioner may, by written order, permit such further operation of the organization as it may find to be in the best interest of enrolled participants, to the end that such enrolled participants will be afforded the greatest practical opportunity to obtain continuing health care coverage: PROVIDED, FURTHER, That if the organization is qualified to operate as a health care service contractor under chapter 48.44 RCW, it may continue to operate as such when it obtains the appropriate license.

(3) The commissioner may apply to any court for such legal or equitable relief as it deems necessary to effectively carry out the purposes of this chapter, including, but not limited to, an action in any court of competent jurisdiction to enjoin any such acts or practices and to enforce compliance with this chapter or any rule or order hereunder. Upon a proper showing a permanent or temporary injunction, restraining order, or writ of mandamus shall be granted and a receiver or conservator may be appointed for the defendant or the defendant's assets. The commissioner may not be required to post a bond. [1975 1st ex.s. c 290 § 14.]

48.46.135 Fine in addition to or in lieu of suspension, revocation, or refusal. After hearing or upon stipulation by the registrant and in addition to or in lieu of the suspension, revocation, or refusal to renew any registration of a health maintenance organization, the commissioner may levy a fine against the party involved for each offense in an amount not less than fifty dollars and not more than ten thousand dollars. The order levying such fine shall specify the period within which the fine shall be fully paid and which period shall not be less than fifteen nor more than thirty days from the date of such order. Upon failure to pay any such fine when due the commissioner shall revoke the registration of the registrant, if not already revoked, and the fine shall be recovered in a civil action brought on behalf of the commissioner by the attorney general. Any fine so collected shall be paid by the commissioner to the state treasurer for the account of the general fund. [1983 c 202 § 15.]

48.46.140 Fees. Every organization subject to this chapter shall pay to the commissioner the following fees:

(1) For filing a copy of its application for a certificate of registration or amendment thereto, one hundred dollars;

(2) For filing each annual report pursuant to RCW 48.46.080, ten dollars. [1975 1st ex.s. c 290 § 15.]

48.46.170 Effect of chapter as to other laws—Construction. (1) Solicitation of enrolled participants by a health maintenance organization granted a certificate of registration, or its appointed insurance producers or representatives, does not violate any provision of law relating to solicitation or advertising by health professionals.

(2) Any health maintenance organization authorized under this chapter is not violating any law prohibiting the practice by unlicensed persons of podiatric medicine and surgery, chiropractic, dental hygiene, opticianry, dentistry,

optometry, osteopathic medicine and surgery, pharmacy, medicine and surgery, physical therapy, nursing, or psychology. This subsection does not expand a health professional's scope of practice or allow employees of a health maintenance organization to practice as a health professional unless licensed.

(3) This chapter does not alter any statutory obligation, or rule adopted thereunder, in chapter 70.38 RCW.

(4) Any health maintenance organization receiving a certificate of registration pursuant to this chapter is exempt from chapter 48.05 RCW. [2008 c 217 § 55; 2003 c 248 § 17; 1996 c 178 § 13; 1983 c 106 § 7; 1975 1st ex.s. c 290 § 18.]

Additional notes found at www.leg.wa.gov

48.46.180 Duty of employer to inform and make available to employees option of enrolling in health maintenance organization.

(1) The state government, or any political subdivision thereof, which offers its employees a health benefits plan shall make available to and inform its employees or members of the option to enroll in at least one health maintenance organization holding a valid certificate of authority which provides health care services in the geographic areas in which such employees or members reside.

(2) Each employer, public or private, having more than fifty employees in this state which offers its employees a health benefits plan, and each employee benefits fund in this state having more than fifty members which offers its members any form of health benefits shall make available to and inform its employees or members of the option to enroll in at least one health maintenance organization holding a valid certificate of authority which provides health care services in the geographic areas in which a substantial number of such employees or members reside: PROVIDED, That unless at least twenty-five employees agree to participate in a health maintenance organization the employer need not provide such an option: PROVIDED FURTHER, That where such employees are members of a bona fide bargaining unit covered by a labor-management collective bargaining agreement, the selection of the options required by this section may be specified in such agreement: AND PROVIDED FURTHER, That the provisions of this section shall not be mandatory where such members are covered by a Taft-Hartley health care trust, except that the labor-management trustees may contract with a health maintenance organization if a feasibility study determines it is to the advantage of the members to so contract.

(3) Subsections (1) and (2) of this section shall impose no responsibilities or duties upon state government or any political subdivision thereof or any other employer, either public or private, to provide health maintenance organization coverage when no health maintenance organization exists for the purpose of providing health care services in the geographic areas in which the employees or members reside.

(4) No employer in this state shall in any way be required to pay more for health benefits as a result of the application of this section than would otherwise be required by any prevailing collective bargaining agreement or other legally enforceable contract of obligation for the provision of health benefits between such employer and its employees. [1975 1st ex.s. c 290 § 19.]

(2022 Ed.)

48.46.190 Payroll deductions for capitation payments to health maintenance organizations. See RCW 41.04.233.

48.46.200 Rules and regulations. The commissioner may, in accordance with the provisions of the administrative procedure act, chapter 34.05 RCW, promulgate rules and regulations as necessary or proper to carry out the provisions of this chapter. Nothing in this chapter shall be construed to prohibit the commissioner from requiring changes in procedures previously approved by him or her. [2009 c 549 § 7153; 1975 1st ex.s. c 290 § 21.]

48.46.210 Compliance with federal funding requirements—Construction. Nothing in this chapter shall prohibit any health maintenance organization from meeting the requirements of any federal law which would authorize such health maintenance organization to receive federal financial assistance or enroll beneficiaries assisted by federal funds. [1975 1st ex.s. c 290 § 22.]

48.46.220 Review of administrative action. Any party aggrieved by a decision, order, or regulation made under this chapter by the commissioner shall have the right to have such reviewed pursuant to the provisions of the administrative procedure act, chapter 34.05 RCW. [1975 1st ex.s. c 290 § 23.]

48.46.225 Financial failure—Supervision of commissioner—Priority of distribution of assets. (1) Any rehabilitation, liquidation, or conservation of a health maintenance organization is the same as the rehabilitation, liquidation, or conservation of an insurance company and must be conducted under the supervision of the commissioner pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies. The commissioner may apply for an order directing the commissioner to rehabilitate, liquidate, or conserve a health maintenance organization upon any one or more grounds set out in RCW 48.31.030, 48.31.050, and 48.31.080. Enrolled participants have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

(2) For purposes of determining the priority of distribution of general assets, claims of enrolled participants and enrolled participants' beneficiaries have the same priority as established by RCW 48.31.280 for policyholders and beneficiaries of insureds of insurance companies. If an enrolled participant is liable to any provider for services provided pursuant to and covered by the health maintenance agreement, that liability has the status of an enrolled participant claim for distribution of general assets.

(3) A provider who is obligated by statute or agreement to hold enrolled participants harmless from liability for services provided pursuant to and covered by a health care plan has a priority of distribution of the general assets immediately following that of enrolled participants and enrolled participants' beneficiaries under this section. [2003 c 248 § 18; 1990 c 119 § 4.]

48.46.235 Minimum net worth—Requirement to maintain—Determination of amount. (1) Except as provided in subsection (2) of this section, every health mainte-

nance organization must have and maintain a minimum net worth equal to the greater of:

- (a) Three million dollars; or
- (b) Two percent of annual premium earned as reported on the most recent annual financial statement filed with the commissioner on the first one hundred fifty million dollars of premium and one percent of annual premium on the premium in excess of one hundred fifty million dollars; or
- (c) An amount equal to the sum of three months' uncovered expenditures as reported on the most recent financial statement filed with the commissioner.

(2) A health maintenance organization registered before July 27, 1997, that, on July 27, 1997, has a minimum net worth equal to or greater than that required by subsection (1) of this section must continue to have and maintain the minimum net worth required by subsection (1) of this section. A health maintenance organization registered before July 27, 1997, that, on July 27, 1997, does not have the minimum net worth required by subsection (1) of this section must have and maintain a minimum net worth of:

- (a) The amount required immediately prior to July 27, 1997, until December 31, 1997;
- (b) Fifty percent of the amount required by subsection (1) of this section by December 31, 1997;
- (c) Seventy-five percent of the amount required by subsection (1) of this section by December 31, 1998; and
- (d) One hundred percent of the amount required by subsection (1) of this section by December 31, 1999.

(3)(a) In determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the commissioner. An interest obligation relating to the repayment of a subordinated debt must be similarly subordinated.

(b) The interest expenses relating to the repayment of a fully subordinated debt shall not be considered uncovered expenditures.

(c) A subordinated debt incurred by a note meeting the requirement of this section, and otherwise acceptable to the commissioner, shall not be considered a liability and shall be recorded as equity.

(4) Every health maintenance organization shall, when determining liabilities, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, which are unpaid and for which such organization is or may be liable, and to provide for the expense of adjustment or settlement of such claims.

Such liabilities shall be computed in accordance with rules promulgated by the commissioner upon reasonable consideration of the ascertained experience and character of the health maintenance organization. [1997 c 212 § 6; 1990 c 119 § 5.]

48.46.237 Minimum net worth—Domestic or foreign health maintenance organization. (1) For purposes of this section:

(a) "Domestic health maintenance organization" means a health maintenance organization formed under the laws of this state; and

(b) "Foreign health maintenance organization" means a health maintenance organization formed under the laws of the United States, of a state or territory of the United States other than this state, or of the District of Columbia.

(2) If the minimum net worth of a domestic health maintenance organization falls below the minimum net worth required by this chapter, the commissioner shall at once ascertain the amount of the deficiency and serve notice upon the domestic health maintenance organization to cure the deficiency within ninety days after that service of notice.

(3) If the deficiency is not cured, and proof thereof filed with the commissioner within the ninety-day period, the domestic health maintenance organization shall be declared insolvent and shall be proceeded against as authorized by this code or the commissioner shall, consistent with chapters 48.04 and 34.05 RCW, suspend or revoke the registration of the domestic health maintenance organization as being hazardous to its subscribers and the people in this state.

(4) If the deficiency is not cured the domestic health maintenance organization shall not issue or deliver any health maintenance agreement after the expiration of the ninety-day period.

(5) If the minimum net worth of a foreign health maintenance organization falls below the minimum net worth required by this chapter, the commissioner shall, consistent with chapters 48.04 and 34.05 RCW, suspend or revoke the foreign health maintenance organization's registration as being hazardous to its subscribers, enrollees, or the people in this state. [1997 c 212 § 7.]

48.46.240 Funded reserve requirements. (1) Each health maintenance organization obtaining a certificate of registration from the commissioner shall provide and maintain a funded reserve of one hundred fifty thousand dollars. The funded reserve shall be deposited with the commissioner or with any organization/trustee acceptable to him or her in the form of cash, securities eligible for investment by the health maintenance organization pursuant to chapter 48.13 RCW, approved surety bond or any combination of these, and must equal or exceed one hundred fifty thousand dollars. The funded reserve shall be established as an assurance that the uncovered expenditure obligations of the health maintenance organization to the enrolled participants will be performed.

(2) All income from reserves on deposit with the commissioner shall belong to the depositing health maintenance organization and shall be paid to it as it becomes available.

(3) Any funded reserve required by this section shall be considered an asset of the health maintenance organization in determining the organization's net worth.

(4) A health maintenance organization that has made a securities deposit with the commissioner may, at its option, withdraw the securities deposit or any part of the deposit after first having deposited or provided in lieu thereof an approved surety bond, a deposit of cash or securities, or any combination of these or other deposits of equal amount and value to that withdrawn. Any securities and surety bond shall be subject to approval by the commissioner before being substituted. [2009 c 549 § 7154; 1990 c 119 § 6; 1985 c 320 § 4; 1982 c 151 § 3.]

Additional notes found at www.leg.wa.gov

48.46.243 Contract—Participant liability. (1) Subject to subsection (2) of this section, every contract between a health maintenance organization and its participating providers of health care services shall be in writing and shall set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the agreement, the enrolled participant shall not be liable to the provider for any sums owed by the health maintenance organization. Every such contract shall provide that this requirement shall survive termination of the contract.

(2) The provisions of subsection (1) of this section shall not apply:

(a) To emergency care from a provider who is not a participating provider;

(b) To out-of-area services;

(c) To the delivery of covered pediatric oral services that are substantially equal to the essential health benefits benchmark plan; or

(d) In exceptional situations approved in advance by the commissioner, if the health maintenance organization is unable to negotiate reasonable and cost-effective participating provider contracts.

(3) No participating provider, or insurance producer, trustee, or assignee thereof, may maintain an action against an enrolled participant to collect sums owed by the health maintenance organization. [2016 c 122 § 3. Prior: 2013 c 325 § 2; 2013 c 277 § 3; 2008 c 217 § 56; 1990 c 119 § 7.]

Intent—2016 c 122: "It is the intent of the legislature to allow certain provider compensation exhibits to remain confidential by making permanent the provisions of chapter 277, Laws of 2013, which currently expire July 1, 2017, thereby maintaining efficient review and approval of health care plans by the insurance commissioner and fostering innovation in the Washington health insurance market." [2016 c 122 § 1.]

Additional notes found at www.leg.wa.gov

48.46.245 Plan for handling insolvency—Commissioner's review. Each health maintenance organization shall have a plan for handling insolvency which allows for continuation of benefits for the duration of the agreement period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. The commissioner shall approve such a plan if it includes:

(1) Insurance to cover the expenses to be paid for continued benefits after insolvency;

(2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrolled participants' discharge from inpatient facilities;

(3) Use of insolvency reserves established under RCW 48.46.240;

(4) Acceptable letters of credit or approved surety bonds; or

(5) Any other arrangements the commissioner and the organization mutually agree are appropriate to assure that benefits are continued. [1990 c 119 § 8.]

48.46.247 Insolvency—Commissioner's duties—Participants' options—Allocation of coverage. (1)(a) In the event of insolvency of a health care service contractor or

health maintenance organization and upon order of the commissioner, all other carriers then having active enrolled participants under a group plan with the affected agreement holder that participated in the enrollment process with the insolvent health care service contractor or health maintenance organization at a group's last regular enrollment period shall offer the eligible enrolled participants of the insolvent health services contractor or health maintenance organization the opportunity to enroll in an existing group plan without medical underwriting during a thirty-day open enrollment period, commencing on the date of the insolvency. Eligible enrolled participants shall not be subject to preexisting condition limitations except to the extent that a waiting period for a preexisting condition has not been satisfied under the insolvent carrier's group plan. An open enrollment shall not be required where the agreement holder participates in a self-insured, self-funded, or other health plan exempt from commissioner rule, unless the plan administrator and agreement holder voluntarily agree to offer a simultaneous open enrollment and extend coverage under the same enrollment terms and conditions as are applicable to carriers under this title and rules adopted under this title. If an exempt plan was offered during the last regular open enrollment period, then the carrier may offer the agreement holder the same coverage as any self-insured plan or plans offered by the agreement holder without regard to coverage, benefit, or provider requirements mandated by this title for the duration of the current agreement period.

(b) For purposes of this subsection only, the term "carrier" means a health maintenance organization or a health care service contractor. In the event of insolvency of a carrier and if no other carrier has active enrolled participants under a group plan with the affected agreement holder, or if the commissioner determines that the other carriers lack sufficient health care delivery resources to assure that health services will be available or accessible to all of the group enrollees of the insolvent carrier, then the commissioner shall allocate equitably the insolvent carrier's group agreements for these groups among all carriers that operate within a portion of the insolvent carrier's area, taking into consideration the health care delivery resources of each carrier. Each carrier to which a group or groups are allocated shall offer the agreement holder, without medical underwriting, the carrier's existing coverage that is most similar to each group's coverage with the insolvent carrier at rates determined in accordance with the successor carrier's existing rating methodology. The eligible enrolled participants shall not be subject to preexisting condition limitations except to the extent that a waiting period for a preexisting condition has not been satisfied under the insolvent carrier's group plan. No offering by a carrier shall be required where the agreement holder participates in a self-insured, self-funded, or other health plan exempt from commissioner rule. The carrier may offer the agreement holder the same coverage as any self-insured plan or plans offered by the agreement holder without regard to coverage, benefit, or provider requirements mandated by this title for the duration of the current agreement period.

(2) The commissioner shall also allocate equitably the insolvent carrier's nongroup enrolled participants who are unable to obtain coverage among all carriers that operate within a portion of the insolvent carrier's service area, taking

into consideration the health care delivery resources of the carrier. Each carrier to which nongroup enrolled participants are allocated shall offer the nongroup enrolled participants the carrier's existing comprehensive conversion plan, without additional medical underwriting, at rates determined in accordance with the successor carrier's existing rating methodology. The eligible enrolled participants shall not be subject to preexisting condition limitations except to the extent that a waiting period for a preexisting condition has not been satisfied under the insolvent carrier's plan.

(3) Any agreements covering participants allocated pursuant to subsections (1)(b) and (2) of this section to carriers pursuant to this section may be rerated after ninety days of coverage.

(4) A limited health care service contractor shall not be required to offer services other than its one limited health care service to any enrolled participant of an insolvent carrier. [1990 c 119 § 9.]

48.46.250 Coverage of dependent children—Newborn infants, congenital anomalies—Notification period.

(1) Any health maintenance agreement under this chapter which provides coverage for dependent children of the enrolled participant shall provide the same coverage for newborn infants of the enrolled participant from and after the moment of birth. Coverage provided under this section shall include, but not be limited to, coverage for congenital anomalies of such children from the moment of birth.

(2) If payment of an additional premium is required to provide coverage for a child, the agreement may require that notification of birth of a newly born child and payment of the required premiums must be furnished to the health maintenance organization. The notification period shall be no less than sixty days from the date of birth. This subsection applies to agreements issued or renewed on or after January 1, 1984. [1984 c 4 § 2; 1983 c 202 § 12.]

48.46.260 Individual health maintenance agreement—Return within ten days of delivery—Refunds—Void from beginning.

Every subscriber of an individual health maintenance agreement may return the agreement to the health maintenance organization or the insurance producer through whom it was purchased within ten days of its delivery to the subscriber if, after examination of the agreement, the subscriber is not satisfied with it for any reason. The health maintenance organization shall refund promptly any fee paid for the agreement. An additional ten percent penalty shall be added to any premium refund due which is not paid within thirty days of return of the policy to the health maintenance organization or insurance producer. Upon such return of the agreement, it shall be void from the beginning and the parties shall be in the same position as if no agreement had been issued. Notice of the provisions of this section shall be printed on the face of each such agreement or be attached thereto. [2008 c 217 § 57; 1983 c 202 § 13.]

Additional notes found at www.leg.wa.gov

48.46.270 Financial interests of health maintenance organization authorities, restricted—Exceptions, regulations. (1) No person having any authority in the investment or disposition of the funds of a health maintenance organiza-

tion and no officer or director of a health maintenance organization shall accept, except for the health maintenance organization, or be the beneficiary of any fee, brokerage, gift, commission, or other emolument because of any sale of health care service agreements or any investment, loan, deposit, purchase, sale, payment, or exchange made by or for the health maintenance organization, or be pecuniarily interested therein in any capacity; except, that such a person may procure a loan from the health maintenance organization directly upon approval by two-thirds of its directors and upon the pledge of securities eligible for the investment of the health maintenance organization's funds under this title.

(2) The commissioner may, by regulations, from time to time, define and permit additional exceptions to the prohibition contained in subsection (1) of this section solely to enable payment of reasonable compensation to a director who is not otherwise an officer or employee of the health maintenance organization, or to a corporation or firm in which the director is interested, for necessary services performed or sales or purchases made to or for the health maintenance organization in the ordinary course of the health maintenance organization's business and in the usual private professional or business capacity of the director or the corporation or firm. [1985 c 320 § 5; 1983 c 202 § 14.]

48.46.272 Diabetes coverage—Definitions. The legislature finds that diabetes imposes a significant health risk and tremendous financial burden on the citizens and government of the state of Washington, and that access to the medically accepted standards of care for diabetes, its treatment and supplies, and self-management training and education is crucial to prevent or delay the short and long-term complications of diabetes and its attendant costs.

(1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Person with diabetes" means a person diagnosed by a health care provider as having insulin using diabetes, non-insulin using diabetes, or elevated blood glucose levels induced by pregnancy; and

(b) "Health care provider" means a health care provider as defined in RCW 48.43.005.

(2) All health benefit plans offered by health maintenance organizations, issued or renewed after January 1, 1998, shall provide benefits for at least the following services and supplies for persons with diabetes:

(a) For health benefit plans that include coverage for pharmacy services, appropriate and medically necessary equipment and supplies, as prescribed by a health care provider, that includes but is not limited to insulin, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes, and glucagon emergency kits; and

(b) For all health benefit plans, outpatient self-management training and education, including medical nutrition therapy, as ordered by the health care provider. Diabetes outpatient self-management training and education may be provided only by health care providers with expertise in diabetes. Nothing in this section prevents the health maintenance

organization from restricting patients to seeing only health care providers who have signed participating provider agreements with the health maintenance organization or an insuring entity under contract with the health maintenance organization.

(3) Except as provided in RCW 48.43.780, coverage required under this section may be subject to customary cost-sharing provisions established for all other similar services or supplies within a policy.

(4) Health care coverage may not be reduced or eliminated due to this section.

(5) Services required under this section shall be covered when deemed medically necessary by the medical director, or his or her designee, subject to any referral and formulary requirements.

(6) The health maintenance organization need not include the coverage required in this section in a group contract offered to an employer or other group that offers to its eligible enrollees a self-insured health plan not subject to mandated benefits status under this title that does not offer coverage similar to that mandated under this section.

(7) This section does not apply to the health benefit plans that provide benefits identical to the schedule of services covered by the basic health plan. [2020 c 346 § 10; 2020 c 245 § 6; 2004 c 244 § 14; 1997 c 276 § 5.]

Reviser's note: This section was amended by 2020 c 245 § 6 and by 2020 c 346 § 10, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Intent—2020 c 346: See note following RCW 70.14.165.

Additional notes found at www.leg.wa.gov

48.46.274 Prescribed, self-administered anticancer medication. (1) Each health plan issued or renewed on or after January 1, 2012, that provides coverage for cancer chemotherapy treatment must provide coverage for prescribed, self-administered anticancer medication that is used to kill or slow the growth of cancerous cells on a basis at least comparable to cancer chemotherapy medications administered by a health care provider or facility as defined in *RCW 48.43.005 (25) and (26).

(2) Nothing in this section may be interpreted to prohibit a health plan from administering a formulary or preferred drug list, requiring prior authorization, or imposing other appropriate utilization controls in approving coverage for any chemotherapy. [2020 c 18 § 22; 2011 c 159 § 6.]

***Reviser's note:** RCW 48.43.005 was alphabetized pursuant to RCW 1.08.015(2)(k), changing subsections (25) and (26) to subsections (27) and (28).

Explanatory statement—2020 c 18: See note following RCW 43.79A.040.

Findings—2011 c 159: See note following RCW 41.05.175.

48.46.275 Mammograms—Insurance coverage. Each health maintenance agreement issued or renewed after January 1, 1990, that provides benefits for hospital or medical care shall provide benefits for screening or diagnostic mammography services, provided that such services are delivered upon the recommendation of the patient's physician or advanced registered nurse practitioner as authorized by the nursing care quality assurance commission pursuant to chapter 18.79 RCW or physician assistant pursuant to chapter 18.71A RCW.

ter 18.79 RCW or physician assistant pursuant to chapter 18.71A RCW.

All services must be provided by the health maintenance organization or rendered upon referral by the health maintenance organization. This section shall not be construed to prevent the application of standard agreement provisions applicable to other benefits such as deductible or copayment provisions. This section does not limit the authority of a health maintenance organization to negotiate rates and contract with specific providers for the delivery of mammography services. This section shall not apply to medicare supplement policies or supplemental contracts covering a specified disease or other limited benefits. [1994 sp.s. c 9 § 735; 1989 c 338 § 4.]

Additional notes found at www.leg.wa.gov

48.46.277 Prostate cancer screening. (1) Each health maintenance agreement issued or renewed after December 31, 2006, that provides coverage for hospital or medical expenses shall provide coverage for prostate cancer screening, provided that the screening is delivered upon the recommendation of the patient's physician, advanced registered nurse practitioner, or physician assistant.

(2) All services must be provided by the health maintenance organization or rendered upon a referral by the health maintenance organization.

(3) This section shall not be construed to prevent the application of standard policy provisions applicable to other benefits, such as deductible or copayment provisions. This section does not limit the authority of a health maintenance organization to negotiate rates and contract with specific providers for the delivery of prostate cancer screening services. This section shall not apply to medicare supplemental policies or supplemental contracts covering a specified disease or other limited benefits. [2006 c 367 § 5.]

48.46.280 Reconstructive breast surgery. (1) Any health care service plan issued, amended, or renewed after July 24, 1983, shall provide coverage for reconstructive breast surgery resulting from a mastectomy which resulted from disease, illness, or injury.

(2) Any health care service plan issued, amended, or renewed after January 1, 1986, shall provide coverage for all stages of one reconstructive breast reduction on the nondiseased breast to make it equal in size with the diseased breast after definitive reconstructive surgery on the diseased breast has been performed. [1985 c 54 § 8; 1983 c 113 § 4.]

Additional notes found at www.leg.wa.gov

48.46.285 Mastectomy, lumpectomy. No health maintenance organization under this chapter may refuse coverage or cancel or decline coverage solely because of a mastectomy or lumpectomy performed on the insured or prospective insured more than five years previously. The amount of benefits payable, or any term, rate, condition, or type of coverage shall not be restricted, modified, excluded, increased, or reduced solely on the basis of a mastectomy or lumpectomy performed on the insured or prospective insured more than five years previously. [1985 c 54 § 4.]

Additional notes found at www.leg.wa.gov

48.46.291 Mental health services—Health plans—Definition—Coverage required, when. (1) For the purposes of this section, "mental health services" means:

(a) For health benefit plans issued or renewed before January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on June 11, 2020, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: (i) Substance related disorders; (ii) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; (iii) skilled nursing facility services, home health care, residential treatment, and custodial care; and (iv) court ordered treatment unless the health maintenance organization's medical director or designee determines the treatment to be medically necessary; and

(b) For a health benefit plan or a plan deemed by the commissioner to have a short-term limited purpose or duration, issued or renewed on or after January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental health and substance use disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on June 11, 2020, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005.

(2) A health benefit plan or a plan deemed by the commissioner to have a short-term limited purpose or duration, offered by health maintenance organizations that provide coverage for medical and surgical services shall provide coverage for:

(a) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services. If the health benefit plan imposes any deductible, mental health services shall be included with medical and surgical services for the purpose of meeting the deductible requirement. Treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services; and

(b) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.

(3) This section does not prohibit a requirement that mental health services be medically necessary, if a compara-

ble requirement is applicable to medical and surgical services.

(4) Nothing in this section shall be construed to prevent the management of mental health services if a comparable requirement is applicable to medical and surgical services. [2020 c 228 § 6; 2007 c 8 § 4; 2006 c 74 § 3; 2005 c 6 § 5.]

Findings—Intent—Severability—2005 c 6: See notes following RCW 41.05.600.

Additional notes found at www.leg.wa.gov

48.46.292 Mental health treatment—Waiver of pre-authorization for persons involuntarily committed. A health maintenance organization providing services or benefits for hospital or medical care coverage in this state shall waive a preauthorization from the health maintenance organization before an enrolled participant or the enrolled participant's covered dependents receive mental health treatment rendered by a state hospital as defined in RCW 72.23.010 if the enrolled participant or the enrolled participant's covered dependents are involuntarily committed to a state hospital as defined in RCW 72.23.010. [1993 c 272 § 5.]

Additional notes found at www.leg.wa.gov

48.46.300 Future dividends or refunds, restricted—Issuance or sale of securities regulated. (1) No health maintenance organization nor any individual acting in behalf thereof may guarantee or agree to the payment of future dividends or future refunds of unused charges or savings in any specific or approximate amounts or percentages in respect to any contract being offered to the public, except in a group contract containing an experience refund provision.

(2) The issuance, sale, or offer for sale in this state of securities of its own issue by any health maintenance organization domiciled in this state other than the memberships and bonds of a nonprofit corporation are subject to the provisions of chapter 48.06 RCW relating to obtaining solicitation permits. [1983 c 106 § 8.]

48.46.310 Registration not endorsement. The granting of a certificate of registration to a health maintenance organization is permissive only, and does not constitute an endorsement by the insurance commissioner of any person or thing related to the health maintenance organization, and no person may advertise or display a certificate of registration for use as an inducement in any solicitation. [1983 c 106 § 9.]

48.46.320 Dependent children, termination of coverage, conditions. Any health maintenance agreement which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the agreement shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both: (1) Incapable of self-sustaining employment by reason of developmental or physical disability; and (2) chiefly dependent upon the subscriber for support and maintenance, if proof of such incapacity and dependency is furnished to the health maintenance organization by the enrolled participant within thirty-one days of the child's attainment of the limiting age and subsequently as required by the health maintenance organization but not more frequently than annually after the

two-year period following the child's attainment of the limiting age. [2020 c 274 § 38; 1985 c 320 § 6; 1983 c 106 § 10.]

48.46.325 Option to cover child under age twenty-six.

(1) Each individual health maintenance agreement that is not grandfathered and that provides coverage for a subscriber's child must offer the option of covering any child under the age of twenty-six.

(2) Each group health maintenance agreement that is not grandfathered and that provides coverage for a participating member's child must offer each participating member the option of covering any child under the age of twenty-six.

(3) Each grandfathered individual or group health maintenance agreement that provides coverage for a subscriber's child must offer the option of covering any child under the age of twenty-six, unless that child is eligible to enroll in an eligible health plan sponsored by the child's employer or the child's spouse's employer.

(4) As used in this section, "grandfathered" has the same meaning as "grandfathered health plan" in RCW 48.43.005. [2012 c 211 § 19; 2011 c 314 § 8; 2007 c 259 § 22.]

Additional notes found at www.leg.wa.gov

48.46.340 Return of agreement within ten days.

Every subscriber of an individual health maintenance agreement may return the agreement to the health maintenance organization or the insurance producer through whom it was purchased within ten days of its delivery to the subscriber if, after examination of the agreement, the subscriber is not satisfied with it for any reason. The health maintenance organization shall refund promptly any fee paid for the agreement. Upon such return of the agreement, it shall be void from the beginning and the parties shall be in the same position as if no agreement had been issued. Notice of the substance of this section shall be printed on the face of each such agreement or be attached thereto. [2008 c 217 § 58; 1983 c 106 § 12.]

Additional notes found at www.leg.wa.gov

48.46.350 Chemical dependency treatment. Each group agreement for health care services that is delivered or issued for delivery or renewed on or after January 1, 1988, must contain provisions providing benefits for the treatment of chemical dependency rendered to covered persons by a provider which is an "approved substance use disorder treatment program" under *RCW 70.96A.020(2). However, this section does not apply to any agreement written as supplemental coverage to any federal or state programs of health care including, but not limited to, Title XVIII health insurance for the aged, which is commonly referred to as Medicare, Parts A&B, and amendments thereto. Treatment must be covered under the chemical dependency coverage if treatment is rendered by the health maintenance organization or if the health maintenance organization refers the enrolled participant or the enrolled participant's dependents to a physician licensed under chapter 18.57 or 18.71 RCW, or to a qualified counselor employed by an approved substance use disorder treatment program described in *RCW 70.96A.020(2). In all cases, a health maintenance organization retains the right to diagnose the presence of chemical dependency and select the modality of treatment that best serves the interest of the health maintenance organization's enrolled participant, or the

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enrolled participant's covered dependent. [2018 c 201 § 8013; 2003 c 248 § 19; 1990 1st ex.s. c 3 § 14; 1987 c 458 § 18; 1983 c 106 § 13.]

*Reviser's note: RCW 70.96A.020 was repealed by 2016 sp.s. c 29 § 301.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Chemical dependency benefits, rules: RCW 48.21.197.

Additional notes found at www.leg.wa.gov

48.46.355 "Chemical dependency" defined. For the purposes of RCW 48.46.350, "chemical dependency" means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance regulated under chapter 69.50 RCW and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted. [1987 c 458 § 19.]

Additional notes found at www.leg.wa.gov

48.46.360 Payment of cost of agreement directly to holder during labor dispute—Changes restricted—Notice to employee. Any employee whose compensation includes a health maintenance agreement, the cost of which is paid in full or in part by an employer including the state of Washington, its political subdivisions, or municipal corporations, or paid by payroll deduction, may pay the cost as it becomes due directly to the agreement holder whenever the employee's compensation is suspended or terminated directly or indirectly as a result of a strike, lockout, or other labor dispute, for a period not exceeding six months and at the rate and coverages as the health maintenance agreement provides. During that period of time, such agreement may not be altered or changed. Nothing in this section impairs the right of the health maintenance organization to make normal decreases or increases in the cost of the health maintenance agreement upon expiration and renewal of the agreement, in accordance with the agreement. Thereafter, if such health maintenance agreement is no longer available, the employee shall be given the opportunity to convert as specified in RCW 48.46.450 and 48.46.460. When the employee's compensation is so suspended or terminated, the employee shall be notified immediately by the agreement holder in writing, by mail addressed to the address last of record with the agreement holder, that the employee may pay the cost of the health maintenance agreement to the agreement holder as it becomes due as provided in this section. Payment must be made when due or the coverage may be terminated by the health maintenance organization. [1985 c 7 § 116; 1983 c 106 § 14.]

48.46.370 Coverage not denied for disability. No health maintenance organization may deny coverage to a person solely on account of the presence of any disability. Nothing in this section may be construed as limiting a health main-

tenance organization's authority to deny or otherwise limit coverage to a person when the person because of a medical condition does not meet the essential eligibility requirements established by the health maintenance organization for purposes of determining coverage for any person. [2020 c 274 § 39; 1983 c 106 § 15.]

48.46.375 Benefits for prenatal diagnosis of congenital disorders—Agreements entered into or renewed on or after January 1, 1990. On or after January 1, 1990, every group health maintenance agreement entered into or renewed that covers hospital, medical, or surgical expenses and which provides benefits for pregnancy, childbirth, or related medical conditions to enrollees of such groups, shall offer benefits for prenatal diagnosis of congenital disorders of the fetus by means of screening and diagnostic procedures during pregnancy to such enrollees when those services are determined to be medically necessary by the health maintenance organization in accord with standards set in rule by the board of health: PROVIDED, That such procedures shall be covered only if rendered directly by the health maintenance organization or upon referral by the health maintenance organization. Every group health maintenance organization shall communicate the availability of such coverage to all groups covered and to all groups with whom they are negotiating. [1988 c 276 § 8.]

Prenatal testing—Limitation on changes to coverage: RCW 48.42.090.

48.46.380 Notice of reason for cancellation, denial, or refusal to renew agreement. Every authorized health maintenance organization, upon canceling, denying, or refusing to renew any individual health maintenance agreement, shall, upon written request, directly notify in writing the applicant or enrolled participant as appropriate, of the reasons for the action by the health maintenance organization. Any benefits, terms, rates, or conditions of such agreement which are restricted, excluded, modified, increased, or reduced shall, upon written request, be set forth in writing and supplied to the individual. The written communications required by this section shall be phrased in simple language which is readily understandable to a person of average intelligence, education, and reading ability. [1993 c 492 § 291; 1983 c 106 § 16.]

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

Additional notes found at www.leg.wa.gov

48.46.390 Providing information on cancellation or refusal—No liability for insurance commissioner or health maintenance organization. With respect to the provisions of health maintenance agreements as set forth in RCW 48.46.380, there shall be no liability on the part of, and no cause of action of any nature shall arise against, the insurance commissioner, the commissioner's agents, or members of the commissioner's staff, or against any health maintenance organization, its authorized representative, its agents, its employees, for providing to the health maintenance organization information as to reasons for cancellation or refusal to issue or renew, for libel or slander on the basis of any statement made by any of them in any written notice of cancellation or refusal to issue or renew, or in any other communications, oral or written, specifying the reasons for cancellation or refusal to issue or renew or the providing of information

pertaining thereto, or for statements made or evidence submitted in any hearing conducted in connection therewith. [1983 c 106 § 17.]

48.46.400 False or misleading advertising prohibited. No person may knowingly make, publish, or disseminate any false, deceptive, or misleading representation or advertising in the conduct of the business of a health maintenance organization, or relative to the business of a health maintenance organization or to any person engaged therein. [1983 c 106 § 18.]

48.46.410 Misrepresentations to induce termination or retention of agreement prohibited. No health maintenance organization nor any person representing a health maintenance organization may by misrepresentation or misleading comparisons induce or attempt to induce any member of a health maintenance organization to terminate or retain an agreement or membership in the organization. [1983 c 106 § 19.]

48.46.420 Penalty for violations. (1) Except as otherwise provided in this chapter, any health maintenance organization which, or person who, violates any provision of this chapter is guilty of a gross misdemeanor.

(2) A health maintenance organization that fails to comply with the net worth requirements of this chapter must cure that defect in compliance with an order of the commissioner rendered in conformity with rules adopted pursuant to chapter 34.05 RCW. The commissioner is authorized to take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its enrolled participants. [2003 c 250 § 12; 1990 c 119 § 10; 1983 c 106 § 20.]

Additional notes found at www.leg.wa.gov

48.46.430 Enforcement authority of commissioner. For the purposes of this chapter, the insurance commissioner shall have the same powers and duties of enforcement as are provided in RCW 48.02.080. [1983 c 106 § 21.]

48.46.440 Continuation option to be offered. Every health maintenance organization that issues agreements providing group coverage for hospital or medical care shall offer the agreement holder an option to include an agreement provision granting a person who becomes ineligible for coverage under the group agreement, the right to continue the group benefits for a period of time and at a rate agreed upon. The agreement provision shall provide that when such coverage terminates the covered person may convert to an agreement as provided in RCW 48.46.450. [1984 c 190 § 8.]

Legislative intent—Severability—1984 c 190: See notes following RCW 48.21.250.

Additional notes found at www.leg.wa.gov

48.46.450 Conversion agreement to be offered—Exceptions, conditions. (1) Except as otherwise provided by this section, any group health maintenance agreement that provides benefits for hospital or medical care must contain a provision granting a person covered by the group agreement the right to obtain a conversion agreement from the health

maintenance organization upon termination of the person's eligibility for coverage under the group agreement.

(2) A health maintenance organization need not offer a conversion agreement to:

(a) A person whose coverage under the group agreement ended when the person's employment or membership was terminated for misconduct: PROVIDED, That when a person's employment or membership is terminated for misconduct, a conversion policy shall be offered to the spouse and/or dependents of the terminated employee or member. The policy shall include in the conversion provisions the same conversion rights and conditions which are available to employees or members and their spouses and/or dependents who are terminated for reasons other than misconduct;

(b) A person who is eligible for federal medicare coverage; or

(c) A person who is covered under another group plan, policy, contract, or agreement providing benefits for hospital or medical care.

(3) To obtain the conversion agreement, a person must submit a written application and the first premium payment for the conversion agreement not later than thirty-one days after the date the person's eligibility for group coverage terminates or thirty-one days after the date the person received notice of termination of coverage, whichever is later. The conversion agreement shall become effective without lapse of coverage, immediately following termination of coverage under the group agreement.

(4) If a health maintenance organization or group agreement holder does not renew, cancels, or otherwise terminates the group agreement, the health maintenance organization must offer a conversion agreement to any person who was covered under the terminated agreement unless the person is eligible to obtain group benefits for hospital or medical care within thirty-one days after such nonrenewal, cancellation, or termination of the group agreement or thirty-one days after the date the person received notice of termination of coverage, whichever is later.

(5) The health maintenance organization shall determine the premium for the conversion agreement in accordance with the organization's table of premium rates applicable to the age and class of risk of each person to be covered under the agreement and the type and amount of benefits provided. [2010 c 110 § 3; 1984 c 190 § 9.]

Legislative intent—Severability—1984 c 190: See notes following RCW 48.21.250.

Additional notes found at www.leg.wa.gov

48.46.460 Conversion agreement—Restrictions and requirements—Rules. (1) A health maintenance organization must offer a conversion agreement for comprehensive health care services and shall not require proof of insurability as a condition for issuance of the conversion agreement.

(2) A conversion agreement may not contain an exclusion for preexisting conditions for an applicant.

(3) A conversion agreement need not provide benefits identical to those provided under the group agreement. The conversion agreement may contain provisions requiring the person covered by the conversion agreement to pay reasonable deductibles and copayments, except for preventive service benefits as defined in 45 C.F.R. 147.130 (2010), imple-

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menting sections 2701 through 2763, 2791, and 2792 of the public health service act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended.

(4) The insurance commissioner shall adopt rules to establish minimum benefit standards for conversion agreements.

(5) The commissioner shall adopt rules to establish specific standards for conversion agreement provisions. These rules may include but are not limited to:

(a) Terms of renewability;

(b) Nonduplication of coverage;

(c) Benefit limitations, exceptions, and reductions; and

(d) Definitions of terms. [2019 c 33 § 6; 2011 c 314 § 9; 1984 c 190 § 10.]

Effective date—2019 c 33: See note following RCW 48.43.005.

Legislative intent—Severability—1984 c 190: See notes following RCW 48.21.250.

48.46.470 Endorsement of modifications. If an individual health care service agreement is issued on any basis other than as applied for, an endorsement setting forth such modification must accompany and be attached to the agreement. No agreement shall be effective unless the endorsement is signed by the applicant, and a signed copy thereof returned to the health maintenance organization. [1985 c 320 § 7.]

48.46.480 Continuation of coverage of former family members. Every health care service agreement issued, amended, or renewed after January 1, 1986, for an individual and his or her dependents shall contain provisions to assure that the covered spouse and/or dependents, in the event that any cease to be a qualified family member by reason of termination of marriage or death of the principal enrollee, shall have the right to continue the health maintenance agreement without a physical examination, statement of health, or other proof of insurability. [1985 c 320 § 8.]

48.46.490 Coverage for adopted children. (1) Any health maintenance agreement under this chapter which provides coverage for dependent children, as defined in the agreement of the enrolled participant, shall cover adoptive children placed with the enrolled participant on the same basis as other dependents, as provided in RCW 48.01.180.

(2) If payment of an additional premium is required to provide coverage for a child, the agreement may require that notification of placement of a child for adoption and payment of the required premium must be furnished to the health maintenance organization. The notification period shall be no less than sixty days from the date of placement. [1986 c 140 § 5.]

Additional notes found at www.leg.wa.gov

48.46.500 Cancellation of rider. Upon application by an enrollee, a rider shall be canceled if at least five years after its issuance, no health care services have been received by the enrollee during that time for the condition specified in the rider, and a physician, selected by the carrier for that purpose, agrees in writing to the full medical recovery of the enrollee from that condition, such agreement not to be unreasonably withheld. The option of the enrollee to apply for cancellation

shall be disclosed on the face of the rider in clear and conspicuous language.

For purposes of this section, a rider is a legal document that modifies a contract to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions. [1987 c 37 § 4.]

48.46.510 Phenylketonuria. (1) The legislature finds that:

(a) Phenylketonuria is a rare inherited genetic disorder.

(b) Children with phenylketonuria are unable to metabolize an essential amino acid, phenylalanine, which is found in the proteins of most food.

(c) To remain healthy, children with phenylketonuria must maintain a strict diet and ingest a mineral and vitamin-enriched formula.

(d) Children who do not maintain their diets with the formula acquire severe mental and physical difficulties.

(e) Originally, the formulas were listed as prescription drugs but were reclassified as medical foods to increase their availability.

(2) Subject to requirements and exceptions which may be established by rules adopted by the commissioner, any agreement for health care services delivered or issued for delivery or renewed in this state on or after September 1, 1988, shall provide coverage for the formulas necessary for the treatment of phenylketonuria. Such formulas shall be covered when deemed medically necessary by the medical director or his or her designee of the health maintenance organization and if provided by the health maintenance organization or upon the health maintenance organization's referral. Formulas shall be covered at the usual and customary rates for such formulas, subject to contract provisions with respect to deductible amounts or copayments. [1988 c 173 § 4.]

48.46.520 Neurodevelopmental therapies—Employer-sponsored group contracts. (1) Each employer-sponsored group contract for comprehensive health care service which is entered into, or renewed, on or after twelve months after July 23, 1989, shall include coverage for neurodevelopmental therapies for covered individuals age six and under.

(2) Benefits provided under this section shall cover the services of those authorized to deliver occupational therapy, speech therapy, and physical therapy. Covered benefits and treatment must be rendered or referred by the health maintenance organization, and delivered pursuant to the referral and periodic review of a holder of a license issued pursuant to chapter 18.71 or 18.57 RCW or where treatment is rendered by such licensee. Nothing in this section shall prohibit a health maintenance organization from negotiating rates with qualified providers.

(3) Benefits provided under this section shall be for medically necessary services as determined by the health maintenance organization. Benefits shall be provided for the maintenance of a covered enrollee in cases where significant deterioration in the patient's condition would result without the service. Benefits shall be provided to restore and improve function.

(4) It is the intent of this section that employers purchasing comprehensive group coverage including the benefits

required by this section, together with the health maintenance organization, retain authority to design and employ utilization and cost controls. Therefore, benefits provided under this section may be subject to contractual provisions regarding deductible amounts and/or copayments established by the employer purchasing coverage and the health maintenance organization. Benefits provided under this section may be subject to standard waiting periods for preexisting conditions, and may be subject to the submission of written treatment plans.

(5) In recognition of the intent expressed in subsection (4) of this section, benefits provided under this section may be subject to contractual provisions establishing annual and/or lifetime benefit limits. Such limits may define the total dollar benefits available, or may limit the number of services delivered as agreed by the employer purchasing coverage and the health maintenance organization. [1989 c 345 § 3.]

48.46.530 Temporomandibular joint disorders—Insurance coverage. (1) Except as provided in this section, a health maintenance agreement entered into or renewed after December 31, 1989, shall offer optional coverage for the treatment of temporomandibular joint disorders.

(a) Health maintenance organizations offering medical coverage only may limit benefits in such coverages to medical services related to treatment of temporomandibular joint disorders. No health maintenance organizations offering medical and dental coverage may limit benefits in such coverage to dental services related to treatment of temporomandibular joint disorders. No health maintenance organization offering medical coverage only may define all temporomandibular joint disorders as purely dental in nature.

(b) Health maintenance organizations offering optional temporomandibular joint disorder coverage as provided in this section may, but are not required to, offer lesser or no temporomandibular joint disorder coverage as part of their basic group disability contract.

(c) Benefits and coverage offered under this section may be subject to negotiation to promote broad flexibility in potential benefit coverage. This flexibility shall apply to services to be reimbursed, determination of treatments to be considered medically necessary, systems through which services are to be provided, including referral systems and use of other providers, and related issues.

(2) Unless otherwise directed by law, the insurance commissioner shall adopt rules, to be implemented on January 1, 1993, establishing minimum benefits, terms, definitions, conditions, limitations, and provisions for the use of reasonable deductibles and copayments.

(3) A health maintenance organization need not make the offer of coverage required by this section to an employer or other group that offers to its eligible enrollees a self-insured health plan not subject to mandated benefit statutes under Title 48 RCW that does not provide coverage for temporomandibular joint disorders. [1989 c 331 § 4.]

Legislative finding—Effective date—1989 c 331: See notes following RCW 48.21.320.

48.46.535 Prescriptions—Preapproval of individual claims—Subsequent rejection prohibited—Written record required. Health maintenance organizations who

through an authorized representative have first approved, by any means, an individual prescription claim as eligible may not reject that claim at some later date. Pharmacists or drug dispensing outlets who obtain preapproval of claims shall keep a written record of the preapproval that consists of identification by name and telephone number of the person who approved the claim. [1993 c 253 § 5.]

Findings—Effective date—1993 c 253: See notes following RCW 48.20.525.

48.46.540 Nonresident pharmacies. For the purposes of this chapter, a nonresident pharmacy is defined as any pharmacy located outside this state that ships, mails, or delivers, in any manner, except when delivered in person to an enrolled participant or his/her representative, controlled substances, legend drugs, or devices into this state.

After October 1, 1991, a health maintenance organization providing coverage of prescription drugs from nonresident pharmacies may only provide coverage from licensed nonresident pharmacies. The health maintenance organizations shall obtain proof of current licensure in conformity with this section and RCW 18.64.350 through 18.64.400 from the nonresident pharmacy and keep that proof of licensure on file.

The department may request from the health maintenance organization the proof of current licensure for all nonresident pharmacies through which the insurer is providing coverage for prescription drugs for residents of the state of Washington. This information, which may constitute a full or partial customer list, shall be confidential and exempt from public disclosure, and from the requirements of chapter 42.56 RCW. The board or the department shall not be restricted in the disclosure of the name of a nonresident pharmacy that is or has been licensed under RCW 18.64.360 or 18.64.370 or of the identity of a nonresident pharmacy disciplined under RCW 18.64.350 through 18.64.400. [2005 c 274 § 315; 1991 c 87 § 10.]

Additional notes found at www.leg.wa.gov

48.46.565 Foot care services. Except to the extent that a health maintenance organization contracts with a group medical practice which only treats that organization's patients, a health maintenance organization may not discriminate in the terms and conditions, including reimbursement, for the provision of foot care services between physicians and surgeons licensed under chapters 18.22, 18.57, and 18.71 RCW. [1999 c 64 § 1.]

Intent—1999 c 64: "This act is intended to be procedural and not to impair the obligation of any existing contract." [1999 c 64 § 2.]

Additional notes found at www.leg.wa.gov

48.46.570 Denturist services. Notwithstanding any provision of any health maintenance organization agreement covering dental care as provided for in this chapter, effective January 1, 1995, benefits shall not be denied thereunder for any service performed by a denturist licensed under chapter 18.30 RCW if (1) the service performed was within the lawful scope of such person's license, and (2) such agreement would have provided benefits if such service had been performed by a dentist licensed under chapter 18.32 RCW.

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[1995 c 1 § 25 (Initiative Measure No. 607, approved November 8, 1994).]

Additional notes found at www.leg.wa.gov

48.46.575 Doctor of osteopathic medicine and surgery—Discrimination based on board certification is prohibited. A health maintenance organization that provides health care services to the general public may not discriminate against a qualified doctor of osteopathic medicine and surgery licensed under chapter 18.57 RCW, who has applied to practice with the health maintenance organization, solely because that practitioner was board certified or eligible under an approved osteopathic certifying board instead of board certified or eligible respectively under an approved medical certifying board. [1995 c 64 § 1.]

48.46.580 When injury caused by intoxication or use of narcotics. A health maintenance organization may not deny coverage for the treatment of an injury solely because the injury was sustained as a consequence of the enrolled participant's being intoxicated or under the influence of a narcotic. [2004 c 112 § 5.]

Finding—Application—2004 c 112: See notes following RCW 48.20.385.

48.46.600 Disclosure of certain material transactions—Report—Information is confidential. (1) Every health maintenance organization domiciled in this state shall file a report with the commissioner disclosing material acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements unless these acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements have been submitted to the commissioner for review, approval, or information purposes under other provisions of this title or other requirements.

(2) The report required in subsection (1) of this section is due within fifteen days after the end of the calendar month in which any of the transactions occur.

(3) One complete copy of the report, including any exhibits or other attachments filed as part of the report, shall be filed with the:

- (a) Commissioner; and
- (b) National association of insurance commissioners.

(4) All reports obtained by or disclosed to the commissioner under this section and RCW 48.46.605 through 48.46.625 are exempt from public inspection and copying and shall not be subject to subpoena. These reports shall not be made public by the commissioner, the national association of insurance commissioners, or any other person, except to insurance departments of other states, without the prior written consent of the health maintenance organization to which it pertains unless the commissioner, after giving the health maintenance organization that would be affected by disclosure notice and a hearing under chapter 48.04 RCW, determines that the interest of policyholders, subscribers, shareholders, or the public will be served by the publication, in which event the commissioner may publish all or any part of the report in the manner he or she deems appropriate. [1995 c 86 § 19.]

48.46.605 Material acquisitions or dispositions. No acquisitions or dispositions of assets need be reported pursuant to RCW 48.46.600 if the acquisitions or dispositions are not material. For purposes of RCW 48.46.600 through 48.46.625, a material acquisition, or the aggregate of any series of related acquisitions during any thirty-day period; or disposition, or the aggregate of any series of related dispositions during any thirty-day period is an acquisition or disposition that is nonrecurring and not in the ordinary course of business and involves more than five percent of the reporting health maintenance organization's total assets as reported in its most recent statutory statement filed with the commissioner. [1995 c 86 § 20.]

48.46.610 Asset acquisitions—Asset dispositions. (1) Asset acquisitions subject to RCW 48.46.600 through 48.46.625 include every purchase, lease, exchange, merger, consolidation, succession, or other acquisition other than the construction or development of real property by or for the reporting health maintenance organization or the acquisition of materials for such purpose.

(2) Asset dispositions subject to RCW 48.46.600 through 48.46.625 include every sale, lease, exchange, merger, consolidation, mortgage, hypothecation, abandonment, destruction, other disposition, or assignment, whether for the benefit of creditors or otherwise. [1995 c 86 § 21.]

48.46.615 Report of a material acquisition or disposition of assets—Information required. The following information is required to be disclosed in any report of a material acquisition or disposition of assets:

- (1) Date of the transaction;
- (2) Manner of acquisition or disposition;
- (3) Description of the assets involved;
- (4) Nature and amount of the consideration given or received;
- (5) Purpose of or reason for the transaction;
- (6) Manner by which the amount of consideration was determined;
- (7) Gain or loss recognized or realized as a result of the transaction; and
- (8) Names of the persons from whom the assets were acquired or to whom they were disposed. [1995 c 86 § 22.]

48.46.620 Material nonrenewals, cancellations, or revisions of ceded reinsurance agreements. (1) No nonrenewals, cancellations, or revisions of ceded reinsurance agreements need be reported under RCW 48.46.600 if the nonrenewals, cancellations, or revisions are not material. For purposes of RCW 48.46.600 through 48.46.625, a material nonrenewal, cancellation, or revision is one that affects:

(a) More than fifty percent of a health maintenance organization's total reserve credit taken for business ceded, on an annualized basis, as indicated in the health maintenance organization's most recent annual statement;

(b) More than ten percent of a health maintenance organization's total cession when it is replaced by one or more unauthorized reinsurers; or

(c) Previously established collateral requirements, when they have been reduced or waived as respects one or more

unauthorized reinsurers representing collectively more than ten percent of a total cession.

(2) However, a filing is not required if a health maintenance organization's total reserve credit taken for business ceded represents, on an annualized basis, less than ten percent of the statutory reserve requirement prior to any cession. [1995 c 86 § 23.]

48.46.625 Report of a material nonrenewal, cancellation, or revision of ceded reinsurance agreements—Information required. The following is required to be disclosed in any report of a material nonrenewal, cancellation, or revision of ceded reinsurance agreements:

(1) The effective date of the nonrenewal, cancellation or revision;

(2) The description of the transaction with an identification of the initiator;

(3) The purpose of or reason for the transaction; and

(4) If applicable, the identity of the replacement reinsurers. [1995 c 86 § 24.]

48.46.900 Liberal construction. It is intended that the provisions of this chapter shall be liberally construed to accomplish the purposes provided for and authorized herein. [1975 1st ex.s. c 290 § 24.]

48.46.920 Short title. This 1975 amendatory act may be known and cited as "The Washington Health Maintenance Organization Act of 1975". [1975 1st ex.s. c 290 § 27.]

48.46.930 Construction—Chapter applicable to state registered domestic partnerships—2009 c 521. For the purposes of this chapter, the terms spouse, marriage, marital, husband, wife, widow, widower, next of kin, and family shall be interpreted as applying equally to state registered domestic partnerships or individuals in state registered domestic partnerships as well as to marital relationships and married persons, and references to dissolution of marriage shall apply equally to state registered domestic partnerships that have been terminated, dissolved, or invalidated, to the extent that such interpretation does not conflict with federal law. Where necessary to implement chapter 521, Laws of 2009, gender-specific terms such as husband and wife used in any statute, rule, or other law shall be construed to be gender neutral, and applicable to individuals in state registered domestic partnerships. [2009 c 521 § 127.]

Chapter 48.47 RCW

MANDATED HEALTH BENEFITS

Sections

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| 48.47.005 | Legislative findings—Purpose. |
| 48.47.010 | Definitions. |
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48.47.005 Legislative findings—Purpose. The legislature finds that there is a continued interest in mandating certain health coverages or offering of health coverages by

health carriers; and that improved access to these health care services to segments of the population which desire them can provide beneficial social and health consequences which may be in the public interest.

The legislature finds further, however, that the cost ramifications of expanding health coverages is of continuing concern; and that the merits of a particular mandated benefit must be balanced against a variety of consequences which may go far beyond the immediate impact upon the cost of insurance coverage. The legislature hereby finds and declares that a systematic review of proposed mandated benefits, which explores all the ramifications of such proposed legislation, will assist the legislature in determining whether mandating a particular coverage or offering is in the public interest. The purpose of this chapter is to establish a procedure for the proposal, review, and determination of mandated benefit necessity. [1997 c 412 § 1; 1984 c 56 § 1. Formerly RCW 48.42.060.]

48.47.010 Definitions. Unless otherwise specifically provided, the definitions in this section apply throughout this chapter.

(1) "Appropriate committees of the legislature" or "committees" means nonfiscal standing committees of the Washington state senate and house of representatives that have jurisdiction over statutes that regulate health carriers, health care facilities, health care providers, or health care services.

(2) "Department" means the Washington state department of health.

(3) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 RCW, drug and alcohol treatment facilities licensed under *chapter 70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision or instrumentality of the state, and such other facilities as required by federal law and implementing regulations.

(4) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(5) "Health care service" or "service" means a service, drug, or medical equipment offered or provided by a health care facility and a health care provider relating to the prevention, cure, or treatment of illness, injury, or disease.

(6) "Health carrier" or "carrier" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, a health maintenance organization as defined in RCW 48.46.020, plans operating under the state health care author-

ity under chapter 41.05 RCW, the state health insurance pool operating under chapter 48.41 RCW, and insuring entities regulated in chapter 48.43 RCW.

(7) "Mandated health benefit," "mandated benefit," or "benefit" means coverage or offering required by law to be provided by a health carrier to: (a) Cover a specific health care service or services; (b) cover treatment of a specific condition or conditions; or (c) contract, pay, or reimburse specific categories of health care providers for specific services; however, it does not mean benefits established pursuant to chapter 74.09, 41.05, or 70.47 RCW, or scope of practice modifications pursuant to chapter 18.120 RCW. [1997 c 412 § 2.]

*Reviser's note: Chapter 70.96A RCW was repealed and/or recodified in its entirety pursuant to 2016 sp.s. c 29 §§ 301, 601, and 701.

48.47.020 Submission of mandated health benefit proposal—Review—Benefit must be authorized by law. Mandated health benefits shall be established as follows:

(1) Every person who, or organization that, seeks to establish a mandated benefit shall, at least ninety days prior to a regular legislative session, submit a mandated benefit proposal to the appropriate committees of the legislature, assessing the social impact, financial impact, and evidence of health care service efficacy of the benefit in strict adherence to the criteria enumerated in RCW 48.47.030.

(2) The chair of a committee may request that the department examine the proposal using the criteria set forth in RCW 48.47.030, however, such request must be made no later than nine months prior to a subsequent regular legislative session.

(3) To the extent that funds are appropriated for this purpose, the department shall report to the appropriate committees of the legislature on the appropriateness of adoption no later than thirty days prior to the legislative session during which the proposal is to be considered.

(4) Mandated benefits must be authorized by law. [1997 c 412 § 3; 1989 1st ex.s. c 9 § 221; 1987 c 150 § 79; 1984 c 56 § 2. Formerly RCW 48.42.070.]

Additional notes found at www.leg.wa.gov

48.47.030 Mandated health benefit proposal—Guidelines for assessing impact—Inclusion of ad hoc review panels—Health care authority. (1) Based on the availability of relevant information, the following criteria shall be used to assess the impact of proposed mandated benefits:

(a) The social impact: (i) To what extent is the benefit generally utilized by a significant portion of the population? (ii) To what extent is the benefit already generally available? (iii) If the benefit is not generally available, to what extent has its unavailability resulted in persons not receiving needed services? (iv) If the benefit is not generally available, to what extent has its unavailability resulted in unreasonable financial hardship? (v) What is the level of public demand for the benefit? (vi) What is the level of interest of collective bargaining agents in negotiating privately for inclusion of this benefit in group contracts?

(b) The financial impact: (i) To what extent will the benefit increase or decrease the cost of treatment or service? (ii) To what extent will the coverage increase the appropriate use

of the benefit? (iii) To what extent will the benefit be a substitute for a more expensive benefit? (iv) To what extent will the benefit increase or decrease the administrative expenses of health carriers and the premium and administrative expenses of policyholders? (v) What will be the impact of this benefit on the total cost of health care services and on premiums for health coverage? (vi) What will be the impact of this benefit on costs for state purchased health care? (vii) What will be the impact of this benefit on affordability and access to coverage?

(c) Evidence of health care service efficacy:

(i) If a mandatory benefit of a specific service is sought, to what extent has there been conducted professionally accepted controlled trials demonstrating the health consequences of that service compared to no service or an alternative service?

(ii) If a mandated benefit of a category of health care provider is sought, to what extent has there been conducted professionally accepted controlled trials demonstrating the health consequences achieved by the mandated benefit of this category of health care provider?

(iii) To what extent will the mandated benefit enhance the general health status of the state residents?

(2) The department shall consider the availability of relevant information in assessing the completeness of the proposal.

(3) The department may supplement these criteria to reflect new relevant information or additional significant issues.

(4) The department shall establish, where appropriate, ad hoc panels composed of related experts, and representatives of carriers, consumers, providers, and purchasers to assist in the proposal review process. Ad hoc panel members shall serve without compensation.

(5) The health care authority shall evaluate the reasonableness and accuracy of cost estimates associated with the proposed mandated benefit that are provided to the department by the proposer or other interested parties, and shall provide comment to the department. Interested parties may, in addition, submit data directly to the department. [1997 c 412 § 4; 1984 c 56 § 3. Formerly RCW 48.42.080.]

Chapter 48.49 RCW

BALANCE BILLING PROTECTION ACT

Sections

48.49.003	Findings—Intent—2019 c 427.
48.49.005	Short title.
48.49.010	Definitions.
48.49.020	Balance billing—When prohibited—Carrier's duty to hold an enrollee harmless from balance billing under certain circumstances.
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48.49.190	Reports to legislature.
48.49.900	Effective date—2019 c 427.

48.49.003 Findings—Intent—2019 c 427. (1) The legislature finds that:

(a) Consumers receive surprise bills or balance bills for services provided at nonparticipating facilities or by nonparticipating health care providers at in-network facilities;

(b) Consumers must not be placed in the middle of contractual disputes between providers and health insurance carriers; and

(c) Facilities, providers, and health insurance carriers all share responsibility to ensure consumers have transparent information on network providers and benefit coverage, and the insurance commissioner is responsible for ensuring that provider networks include sufficient numbers and types of contracted providers to reasonably ensure consumers have in-network access for covered benefits.

(2) It is the intent of the legislature to:

(a) Ban balance billing of consumers enrolled in fully insured, regulated insurance plans and plans offered to public employees under chapter 41.05 RCW for the services described in RCW 48.49.020, and to provide self-funded group health plans with an option to elect to be subject to the provisions of this chapter;

(b) Remove consumers from balance billing disputes and require that nonparticipating providers and carriers negotiate nonparticipating provider payments in good faith under the terms of this chapter;

(c) Align Washington state law with the federal balance billing prohibitions and transparency protections in sections 2799A-1 et seq. of the public health service act (P.L. 116-260) and implementing federal regulations in effect on March 31, 2022, while maintaining provisions of this chapter that provide greater protection for consumers; and

(d) Provide an environment that encourages self-funded groups to negotiate payments in good faith with nonparticipating providers and facilities in return for balance billing protections. [2022 c 263 § 6; 2019 c 427 § 1.]

Effective date—2022 c 263: See note following RCW 43.371.100.

48.49.005 Short title. This chapter may be known and cited as the balance billing protection act. [2019 c 427 § 4.]

48.49.010 Definitions. The definitions in RCW 48.43.005 apply throughout this chapter unless the context clearly requires otherwise. [2019 c 427 § 5.]

48.49.020 Balance billing—When prohibited—Carrier's duty to hold an enrollee harmless from balance billing under certain circumstances. (1) A nonparticipating provider or facility may not balance bill an enrollee for the following health care services as provided in section 2799A-1(b) of the public health service act (42 U.S.C. Sec. 300gg-111(b)) and implementing federal regulations in effect on March 31, 2022:

(a) Emergency services provided to an enrollee;
 (b) Nonemergency health care services performed by nonparticipating providers at certain participating facilities; or

(c) Air ambulance services.

(2) Payment for services described in subsection (1) of this section is subject to the provisions of sections 2799A-1 and 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and implementing federal regulations in effect on March 31, 2022, except that:

(a) Until July 1, 2023, or a later date determined by the commissioner, RCW 48.49.160 and 48.49.040 apply to the nonparticipating provider or facility payment standard and dispute resolution process for services described in subsection (1) of this section, other than air ambulance services;

(b) A health care provider, health care facility, or air ambulance service provider may not request or require a patient at any time, for any procedure, service, or supply, to sign or otherwise execute by oral, written, or electronic means, any document that would attempt to avoid, waive, or alter any provision of RCW 48.49.020 and 48.49.030 or sections 2799A-1 et seq. of the public health service act (P.L. 116-260) and implementing federal regulations in effect on March 31, 2022;

(c) If the enrollee pays a nonparticipating provider, nonparticipating facility, or nonparticipating air ambulance service provider an amount that exceeds the in-network cost-sharing amount determined under sections 2799A-1 and 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and implementing federal regulations as in effect on March 31, 2022, the provider or facility must refund any amount in excess of the in-network cost-sharing amount to the enrollee within 30 business days of receipt. Interest must be paid to the enrollee for any unrefunded payments at a rate of 12 percent beginning on the first calendar day after the 30 business days; and

(d) Carriers must make available through electronic and other methods of communication generally used by a provider to verify enrollee eligibility and benefits information regarding whether an enrollee's health plan is subject to the requirements of this chapter or section 2799A-1 et seq. of the public health service act (42 U.S.C. Sec. 300gg-111 et seq.) and implementing federal regulations in effect on March 31, 2022.

(3) A behavioral health emergency services provider may not balance bill an enrollee for emergency services provided to an enrollee.

(4) Payment for emergency services provided by behavioral health emergency services providers under subsection

(3) of this section is subject to RCW 48.49.030, 48.49.160, and 48.49.040.

(5) This section applies to health care providers, facilities, or behavioral health emergency services providers providing services to members of entities administering a self-funded group health plan and its plan members only if the entity has elected to participate in this section and RCW 48.49.030, 48.49.160, and 48.49.040 as provided in RCW 48.49.130. [2022 c 263 § 7; 2019 c 427 § 6.]

Effective date—2022 c 263: See note following RCW 43.371.100.

48.49.030 Enrollee's obligation to pay for services.

(1) If an enrollee receives emergency services from a behavioral health emergency services provider under the circumstances described in RCW 48.49.020(3):

(a) The enrollee satisfies his or her obligation to pay for the health care services if he or she pays the in-network cost-sharing amount specified in the enrollee's or applicable group's health plan contract. The enrollee's obligation must be determined using the methodology for calculating the qualifying payment amount as described in 45 C.F.R. Sec. 149.140 as in effect on March 31, 2022. The carrier must provide an explanation of benefits to the enrollee and the nonparticipating provider that reflects the cost-sharing amount determined under this subsection.

(b) The carrier, nonparticipating behavioral health emergency services provider, and an agent, trustee, or assignee of the carrier or nonparticipating behavioral health emergency services provider must ensure that the enrollee incurs no greater cost than the amount determined under (a) of this subsection.

(c) The nonparticipating behavioral health emergency services provider and an agent, trustee, or assignee of the nonparticipating behavioral health emergency services provider may not balance bill or otherwise attempt to collect from the enrollee any amount greater than the amount determined under (a) of this subsection. This does not impact the behavioral health emergency services provider's ability to collect a past due balance for that cost-sharing amount with interest.

(d) The carrier must treat any cost-sharing amounts determined under (a) of this subsection paid by the enrollee for a nonparticipating behavioral health emergency services provider's services in the same manner as cost-sharing for health care services provided by an in-network behavioral health emergency services provider and must apply any cost-sharing amounts paid by the enrollee for such services toward the enrollee's maximum out-of-pocket payment obligation.

(e) If the enrollee pays the nonparticipating behavioral health emergency services provider an amount that exceeds the in-network cost-sharing amount determined under (a) of this subsection, the behavioral health emergency services provider must refund any amount in excess of the in-network cost-sharing amount to the enrollee within thirty business days of receipt. Interest must be paid to the enrollee for any unrefunded payments at a rate of twelve percent beginning on the first calendar day after the thirty business days.

(2) This section shall only apply to health care providers, facilities, or behavioral health emergency services providers providing services to members of entities administering a self-funded group health plan and its plan members if the

entity has elected to participate in this section and RCW 48.49.020, 48.49.160, and 48.49.040 as provided in RCW 48.49.130. [2022 c 263 § 8; 2019 c 427 § 7.]

Effective date—2022 c 263: See note following RCW 43.371.100.

48.49.040 Dispute resolution process—Determination of commercially reasonable payment amount. (1) Effective July 1, 2023, or a later date determined by the commissioner, services described in RCW 48.49.020(1) other than air ambulance services are subject to the independent dispute resolution process established in sections 2799A-1 and 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and implementing federal regulations in effect on July 1, 2023, or a later date determined by the commissioner. Until July 1, 2023, or a later date determined by the commissioner, the arbitration process in this section governs the dispute resolution process for those services.

(2) Effective July 1, 2023, or a later date determined by the commissioner, services described in RCW 48.49.020(3) are subject to the independent dispute resolution process established in section 2799A-1 and 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and implementing federal regulations in effect on July 1, 2023, or a later date determined by the commissioner. Until July 1, 2023, or a later date determined by the commissioner or if the federal independent dispute resolution process is not available to the state for resolution of these disputes, the arbitration process in this section governs the dispute resolution process for those services.

(3)(a) Notwithstanding RCW 48.43.055 and 48.18.200, if good faith negotiation, as described in RCW 48.49.030, does not result in resolution of the dispute, and the carrier or nonparticipating provider, facility, or behavioral health emergency services provider chooses to pursue further action to resolve the dispute, the carrier or nonparticipating provider, facility, or behavioral health emergency services provider shall initiate arbitration to determine a commercially reasonable payment amount. To initiate arbitration, the carrier or nonparticipating provider, facility, or behavioral health emergency services provider must provide written notification to the commissioner and the noninitiating party no later than ten calendar days following completion of the period of good faith negotiation under RCW 48.49.030. The notification to the noninitiating party must state the initiating party's final offer. No later than thirty calendar days following receipt of the notification, the noninitiating party must provide its final offer to the initiating party. The parties may reach an agreement on reimbursement during this time and before the arbitration proceeding.

(b) Notwithstanding (a) of this subsection (3), where a dispute resolution matter initiated under sections 2799A-1 and 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and implementing federal regulations in effect on March 31, 2022, results in a determination by a certified independent dispute resolution entity that such process does not apply to the dispute or to portions thereof, a carrier, provider, facility, or behavioral health emergency services provider may initiate arbitration described in this section for such dispute:

(i) Without completing good faith negotiation under RCW 48.49.160 if the open negotiation period required under sections 2799A-1 and 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and implementing federal regulations in effect on March 31, 2022, has been completed; and

(ii) By providing written notification to the commissioner and the noninitiating party no later than 10 calendar days following the date notice is received by the parties from the certified independent dispute resolution entity that the federal independent dispute resolution process is not applicable to the dispute.

(4) Multiple claims may be addressed in a single arbitration proceeding if the claims at issue:

(a) Involve identical carrier and provider, provider group, facility, or behavioral health emergency services provider parties;

(b) Involve claims with the same procedural code, or a comparable code under a different procedural code system; and

(c) Occur within the same 30 business day period.

(5) Within seven calendar days of receipt of notification from the initiating party, the commissioner must provide the parties with a list of approved arbitrators or entities that provide arbitration. The arbitrators on the list must be trained by the American arbitration association or the American health lawyers association and must have experience in matters related to medical or health care services. The parties may agree on an arbitrator from the list provided by the commissioner. If the parties do not agree on an arbitrator, they must notify the commissioner who must provide them with the names of five arbitrators from the list. Each party may veto two of the five named arbitrators. If one arbitrator remains, that person is the chosen arbitrator. If more than one arbitrator remains, the commissioner must choose the arbitrator from the remaining arbitrators. The parties and the commissioner must complete this selection process within twenty calendar days of receipt of the original list from the commissioner.

(6) Each party must make written submissions to the arbitrator in support of its position no later than thirty calendar days after the final selection of the arbitrator. Each party must include in their written submission the evidence and methodology for asserting that the amount proposed to be paid is or is not commercially reasonable. A party that fails to make timely written submissions under this section without good cause shown shall be considered to be in default and the arbitrator shall require the party in default to pay the final offer amount submitted by the party not in default and may require the party in default to pay expenses incurred to date in the course of arbitration, including the arbitrator's expenses and fees and the reasonable attorneys' fees of the party not in default.

(7) If the parties agree on an out-of-network rate for the services at issue after providing the arbitration initiation notice to the commissioner but before the arbitrator has made their decision, the amount agreed to by the parties for the service will be treated as the out-of-network rate for the service. The initiating party must send a notification to the commissioner and to the arbitrator, as soon as possible, but no later than three business days after the date of the agreement. The

notification must include the out-of-network rate for the service and signatures from authorized signatories for both parties.

(8)(a) No later than thirty calendar days after the receipt of the parties' written submissions, the arbitrator must: Issue a written decision requiring payment of the final offer amount of either the initiating party or the noninitiating party; notify the parties of its decision; and provide the decision and the information described in RCW 48.49.050 regarding the decision to the commissioner. The arbitrator's decision must include an explanation of the elements of the parties' submissions the arbitrator relied upon to make their decision and why those elements were relevant to their decision.

(b) In reviewing the submissions of the parties and making a decision related to whether payment should be made at the final offer amount of the initiating party or the noninitiating party, the arbitrator must consider the following factors:

(i) The evidence and methodology submitted by the parties to assert that their final offer amount is reasonable; and

(ii) Patient characteristics and the circumstances and complexity of the case, including time and place of service and whether the service was delivered at a level I or level II trauma center or a rural facility, that are not already reflected in the provider's billing code for the service.

(c) The arbitrator may not require extrinsic evidence of authenticity for admitting data from the Washington state all-payer claims database data set developed under RCW 43.371.100 into evidence.

(d) The arbitrator may also consider other information that a party believes is relevant to the factors included in (b) of this subsection or other factors the arbitrator requests and information provided by the parties that is relevant to such request, including the Washington state all-payer claims database data set developed under RCW 43.371.100.

(9) Expenses incurred in the course of arbitration, including the arbitrator's expenses and fees, but not including attorneys' fees, must be divided equally among the parties to the arbitration. The commissioner may establish allowable arbitrator fee ranges or an arbitrator fee schedule by rule. Arbitrator fees must be paid to the arbitrator by a party within 30 calendar days following receipt of the arbitrator's decision by the party. The enrollee is not liable for any of the costs of the arbitration and may not be required to participate in the arbitration proceeding as a witness or otherwise.

(10) Within 10 business days of a party notifying the commissioner and the noninitiating party of intent to initiate arbitration, both parties shall agree to and execute a nondisclosure agreement. The nondisclosure agreement must not preclude the arbitrator from submitting the arbitrator's decision to the commissioner under subsection (6) of this section or impede the commissioner's duty to prepare the annual report under RCW 48.49.050.

(11) The decision of the arbitrator is final and binding on the parties to the arbitration and is not subject to judicial review.

(12) Chapter 7.04A RCW applies to arbitrations conducted under this section, but in the event of a conflict between this section and chapter 7.04A RCW, this section governs.

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(13) For dispute resolution proceedings initiated under RCW 48.49.135(2)(b), the arbitration provisions of this section apply except that:

(a) The issue before the arbitrator will be the commercially reasonable payment for applicable services addressed in the alternate access delivery request rather than the commercially reasonable payment for single or multiple claims under subsection (4) of this section. The arbitrator shall issue a decision related to whether payment for the applicable services should be made at the final offer amount of the carrier or the final offer amount of the provider or facility. The arbitrator's decision is final and binding on the parties for services rendered to enrollees from the effective date of the amended alternate access delivery request approved under RCW 48.49.135(2)(b) to either the expiration date of the amended alternate access delivery request, or at the time that a provider contract and provider compensation agreement are executed between the parties, whichever occurs first;

(b) During the period from the effective date of the amended alternate access delivery request to issuance of the arbitrator's decision, the allowed amount paid to providers or facilities for the applicable services addressed in the amended alternate access delivery request shall be a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area; and

(c) The proceedings are subject to the arbitration process described in this section, and not to the independent dispute resolution process established in sections 2799A-1 and 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and implementing federal regulations in effect on March 31, 2022.

(14) Air ambulance services are subject to the independent dispute resolution process established in sections 2799A-1 and 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and implementing federal regulations in effect on March 31, 2022.

(15) This section applies to health care providers, facilities, or behavioral health emergency services providers providing services to members of entities administering a self-funded group health plan and its plan members only if the entity has elected to participate in RCW 48.49.020 and 48.49.030, 48.49.160, and this section as provided in RCW 48.49.130.

(16) An entity administering a self-funded group health plan that has elected to participate in this section pursuant to RCW 48.49.130 shall comply with the provisions of this section. [2022 c 263 § 11; 2019 c 427 § 8.]

Effective date—2022 c 263: See note following RCW 43.371.100.

48.49.050 Commissioner's annual report on dispute resolution information regarding arbitration over commercially reasonable payment amounts. (Expires January 1, 2023.) (1) The commissioner must prepare an annual report summarizing the dispute resolution information provided by arbitrators under RCW 48.49.040. The report must include summary information related to the matters decided through arbitration, as well as the following information for each dispute resolved through arbitration: The name of the carrier; the name of the health care provider; the health care provider's employer or the business entity in which the provider has an ownership interest; the health care facility where

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the services were provided; and the type of health care services at issue.

(2) The commissioner must post the report on the office of the insurance commissioner's website and submit the report in compliance with RCW 43.01.036 to the appropriate committees of the legislature, annually by July 1st.

(3) This section expires January 1, 2023. [2022 c 263 § 12; 2019 c 427 § 9.]

Effective date—2022 c 263: See note following RCW 43.371.100.

48.49.060 Notice of consumer rights—Development of standard template language by commissioner. (1) The commissioner, in consultation with health carriers, health care providers, health care facilities, and consumers, must develop standard template language for a notice of consumer rights notifying consumers of their rights under this chapter, and sections 2799A-1 and 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and implementing federal regulations in effect on March 31, 2022.

(2) The standard template language must include contact information for the office of the insurance commissioner so that consumers may contact the office of the insurance commissioner if they believe they have received a balance bill in violation of this chapter.

(3) The office of the insurance commissioner shall determine by rule when and in what format health carriers, health care providers, and health care facilities must provide consumers with the notice developed under this section. [2022 c 263 § 13; 2019 c 427 § 10.]

Effective date—2022 c 263: See note following RCW 43.371.100.

48.49.070 Hospital, ambulatory surgical facility, or behavioral health emergency services provider—Requirement to provide certain information on website or upon consumer request—Requirement to provide carriers with nonemployed provider lists. (1)(a) A hospital, ambulatory surgical facility, or behavioral health emergency services provider must post the following information on its website, if one is available:

(i) The listing of the carrier health plan provider networks with which the hospital, ambulatory surgical facility, or behavioral health emergency services provider is an in-network provider, based upon the information provided by the carrier pursuant to RCW 48.43.730(7); and

(ii) The notice of consumer rights developed under RCW 48.49.060.

(b) If the hospital, ambulatory surgical facility, or behavioral health emergency services provider does not maintain a website, this information must be provided to consumers upon an oral or written request.

(2) Posting or otherwise providing the information required in this section does not relieve a hospital, ambulatory surgical facility, or behavioral health emergency services provider of its obligation to comply with the provisions of this chapter.

(3) Not less than thirty days prior to executing a contract with a carrier, a hospital or ambulatory surgical facility must provide the carrier with a list of the nonemployed providers or provider groups contracted to provide emergency medicine, anesthesiology, pathology, radiology, neonatology, sur-

gery, hospitalist, intensivist[,] and diagnostic services, including radiology and laboratory services at the hospital or ambulatory surgical facility. The hospital or ambulatory surgical facility must notify the carrier within thirty days of a removal from or addition to the nonemployed provider list. A hospital or ambulatory surgical facility also must provide an updated list of these providers within fourteen calendar days of a request for an updated list by a carrier. [2022 c 263 § 14; 2019 c 427 § 11.]

Effective date—2022 c 263: See note following RCW 43.371.100.

48.49.080 Health care provider—Requirement to provide certain information on website or upon consumer request—Requirement to submit network status information to carriers. (1)(a) A health care provider must provide the following information on its website, if one is available:

(i) The listing of the carrier health plan provider networks with which the provider contracts, based upon the information provided by the carrier pursuant to RCW 48.43.730(7); and

(ii) The notice of consumer rights developed under RCW 48.49.060.

(b) If the health care provider does not maintain a website, this information must be provided to consumers upon an oral or written request.

(2) Posting or otherwise providing the information required in this section does not relieve a provider of its obligation to comply with the provisions of this chapter.

(3) An in-network provider must submit accurate information to a carrier regarding the provider's network status in a timely manner, consistent with the terms of the contract between the provider and the carrier. [2019 c 427 § 12.]

48.49.090 Carrier—Requirement to update website and provider directory—Requirement to provide enrollee with certain information. (1) A carrier must update its website and provider directory no later than thirty days after the addition or termination of a facility or provider.

(2) A carrier must provide an enrollee with:

(a) A clear description of the health plan's out-of-network health benefits;

(b) The notice of consumer rights developed under RCW 48.49.060;

(c) Notification that if the enrollee receives services from an out-of-network provider, facility, or behavioral health emergency services provider, under circumstances other than those described in RCW 48.49.020, the enrollee will have the financial responsibility applicable to services provided outside the health plan's network in excess of applicable cost-sharing amounts and that the enrollee may be responsible for any costs in excess of those allowed by the health plan;

(d) Information on how to use the carrier's member transparency tools under RCW 48.43.007;

(e) Upon request, information regarding whether a health care provider is in-network or out-of-network, and whether there are in-network providers available to provide emergency medicine, anesthesiology, pathology, radiology, neonatology, surgery, hospitalist, intensivist[,] and diagnostic services, including radiology and laboratory services at spec-

ified in-network hospitals or ambulatory surgical facilities; and

(f) Upon request, an estimated range of the out-of-pocket costs for an out-of-network benefit. [2022 c 263 § 15; 2019 c 427 § 13.]

Effective date—2022 c 263: See note following RCW 43.371.100.

48.49.100 Pattern of unresolved violations—Enforcement action by department of health or appropriate disciplining authority. (1) If the commissioner has cause to believe that any health care provider, hospital, ambulatory surgical facility, or behavioral health emergency services provider, has engaged in a pattern of unresolved violations of RCW 48.49.020 or 48.49.030, the commissioner may submit information to the department of health or the appropriate disciplining authority for action. Prior to submitting information to the department of health or the appropriate disciplining authority, the commissioner may provide the health care provider, hospital, ambulatory surgical facility, or behavioral health emergency services provider, with an opportunity to cure the alleged violations or explain why the actions in question did not violate RCW 48.49.020 or 48.49.030.

(2) If any health care provider, hospital, ambulatory surgical facility, or behavioral health emergency services provider, has engaged in a pattern of unresolved violations of RCW 48.49.020 or 48.49.030, the department of health or the appropriate disciplining authority may levy a fine or cost recovery upon the health care provider, hospital, ambulatory surgical facility, or behavioral health emergency services provider in an amount not to exceed the applicable statutory amount per violation and take other action as permitted under the authority of the department or disciplining authority. Upon completion of its review of any potential violation submitted by the commissioner or initiated directly by an enrollee, the department of health or the disciplining authority shall notify the commissioner of the results of the review, including whether the violation was substantiated and any enforcement action taken as a result of a finding of a substantiated violation.

(3) If a carrier has engaged in a pattern of unresolved violations of any provision of this chapter, the commissioner may levy a fine or apply remedies authorized under this chapter, chapter 48.02 RCW, RCW 48.44.166, 48.46.135, or 48.05.185.

(4) For purposes of this section, "disciplining authority" means the agency, board, or commission having the authority to take disciplinary action against a holder of, or applicant for, a professional or business license upon a finding of a violation of chapter 18.130 RCW or a chapter specified under RCW 18.130.040. [2022 c 263 § 16; 2019 c 427 § 14.]

Effective date—2022 c 263: See note following RCW 43.371.100.

48.49.110 Rule-making authority. (1) The commissioner may adopt rules to implement and administer this chapter, including rules governing the dispute resolution process established in RCW 48.49.040.

(2) The commissioner may adopt rules to adopt or incorporate by reference without material change federal regulations adopted on or after March 31, 2022, that implement P.L.

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116-260 (enacted December 27, 2020). [2022 c 263 § 20; 2019 c 427 § 15.]

Effective date—2022 c 263: See note following RCW 43.371.100.

48.49.120 No application of chapter to health plans under chapter 74.09 RCW. This chapter does not apply to health plans that provide benefits under chapter 74.09 RCW. [2019 c 427 § 22.]

48.49.130 Application of chapter to self-funded group health plans that elect to participate in balance billing protection provisions—Annual notice to commissioner. As authorized in 45 C.F.R. Sec. 149.30 as in effect on March 31, 2022, the provisions of this chapter apply to a self-funded group health plan whether governed by or exempt from the provisions of the federal employee retirement income security act of 1974 (29 U.S.C. Sec. 1001 et seq.) only if the self-funded group health plan elects to participate in the provisions of RCW 48.49.020 and 48.49.030, 48.49.160, and 48.49.040. To elect to participate in these provisions, the self-funded group health plan shall provide notice, on an annual basis, to the commissioner in a manner prescribed by the commissioner, attesting to the plan's participation and agreeing to be bound by RCW 48.49.020 and 48.49.030, 48.49.160, and 48.49.040. An entity administering a self-funded health benefits plan that elects to participate under this section, shall comply with the provisions of RCW 48.49.020 and 48.49.030, 48.49.160, and 48.49.040. [2022 c 263 § 17; 2019 c 427 § 23.]

Effective date—2022 c 263: See note following RCW 43.371.100.

48.49.135 Determining the adequacy of provider networks—Required considerations. (1) When determining the adequacy of a proposed provider network or the ongoing adequacy of an in-force provider network, the commissioner must review the carrier's proposed provider network or in-force provider network to determine whether the network includes a sufficient number of contracted providers of emergency medicine, anesthesiology, pathology, radiology, neonatology, surgery, hospitalist, intensivist[,] and diagnostic services, including radiology and laboratory services at or for the carrier's contracted in-network hospitals or ambulatory surgical facilities to reasonably ensure enrollees have in-network access to covered benefits delivered at that facility.

(2)(a) When determining the adequacy of a proposed provider network or the ongoing adequacy of an in-force provider network, the commissioner may allow a carrier to submit an alternate access delivery request. The commissioner shall define the circumstances under which a carrier may submit an alternate access delivery request and the requirements for submission and approval of such a request in rule. To submit an alternate access delivery request, a carrier shall:

(i) Ensure that enrollees will not bear any greater cost of receiving services under the alternate access delivery request than if the provider or facility was contracted with the carrier or make other arrangements acceptable to the commissioner;

(ii) Provide substantial evidence of good faith efforts on its part to contract with providers or facilities. If a carrier is submitting an alternate access delivery request for the same service and geographic area as a previously approved request,

the carrier shall provide new or additional evidence of good faith efforts to contract associated with the current request;

(iii) Demonstrate that there is not an available provider or facility with which the carrier can contract to meet the commissioner's provider network standards; and

(iv) For services for which balance billing is prohibited under RCW 48.49.020, notify out-of-network providers or facilities that deliver the services referenced in the alternate access delivery request within five days of submitting the request to the commissioner. Any notification provided under this subsection shall include contact information for carrier staff who can provide detailed information to the affected provider or facility regarding the submitted alternate access delivery request.

(b) For services for which balance billing is prohibited under RCW 48.49.020, a carrier may not treat its payment of nonparticipating providers or facilities under this chapter or P.L. 116-260 (enacted December 27, 2020) as a means to satisfy network access standards established by the commissioner unless all requirements of this subsection are met.

(i) If a carrier is unable to obtain a contract with a provider or facility delivering services addressed in an alternate access delivery request to meet network access requirements, the carrier may ask the commissioner to amend the alternate access delivery request if the carrier's communication to the commissioner occurs at least three months after the effective date of the alternate access delivery request and demonstrates substantial evidence of good faith efforts on its part to contract for delivery of services during that three-month time period. If the carrier has demonstrated substantial evidence of good faith efforts on its part to contract, the commissioner shall allow a carrier to use the dispute resolution process provided in RCW 48.49.040 to determine the amount that will be paid to providers or facilities for services referenced in the alternate access delivery request. The commissioner may determine by rule the associated processes for use of the dispute resolution process under this subsection.

(ii) Once notification is provided by the carrier to a provider or facility under (a) of this subsection, a carrier is not responsible for reimbursing a provider's or facility's charges in excess of the amount charged by the provider or facility for the same or similar service at the time the notification was provided. The provider or facility shall accept this reimbursement as payment in full.

(3) When determining the adequacy of a carrier's proposed provider network or the ongoing adequacy of an in-force provider network, beginning January 1, 2023, the commissioner shall require that the carrier's proposed provider network or in-force provider network include a sufficient number of contracted behavioral health emergency services providers. [2022 c 263 § 18; 2019 c 427 § 25. Formerly RCW 48.49.150.]

Effective date—2022 c 263: See note following RCW 43.371.100.

48.49.140 Liberal construction of chapter to promote public interest. This chapter must be liberally construed to promote the public interest by ensuring that consumers are not billed out-of-network charges and do not receive additional bills from providers under the circumstances described in RCW 48.49.020. [2019 c 427 § 24.]

48.49.160 Allowed amounts paid to nonparticipating providers. (1)(a) Until July 1, 2023, or a later date determined by the commissioner under RCW 48.49.040, the allowed amount paid to a nonparticipating provider for health care services described under RCW 48.49.020(1) other than air ambulance services shall be a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area. Within 30 calendar days of receipt of a claim from a nonparticipating provider or facility, the carrier shall offer to pay the provider or facility a commercially reasonable amount. If the nonparticipating provider or facility wants to dispute the carrier's payment, the provider or facility must notify the carrier no later than 30 calendar days after receipt of payment or payment notification from the carrier. If the nonparticipating provider or facility disputes the carrier's initial offer, the carrier and provider or facility have 30 calendar days from the initial offer to negotiate in good faith. If the carrier and the nonparticipating provider or facility do not agree to a commercially reasonable payment amount within 30 calendar days, and the carrier or nonparticipating provider or facility chooses to pursue further action to resolve the dispute, the dispute shall be resolved as provided in RCW 48.49.040.

(b) The carrier must make payments for health care services described in RCW 48.49.020(1) provided by nonparticipating providers or facilities directly to the provider or facility, rather than the enrollee.

(2)(a) The allowed amount paid to a nonparticipating behavioral health emergency services provider for behavioral health emergency services shall be a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area. Within 30 calendar days of receipt of a claim from a nonparticipating behavioral health emergency services provider, the carrier shall offer to pay the behavioral health emergency services provider a commercially reasonable amount. If the nonparticipating behavioral health emergency services provider wants to dispute the carrier's payment, the behavioral health emergency services provider must notify the carrier no later than 30 calendar days after receipt of payment or payment notification from the carrier. If the nonparticipating behavioral health emergency services provider disputes the carrier's initial offer, the carrier and behavioral health emergency services provider have 30 calendar days from the initial offer to negotiate in good faith. If the carrier and the nonparticipating behavioral health emergency services provider do not agree to a commercially reasonable payment amount within 30 calendar days, and the carrier or nonparticipating behavioral health emergency services provider chooses to pursue further action to resolve the dispute, the dispute shall be resolved as provided in RCW 48.49.040.

(b) The carrier must make payments for behavioral health emergency services provided by nonparticipating behavioral health emergency services providers directly to the provider, rather than the enrollee.

(3) This section shall only apply to health care providers, facilities, or behavioral health emergency services providers providing services to members of entities administering a self-funded group health plan and its plan members if the entity has elected to participate in RCW 48.49.020,

48.49.030, and 48.49.040, and this section as provided in RCW 48.49.130. [2022 c 263 § 9.]

Effective date—2022 c 263: See note following RCW 43.371.100.

48.49.170 Application of state and federal requirements—Applicability information access—Waivers prohibited. (1) Carriers must make available through electronic and other methods of communication generally used by a provider or facility to verify enrollee eligibility and benefits information regarding whether an enrollee's health plan is subject to the requirements of this chapter or section 2799A-1 et seq. of the public health service act (42 U.S.C. Sec. 300gg-111 et seq.) and implementing federal regulations in effect on March 31, 2022.

(2) A health care provider, health care facility, behavioral health emergency services provider, or air ambulance service provider may not request or require a patient at any time, for any procedure, service, or supply, to sign or otherwise execute by oral, written, or electronic means, any document that would attempt to avoid, waive, or alter any provision of RCW 48.49.020 and 48.49.030 or sections 2799A-1 et seq. of the public health service act (P.L. 116-260) and implementing federal regulations in effect on March 31, 2022.

(3) This section shall only apply to health care providers, facilities, or behavioral health emergency services providers providing services to members of entities administering a self-funded group health plan and its plan members if the entity has elected to participate in RCW 48.49.020, 48.49.030, 48.49.160, and 48.49.040 as provided in RCW 48.49.130. [2022 c 263 § 10.]

Effective date—2022 c 263: See note following RCW 43.371.100.

48.49.180 Commissioner authority—Enforcement—Penalties. The commissioner is authorized to enforce provisions of P.L. 116-260 (enacted December 27, 2020, as the consolidated appropriations act of 2021) that are applicable to or regulate the conduct of carriers issuing health plans or grandfathered health plans to residents of Washington state on or after January 1, 2022. In addition to the enforcement actions authorized under RCW 48.02.080, the commissioner may impose a civil monetary penalty in an amount not to exceed \$100 for each day for each individual with respect to which a failure to comply with these provisions occurs. [2022 c 263 § 19.]

Effective date—2022 c 263: See note following RCW 43.371.100.

48.49.190 Reports to legislature. (1) On or before October 1, 2023, the commissioner, in collaboration with the health care authority and the department of health, must submit a report and any recommendations to the appropriate policy and fiscal committees of the legislature as to how balance billing for ground ambulance services can be prevented and whether ground ambulance services should be subject to the balance billing restrictions of this chapter. In developing the report and any recommendations, the commissioner must:

(a) Consider any recommendations made to congress by the advisory committee established in section 117 of P.L. 116-260 to review options to improve the disclosure of charges and fees for ground ambulance services, better (2022 Ed.)

inform consumers of insurance options for such services, and protect consumers from balance billing; and

(b) Consult with the department of health, the health care authority, the state auditor, consumers, hospitals, carriers, private ground ambulance service providers, fire service agencies, and local governmental entities that operate ground ambulance services, and include their perspectives in the final report.

(2) For purposes of this section, "ground ambulance services" means organizations licensed by the department of health that operate one or more ground vehicles designed and used to transport the ill and injured and to provide personnel, facilities, and equipment to treat patients before and during transportation. [2022 c 263 § 21.]

Effective date—2022 c 263: See note following RCW 43.371.100.

48.49.900 Effective date—2019 c 427. Except for section 26 of this act, this act takes effect January 1, 2020. [2019 c 427 § 31.]

Chapter 48.50 RCW

INSURANCE FRAUD REPORTING IMMUNITY ACT

Sections

48.50.010	Short title.
48.50.020	Definitions.
48.50.030	Release of information or evidence by insurer.
48.50.040	Notification by insurer.
48.50.050	Release of information by authorized agencies.
48.50.055	Release of information to requesting insurer.
48.50.070	Immunity from liability for releasing information.
48.50.075	Immunity from liability for denying claim based on written opinion of authorized agency.
48.50.090	Local ordinances not preempted.

48.50.010 Short title. This chapter shall be known and may be cited as the Insurance Fraud Reporting Immunity Act. [1995 c 285 § 20; 1979 ex.s. c 80 § 1.]

Additional notes found at www.leg.wa.gov

48.50.020 Definitions. As used in this chapter the following terms have the meanings indicated unless the context clearly requires otherwise.

(1) "Authorized agency" means a public agency or its official representative having legal authority to investigate criminal activity or the cause of a fire or to initiate criminal proceedings, including the following persons and agencies:

(a) The chief of the Washington state patrol and the director of fire protection;

(b) The prosecuting attorney of the county where the criminal activity occurred;

(c) State, county, and local law enforcement agencies;

(d) The state attorney general;

(e) The federal bureau of investigation, or any other federal law enforcement agency;

(f) The United States attorney's office; and

(g) The office of the insurance commissioner.

(2) "Insurer" means any insurer, as defined in RCW 48.01.050 and any self-insurer.

(3) "Relevant information" means information having any tendency to make the existence of any fact that is of consequence to the investigation or determination of criminal activity or the cause of any fire more probable or less proba-

ble than it would be without the information. [2000 c 254 § 1. Prior: 1995 c 369 § 36; 1995 c 285 § 21; 1986 c 266 § 77; 1985 c 470 § 27; 1979 ex.s. c 80 § 2.]

Additional notes found at www.leg.wa.gov

48.50.030 Release of information or evidence by insurer. (1) Any authorized agency may request, in writing, that an insurer release to the agency any or all relevant information or evidence which the insurer may have in its possession relating to criminal activity, if such information or evidence is deemed important by the agency in its discretion.

(2) An insurer who has reason to believe that a person participated or is participating in criminal activity relating to a contract of insurance may report relevant information to an authorized agency.

(3) The information provided to an authorized agency under this section may include, without limitation:

(a) Pertinent insurance policy information relating to a claim under investigation and any application for such a policy;

(b) Policy premium payment records which are available;

(c) History of previous claims in which the person was involved; and

(d) Material relating to the investigation of the loss, including statements of any person, proof of loss, and any other evidence found in the investigation.

(4) The insurer receiving a request under subsection (1) of this section shall furnish all relevant information requested to the agency within a reasonable time, orally or in writing. [1995 c 285 § 22; 1979 ex.s. c 80 § 3.]

Additional notes found at www.leg.wa.gov

48.50.040 Notification by insurer. (1) When an insurer has reason to believe that a fire loss reported to the insurer may be of other than accidental cause, the insurer shall notify the chief of the Washington state patrol, through the director of fire protection, in the manner prescribed under RCW 48.05.320 concerning the circumstances of the fire loss, including any and all relevant material developed from the insurer's inquiry into the fire loss.

(2) Notification of the chief of the Washington state patrol, through the director of fire protection, under subsection (1) of this section does not relieve the insurer of the duty to respond to a request for information from any other authorized agency and does not bar an insurer from other reporting under RCW 48.50.030(2). [2000 c 254 § 2. Prior: 1995 c 369 § 37; 1995 c 285 § 23; 1986 c 266 § 91; 1979 ex.s. c 80 § 4.]

Additional notes found at www.leg.wa.gov

48.50.050 Release of information by authorized agencies. An authorized agency receiving information under RCW 48.50.030, 48.50.040, or 48.50.055 may release or provide such information to any other authorized agencies. [2000 c 254 § 3; 1979 ex.s. c 80 § 5.]

48.50.055 Release of information to requesting insurer. An insurer providing information to an authorized agency or agencies under RCW 48.50.030 or 48.50.040 may request that an authorized agency furnish to the insurer any or all relevant information possessed by the agency relating to

the particular fire loss. At their discretion, and unless prohibited by any other provision of law, the agency or agencies may release or provide information to the requesting insurer. [2000 c 254 § 4.]

48.50.070 Immunity from liability for releasing information. Any licensed insurance producer, title insurance agent, or insurer or person acting in the insurer's behalf, health maintenance organization or person acting in behalf of the health maintenance organization, health care service contractor or person acting in behalf of the health care service contractor, or any authorized agency which releases information, whether oral or written, to the commissioner, the national insurance crime bureau, the national association of insurance commissioners, other law enforcement agent or agency, or another insurer under RCW 48.50.030, 48.50.040, 48.50.050, 48.50.055, or 48.135.050 is immune from liability in any civil or criminal action, suit, or prosecution arising from the release of the information, unless actual malice on the part of the insurance producer, title insurance agent, insurer, health care maintenance organization, health care service contractor, or authorized agency against the insured is shown. [2008 c 217 § 59; 2006 c 284 § 14; 2000 c 254 § 5; 1980 c 102 § 9; 1979 ex.s. c 80 § 7.]

Additional notes found at www.leg.wa.gov

48.50.075 Immunity from liability for denying claim based on written opinion of authorized agency. In denying a claim, an insurer, health maintenance organization, or health care service contractor who relies upon a written opinion from an authorized agency specifically enumerated in RCW 48.50.020(1) (a) through (g) that criminal activity that is related to that claim is being investigated, or a crime has been charged, and that the claimant is a target of the investigation or has been charged with a crime, is not liable for bad faith or other noncontractual theory of damages as a result of this reliance.

Immunity under this section shall exist only so long as the incident for which the claimant may be responsible is under active investigation or prosecution, or the authorized agency states its position that the claim includes or is a result of criminal activity in which the claimant was a participant. [2006 c 284 § 15; 1995 c 285 § 24; 1981 c 320 § 2.]

Additional notes found at www.leg.wa.gov

48.50.090 Local ordinances not preempted. This chapter does not preempt or preclude any county or municipality from enacting ordinances relating to fire prevention or control of arson. [1979 ex.s. c 80 § 9.]

Chapter 48.53 RCW

FIRE INSURANCE—ARSON FRAUD REDUCTION

Sections

48.53.010	Purpose.
48.53.020	Designation of high arson incidence areas and classes of occupancy—Anti-arson application, contents.
48.53.030	Cancellation of policy—Conditions required for.
48.53.040	Cancellation of policy—Procedure.
48.53.050	Issuance or cancellation of policy in violation of chapter.
48.53.060	Adoption of rules.

48.53.010 Purpose. It is the purpose of this chapter to reduce the incidence of arson fraud by requiring insurers to obtain specified information prior to issuing a fire insurance policy for certain structures and by authorizing insurers to cancel fire insurance policies when characteristics frequently associated with arson fraud are present. [1982 c 110 § 1.]

48.53.020 Designation of high arson incidence areas and classes of occupancy—Anti-arson application, contents. (1) The chief of the Washington state patrol, through the director of fire protection, may designate certain classes of occupancy within a geographic area or may designate geographic areas as having an abnormally high incidence of arson. This designation shall not be a valid reason for cancellation, refusal to issue or renew, modification, or increasing the premium for any fire insurance policy.

(2) A fire insurance policy may not be issued to insure any property within a class of occupancy within a geographic area or within a geographic area designated by the chief of the Washington state patrol, through the director of fire protection, as having an abnormally high incidence of arson until the applicant has submitted an anti-arson application and the insurer or the insurer's representative has inspected the property. The application shall be prescribed by the chief of the Washington state patrol, through the director of fire protection, and shall contain but not be limited to the following:

(a) The name and address of the prospective insured and any mortgagees or other parties having an ownership interest in the property to be insured;

(b) The amount of insurance requested and the method of valuation used to establish the amount of insurance;

(c) The dates and selling prices of the property, if any, during the previous three years;

(d) Fire losses exceeding one thousand dollars during the previous five years for property in which the prospective insured held an equity interest or mortgage;

(e) Current corrective orders pertaining to fire, safety, health, building, or construction codes that have not been complied with within the time period or any extension of such time period authorized by the authority issuing such corrective order applicable to the property to be insured;

(f) Present or anticipated occupancy of the structure, and whether a certificate of occupancy has been issued;

(g) Signature and title, if any, of the person submitting the application.

(3) If the facts required to be reported by subsection (2) of this section materially change, the insured shall notify the insurer of any such change within fourteen days.

(4) An anti-arson application is not required for: (a) Fire insurance policies covering one to four-unit owner-occupied residential dwellings; (b) policies existing as of June 10, 1982; or (c) the renewal of these policies.

(5) An anti-arson application shall contain a notice stating: "Designation of a class of occupancy within a geographic area or geographic areas as having an abnormally high incidence of arson shall not be a valid reason for cancellation, refusal to issue or renew, modification, or increasing the premium for any fire insurance policy." [1995 c 369 § 38; 1986 c 266 § 92; 1982 c 110 § 2.]

Additional notes found at www.leg.wa.gov

48.53.030 Cancellation of policy—Conditions required for. Notwithstanding the provisions of RCW 48.18.290, where two or more of the following conditions exist, an insurer may, under RCW 48.53.040, cancel a fire insurance policy for any structure:

(1) Which, without reasonable explanation, is unoccupied for more than sixty consecutive days, or in which at least sixty-five percent of the rental units are unoccupied for more than one hundred twenty consecutive days unless the structure is maintained for seasonal occupancy or is under construction or repair;

(2) On which, without reasonable explanation, progress toward completion of permanent repairs has not occurred within sixty days after receipt of funds following satisfactory adjustment or adjudication of loss resulting from a fire;

(3) Which, because of its physical condition, is in danger of collapse;

(4) For which, because of its physical condition, a vacation or demolition order has been issued, or which has been declared unsafe in accordance with applicable law;

(5) From which fixed and salvageable items have been removed, indicating an intent to vacate the structure;

(6) For which, without reasonable explanation, heat, water, sewer, and electricity are not furnished for sixty consecutive days; and

(7) Which is not maintained in substantial compliance with fire, safety, and building codes. [1982 c 110 § 3.]

48.53.040 Cancellation of policy—Procedure. An insurer may cancel a fire insurance policy when the requirements of RCW 48.53.030 are met only in accordance with the following procedure:

(1) The insurer shall, not less than five days prior to cancellation, issue written notice of cancellation to the insured or the insured's representative in charge of the policy. The notice shall contain at least the following:

(a) The date that the policy will be canceled;

(b) A description of the specific facts justifying the cancellation;

(c) A copy of this chapter; and

(d) The name, title, address, and telephone number of the insurer's employee who may be contacted regarding cancellation of the policy.

(2) The notice required by this section shall be actually delivered or mailed to the insured by certified mail, return receipt requested, and in addition by first-class mail. A copy of the notice shall, at the time of delivery or mailing to the insured, or the insured's representative in charge of the policy, be mailed to the insurance commissioner.

(3) The insurer shall also comply with the requirements of *RCW 48.18.290 (1)(b), (2) and (3), and shall provide not less than twenty days notice of cancellation to each mortgagee, pledgee, or other person shown by the policy to have an interest in any loss which may occur thereunder except as provided in subsection (1) of this section.

(4) The portion of any premium paid to the insurer on account of the policy, unearned because of the cancellation and in an amount as computed on a pro rata basis, must be actually paid or mailed to the insured or other person entitled thereto as shown by the policy or any endorsement thereon,

as soon as possible, and no later than thirty days after the date that the notice of cancellation was issued. [1982 c 110 § 4.]

*Reviser's note: RCW 48.18.290 was amended by 2006 c 8 § 212, changing subsection (1)(b) to subsection (1)(c).

48.53.050 Issuance or cancellation of policy in violation of chapter. (1) Any fire insurance policy issued in violation of this chapter shall not be canceled by the insurer under the procedures authorized by this chapter.

(2) Cancellation of a fire insurance policy in violation of this chapter shall constitute a violation of this title. [1982 c 110 § 5.]

48.53.060 Adoption of rules. Rules designating geographic areas or classes of occupancy as having an abnormally high incidence of arson, and any other rules necessary to implement this chapter shall be adopted by the chief of the Washington state patrol, through the director of fire protection, under chapter 34.05 RCW. [1995 c 369 § 39; 1986 c 266 § 93; 1982 c 110 § 6.]

Additional notes found at www.leg.wa.gov

Chapter 48.56 RCW

INSURANCE PREMIUM FINANCE COMPANY ACT

Sections

48.56.010	Short title.
48.56.020	Definitions.
48.56.030	License—Required—Fees—Information to be furnished—Penalty.
48.56.040	Investigation of applicant—Qualifications—Hearing.
48.56.050	Revocation, suspension, or refusal to renew.
48.56.060	Records.
48.56.070	Rules and regulations.
48.56.080	Premium finance agreement.
48.56.090	Service charge.
48.56.100	Delinquency charge—Cancellation charge.
48.56.110	Cancellation of insurance contract.
48.56.120	Cancellation of insurance contract—Return of unearned premiums.
48.56.130	Filing of agreement.
48.56.900	Effective date—1969 ex.s. c 190.

48.56.010 Short title. This chapter shall be known and may be cited as "The Insurance Premium Finance Company Act". [1969 ex.s. c 190 § 1.]

48.56.020 Definitions. As used in this chapter:

(1) "Insurance premium finance company" means a person engaged in the business of entering into insurance premium finance agreements.

(2) "Premium finance agreement" means an agreement by which an insured or prospective insured promises to pay to a premium finance company the amount advanced or to be advanced under the agreement to an insurer or to an insurance producer in payment of premiums on an insurance contract together with a service charge as authorized and limited by this chapter and as security therefor the insurance premium finance company receives an assignment of the unearned premium.

(3) "Licensee" means a premium finance company holding a license issued by the insurance commissioner under this chapter. [2008 c 217 § 60; 1969 ex.s. c 190 § 2.]

Additional notes found at www.leg.wa.gov

48.56.030 License—Required—Fees—Information to be furnished—Penalty. (1) No person shall engage in the business of financing insurance premiums in the state without first having obtained a license as a premium finance company from the commissioner. Any person who shall engage in the business of financing insurance premiums in the state without obtaining a license as provided hereunder shall, upon conviction, be guilty of a misdemeanor and shall be subject to the penalties provided in this chapter.

(2)(a) Application to the commissioner for the license shall be made on forms furnished by the commissioner. As part of, or in connection with, this application, the applicant and, at the commissioner's discretion, any or all stockholders, directors, partners, officers, and employees of the business shall furnish information concerning his or her identity, including fingerprints for submission to the Washington state patrol, the federal bureau of investigation, and any governmental agency or entity authorized to receive this information for a state and national criminal history background check; personal history; experience; business records; purposes; and other pertinent information, as the commissioner may reasonably require.

(b) The annual license fee shall be one hundred dollars. Licenses may be renewed from year to year as of the first day of May of each year upon payment of the fee of one hundred dollars. The fee for the license shall be paid to the insurance commissioner.

(3) The person to whom the license or the renewal may be issued shall file sworn answers, subject to the penalties of perjury, to such interrogatories as the commissioner may require. The commissioner shall have authority, at any time, to require the applicant to disclose fully the identity of all stockholders, directors, partners, officers, and employees and may, in his or her discretion, refuse to issue or renew a license in the name of any firm, partnership, or corporation if he or she finds that any officer, employee, stockholder, or partner who may materially influence the applicant's conduct does not meet the standards of this chapter.

(4) This section shall not apply to any savings and loan association, bank, trust company, consumer loan company, industrial loan company or credit union authorized to do business in this state but RCW 48.56.080 through 48.56.130 and any rules adopted by the commissioner pertaining to such sections shall be applicable to such organizations, if otherwise eligible, under all premium finance transactions wherein an insurance policy, other than a life or disability insurance policy, or any rights thereunder is made the security or collateral for the repayment of the debt, however, neither this section nor the provisions of this chapter shall be applicable to the inclusion of insurance in a retail installment transaction or to insurance purchased in connection with a real estate transaction, mortgage, deed of trust, or other security instrument or an insurance company authorized to do business in this state unless the insurance company elects to become a licensee.

(5) If in the process of verifying fingerprints under subsection (2) of this section, business records, or other information the commissioner's office incurs fees or charges from another governmental agency or from a business firm, the amount of the fees or charges shall be paid to the commis-

sioner's office by the applicant. [2002 c 227 § 4; 1969 ex.s. c 190 § 3.]

Additional notes found at www.leg.wa.gov

48.56.040 Investigation of applicant—Qualifications—Hearing. (1) Upon the filing of an application and the payment of the license fee the commissioner shall make an investigation of each applicant and shall issue a license if the applicant is qualified in accordance with this chapter. If the commissioner does not so find, he or she shall, within thirty days after he or she has received such application, at the request of the applicant, give the applicant a full hearing.

(2) The commissioner shall issue or renew a license as may be applied for when he or she is satisfied that the person to be licensed—

(a) is competent and trustworthy and intends to act in good faith in the capacity involved by the license applied for,

(b) has a good business reputation and has had experience, training, or education so as to be qualified in the business for which the license is applied for, and

(c) if a corporation, is a corporation incorporated under the laws of the state or a foreign corporation authorized to transact business in the state. [2009 c 549 § 7155; 1969 ex.s. c 190 § 4.]

48.56.050 Revocation, suspension, or refusal to renew. (1) The commissioner may revoke or suspend the license of any premium finance company when and if after investigation it appears to the commissioner that—

(a) any license issued to such company was obtained by fraud,

(b) there was any misrepresentation in the application for the license,

(c) the holder of such license has otherwise shown himself or herself untrustworthy or incompetent to act as a premium finance company, or

(d) such company has violated any of the provisions of this chapter.

(2) Before the commissioner shall revoke, suspend, or refuse to renew the license of any premium finance company, he or she shall give to such person an opportunity to be fully heard and to introduce evidence in his or her behalf. In lieu of revoking or suspending the license for any of the causes enumerated in this section, after hearing as herein provided, the commissioner may subject such company to a penalty of not more than two hundred dollars for each offense when in his or her judgment he or she finds that the public interest would not be harmed by the continued operation of such company. The amount of any such penalty shall be paid by such company through the office of the commissioner to the state treasurer. At any hearing provided by this section, the commissioner shall have authority to administer oaths to witnesses. Anyone testifying falsely, after having been administered such oath, shall be subject to the penalty of perjury.

(3) If the commissioner refuses to issue or renew any license or if any applicant or licensee is aggrieved by any action of the commissioner, said applicant or licensee shall have the right to a hearing and court proceeding as provided by statute. [2009 c 549 § 7156; 1969 ex.s. c 190 § 5.]

(2022 Ed.)

48.56.060 Records. (1) Every licensee shall maintain records of its premium finance transactions and the said records shall be open to examination and investigation by the commissioner. The commissioner may at any time require any licensee to bring such records as he or she may direct to the commissioner's office for examination.

(2) Every licensee shall preserve its records of such premium finance transactions, including cards used in a card system, for at least three years after making the final entry in respect to any premium finance agreement. The preservation of records in photographic form shall constitute compliance with this requirement. [2009 c 549 § 7157; 1969 ex.s. c 190 § 6.]

48.56.070 Rules and regulations. The commissioner shall have authority to make and enforce such reasonable rules and regulations as may be necessary in making effective the provisions of this chapter, but such rules and regulations shall not be contrary to nor inconsistent with the provisions of this chapter. [1969 ex.s. c 190 § 7.]

48.56.080 Premium finance agreement. (1) A premium finance agreement shall:

(a) Be dated, signed by or on behalf of the insured, and the printed portion thereof shall be in at least eight point type;

(b) Contain the name and place of business of the insurance producer negotiating the related insurance contract, the name and residence or the place of business of the premium finance company to which payments are to be made, a description of the insurance contracts involved and the amount of the premium therefor; and

(c) Set forth the following items where applicable:

(i) The total amount of the premiums;

(ii) The amount of the down payment;

(iii) The principal balance (the difference between items (i) and (ii));

(iv) The amount of the service charge;

(v) The balance payable by the insured (sum of items (iii) and (iv)); and

(vi) The number of installments required, the amount of each installment expressed in dollars, and the due date or period thereof.

(2) The items set out in subsection (1)(c) of this section need not be stated in the sequence or order in which they appear in that subsection, and additional items may be included to explain the computations made in determining the amount to be paid by the insured.

(3) The information required by subsection (1) of this section shall only be required in the initial agreement where the premium finance company and the insured enter into an open end credit transaction, which is defined as follows: A plan prescribing the terms of credit transactions which may be made thereunder from time to time and under the terms of which a finance charge may be computed on the outstanding unpaid balance from time to time thereunder.

(4) A copy of the premium finance agreement shall be given to the insured at the time or within ten days of its execution, except where the application has been signed by the insured and all the finance charges are one dollar or less per payment. In addition, the premium finance company shall deliver or mail a copy of the premium finance agreement or

notice identifying policy, insured, and insurance producer to each insurer that has premiums involved in the transaction, within thirty days of the execution of the premium finance agreement.

(5) It shall be illegal for a premium finance company to offset funds of an insurance producer with funds belonging to an insured. Premiums advanced by a premium finance company are funds belonging to the insured and shall be held in a fiduciary relationship. [2008 c 217 § 61; 1975-76 2nd ex.s. c 119 § 6; 1969 ex.s. c 190 § 8.]

Additional notes found at www.leg.wa.gov

48.56.090 Service charge. (1) A premium finance company shall not charge, contract for, receive, or collect a service charge other than as permitted by this chapter.

(2) The service charge is to be computed on the balance of the premiums due (after subtracting the down payment made by the insured in accordance with the premium finance agreement) from the effective date of the insurance coverage, for which the premiums are being advanced, to and including the date when the final installment of the premium finance agreement is payable.

(3) The service charge shall be a maximum of ten dollars per one hundred dollars per year plus an acquisition charge of ten dollars per premium finance agreement which need not be refunded upon cancellation or prepayment. [1969 ex.s. c 190 § 9.]

48.56.100 Delinquency charge—Cancellation charge. A premium finance agreement may provide for the payment by the insured of a delinquency charge of one dollar to a maximum of five percent of the delinquent installment that is in default for a period of five days or more except that if the loan is primarily for personal, family, or household purposes the delinquency charge shall not exceed five dollars.

If the default results in the cancellation of any insurance contract listed in the agreement, the agreement may provide for the payment by the insured of a cancellation charge equal to the difference between any delinquency charge imposed with respect to the installment in default and five dollars. [1995 c 72 § 1; 1969 ex.s. c 190 § 10.]

48.56.110 Cancellation of insurance contract. (1) When a premium finance agreement contains a power of attorney enabling the premium finance company to cancel any insurance contract or contracts listed in the agreement, the insurance contract or contracts shall not be canceled by the premium finance company unless such cancellation is effectuated in accordance with this section.

(2) Not less than ten days' written notice shall be mailed to the insured of the intent of the premium finance company to cancel the insurance contract unless the default is cured within such ten-day period.

(3) After expiration of such ten-day period, the premium finance company may thereafter request in the name of the insured, cancellation of such insurance contract or contracts by mailing to the insurer a notice of cancellation, and the insurance contract shall be canceled as if such notice of cancellation had been submitted by the insured himself or herself, but without requiring the return of the insurance contract or contracts. The premium finance company shall also mail a

notice of cancellation to the insured at his or her last known address.

(4) All statutory, regulatory, and contractual restrictions providing that the insurance contract may not be canceled unless notice is given to a governmental agency, mortgagee, or other third party shall apply where cancellation is effected under the provisions of this section. The insurer shall give the prescribed notice in behalf of itself or the insured to any governmental agency, mortgagee, or other third party on or before the second business day after the day it receives the notice of cancellation from the premium finance company and shall determine the effective date of cancellation taking into consideration the number of days notice required to complete the cancellation. [2010 c 8 § 11006; 2009 c 549 § 7158; 1969 ex.s. c 190 § 11.]

48.56.120 Cancellation of insurance contract—Return of unearned premiums. (1) Whenever a financed insurance contract is canceled, the insurer shall return whatever gross unearned premiums are due under the insurance contract to the premium finance company for the account of the insured or insureds.

(2) In the event that the crediting of return premiums to the account of the insured results in a surplus over the amount due from the insured, the premium finance company shall refund such excess to the insured: PROVIDED, That no such refund shall be required if it amounts to less than one dollar. [1969 ex.s. c 190 § 12.]

48.56.130 Filing of agreement. No filing of the premium finance agreement shall be necessary to perfect the validity of such agreement as a secured transaction as against creditors, subsequent purchasers, pledgees, encumbrancers, successors, or assigns. [1969 ex.s. c 190 § 13.]

48.56.900 Effective date—1969 ex.s. c 190. This act is necessary for the immediate preservation of the public peace, health and safety, the support of the state government and its existing public institutions, and shall take effect on the sixtieth day following passage by the legislature and submission to the governor for action. [1969 ex.s. c 190 § 15.]

Chapter 48.58 RCW

RIOT REINSURANCE REIMBURSEMENT

Sections

48.58.010 Riot reinsurance reimbursement—Assessments.

48.58.010 Riot reinsurance reimbursement—Assessments. (1) The commissioner may reimburse the secretary of the department of housing and urban development under the provisions of Section 1223(a)(1) of the Urban Property Protection and Reinsurance Act of 1968 (Public Law 90-448) for losses reinsured by the secretary of the department of housing and urban development and occurring in this state on or after August 1, 1968. After receipt by the state treasurer of a statement requesting reimbursement from the secretary of the department of housing and urban development and upon certification promptly made by the commissioner of insurance, hereafter referred to as the commissioner, of the correctness of the amount thereof, the commissioner is hereby authorized

to provide for an assessment upon insurers authorized to do business in this state in amounts sufficient to pay reimbursement to the secretary of the department of housing and urban development: PROVIDED, That the amount assessed each insurer shall be in the same proportion that the premiums written by each insurer in this state bear to the aggregate premiums written in this state by all insurance companies on those lines for which reinsurance was available in this state from the secretary of the department of housing and urban development during the preceding calendar year.

(2) In the event any insurer fails, by reason of insolvency, to pay any assessment as provided herein, the amount assessed each insurer, as computed under subsection (1) of this section, shall be immediately recalculated excluding therefrom the insolvent insurer so that its assessment is, in effect, assumed and redistributed among the remaining insurers.

(3) When assessments as provided herein are made, the individual insurer, after having paid the full amount assessed against the insurer, may deduct from future premium tax liabilities an amount not to exceed twenty percent per annum until such deductions equal the amount of the assessment levied against the insurer.

(4) This section shall cease to be of any force and effect upon termination of the Urban Property Protection and Reinsurance Act of 1968 (Public Law 90-448), except that obligations incurred pursuant to the provisions of this section shall not be impaired by the expiration of the same.

(5) Notwithstanding the termination of the Urban Property Protection and Reinsurance Act of 1968 (Public Law 90-448), the commissioner is authorized to continue in force the program developed in response to that act, the Washington essential property insurance inspection and placement program, in order to provide essential property insurance within the state where it cannot be obtained through the normal insurance market. [1987 c 128 § 1; 1980 c 32 § 9; 1969 ex.s. c 140 § 1.]

Chapter 48.62 RCW

LOCAL GOVERNMENT INSURANCE TRANSACTIONS

Sections

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48.62.171	Dissemination of information—Civil immunity.
48.62.900	Effective date, implementation, application—1991 sp.s. c 30.

48.62.011 Legislative intent—Construction. (1) This chapter is intended to provide the exclusive source of local government entity authority to individually or jointly self-insure risks, jointly purchase insurance or reinsurance, and to contract for risk management, claims, and administrative services. This chapter shall be liberally construed to grant local government entities maximum flexibility in self-insuring to the extent the self-insurance programs are operated in a safe and sound manner. This chapter is intended to require prior approval for the establishment of every individual local government self-insured employee health and welfare benefit program and every joint local government self-insurance program. In addition, this chapter is intended to require every local government entity that establishes a self-insurance program not subject to prior approval to notify the state of the existence of the program and to comply with the regulatory and statutory standards governing the management and operation of the programs as provided in this chapter. This chapter is not intended to authorize or regulate self-insurance of unemployment compensation under chapter 50.44 RCW, or industrial insurance under chapter 51.14 RCW.

(2) This chapter is further intended to enable the board of pilotage commissioners to participate in a local government joint self-insurance program covering liability risks. [2019 c 26 § 1; 1991 sp.s. c 30 § 1.]

48.62.021 Definitions. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Health and welfare benefits" means a plan or program established by a local government entity or entities for the purpose of providing its employees and their dependents, and in the case of school districts, its district employees, students, directors, or any of their dependents, with health care, accident, disability, death, and salary protection benefits.

(2) "Local government entity" or "entity" means every unit of local government, both general purpose and special purpose, and includes, but is not limited to, counties, cities, towns, port districts, public utility districts, water-sewer districts, school districts, fire protection districts, irrigation districts, metropolitan municipal corporations, conservation districts, and other political subdivisions, governmental subdivisions, municipal corporations, quasi-municipal corporations, nonprofit corporations comprised of only units of local government, or a group comprised of local governments joined by an interlocal agreement authorized by chapter 39.34 RCW.

(3) "Nonprofit corporation" or "corporation" has the same meaning as defined in RCW 24.03A.010 or a similar statute with similar intent within the entity's state of domicile.

(4) "Property and liability risks" includes the risk of property damage or loss sustained by a local government entity and the risk of claims arising from the tortious or negligent conduct or any error or omission of the local government entity, its officers, employees, agents, or volunteers as a

result of which a claim may be made against the local government entity.

(5) "Risk assumption" means a decision to absorb the entity's financial exposure to a risk of loss without the creation of a formal program of advance funding of anticipated losses.

(6) "Self-insurance" means a formal program of advance funding and management of entity financial exposure to a risk of loss that is not transferred through the purchase of an insurance policy or contract.

(7) "State risk manager" means the risk manager of the office of risk management within the department of enterprise services. [2021 c 176 § 5229. Prior: 2015 c 109 § 2; prior: 2011 1st sp.s. c 43 § 520; 2004 c 255 § 2; 2002 c 332 § 24; 1999 c 153 § 60; 1991 sp.s. c 30 § 2.]

Effective date—2021 c 176: See note following RCW 24.03A.005.

Effective date—Purpose—2011 1st sp.s. c 43: See notes following RCW 43.19.003.

Findings—Intent—2004 c 255: "The legislature finds that recent increases in property and liability insurance premiums experienced by some nonprofit organizations have the potential to negatively impact the ability of these organizations to continue to offer the level of service they provide in our communities. The legislature finds that nonprofit organizations are distinct from private for-profit businesses. By their very nature, nonprofit organizations are formed for purposes other than generating a profit, and are restricted from distributing any part of the organization's income to its directors or officers. Because of these characteristics, nonprofit organizations provide a unique public good to the residents in our state.

The legislature finds that in order to sustain the financial viability of nonprofit organizations, they should be provided with alternative options for insuring against risks. The legislature further finds that local government entities and nonprofit organizations share the common goal of providing services beneficial to the public interest. The legislature finds that allowing nonprofit organizations and local government entities to pool risk in self-insurance risk pools may be of mutual benefit for both types of entities. Therefore, it is the intent of the legislature to allow nonprofit organizations to form or participate in self-insurance risk pools with other nonprofit organizations or with local government entities where authority for such risk pooling arrangements does not currently exist in state or federal law." [2004 c 255 § 1.]

Intent—Effective date—2002 c 332: See notes following RCW 43.19.760.

Additional notes found at www.leg.wa.gov

48.62.031 Authority to self-insure—Options—Risk manager. (1) The governing body of a local government entity may individually self-insure, may join or form a self-insurance program together with other entities, including the board of pilotage commissioners, and may jointly purchase insurance or reinsurance with those other entities for property and liability risks, and health and welfare benefits only as permitted under this chapter. In addition, the entity or entities may contract for or hire personnel to provide risk management, claims, and administrative services in accordance with this chapter.

(2) The agreement to form a joint self-insurance program shall be made under chapter 39.34 RCW and may create a separate legal or administrative entity with powers delegated thereto.

(3) Every individual and joint self-insurance program is subject to audit by the state auditor.

(4) If provided for in the agreement or contract established under chapter 39.34 RCW, a joint self-insurance program may, in conformance with this chapter:

(a) Contract or otherwise provide for risk management and loss control services;

(b) Contract or otherwise provide legal counsel for the defense of claims and other legal services;

(c) Consult with the state insurance commissioner and the state risk manager;

(d) Jointly purchase insurance and reinsurance coverage in such form and amount as the program's participants agree by contract;

(e) Obligate the program's participants to pledge revenues or contribute money to secure the obligations or pay the expenses of the program, including the establishment of a reserve or fund for coverage; and

(f) Possess any other powers and perform all other functions reasonably necessary to carry out the purposes of this chapter.

(5) A self-insurance program formed and governed under this chapter that has decided to assume a risk of loss must have available for inspection by the state auditor a written report indicating the class of risk or risks the governing body of the entity has decided to assume.

(6) Every joint self-insurance program governed by this chapter shall appoint the risk manager as its attorney to receive service of, and upon whom shall be served, all legal process issued against it in this state upon causes of action arising in this state.

(a) Service upon the risk manager as attorney shall constitute service upon the program. Service upon joint insurance programs subject to chapter 30, Laws of 1991 sp. sess. can be had only by service upon the risk manager. At the time of service, the plaintiff shall pay to the risk manager a fee to be set by the risk manager, taxable as costs in the action.

(b) With the initial filing for approval with the risk manager, each joint self-insurance program shall designate by name and address the person to whom the risk manager shall forward legal process so served upon him or her. The joint self-insurance program may change such person by filing a new designation.

(c) The appointment of the risk manager as attorney shall be irrevocable, shall bind any successor in interest or to the assets or liabilities of the joint self-insurance program, and shall remain in effect as long as there is in force in this state any contract made by the joint self-insurance program or liabilities or duties arising therefrom.

(d) The risk manager shall keep a record of the day and hour of service upon him or her of all legal process. A copy of the process, by registered mail with return receipt requested, shall be sent by the risk manager, to the person designated for the purpose by the joint self-insurance program in its most recent such designation filed with the risk manager. No proceedings shall be had against the joint self-insurance program, and the program shall not be required to appear, plead, or answer, until the expiration of forty days after the date of service upon the risk manager. [2019 c 26 § 3; 2015 c 109 § 3; 2005 c 147 § 1; 1991 sp.s. c 30 § 3.]

48.62.034 Joint self-insurance program—Actions authorized. (1) For the purpose of carrying out a joint self-insurance program, a joint self-insurance program and a separate legal entity created under RCW 48.62.031 each may:

(a) Contract indebtedness and issue and sell revenue bonds evidencing such indebtedness or establish lines of credit pursuant to and in the manner provided for local governments in chapter 39.46 RCW with the joint board under RCW 39.34.030; board of directors under RCW 48.62.081; or governing board of a separate legal entity formed under RCW 48.62.031, performing the functions to be performed by the governing body of a local government under chapter 39.46 RCW and appointing a treasurer to perform the functions to be performed by the treasurer under chapter 39.46 RCW;

(b) Contract indebtedness and issue and sell short-term obligations evidencing such indebtedness pursuant to and in the manner provided for municipal corporations in chapter 39.50 RCW with the joint board under RCW 39.34.030; board of directors under RCW 48.62.081; or governing board of a separate legal entity formed under RCW 48.62.031, performing the functions to be performed by the governing body of a municipal corporation under chapter 39.50 RCW; and

(c) Contract indebtedness and issue and sell refunding bonds pursuant to and in the manner provided for public bodies in chapter 39.53 RCW with the joint board under RCW 39.34.030; board of directors under RCW 48.62.081; or governing board of a separate legal entity formed under RCW 48.62.031, performing the functions to be performed by the governing body of a public body under chapter 39.53 RCW.

(2) For the purpose of carrying out a joint self-insurance program, a joint self-insurance program and a separate legal entity formed under RCW 48.62.031 each may make loans of the proceeds of revenue bonds issued under this section to a joint self-insurance program or a local government entity that has joined or formed a joint self-insurance program.

(3) For the purpose of carrying out a joint self-insurance program, a joint self-insurance program and each local government entity that has joined or formed a joint self-insurance program may accept loans of the proceeds of revenue bonds issued under this section. [2005 c 147 § 2.]

48.62.037 Board of pilotage commissioners—Participation in joint self-insurance program—Liability insurance coverage. The board of pilotage commissioners may participate in a local government joint self-insurance program formed or operating in accordance with this chapter. The board of pilotage commissioners may participate in the program to obtain liability insurance coverage, but not property insurance coverage. [2019 c 26 § 2.]

48.62.061 Rule making by state risk manager—Standards. The state risk manager shall adopt rules governing the management and operation of both individual and joint local government self-insurance programs covering property or liability risks. The state risk manager shall also adopt rules governing the management and operation of both individual and joint local government self-insured health and welfare benefits programs. All rules shall be appropriate for the type of program and class of risk covered. The state risk manager's rules shall include:

(1) Standards for the management, operation, and solvency of self-insurance programs, including the necessity and frequency of actuarial analyses and claims audits;

(2) Standards for claims management procedures; and

(3) Standards for contracts between self-insurance programs and private businesses including standards for contracts between third-party administrators and programs. [2010 1st sp.s. c 7 § 55; 1991 sp.s. c 30 § 6.]

Additional notes found at www.leg.wa.gov

48.62.071 Program approval required—State risk manager—Plan of management and operation. Before the establishment of a joint self-insurance program covering property or liability risks by local government entities, or an individual or joint local government self-insured health and welfare benefits program, the entity or entities must obtain the approval of the state risk manager. Risk manager approval is not required for the establishment of an individual local government self-insurance program covering property or liability risks. The entity or entities proposing creation of a self-insurance program requiring prior approval shall submit a plan of management and operation to the state risk manager and the state auditor that provides at least the following information:

(1) The risk or risks to be covered, including any coverage definitions, terms, conditions, and limitations or in the case of health and welfare benefits programs, the benefits to be provided, including any benefit definitions, terms, conditions, and limitations;

(2) The amount and method of financing the benefits or covered risks, including the initial capital and proposed rates and projected premiums;

(3) The proposed claim reserving practices;

(4) The proposed purchase and maintenance of insurance or reinsurance in excess of the amounts retained by the self-insurance program;

(5) In the case of a joint program, the legal form of the program, including but not limited to any bylaws, charter, or trust agreement;

(6) In the case of a joint program, the agreements with members of the program defining the responsibilities and benefits of each member and management;

(7) The proposed accounting, depositing, and investment practices of the program;

(8) The proposed time when actuarial analysis will be first conducted and the frequency of future actuarial analysis;

(9) A designation of the individual upon whom service of process shall be executed on behalf of the program. In the case of a joint program, a designation of the individual to whom service of process shall be forwarded by the risk manager on behalf of the program;

(10) All contracts between the program and private persons providing risk management, claims, or other administrative services;

(11) A professional analysis of the feasibility of creation and maintenance of the program; and

(12) Any other information required by rule of the state risk manager that is necessary to determine the probable financial and management success of the program or that is necessary to determine compliance with this chapter. [1991 sp.s. c 30 § 7.]

48.62.081 Multistate program participants—Requirements. A local government entity may participate in a joint self-insurance program covering property or liability

risks with similar local government entities from other states if the program satisfies the following requirements:

(1) Only those local government entities of this state and similar entities of other states that are provided insurance by the program may have ownership interest in the program;

(2) The participating local government entities of this state and other states shall elect a board of directors to manage the program, a majority of whom shall be affiliated with one or more of the participating entities;

(3) The program must provide coverage through the delivery to each participating entity of one or more written policies effecting insurance of covered risks;

(4) The program shall be financed, including the payment of premiums and the contribution of initial capital, in accordance with the plan of management and operation submitted to the state risk manager in accordance with this chapter;

(5) The financial statements of the program shall be audited annually by the certified public accountants for the program, and such audited financial statements shall be delivered to the Washington state auditor and the state risk manager not more than one hundred twenty days after the end of each fiscal year of the program;

(6) The investments of the program shall be initiated only with financial institutions and/or broker-dealers doing business in those states in which participating entities are located, and such investments shall be audited annually by the certified public accountants for the program, and a list of such investments shall be delivered to the Washington state auditor not more than one hundred twenty days after the end of each fiscal year of the program;

(7) The treasurer of a multistate joint self-insurance program shall be designated by resolution of the program and such treasurer shall be located in the state of one of the participating entities;

(8) The participating entities may have no contingent liabilities for covered claims, other than liabilities for unpaid premiums, retrospective premiums, or assessments, if assets of the program are insufficient to cover the program's liabilities; and

(9) The program shall obtain approval from the state risk manager in accordance with this chapter and shall remain in compliance with the provisions of this chapter, except to the extent that such provisions are modified by or inconsistent with this section. [1991 sp.s. c 30 § 8.]

48.62.091 Program approval or disapproval—Procedures—Annual report. (1) Within one hundred twenty days of receipt of a plan of management and operation, the state risk manager shall either approve or disapprove the formation of the self-insurance program after reviewing the plan to determine whether the proposed program complies with this chapter and all rules adopted in accordance with this chapter.

(2) If the state risk manager denies a request for approval, the state risk manager shall specify in detail the reasons for denial and the manner in which the program fails to meet the requirements of this chapter or any rules adopted in accordance with this chapter.

(3) Whenever the state risk manager determines that a joint self-insurance program covering property or liability risks or an individual or joint self-insured health and welfare

benefits program is in violation of this chapter or is operating in an unsafe financial condition, the state risk manager may issue and serve upon the program an order to cease and desist from the violation or practice.

(a) The state risk manager shall deliver the order to the appropriate entity or entities directly or mail it to the appropriate entity or entities by registered mail with return receipt requested.

(b) If the program violates the order or has not taken steps to comply with the order after the expiration of twenty days after the cease and desist order has been received by the program, the program is deemed to be operating in violation of this chapter, and the state risk manager shall notify the state auditor and the attorney general of the violation.

(c) After hearing or with the consent of a program governed by this chapter and in addition to or in lieu of a continuation of the cease and desist order, the risk manager may levy a fine upon the program in an amount not less than three hundred dollars and not more than ten thousand dollars. The order levying such fine shall specify the period within which the fine shall be fully paid. The period within which such fines shall be paid shall not be less than fifteen nor more than thirty days from the date of such order. Upon failure to pay any such fine when due the risk manager shall request the attorney general to bring a civil action on the risk manager's behalf to collect the fine. The risk manager shall pay any fine so collected to the state treasurer for the account of the general fund.

(4) Each self-insurance program approved by the state risk manager shall annually file a report with the state risk manager and state auditor providing:

(a) Details of any changes in the articles of incorporation, bylaws, or interlocal agreement;

(b) Copies of all the insurance coverage documents;

(c) A description of the program structure, including participants' retention, program retention, and excess insurance limits and attachment point;

(d) An actuarial analysis, if required;

(e) A list of contractors and service providers;

(f) The financial and loss experience of the program; and

(g) Such other information as required by rule of the state risk manager.

(5) No self-insurance program requiring the state risk manager's approval may engage in an act or practice that in any respect significantly differs from the management and operation plan that formed the basis for the state risk manager's approval of the program unless the program first notifies the state risk manager in writing and obtains the state risk manager's approval. The state risk manager shall approve or disapprove the proposed change within sixty days of receipt of the notice. If the state risk manager denies a requested change, the risk manager shall specify in detail the reasons for denial and the manner in which the program would fail to meet the requirements of this chapter or any rules adopted in accordance with this chapter. [1991 sp.s. c 30 § 9.]

48.62.101 Access to information—Executive sessions—Public records act. (1) All self-insurance programs governed by this chapter may provide for executive sessions in accordance with chapter 42.30 RCW to consider litigation and settlement of claims when it appears that public discus-

sion of these matters would impair the program's ability to conduct its business effectively.

(2) Notwithstanding any provision to the contrary contained in the public records act, chapter 42.56 RCW, in a claim or action against the state or a local government entity, no person is entitled to discover that portion of any funds or liability reserve established for purposes of satisfying a claim or cause of action, except that the reserve is discoverable in a supplemental or ancillary proceeding to enforce a judgment. All other records of individual or joint self-insurance programs are subject to disclosure in accordance with chapter 42.56 RCW.

(3) In accordance with chapter 42.56 RCW, bargaining groups representing local government employees shall have reasonable access to information concerning the experience and performance of any health and welfare benefits program established for the benefit of such employees. [2005 c 274 § 316; 1991 sp.s. c 30 § 10.]

48.62.111 Investments—Designated treasurer—Deposit requirements—Bond. (1) The assets of a joint self-insurance program governed by this chapter may be invested only in accordance with the general investment authority that participating members possess as a governmental entity.

(2) Except as provided in subsection (3) of this section, a joint self-insurance program may invest all or a portion of its assets by depositing the assets with the treasurer of a county within whose territorial limits any of its member local government entities lie, to be invested by the treasurer for the joint program.

(3) Local government members of a joint self-insurance program, and the board of pilotage commissioners, may by resolution of the program designate some other person having experience in financial or fiscal matters as treasurer of the program, if that designated treasurer is located in Washington state. The program shall, unless the program's treasurer is a county treasurer, require a bond obtained from a surety company authorized to do business in Washington in an amount and under the terms and conditions that the program finds will protect against loss arising from mismanagement or malfeasance in investing and managing program funds. The program may pay the premium on the bond.

All program funds must be paid to the treasurer and shall be disbursed by the treasurer only on warrants issued by the treasurer or a person appointed by the program and upon orders or vouchers approved by the program or as authorized under chapters 35A.40 and 42.24 RCW. The treasurer shall establish a program account, into which shall be recorded all program funds, and the treasurer shall maintain special accounts as may be created by the program into which the treasurer shall record all money as the program may direct by resolution.

(4) The treasurer of the joint program shall deposit all program funds in a public depository or depositories as defined in RCW 39.58.010(15) and under the same restrictions, contracts, and security as provided for any participating member, and the depository shall be designated by resolution of the program.

(5) A joint self-insurance program may invest all or a portion of its assets by depositing the assets with the state investment board, to be invested by the state investment

board in accordance with chapter 43.33A RCW. The state investment board shall designate a manager for those funds to whom the program may direct requests for disbursement upon orders or vouchers approved by the program or as authorized under chapters 35A.40 and 42.24 RCW.

(6) All interest and earnings collected on joint program funds belong to the program and must be deposited to the program's credit in the proper program account.

(7) A joint program may require a reasonable bond from any person handling money or securities of the program and may pay the premium for the bond.

(8) Subsections (3) and (4) of this section do not apply to a multistate joint self-insurance program governed by RCW 48.62.081. [2019 c 26 § 4; 2003 c 248 § 20; 1991 sp.s. c 30 § 11.]

48.62.121 General operating regulations—Employee remuneration—Governing control—School districts—Use of insurance producers and surplus line brokers—Health care services—Trusts. (1) No employee or official of a local government entity or the board of pilotage commissioners may directly or indirectly receive anything of value for services rendered in connection with the operation and management of a self-insurance program other than the salary and benefits provided by his or her employer or the reimbursement of expenses reasonably incurred in furtherance of the operation or management of the program. No employee or official of a local government entity or the board of pilotage commissioners may accept or solicit anything of value for personal benefit or for the benefit of others under circumstances in which it can be reasonably inferred that the employee's or official's independence of judgment is impaired with respect to the management and operation of the program.

(2)(a) No local government entity may participate in a joint self-insurance program in which local government entities do not retain complete governing control. This prohibition does not apply to:

(i) Local government contribution to a self-insured employee health and welfare benefits plan otherwise authorized and governed by state statute;

(ii) Local government participation in a multistate joint program where control is shared with local government entities from other states;

(iii) Local government contribution to a self-insured employee health and welfare benefit trust in which the local government shares governing control with their employees; or

(iv) Local government participation in a joint self-insurance program with the board of pilotage commissioners, as authorized in RCW 48.62.037.

(b) If a local government self-insured health and welfare benefit program, established by the local government as a trust, shares governing control of the trust with its employees:

(i) The local government must maintain at least a fifty percent voting control of the trust;

(ii) No more than one voting, nonemployee, union representative selected by employees may serve as a trustee; and

(iii) The trust agreement must contain provisions for resolution of any deadlock in the administration of the trust.

(3) Moneys made available and moneys expended by school districts and educational service districts for self-insurance under this chapter are subject to such rules of the superintendent of public instruction as the superintendent may adopt governing budgeting and accounting. However, the superintendent shall ensure that the rules are consistent with those adopted by the state risk manager for the management and operation of self-insurance programs.

(4) RCW 48.30.140, 48.30.150, 48.30.155, and 48.30.157 apply to the use of insurance producers and surplus line brokers by local government self-insurance programs.

(5) Every individual and joint local government self-insured health and welfare benefits program that provides comprehensive coverage for health care services shall include mandated benefits that the state health care authority is required to provide under RCW 41.05.170 and 41.05.180. The state risk manager may adopt rules identifying the mandated benefits.

(6) An employee health and welfare benefit program established as a trust shall contain a provision that trust funds be expended only for purposes of the trust consistent with statutes and rules governing the local government or governments creating the trust. [2019 c 26 § 5; 2009 c 162 § 29; 2008 c 217 § 62; 1993 c 458 § 1; 1991 sp.s. c 30 § 12.]

Additional notes found at www.leg.wa.gov

48.62.123 Existing benefit program established as a trust—Risk manager—Limited extension of deadline for compliance. No local government self-insured employee health and welfare benefit program established as a trust by a local government entity or entities prior to July 25, 1993, may continue in operation unless such program complies with the provisions of this chapter within one hundred eighty days after July 25, 1993. The state risk manager may extend such period if the risk manager finds that such local government entity or entities are making a good faith effort and taking all necessary steps to comply with this chapter; however, in no event may the risk manager extend the period required for compliance more than ninety days after the expiration of the initial one hundred eighty-day period. [1993 c 458 § 2.]

Additional notes found at www.leg.wa.gov

48.62.125 Educational service districts—Rules—Superintendent of public instruction. All rules adopted by the superintendent of public instruction by January 1, 1992, that apply to self-insurance programs of educational service districts remain in effect until expressly amended, repealed, or superseded by the state risk manager or the state health care authority. [1991 sp.s. c 30 § 31.]

48.62.131 Preexisting programs—Notice to state auditor. Every local government entity that has established a self-insurance program not subject to the prior approval requirements of this chapter shall provide written notice to the state auditor of the existence of the program. The notice must identify the manager of the program and the class or classes of risk self-insured. The notice must also identify all investments and distribution of assets of the program, the current depository of assets and the program's designation of asset depository and investment agent as required by RCW 48.62.111. In addition, the local government entity shall

notify the state auditor whenever the program covers a new class of risk or discontinues the self-insurance of a class of risk. [1991 sp.s. c 30 § 13.]

48.62.141 Insufficient assets—Program requirement. Every joint self-insurance program covering liability or property risks, excluding multistate programs governed by RCW 48.62.081 and nonprofit risk pools formed under *RCW 48.62.036 and chapter 48.180 RCW, shall provide for the contingent liability of participants in the program if assets of the program are insufficient to cover the program's liabilities. [2015 c 109 § 4; 1991 sp.s. c 30 § 14.]

*Reviser's note: RCW 48.62.036 was repealed by 2015 c 109 § 18.

48.62.151 Insurance premium taxes—Exemption. A joint self-insurance program approved in accordance with this chapter is exempt from insurance premium taxes, from fees assessed under chapter 48.02 RCW, from chapters 48.32 and 48.32A RCW, from business and occupations taxes imposed under chapter 82.04 RCW, and from any assigned risk plan or joint underwriting association otherwise required by law. This section does not apply to and no exemption is provided for insurance companies issuing policies to cover program risks, nor does it apply to or provide an exemption for third-party administrators, surplus line brokers, or insurance producers serving the self-insurance program. [2009 c 162 § 30; 2008 c 217 § 63; 1991 sp.s. c 30 § 15.]

Additional notes found at www.leg.wa.gov

48.62.161 Establishment of fee to cover costs—State risk manager. (1) The state risk manager shall establish and charge an investigation fee in an amount necessary to cover the costs for the initial review and approval of a self-insurance program. The fee must accompany the initial submission of the plan of operation and management.

(2) The costs of subsequent reviews and investigations shall be charged to the self-insurance program being reviewed or investigated in accordance with the actual time and expenses incurred in the review or investigation.

(3) The state risk manager may calculate, levy, and collect from each joint property and liability self-insurance program and each individual and joint health and welfare benefit program regulated by this chapter a start-up assessment to pay initial expenses and operating costs of the risk manager's office in administering this chapter. Any program failing to remit its assessment when due is subject to denial of permission to operate or to a cease and desist order until the assessment is paid. [2010 1st sp.s. c 7 § 56; 1991 sp.s. c 30 § 16.]

Additional notes found at www.leg.wa.gov

48.62.171 Dissemination of information—Civil immunity. (1) Any person who files reports or furnishes other information required under Title 48 RCW, required by the risk manager or the state auditor under authority granted by Title 48 RCW, or which is useful to the risk manager or the state auditor in the administration of Title 48 RCW, shall be immune from liability in any civil action or suit arising from the filing of any such report or furnishing such information to the risk manager or to the state auditor, unless actual malice, fraud, or bad faith is shown.

(2) The risk manager and the state auditor, and the agents and employees of each, are immune from liability in any civil action or suit arising from the publication of any report or bulletins or arising from dissemination of information related to the official activities of the risk manager, the advisory boards, or the state auditor, unless actual malice, fraud, or bad faith is shown.

(3) The immunity granted by this section is in addition to any common law or statutory privilege or immunity enjoyed by such person, and nothing in this section is intended to abrogate or modify in any way such common law or statutory privilege or immunity. [1991 sp.s. c 30 § 17.]

48.62.900 Effective date, implementation, application—1991 sp.s. c 30. (1) This act shall take effect January 1, 1992, but the state risk manager shall take all steps necessary to implement this act on its effective date.

(2) Every individual local government self-insured employee health and welfare plan and self-insurance program that has been in continuous operation for at least one year before January 1, 1992, need not obtain approval to continue operations until January 1, 1993, but must comply with all other provisions of this act.

(3) Local government entity authority to self-insure employee health and welfare benefits applies retroactively to 1979. [1991 sp.s. c 30 § 30.]

Chapter 48.64 RCW

AFFORDABLE HOUSING ENTITIES—JOINT SELF-INSURANCE PROGRAMS

Sections

48.64.005	Intent—Liberal construction.
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48.64.090	Program may designate treasurer—Bond.
48.64.100	Employees or officials of a participating affordable housing entity—Restrictions on receiving anything of value.
48.64.110	Programs are exempt from certain taxes and fees.
48.64.120	Investigation fee—Amount determined by state risk manager.
48.64.130	Immunity from liability in civil actions—Filing, furnishing, or using information.
48.64.900	Effective date—2009 c 314.

48.64.005 Intent—Liberal construction. This chapter is intended to provide authority for two or more affordable housing entities to participate in a joint self-insurance program covering property or liability risks. This chapter provides affordable housing entities with the exclusive source of authority to jointly self-insure property and liability risks, jointly purchase insurance or reinsurance, and to contract for risk management, claims, and administrative services with other affordable housing entities. This chapter must be liberally construed to grant affordable housing entities maximum

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flexibility in jointly self-insuring to the extent the self-insurance programs are operated in a safe and sound manner. This chapter is intended to require prior approval for the establishment of every joint self-insurance program. In addition, this chapter is intended to require every joint self-insurance program for affordable housing entities established under this chapter to notify the state of the existence of the program and to comply with the regulatory and statutory standards governing the management and operation of the programs as provided in this chapter. This chapter is not intended to authorize or regulate self-insurance of unemployment compensation under chapter 50.44 RCW or industrial insurance under chapter 51.14 RCW. [2009 c 314 § 1.]

48.64.010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Affordable housing" means housing projects in which some of the dwelling units may be purchased or rented on a basis that is affordable to households with an income of eighty percent or less of the county median family income, adjusted for family size.

(2) "Affordable housing entity" means any of the following:

(a) A housing authority created under the laws of this state or another state and any agency or instrumentality of a housing authority including, but not limited to, a legal entity created to conduct a joint self-insurance program for housing authorities that is operating in accordance with chapter 48.62 RCW;

(b) A nonprofit corporation, whether organized under the laws of this state or another state, that is engaged in providing affordable housing and is necessary for the completion, management, or operation of a project because of its access to funding sources that are not available to a housing authority, as described in this section; or

(c) A general or limited partnership or limited liability company, whether organized under the laws of this state or another state, that is engaged in providing affordable housing as defined in this section. A partnership or limited liability company may only be considered an affordable housing entity if a housing authority or nonprofit corporation, as described in this subsection, satisfies any of the following conditions: (i) It has, or has the right to acquire, a financial or ownership interest in the partnership or limited liability company; (ii) it possesses the power to direct management or policies of the partnership or limited liability company; or (iii) it has entered into a contract to lease, manage, or operate the affordable housing owned by the partnership or limited liability company.

(3) "Property and liability risks" includes the risk of property damage or loss sustained by an affordable housing entity and the risk of claims arising from the tortious or negligent conduct or any error or omission of the entity, its officers, employees, agents, or volunteers as a result of which a claim may be made against the entity.

(4) "Self-insurance" means a formal program of advance funding and management of entity financial exposure to a risk of loss that is not transferred through the purchase of an insurance policy or contract.

(5) "State risk manager" means the risk manager of the office of risk management within the department of enterprise services. [2011 1st sp.s. c 43 § 521; 2009 c 314 § 2.]

Effective date—Purpose—2011 1st sp.s. c 43: See notes following RCW 43.19.003.

48.64.020 Rules necessary to implement multistate program—State risk manager. Prior to the approval of a multistate joint self-insurance program for affordable housing entities, the state risk manager shall adopt rules further clarifying the definitions of "affordable housing" and "affordable housing entity" as defined in RCW 48.64.010, and the conditions and limitations under which affordable housing entities may participate or be expelled from the joint self-insurance program. [2009 c 314 § 3.]

48.64.030 Authority to join or form program—Requirements—Terms of agreement. (1) The governing body of an affordable housing entity may join or form a self-insurance program together with one or more other affordable housing entities, and may jointly purchase insurance or reinsurance with one or more other affordable housing entities for property and liability risks only as permitted under this chapter. Affordable housing entities may contract for or hire personnel to provide risk management, claims, and administrative services in accordance with this chapter.

(2) The agreement to form a joint self-insurance program may include the organization of a separate legal or administrative entity with powers delegated to the entity. The entity may be a nonprofit corporation, limited liability company, partnership, trust, or other form of entity, whether organized under the laws of this state or another state.

(3) If provided for in the organizational documents, a joint self-insurance program may, in conformance with this chapter:

(a) Contract or otherwise provide for risk management and loss control services;

(b) Contract or otherwise provide legal counsel for the defense of claims and other legal services;

(c) Consult with the state insurance commissioner and the state risk manager;

(d) Jointly purchase insurance and reinsurance coverage in a form and amount as provided for in the organizational documents;

(e) Obligate the program's participants to pledge revenues or contribute money to secure the obligations or pay the expenses of the program, including the establishment of a reserve or fund for coverage; and

(f) Possess any other powers and perform all other functions reasonably necessary to carry out the purposes of this chapter.

(4) Every joint self-insurance program governed by this chapter must appoint the state risk manager as its attorney to receive service of, and upon whom must be served, all legal process issued against the program in this state upon causes of action arising in this state.

(a) Service upon the state risk manager as attorney constitutes service upon the program. Service upon joint self-insurance programs subject to this chapter may only occur by service upon the state risk manager. At the time of service,

the plaintiff shall pay to the state risk manager a fee to be set by the state risk manager, taxable as costs in the action.

(b) With the initial filing for approval with the state risk manager, each joint self-insurance program must designate by name and address the person to whom the state risk manager must forward legal process that is served upon him or her. The joint self-insurance program may change this person by filing a new designation.

(c) The appointment of the state risk manager as attorney is irrevocable, binds any successor in interest or to the assets or liabilities of the joint self-insurance program, and remains in effect as long as there is in force in this state any contract made by the joint self-insurance program or liabilities or duties arising from the contract.

(d) The state risk manager shall keep a record of the day and hour of service upon him or her of all legal process. A copy of the process, by registered mail with return receipt requested, must be sent by the state risk manager to the person designated to receive legal process by the joint self-insurance program in its most recent designation filed with the state risk manager. Proceedings must not commence against the joint self-insurance program, and the program must not be required to appear, plead, or answer, until the expiration of forty days after the date of service upon the state risk manager. [2009 c 314 § 4.]

48.64.040 When chapter not applicable. This chapter does not apply to an affordable housing entity that:

(1) Individually self-insures for property and liability risks; or

(2) Participates in a risk pooling arrangement, including a risk retention group or a risk purchasing group, regulated under chapter 48.92 RCW, or is a captive insurer authorized in its state of domicile. [2009 c 314 § 5.]

48.64.050 Management and operation of programs—Rules adopted by state risk manager. The state risk manager shall adopt rules governing the management and operation of joint self-insurance programs for affordable housing entities that cover property or liability risks. All rules must be appropriate for the type of program and class of risk covered. The state risk manager's rules must include:

(1) Standards for the management, operation, and solvency of joint self-insurance programs, including the necessity and frequency of actuarial analyses and claims audits;

(2) Standards for claims management procedures;

(3) Standards for contracts between joint self-insurance programs and private businesses, including standards for contracts between third-party administrators and programs; and

(4) Standards that preclude housing authorities or other public entities participating in the joint self-insurance program from subsidizing, regardless of the form of subsidy, affordable housing entities that are not housing authorities or public entities. These standards do not apply to the consideration attributable to the ownership interest of a housing authority or public entity in a separate legal or administrative entity organized with respect to the program. [2009 c 314 § 6.]

48.64.060 Program approval required from state risk manager—Plan submission. Before the establishment of a joint self-insurance program covering property or liability risks by affordable housing entities, the entities must obtain the approval of the state risk manager. The entities proposing the creation of a joint self-insurance program requiring prior approval shall submit a plan of management and operation to the state risk manager that provides at least the following information:

- (1) The risk or risks to be covered, including any coverage definitions, terms, conditions, and limitations;
- (2) The amount and method of funding the covered risks, including the initial capital and proposed rates and projected premiums;
- (3) The proposed claim reserving practices;
- (4) The proposed purchase and maintenance of insurance or reinsurance in excess of the amounts retained by the joint self-insurance program;
- (5) The legal form of the program including, but not limited to, any articles of incorporation, bylaws, charter, or trust agreement or other agreement among the participating entities;
- (6) The agreements with participants in the program defining the responsibilities and benefits of each participant and management;
- (7) The proposed accounting, depositing, and investment practices of the program;
- (8) The proposed time when actuarial analysis will be first conducted and the frequency of future actuarial analysis;
- (9) A designation of the individual to whom service of process must be forwarded by the state risk manager on behalf of the program;
- (10) All contracts between the program and private persons providing risk management, claims, or other administrative services;
- (11) A professional analysis of the feasibility of the creation and maintenance of the program;
- (12) A legal determination of the potential federal and state tax liabilities of the program; and
- (13) Any other information required by rule of the state risk manager that is necessary to determine the probable financial and management success of the program or that is necessary to determine compliance with this chapter. [2009 c 314 § 7.]

48.64.070 Multistate programs—Conditions and requirements for participation. An affordable housing entity may participate in a joint self-insurance program covering property or liability risks with similar affordable housing entities from other states if the program satisfies the following requirements:

- (1) An ownership interest in the program is limited to some or all of the affordable housing entities of this state and affordable housing entities of other states that are provided insurance by the program;
- (2) The participating affordable housing entities of this state and other states shall elect a board of directors to manage the program, a majority of whom must be affiliated with one or more of the participating affordable housing entities;
- (3) The program must provide coverage through the delivery to each participating affordable housing entity of

one or more written policies affecting insurance of covered risks;

(4) The program must be financed, including the payment of premiums and the contribution of initial capital, in accordance with the plan of management and operation submitted to the state risk manager in accordance with this chapter;

(5) The financial statements of the program must be audited annually by the certified public accountants for the program, and these audited financial statements must be delivered to the state risk manager not more than one hundred twenty days after the end of each fiscal year of the program;

(6) The investments of the program must be initiated only with financial institutions or broker-dealers, or both, doing business in those states in which participating affordable housing entities are located, and these investments must be audited annually by the certified public accountants for the program;

(7) The treasurer of a multistate joint self-insurance program must be designated by resolution of the program and the treasurer must be located in the state of one of the participating entities;

(8) The participating affordable housing entities may have no contingent liabilities for covered claims, other than liabilities for unpaid premiums, if assets of the program are insufficient to cover the program's liabilities; and

(9) The program must obtain approval from the state risk manager in accordance with this chapter and must remain in compliance with this chapter, except if provided otherwise under this section. [2009 c 314 § 8.]

48.64.080 Program approval or disapproval—Plan review—State risk manager's duties—Violations—Fines—Annual program reports. (1) Within one hundred twenty days of receipt of a plan of management and operation, the state risk manager shall either approve or disapprove of the formation of the joint self-insurance program after reviewing the plan to determine whether the proposed program complies with this chapter and all rules adopted in accordance with this chapter.

(2) If the state risk manager denies a request for approval, the state risk manager shall specify in detail the reasons for denial and the manner in which the program fails to meet the requirements of this chapter or any rules adopted in accordance with this chapter.

(3) If the state risk manager determines that a joint self-insurance program covering property or liability risks is in violation of this chapter or is operating in an unsafe financial condition, the state risk manager may issue and serve upon the program an order to cease and desist from the violation or practice.

(a) The state risk manager shall deliver the order to the appropriate entity or entities directly or mail it to the appropriate entity or entities by certified mail with return receipt requested.

(b) If the program violates the order or has not taken steps to comply with the order after the expiration of twenty days after the cease and desist order has been received by the program, the program is deemed to be operating in violation of this chapter, and the state risk manager shall notify the attorney general of the violation.

(c) After hearing or with the consent of a program governed under this chapter and in addition to or in lieu of a continuation of the cease and desist order, the state risk manager may levy a fine upon the program in an amount not less than three hundred dollars and not more than ten thousand dollars. The order levying the fine must specify the period within which the fine must be fully paid. The period within which the fines must be paid must not be less than fifteen and no more than thirty days from the date of the order. Upon failure to pay the fine when due, the state risk manager shall request the attorney general to bring a civil action on the state risk manager's behalf to collect the fine. The state risk manager shall pay any fine collected to the state treasurer for the account of the general fund.

(4) Each joint self-insurance program approved by the state risk manager shall annually file a report with the state risk manager providing:

(a) Details of any changes in the articles of incorporation, bylaws, charter, or trust agreement or other agreement among the participating affordable housing entities;

(b) Copies of all the insurance coverage documents;

(c) A description of the program structure, including participants' retention, program retention, and excess insurance limits and attachment point;

(d) An actuarial analysis;

(e) A list of contractors and service providers;

(f) The financial and loss experience of the program; and

(g) Other information as required by rule of the state risk manager.

(5) A joint self-insurance program requiring the state risk manager's approval may not engage in an act or practice that in any respect significantly differs from the management and operation plan that formed the basis for the state risk manager's approval of the program unless the program first notifies the state risk manager in writing and obtains the state risk manager's approval. The state risk manager shall approve or disapprove the proposed change within sixty days of receipt of the notice. If the state risk manager denies a requested change, the state risk manager shall specify in detail the reasons for the denial and the manner in which the program would fail to meet the requirements of this chapter or any rules adopted in accordance with this chapter. [2009 c 314 § 9.]

48.64.090 Program may designate treasurer—Bond.

(1) A joint self-insurance program may by resolution of the program designate a person having experience with investments or financial matters as treasurer of the program. The program must require a bond obtained from a surety company in an amount and under the terms and conditions that the program finds will protect against loss arising from mismanagement or malfeasance in investing and managing program funds. The program may pay the premium on the bond.

(2) All interest and earnings collected on joint self-insurance program funds belong to the program and must be deposited to the program's credit in the proper program account. [2009 c 314 § 10.]

48.64.100 Employees or officials of a participating affordable housing entity—Restrictions on receiving anything of value. (1) An employee or official of a participating

affordable housing entity in a joint self-insurance program may not directly or indirectly receive anything of value for services rendered in connection with the operation and management of a self-insurance program other than the salary and benefits provided by his or her employer or the reimbursement of expenses reasonably incurred in furtherance of the operation or management of the program. An employee or official of a participating affordable housing entity in a joint self-insurance program may not accept or solicit anything of value for personal benefit or for the benefit of others under circumstances in which it can be reasonably inferred that the employee's or official's independence of judgment is impaired with respect to the management and operation of the program.

(2) RCW 48.30.140, 48.30.150, and 48.30.157 apply to the use of insurance producers by a joint self-insurance program. [2009 c 314 § 11.]

48.64.110 Programs are exempt from certain taxes and fees.

A joint self-insurance program approved in accordance with this chapter is exempt from insurance premium taxes, fees assessed under chapter 48.02 RCW, chapters 48.32 and 48.32A RCW, business and occupation taxes imposed under chapter 82.04 RCW, and any assigned risk plan or joint underwriting association otherwise required by law. This section does not apply to, and no exemption is provided for, insurance companies issuing policies to cover program risks, and does not apply to or provide an exemption for third-party administrators or insurance producers serving the joint self-insurance program. [2009 c 314 § 12.]

48.64.120 Investigation fee—Amount determined by state risk manager.

(1) The state risk manager shall establish and charge an investigation fee in an amount necessary to cover the costs for the initial review and approval of a joint self-insurance program. The fee must accompany the initial submission of the plan of operation and management.

(2) The costs of subsequent reviews and investigations must be charged to the joint self-insurance program being reviewed or investigated in accordance with the actual time and expenses incurred in the review or investigation.

(3) Any program failing to remit its assessment when due is subject to denial of permission to operate or to a cease and desist order until the assessment is paid. [2009 c 314 § 13.]

48.64.130 Immunity from liability in civil actions—Filing, furnishing, or using information.

(1) Any person who files reports or furnishes other information required under this title, required by the state risk manager under the authority granted under this title, or which is useful to the state risk manager in the administration of this title, is immune from liability in any civil action or suit arising from the filing of any such report or furnishing such information to the state risk manager, unless actual malice, fraud, or bad faith is shown.

(2) The state risk manager and his or her agents and employees are immune from liability in any civil action or suit arising from the publication of any report or bulletins or arising from dissemination of information related to the offi-

cial activities of the state risk manager unless actual malice, fraud, or bad faith is shown.

(3) The immunity granted under this section is in addition to any common law or statutory privilege or immunity enjoyed by such person. This section is not intended to abrogate or modify in any way such common law or statutory privilege or immunity. [2010 c 8 § 11007; 2009 c 314 § 14.]

48.64.900 Effective date—2009 c 314. This act takes effect January 1, 2010. [2009 c 314 § 17.]

Chapter 48.66 RCW MEDICARE SUPPLEMENTAL HEALTH INSURANCE ACT

Sections

48.66.010	Short title—Intent—Application of chapter.
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48.66.025	Restrictions on issuers—Age of applicants—Preexisting conditions.
48.66.030	Renewability—Benefit standards—Benefit limitations.
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48.66.041	Minimum standards required by rule—Waiver.
48.66.045	Mandated coverage for replacement policies—Rates on a community-rated basis.
48.66.050	Policy or certificate provisions prohibited by rule—Waivers restricted.
48.66.055	Termination or disenrollment—Application for coverage—Eligible persons—Types of policies—Guaranteed issue periods.
48.66.057	Rejection of medicare eligible person—When notice and information must be provided to applicant.
48.66.060	Equal coverage of sickness and accidents.
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48.66.140	Medical history.
48.66.150	Reporting and recordkeeping, separate data required.
48.66.160	Federal law supersedes.
48.66.165	Conformity with federal law—Rules.
48.66.910	Effective date—1981 c 153.
48.66.920	Construction—Chapter applicable to state registered domestic partnerships—2009 c 521.

48.66.010 Short title—Intent—Application of chapter. This chapter shall be known and may be cited as "The Medicare Supplemental Health Insurance Act" and is intended to govern the content and sale of medicare supplemental insurance as defined in this chapter. The provisions of this chapter shall apply in addition to, rather than in place of, other requirements of Title 48 RCW. [1981 c 153 § 1.]

48.66.020 Definitions. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Medicare supplemental insurance" or "medicare supplement insurance policy" refers to a group or individual policy of disability insurance or a subscriber contract of a health care service contractor, a health maintenance organization, or a fraternal benefit society, which relates its benefits to medicare, or which is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare

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for the hospital, medical, or surgical expenses of persons eligible for medicare. Such term does not include:

(a) A policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations; or

(b) A policy issued pursuant to a contract under section 1876 of the federal social security act (42 U.S.C. Sec. 1395 et seq.), or an issued policy under a demonstration specified in 42 U.S.C. Sec. 1395(g)(1); or

(c) Medicare advantage plans established under medicare part C; or

(d) Outpatient prescription drug plans established under medicare part D; or

(e) Any health care prepayment plan that provides benefits pursuant to an agreement under section 1833(a)(1)(A) of the federal social security act.

(2) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

(3) "Medicare advantage plan" means a plan of coverage for health benefits under medicare part C as defined in 42 U.S.C. Sec. 1395w-28(b), and includes:

(a) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

(b) Medical savings account plans coupled with a contribution into a medicare advantage plan medical savings account; and

(c) Medicare advantage private fee-for-service plans.

(4) "Medicare eligible expenses" means health care expenses of the kinds covered by medicare parts A and B, to the extent recognized as reasonable and medically necessary by medicare.

(5) "Applicant" means:

(a) In the case of an individual medicare supplement insurance policy or subscriber contract, the person who seeks to contract for insurance benefits; and

(b) In the case of a group medicare supplement insurance policy or subscriber contract, the proposed certificate holder.

(6) "Certificate" means any certificate delivered or issued for delivery in this state under a group medicare supplement insurance policy.

(7) "Loss ratio" means the incurred claims as a percentage of the earned premium computed under rules adopted by the insurance commissioner.

(8) "Preexisting condition" means a covered person's medical condition that caused that person to have received medical advice or treatment during a specified time period immediately prior to the effective date of coverage.

(9) "Disclosure form" means the form designated by the insurance commissioner which discloses medicare benefits, the supplemental benefits offered by the insurer, and the remaining amount for which the insured will be responsible.

(10) "Issuer" includes insurance companies, health care service contractors, health maintenance organizations, fraternal benefit societies, and any other entity delivering or issu-

ing for delivery medicare supplement policies or certificates to a resident of this state.

(11) "Bankruptcy" means when a medicare advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

(12) "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three days.

(13)(a) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

- (i) A group health plan;
- (ii) Health insurance coverage;
- (iii) Part A or part B of Title XVIII of the social security act (medicare);
- (iv) Title XIX of the social security act (medicaid), other than coverage consisting solely of benefits under section 1928;
- (v) Chapter 55 of Title 10 U.S.C. (CHAMPUS);
- (vi) A medical care program of the Indian health service or of a tribal organization;
- (vii) A state health benefits risk pool;
- (viii) A health plan offered under chapter 89 of Title 5 U.S.C. (federal employees health benefits program);
- (ix) A public health plan as defined in federal regulation; and

(x) A health benefit plan under section 5(e) of the peace corps act (22 U.S.C. Sec. 2504(e)).

(b) "Creditable coverage" does not include one or more, or any combination, of the following:

- (i) Coverage only for accident or disability income insurance, or any combination thereof;
- (ii) Coverage issued as a supplement to liability insurance;
- (iii) Liability insurance, including general liability insurance and automobile liability insurance;
- (iv) Worker's compensation or similar insurance;
- (v) Automobile medical payment insurance;
- (vi) Credit-only insurance;
- (vii) Coverage for on-site medical clinics; and
- (viii) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(c) "Creditable coverage" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

- (i) Limited scope dental or vision benefits;
- (ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and
- (iii) Other similar, limited benefits as are specified in federal regulations.

(d) "Creditable coverage" does not include the following benefits if offered as independent, noncoordinated benefits:

- (i) Coverage only for a specified disease or illness; and
- (ii) Hospital indemnity or other fixed indemnity insurance.

(e) "Creditable coverage" does not include the following if it is offered as a separate policy, certificate, or contract of insurance:

- (i) Medicare supplemental health insurance as defined under section 1882(g)(1) of the social security act;
- (ii) Coverage supplemental to the coverage provided under chapter 55 of Title 10 U.S.C.; and
- (iii) Similar supplemental coverage provided to coverage under a group health plan.

(14) "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in 29 U.S.C. Sec. 1002 (employee retirement income security act).

(15) "Insolvency" means when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile. [2005 c 41 § 3; 1996 c 269 § 1; 1995 c 85 § 1; 1992 c 138 § 1; 1981 c 153 § 2.]

Intent—2005 c 41: See note following RCW 48.66.025.

Additional notes found at www.leg.wa.gov

48.66.025 Restrictions on issuers—Age of applicants—Preexisting conditions. (1) An issuer may not deny or condition the issuance or effectiveness of any medicare supplement policy or certificate available for sale in this state, or discriminate in the pricing of a policy or certificate, because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both sixty-five years of age or older and is enrolled for benefits under medicare part B. Each medicare supplement policy and certificate currently available from an insurer must be made available to all applicants who qualify under this subsection without regard to age.

(2) If an applicant qualifies under this section and submits an application during the time period referenced in subsection (1) of this section and, as of the date of application, has had a continuous period of creditable coverage of at least three months, the issuer may not exclude benefits based on a preexisting condition.

(3) If an applicant qualified under this section submits an application during the time period referenced in subsection (1) of this section and, as of the date of application, has had a continuous period of creditable coverage that is less than three months, the issuer must reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. [2005 c 41 § 2.]

Intent—2005 c 41: "This act is intended to satisfy the directive from the centers for medicare and medicaid services requiring states to implement changes to their medicare supplement insurance requirements to comply with the standards prescribed by the medicare modernization act that are consistent with amendments to the national association of insurance commissioners medicare supplement insurance minimum standards model act along with other corrections to be compliant with federal requirements." [2005 c 41 § 1.]

48.66.030 Renewability—Benefit standards—Benefit limitations. (1) A medicare supplement insurance policy which provides for the payment of benefits may not be based

on standards described as "usual and customary," "reasonable and customary," or words of similar import.

(2) Limitations on benefits, such as policy exclusions or waiting periods, shall be labeled in a separate section of the policy or placed with the benefit provisions to which they apply, rather than being included in other sections of the policy, rider, or endorsement. [1992 c 138 § 2; 1981 c 153 § 3.]

48.66.035 Commissioner's approval required. (1) A medicare supplement insurance policy or certificate form or application form, rider, or endorsement shall not be issued, delivered, or used unless it has been filed with and approved by the commissioner.

(2) Rates, or modification of rates, for medicare supplement policies or certificates shall not be used until filed with and approved by the commissioner.

(3) Every filing shall be received not less than thirty days in advance of any such issuance, delivery, or use. At the expiration of such thirty days the form or rate so filed shall be deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the commissioner. The commissioner may extend by not more than an additional fifteen days the period within which he or she may affirmatively approve or disapprove any such form or rate, by giving notice of such extension before expiration of the initial thirty-day waiting period. At the expiration of any such period as so extended, and in the absence of such prior affirmative approval or disapproval, any such form or rate shall be deemed approved. A filing of a form or rate or modification thereto may not be deemed approved unless the filing contains all required documents prescribed by the commissioner. The commissioner may withdraw any such approval at any time for cause. By approval of any such form or rate for immediate use, the commissioner may waive any unexpired portion of such initial thirty-day waiting period.

(4) The commissioner's order disapproving any such form or rate or withdrawing a previous approval shall state the grounds therefor.

(5) A form or rate shall not knowingly be issued, delivered, or used if the commissioner's approval does not then exist. [1992 c 138 § 3.]

48.66.041 Minimum standards required by rule—Waiver. (1) The insurance commissioner shall adopt rules to establish minimum standards for benefits in medicare supplement insurance policies and certificates.

(2) The commissioner shall adopt rules to establish specific standards for medicare supplement insurance policy or certificate provisions. These rules may include but are not limited to:

- (a) Terms of renewability;
- (b) Nonduplication of coverage;
- (c) Benefit limitations, exceptions, and reductions;
- (d) Definitions of terms;
- (e) Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements;
- (f) Establishing uniform methodology for calculating and reporting loss ratios;
- (g) Assuring public access to policies, premiums, and loss ratio information of an issuer of medicare supplement insurance;

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(h) Establishing a process for approving or disapproving proposed premium increases; and

(i) Establishing standards for medicare SELECT policies and certificates.

(3) The insurance commissioner may adopt rules that establish disclosure standards for replacement of policies or certificates by persons eligible for medicare.

(4) The insurance commissioner may by rule prescribe that an informational brochure, designed to improve the buyer's understanding of medicare and ability to select the most appropriate coverage, be provided to persons eligible for medicare by reason of age. The commissioner may require that the brochure be provided to applicants concurrently with delivery of the outline of coverage, except with respect to direct response insurance, when the brochure may be provided upon request but no later than the delivery of the policy.

(5) In the case of a state or federally qualified health maintenance organization, the commissioner may waive compliance with one or all provisions of this section until January 1, 1983. [1993 c 388 § 1; 1992 c 138 § 4; 1982 c 200 § 1.]

48.66.045 Mandated coverage for replacement policies—Rates on a community-rated basis. (1) Every issuer of a medicare supplement insurance policy or certificate providing coverage to a resident of this state issued on or after January 1, 1996, and before June 1, 2010, must:

(a) Unless otherwise provided for in RCW 48.66.055, issue coverage under its standardized benefit plans B, C, D, E, F, G, K, and L without evidence of insurability to any resident of this state who is eligible for both medicare hospital and physician services by reason of age or by reason of disability or end-stage renal disease, if the medicare supplement policy replaces another medicare supplement standardized benefit plan policy or certificate B, C, D, E, F, G, K, or L, or other more comprehensive coverage than the replacing policy; and

(b) Unless otherwise provided for in RCW 48.66.055, issue coverage under its standardized plans A, H, I, and J without evidence of insurability to any resident of this state who is eligible for both medicare hospital and physician services by reason of age or by reason of disability or end-stage renal disease, if the medicare supplement policy replaces another medicare supplement policy or certificate which is the same standardized plan as the replaced policy. After December 31, 2005, plans H, I, and J may be replaced only by the same plan if that plan has been modified to remove outpatient prescription drug coverage.

(2)(a) Unless otherwise provided for in RCW 48.66.055, every issuer of a medicare supplement insurance policy or certificate providing coverage to a resident of this state issued on or after June 1, 2010, must issue coverage under its standardized plans B, C, D, F, F with high deductible, G, G with high deductible, K, L, M, or N without evidence of insurability to any resident of this state who is eligible for both medicare hospital and physician services prior to January 1, 2020, by reason of age or by reason of disability or end-stage renal disease, if the medicare supplement policy or certificate replaces another medicare supplement policy or certificate or other more comprehensive coverage;

(b) Unless otherwise provided in RCW 48.66.055, every issuer of a medicare supplement insurance policy or certificate providing coverage to a resident of this state issued on or after January 1, 2020, must issue coverage under its standardized plans B, D, G, G with high deductible, K, L, M, or N without evidence of insurability to any resident of this state who is eligible for both medicare hospital and physician services on or after January 1, 2020, by reason of age, disability, or end-stage renal disease, if the medicare supplement policy or certificate replaces another medicare supplement policy or certificate or other more comprehensive coverage; and

(c) Unless otherwise provided for in RCW 48.66.055, issue coverage under its standardized plan A without evidence of insurability to any resident of this state who is eligible for both medicare hospital and physician services by reason of age or by reason of disability or end-stage renal disease, if the medicare supplement policy or certificate replaces another standardized plan A medicare supplement policy or certificate.

(3) Every issuer of a medicare supplement insurance policy or certificate providing coverage to a resident of this state issued on or after January 1, 1996, must set rates only on a community-rated basis. Premiums must be equal for all policyholders and certificate holders under a standardized medicare supplement benefit plan form, except that an issuer may vary premiums based on spousal discounts, frequency of payment, and method of payment including automatic deposit of premiums and may develop no more than two rating pools that distinguish between an insured's eligibility for medicare by reason of:

(a) Age; or

(b) Disability or end-stage renal disease. [2019 c 38 § 1; 2010 c 27 § 3; 2009 c 161 § 5; 2005 c 41 § 4; 2004 c 83 § 1; 1999 c 334 § 1; 1995 c 85 § 3.]

Intent—2005 c 41: See note following RCW 48.66.025.

Additional notes found at www.leg.wa.gov

48.66.050 Policy or certificate provisions prohibited by rule—Waivers restricted. (1) The insurance commissioner may issue reasonable rules that specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the commissioner, are unfair, unjust, or unfairly discriminatory to any person insured or proposed to be insured under a medicare supplement insurance policy or certificate.

(2) No medicare supplement insurance policy may use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions. [1992 c 138 § 5; 1981 c 153 § 5.]

48.66.055 Termination or disenrollment—Application for coverage—Eligible persons—Types of policies—Guaranteed issue periods. (1) Under this section, persons eligible for a medicare supplement policy or certificate are those individuals described in subsection (3) of this section who, subject to subsection (3)(b)(ii) of this section, apply to enroll under the policy not later than sixty-three days after the date of the termination of enrollment described in subsection (3) of this section, and who submit evidence of the date of termination or disenrollment, or medicare part D enrollment, with the application for a medicare supplement policy.

(2) With respect to eligible persons, an issuer may not deny or condition the issuance or effectiveness of a medicare supplement policy described in subsection (4) of this section that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a medicare supplement policy.

(3) "Eligible persons" means an individual that meets the requirements of (a), (b), (c), (d), (e), or (f) of this subsection, as follows:

(a) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;

(b)(i) The individual is enrolled with a medicare advantage organization under a medicare advantage plan under part C of medicare, and any of the following circumstances apply, or the individual is sixty-five years of age or older and is enrolled with a program of all inclusive care for the elderly (PACE) provider under section 1894 of the social security act, and there are circumstances similar to those described in this subsection (3)(b) that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a medicare advantage plan:

(A) The certification of the organization or plan has been terminated;

(B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(C) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary of the United States department of health and human services, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal social security act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856 of the federal social security act), or the plan is terminated for all individuals within a residence area;

(D) The individual demonstrates, in accordance with guidelines established by the secretary of the United States department of health and human services, that:

(I) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(II) The organization, an insurance producer, or other entity acting on the organization's behalf materially misrepresented the plan's provisions in marketing the plan to the individual; or

(E) The individual meets other exceptional conditions as the secretary of the United States department of health and human services may provide.

(ii)(A) An individual described in (b)(i) of this subsection may elect to apply (a) of this subsection by substituting, for the date of termination of enrollment, the date on which the individual was notified by the medicare advantage organization of the impending termination or discontinuance of the medicare advantage plan it offers in the area in which the individual resides, but only if the individual disenrolls from the plan as a result of such notification.

(B) In the case of an individual making the election under (b)(ii)(A) of this subsection, the issuer involved shall accept the application of the individual submitted before the date of termination of enrollment, but the coverage under subsection (1) of this section is only effective upon termination of coverage under the medicare advantage plan involved;

(c)(i) The individual is enrolled with:

(A) An eligible organization under a contract under section 1876 (medicare risk or cost);

(B) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(C) An organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan); or

(D) An organization under a medicare select policy; and

(ii) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under (b)(i) of this subsection;

(d) The individual is enrolled under a medicare supplement policy and the enrollment ceases because:

(i)(A) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(B) Of other involuntary termination of coverage or enrollment under the policy;

(ii) The issuer of the policy substantially violated a material provision of the policy; or

(iii) The issuer, an insurance producer, or other entity acting on the issuer's behalf materially misrepresented the policy's provisions in marketing the policy to the individual;

(e)(i) The individual was enrolled under a medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any medicare advantage organization under a medicare advantage plan under part C of medicare, any eligible organization under a contract under section 1876 (medicare risk or cost), any similar organization operating under demonstration project authority, any PACE program under section 1894 of the social security act or a medicare select policy; and

(ii) The subsequent enrollment under (e)(i) of this subsection is terminated by the enrollee during any period within the first twelve months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal social security act);

(f) The individual, upon first becoming eligible for benefits under part A of medicare at age sixty-five, enrolls in a medicare advantage plan under part C of medicare, or in a PACE program under section 1894, and disenrolls from the plan or program by not later than twelve months after the effective date of enrollment; or

(g) The individual enrolls in a medicare part D plan during the initial enrollment period and, at the time of enrollment in part D, was enrolled under a medicare supplement

policy that covers outpatient prescription drugs, and the individual terminates enrollment in the medicare supplement policy and submits evidence of enrollment in medicare part D along with the application for a policy described in subsection (4)(a)(iv) of this section.

(4)(a) An eligible person under subsection (3) of this section is entitled to a medicare supplement policy as follows:

(i) A person eligible under subsection (3)(a), (b), (c), and (d) of this section is entitled to a medicare supplement policy that has a benefit package classified as plan A through F (including F with a high deductible), K, or L, offered by any issuer;

(ii)(A) Subject to (a)(ii)(B) of this subsection, a person eligible under subsection (3)(e) of this section is entitled to the same medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in (a)(i) of this subsection;

(B) After December 31, 2005, if the individual was most recently enrolled in a medicare supplement policy with an outpatient prescription drug benefit, a medicare supplement policy described in this subsection (4)(a)(ii)(B) is:

(I) The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(II) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K, or L policy that is offered by any issuer;

(iii) A person eligible under subsection (3)(f) of this section is entitled to any medicare supplement policy offered by any issuer; and

(iv) A person eligible under subsection (3)(g) of this section is entitled to a medicare supplement policy that has a benefit package classified as plan A, B, C, F (including F with a high deductible), K, or L and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's medicare supplement policy with outpatient prescription drug coverage.

(b) For purposes of this subsection (4), in the case of any individual newly eligible for medicare on or after January 1, 2020, any reference to a medicare supplement policy C or F, including F with high deductible, is deemed to be a reference to a medicare supplement policy D or G, including G with high deductible, respectively, that meets the requirements of this subsection.

(5)(a) At the time of an event described in subsection (3) of this section, and because of which an individual loses coverage or benefits due to the termination of a contract, agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, must notify the individual of his or her rights under this section, and of the obligations of issuers of medicare supplement policies under subsection (1) of this section. The notice must be communicated contemporaneously with the notification of termination.

(b) At the time of an event described in subsection (3) of this section, and because of which an individual ceases enrollment under a contract, agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, must

notify the individual of his or her rights under this section, and of the obligations of issuers of medicare supplement policies under subsection (1) of this section. The notice must be communicated within ten working days of the issuer receiving notification of disenrollment.

(6) Guaranteed issue time periods:

(a) In the case of an individual described in subsection (3)(a) of this section, the guaranteed issue period begins on the later of: (i) The date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation), or (ii) the date that the applicable coverage terminates or ceases, and ends sixty-three days thereafter;

(b) In the case of an individual described in subsection (3)(b), (c), (e), or (f) of this section whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three days after the date the applicable coverage is terminated;

(c) In the case of an individual described in subsection (3)(d)(i) of this section, the guaranteed issue period begins on the earlier of: (i) The date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three days after the date the coverage is terminated;

(d) In the case of an individual described in subsection (3)(b), (d)(ii) and (iii), (e), or (f) of this section, who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty days before the effective date of the disenrollment and ends on the date that is sixty-three days after the effective date;

(e) In the case of an individual described in subsection (3)(g) of this section, the guaranteed issue period begins on the date the individual receives notice pursuant to section 1882(v)(2)(B) of the federal social security act from the medicare supplement issuer during the sixty-day period immediately preceding the initial part D enrollment period and ends on the date that is sixty-three days after the effective date of the individual's coverage under medicare part D; and

(f) In the case of an individual described in subsection (3) of this section but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three days after the effective date.

(7) In the case of an individual described in subsection (3)(e) of this section whose enrollment with an organization or provider described in subsection (3)(e)(i) of this section is involuntarily terminated within the first twelve months of enrollment, and who, without an intervening enrollment, enrolls with another organization or provider, the subsequent enrollment is an initial enrollment as described in subsection (3)(e) of this section.

(8) In the case of an individual described in subsection (3)(f) of this section whose enrollment with a plan or in a program described in subsection (3)(f) of this section is involuntarily terminated within the first twelve months of enrollment, and who, without an intervening enrollment, enrolls in another plan or program, the subsequent enrollment is an ini-

tial enrollment as described in subsection (3)(f) of this section.

(9) For purposes of subsection (3)(e) and (f) of this section, an enrollment of an individual with an organization or provider described in subsection (3)(e)(i) of this section, or with a plan or in a program described in subsection (3)(f) of this section is not an initial enrollment under this subsection after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan, or program. [2019 c 38 § 2; 2008 c 217 § 64; 2005 c 41 § 5; 2002 c 300 § 4.]

Intent—2005 c 41: See note following RCW 48.66.025.

Additional notes found at www.leg.wa.gov

48.66.057 Rejection of medicare eligible person—When notice and information must be provided to applicant. Any medicare eligible person who is rejected for medical reasons, is required to accept restrictive riders, an up-rated premium, or preexisting conditions limitations, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk by at least one member as defined in RCW 48.41.030(14) shall be provided written notice from the issuer of medicare supplement coverage to whom application was made of the decision not to accept the person's application for enrollment, or to require such restrictions. The notice shall further state that the person is eligible for medicare part C coverage offered in the person's geographic area or coverage provided by the Washington state health insurance pool for Washington residents, and shall include information about medicare part C plans offered in the person's geographic area, about the Washington state health insurance pool, and about available resources to assist the person in choosing appropriate coverage. [2009 c 555 § 1.]

48.66.060 Equal coverage of sickness and accidents.

A medicare supplement insurance policy may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents. [1981 c 153 § 6.]

48.66.070 Adjustment of benefits and premiums for medicare cost-sharing. A medicare supplement insurance policy must provide that benefits designed to cover cost-sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes. [1981 c 153 § 7.]

48.66.080 "Benefit period"—"Medicare benefit period"—Minimum requirements. "Benefit period" or "medicare benefit period" may not be defined more restrictively than as defined in the medicare program. [1981 c 153 § 8.]

48.66.090 Guaranteed renewable—Exceptions. All medicare supplement policies must be guaranteed renewable and a medicare supplement insurance policy may not provide that the policy may be canceled or nonrenewed by the insurer solely on the grounds of deterioration of health. The issuer shall not cancel or nonrenew the policy for any reason other

than nonpayment of premium or material misrepresentation. All medicare supplement policies and certificates must include a renewal or continuation provision. The language or specifications of such provision must be appropriately captioned, appear on the first page of the policy, and shall include any reservation by the issuer or a right to change premium. [1992 c 138 § 6; 1981 c 153 § 9.]

48.66.100 Loss ratio requirements—Mass sales practices of individual policies. (1) Medicare supplement insurance policies shall return to policyholders in the form of aggregate benefits under the policy, for the entire period for which rates are computed to provide coverage, loss ratios of:

(a) At least seventy-five percent of the aggregate amount of premiums earned in the case of group policies; and

(b) At least sixty-five percent of the aggregate amount of premiums earned in the case of individual policies.

(2) For the purpose of this section, medicare supplement insurance policies issued as a result of solicitation of individuals through the mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies.

(3) The insurance commissioner may adopt rules sufficient to accomplish the provisions of this section and may, by such rules, impose more stringent or appropriate loss ratio requirements when it is necessary for the protection of the public interest. [1992 c 138 § 7; 1982 c 200 § 2; 1981 c 153 § 10.]

48.66.110 Disclosure by insurer—Outline of coverage required. In order to provide for full and fair disclosure in the sale of medicare supplement policies, a medicare supplement policy or certificate shall not be delivered in this state unless an outline of coverage is delivered to the potential policyholder not later than the time of application for the policy. [1992 c 138 § 8; 1981 c 153 § 11.]

48.66.120 Return of policy and refund of premium—Notice required—Effect of return. (1) Every individual medicare supplement insurance policy issued after January 1, 1982, and every certificate issued pursuant to a group medicare supplement policy after January 1, 1982, shall have prominently displayed on the first page of the policy form or certificate a notice stating in substance that the person to whom the policy or certificate is issued shall be permitted to return the policy or certificate within thirty days of its delivery to the purchaser and to have the premium refunded if, after examination of the policy or certificate, the purchaser is not satisfied with it for any reason. An additional ten percent penalty shall be added to any premium refund due which is not paid within thirty days of return of the policy to the insurer or insurance producer. If a policyholder or purchaser, pursuant to such notice, returns the policy or certificate to the insurer at its home or branch office or to the insurance producer through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy or certificate had been issued.

(2) No later than January 1, 2010, or when the insurer has used all of its existing paper individual medicare supplement insurance policy forms which were in its possession on July 1, 2009, whichever is earlier, the notice required by subsec-

tion (1) of this section shall use the term insurance producer in place of agent. [2008 c 217 § 65; 1983 1st ex.s. c 32 § 12; 1982 c 200 § 3; 1981 c 153 § 12.]

Additional notes found at www.leg.wa.gov

48.66.130 Preexisting condition limitations. (1) On or after January 1, 1996, and notwithstanding any other provision of Title 48 RCW, a medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than three months from the effective date of coverage because it involved a preexisting condition.

(2) On or after January 1, 1996, a medicare supplement policy or certificate shall not define a preexisting condition more restrictively than as a condition for which medical advice was given or treatment was recommended by or received from a physician, or other health care provider acting within the scope of his or her license, within three months before the effective date of coverage.

(3) If a medicare supplement insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations must appear as a separate paragraph of the policy or certificate and be labeled as "Preexisting Condition Limitations."

(4) No exclusion or limitation of preexisting conditions may be applied to policies or certificates replaced in accordance with the provisions of RCW 48.66.045 if the policy or certificate replaced had been in effect for at least three months.

(5) If a medicare supplement policy or certificate replaces another medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new medicare supplement policy or certificate for similar benefits to the extent such time was spent under the original policy.

(6) If a medicare supplement policy or certificate replaces another medicare supplement policy or certificate which has been in effect for at least three months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods for benefits similar to those contained in the original policy or certificate. [2005 c 41 § 6; 2002 c 300 § 3; 1995 c 85 § 2; 1992 c 138 § 9; 1981 c 153 § 13.]

Intent—2005 c 41: See note following RCW 48.66.025.

48.66.140 Medical history. Any time that completion of a medical history of a patient is required in order for an application for a medicare supplement insurance policy to be accepted, that medical history must be completed by the applicant, a relative of the applicant, a legal guardian of the applicant, or a physician. [1981 c 153 § 14.]

48.66.150 Reporting and recordkeeping, separate data required. Commencing with reports for accounting periods beginning on or after January 1, 1982, insurers, health care service contractors, health maintenance organizations, and fraternal benefit societies shall, for reporting and recordkeeping purposes, separate data concerning medicare supplement insurance policies and contracts from data concerning other disability insurance policies and contracts. [1981 c 153 § 15.]

48.66.160 Federal law supersedes. In any case where the provisions of this chapter conflict with provisions of the "Health Insurance For The Aged Act," Title XVIII of the Social Security Amendments of 1965, or any amendments thereto or regulations promulgated thereunder, regarding any contract between the secretary of health and human services and a health maintenance organization, the provisions of the "Health Insurance For The Aged Act" shall supersede and be paramount. [1981 c 153 § 16.]

48.66.165 Conformity with federal law—Rules. The commissioner may adopt, from time-to-time, such rules as are necessary with respect to medicare supplemental insurance to conform Washington policies, contracts, certificates, standards, and practices to the requirements of federal law, specifically including 42 U.S.C. Sec. 1395ss, and federal regulations adopted thereunder. [1991 c 120 § 1.]

48.66.910 Effective date—1981 c 153. This act shall take effect January 1, 1982. [1981 c 153 § 19.]

48.66.920 Construction—Chapter applicable to state registered domestic partnerships—2009 c 521. For the purposes of this chapter, the terms spouse, marriage, marital, husband, wife, widow, widower, next of kin, and family shall be interpreted as applying equally to state registered domestic partnerships or individuals in state registered domestic partnerships as well as to marital relationships and married persons, and references to dissolution of marriage shall apply equally to state registered domestic partnerships that have been terminated, dissolved, or invalidated, to the extent that such interpretation does not conflict with federal law. Where necessary to implement chapter 521, Laws of 2009, gender-specific terms such as husband and wife used in any statute, rule, or other law shall be construed to be gender neutral, and applicable to individuals in state registered domestic partnerships. [2009 c 521 § 128.]

Chapter 48.68 RCW HEALTH CARE SAVINGS ACCOUNT ACT

Sections

48.68.005	Intent—Health care savings accounts authorized.
48.68.010	Duties of governor and responsible agencies—Chapter to remain in effect.

48.68.005 Intent—Health care savings accounts authorized. (1) This chapter shall be known as the health care savings account act.

(2) The legislature recognizes that the costs of health care are increasing rapidly and most individuals are removed from participating in the purchase of their health care.

As a result, it becomes critical to encourage and support solutions to alleviate the demand for diminishing state resources. In response to these increasing costs in health care spending, the legislature intends to clarify that health care savings accounts may be offered as health benefit options to all residents as incentives to reduce unnecessary health services utilization, administration, and paperwork, and to encourage individuals to be in charge of and participate directly in their use of service and health care spending. To alleviate the possible impoverishment of residents requiring

long-term care, health care savings accounts may promote savings for long-term care and provide incentives for individuals to protect themselves from financial hardship due to a long-term health care need.

(3) Health care savings accounts are authorized in Washington state as options to employers and residents. [1995 c 265 § 2.]

Additional notes found at www.leg.wa.gov

48.68.010 Duties of governor and responsible agencies—Chapter to remain in effect. The governor and responsible agencies shall:

(1) Request that the United States congress amend the internal revenue code to treat premiums and contributions to health benefits plans, such as health care savings account programs, basic health plans, conventional and standard health plans offered through a health carrier, by employers, self-employed persons, and individuals, as fully excluded employer expenses and deductible from individual adjusted gross income for federal tax purposes.

(2) Request that the United States congress amend the internal revenue code to exempt from federal income tax interest that accrues in health care savings accounts until such money is withdrawn for expenditures other than eligible health expenses as defined in law.

(3) If all federal statute or regulatory waivers necessary to fully implement this chapter have not been obtained by July 1, 1995, this chapter shall remain in effect. [1995 c 265 § 3.]

Additional notes found at www.leg.wa.gov

Chapter 48.70 RCW SPECIFIED DISEASE INSURANCE ACT

Sections

48.70.010	Legislative intent.
48.70.020	Definitions—Rules.
48.70.030	Expected returns to policyholders—Rules.
48.70.040	Rules required.
48.70.900	Application of chapter.

48.70.010 Legislative intent. This chapter shall be known as the specified disease insurance act and is intended to govern the content and sale of specified disease insurance as defined in this chapter. This chapter applies in addition to, rather than in place of, other requirements of Title 48 RCW. It is the intent of the legislature to guarantee that specified disease policies issued, delivered, or used in this state provide a reasonable level of benefits to the policyholders. This chapter shall be applied broadly to ensure achievement of its aim. [1982 c 181 § 20.]

48.70.020 Definitions—Rules. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Specified disease policy" refers to any insurance policy or contract which provides benefits to a policyholder only in the event that the policyholder contracts the disease or diseases specifically named in the policy.

(2) "Loss ratio" means the incurred claims as a percentage of the earned premium, computed under rules adopted by the commissioner. Earned premiums and incurred claims

shall be computed under rules adopted by the commissioner. [1982 c 181 § 21.]

48.70.030 Expected returns to policyholders—Rules.

(1) Commencing with reports for the accounting periods beginning on or after July 1, 1983, specified disease policies shall be expected to return to policyholders in the form of aggregate loss ratios under the policy:

(a) At least seventy-five percent of the earned premiums in the case of group policies; and

(b) At least sixty percent of the earned premiums in the case of individual policies.

(2) For the purpose of this section, specified disease insurance policies issued as a result of solicitation of individuals through the mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies.

(3) By July 1, 1983, the commissioner shall adopt rules sufficient to accomplish the provisions of this section. [1982 c 181 § 22.]

48.70.040 Rules required. By July 1, 1983, the commissioner shall adopt all rules necessary to ensure that specified disease policies provide a reasonable level of benefits to policyholders, and that purchasers and potential purchasers of such policies are fully informed of the level of benefits provided. [1982 c 181 § 23.]

48.70.900 Application of chapter. This chapter shall apply to all policies issued on or after July 1, 1983. This chapter shall not apply to services provided by health care service contractors as defined in RCW 48.44.010. [1982 c 181 § 24.]

Chapter 48.74 RCW STANDARD VALUATION LAW

Sections

48.74.010	Short title.
48.74.015	Definitions—Applicable after valuation manual is operative.
48.74.020	Valuation of reserve liabilities—Applicable before valuation manual is operative.
48.74.022	Valuation of reserve liabilities—Applicable after valuation manual is operative.
48.74.025	Reserves and related actuarial items—Opinion of a qualified actuary—Requirements for the opinion—Rules—Applicable before valuation manual is operative.
48.74.026	Confidentiality of material submitted under RCW 48.74.025.
48.74.028	Reserves and related actuarial items—Opinion of a qualified actuary—Requirements for the opinion—Rules—Applicable after valuation manual is operative.
48.74.030	Minimum standard for valuation.
48.74.040	Amount of reserves required.
48.74.050	Minimum aggregate reserves.
48.74.060	Other methods of reserve calculation.
48.74.070	Minimum reserve if gross premium less than valuation net premium.
48.74.080	Procedure when specified methods of reserve determination unfeasible.
48.74.090	Valuation of disability insurance.
48.74.100	Valuation manual—Operative date—Changes—Required contents—Use—Commissioner's powers.
48.74.110	Reserves—Principle-based valuation.
48.74.120	Submission of data.
48.74.130	Confidentiality of certain information—Exceptions.

48.74.010 Short title. This chapter may be known and cited as the standard valuation law. [2016 c 142 § 1; 1982 1st ex.s. c 9 § 1.]

(2022 Ed.)

Effective date—2016 c 142: "Sections 1 through 19 of this act take effect January 1, 2017." [2016 c 142 § 21.]

48.74.015 Definitions—Applicable after valuation manual is operative. Beginning on the operative date of the valuation manual, the definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required in RCW 48.74.028.

(2) "Company" means an entity, that:

(a) Has written, issued, or reinsured life insurance contracts, disability insurance contracts, or deposit-type contracts in this state and has at least one such policy in force or on claim; or

(b) Has written, issued, or reinsured life insurance contracts, disability insurance contracts, or deposit-type contracts in any state and is required to hold a certificate of authority to write life insurance, disability insurance, or deposit-type contracts in this state.

(3) "Deposit-type contract" means contracts that do not incorporate mortality or morbidity risks and as may be specified in the valuation manual.

(4) "Disability insurance," which also may be known in the industry as "accident and health insurance," means contracts that incorporate morbidity risk and provide protection against economic loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual.

(5) "Life insurance" means contracts that incorporate mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual.

(6) "NAIC" means the national association of insurance commissioners.

(7) "Policyholder behavior" means any action a policyholder, contract holder, or any other person with the right to elect options, such as a certificate holder, may take under a policy or contract subject to this chapter including, but not limited to, lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization, or benefit elections prescribed by the policy or contract but excluding events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract.

(8) "Principle-based valuation" means a reserve valuation that uses one or more methods or one or more assumptions determined by the insurer and is required to comply with RCW 48.74.110 as specified in the valuation manual.

(9) "Qualified actuary" means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American academy of actuaries qualification standards for actuaries signing such statements and who meets the requirements specified in the valuation manual.

(10) "Tail risk" means a risk that occurs either where the frequency of low probability events is higher than expected under a normal probability distribution or where there are observed events of very significant size or magnitude.

(11) "Valuation manual" means the manual of valuation instructions adopted by the NAIC as specified in this chapter. [2016 c 142 § 2.]

Effective date—2016 c 142: See note following RCW 48.74.010.

48.74.020 Valuation of reserve liabilities—Applicable before valuation manual is operative. This section applies to policies and contracts issued prior to the operative date of the valuation manual.

(1) The commissioner shall annually value, or cause to be valued, the reserve liabilities, hereinafter called reserves, for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurance company doing business in this state issued on or after July 10, 1982, and prior to the operative date of the valuation manual. In calculating such reserves, the commissioner may use group methods and approximate averages for fractions of a year or otherwise. In lieu of the valuation of the reserves herein required of any foreign or alien company, the commissioner may accept any valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when such valuation complies with the minimum standard provided in this chapter.

(2) RCW 48.74.030 through 48.74.090 apply to all policies and contracts, as appropriate, subject to this chapter issued on or after July 10, 1982, and prior to the operative date of the valuation manual and RCW 48.74.100 and 48.74.110 do not apply to any such policies and contracts.

(3) The minimum standard for valuation of policies and contracts issued prior to July 10, 1982, is that provided by the laws immediately prior to that date. [2016 c 142 § 3; 1982 1st ex.s. c 9 § 2.]

Effective date—2016 c 142: See note following RCW 48.74.010.

48.74.022 Valuation of reserve liabilities—Applicable after valuation manual is operative. This section applies to policies and contracts issued on or after the operative date of the valuation manual.

(1) The commissioner shall annually value, or cause to be valued, the reserve liabilities, called reserves, for all outstanding life insurance contracts, annuity and endowment contracts, disability contracts, and deposit-type contracts of every company issued on or after the operative date of the valuation manual. In lieu of the valuation of the reserves required of a foreign or alien company, the commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of any state, or other jurisdiction when the valuation complies with the minimum standard provided in this chapter.

(2) RCW 48.74.100 and 48.74.110 apply to all policies and contracts issued on or after the operative date of the valuation manual. [2016 c 142 § 4.]

Effective date—2016 c 142: See note following RCW 48.74.010.

48.74.025 Reserves and related actuarial items—Opinion of a qualified actuary—Requirements for the opinion—Rules—Applicable before valuation manual is operative. This section applies to actuarial opinions prior to the operative date of the valuation manual.

(1) Every life insurance company doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rule are computed appropriately, are based on

assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The commissioner by rule shall define the specifics of this opinion and add any other items deemed to be necessary to its scope.

(2) Actuarial analysis of reserves and assets supporting reserves.

(a) Every life insurance company, except as exempted by rule, shall also include in the opinion required under subsection (1) of this section an opinion as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rule, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

(b) The commissioner may provide by rule for a transition period for establishing higher reserves that the qualified actuary may deem necessary in order to render the opinion required by this section.

(3) Each opinion required under subsection (2) of this section is governed by the following provisions:

(a) A memorandum, in form and substance acceptable to the commissioner as specified by rule, must be prepared to support each actuarial opinion.

(b) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified by rule or if the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the rules or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare such supporting memorandum as is required by the commissioner.

(4) Every opinion required under this section is governed by the following provisions:

(a) The opinion must be submitted with the annual statement reflecting the valuation of the reserve liabilities for each year ending on or after December 31, 1994.

(b) The opinion applies to all business in force, including individual and group disability insurance, in form and substance acceptable to the commissioner as specified by rule.

(c) The opinion must be based on standards adopted from time to time by the actuarial standards board and on such additional standards as the commissioner may prescribe by rule.

(d) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(e) For purposes of this section, "qualified actuary" means a member in good standing of the American academy of actuaries who meets the requirements set forth in rules adopted by the commissioner.

(f) Except in cases of fraud or willful misconduct, the qualified actuary is not liable for damages to any person, other than the insurance company and the commissioner, for any act, error, omission, decision, or conduct with respect to the actuary's opinion.

(g) Rules adopted by the commissioner shall define disciplinary action by the commissioner against the company or the qualified actuary. [2016 c 142 § 5; 1993 c 462 § 85.]

Effective date—2016 c 142: See note following RCW 48.74.010.

Additional notes found at www.leg.wa.gov

48.74.026 Confidentiality of material submitted under RCW 48.74.025. (1)(a) The opinion and memorandum in support of the opinion submitted to the commissioner under RCW 48.74.025 are confidential and privileged, are exempt from disclosure pursuant to chapter 42.56 RCW, are not subject to subpoena, and are not subject to discovery or admissible in evidence in any private civil action, only if and to the extent that the opinion and memorandum supporting the opinion independently qualify for exemption from disclosure as documents, materials, or information in the possession of the commissioner pursuant to a financial conduct examination.

(b) If independently qualifying for exemption from disclosure, as provided in (a) of this subsection, the provisions of RCW 48.02.065 apply to the opinion and memorandum in support of the opinion to the same extent as documents, materials, and information in possession of the commissioner pursuant to a financial conduct examination.

(2) In addition to the provisions of RCW 48.02.065, (a) through (c) of this subsection apply to the opinion and memorandum in support of the opinion submitted to the commissioner under RCW 48.74.025.

(a) A memorandum in support of the opinion, and any other material provided by the company to the commissioner in connection with the memorandum, may be subject to subpoena for the purpose of defending an action seeking damages from the actuary submitting the memorandum by reason of an action required by this section or by rules adopted under this section.

(b) A memorandum or other material may otherwise be released by the commissioner with the written consent of the company or to the American academy of actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the commissioner for preserving the confidentiality of the memorandum or other material.

(c) Once any portion of the confidential memorandum is cited by the company in its marketing or is cited before a governmental agency other than a state insurance department or is released by the company to the news media, all portions of the confidential memorandum are no longer confidential.

(3) Included in those agencies or organizations with which the commissioner may share the opinion and memorandum in support of the opinion, as provided in this section and RCW 48.02.065, is the office of the attorney general for purposes of investigating any consumer protection or anti-trust action. [2016 c 142 § 7.]

Effective date—2016 c 142: See note following RCW 48.74.010.

(2022 Ed.)

48.74.028 Reserves and related actuarial items—Opinion of a qualified actuary—Requirements for the opinion—Rules—Applicable after valuation manual is operative. This section applies to actuarial opinions of reserves after the operative date of the valuation manual.

(1) Every company with outstanding life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and subject to regulation by the commissioner must annually submit the opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The valuation manual will prescribe the specifics of this opinion including any items deemed to be necessary to its scope.

(2) Every company with outstanding life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and subject to regulation by the commissioner, except as exempted in the valuation manual, must also annually include in the opinion required by subsection (1) of this section, an opinion of the same appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

(3) Each opinion required by this section is governed by the following:

(a) A memorandum, in form and substance as specified in the valuation manual, and acceptable to the commissioner, must be prepared to support each actuarial opinion.

(b) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified in the valuation manual or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the valuation manual or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the commissioner.

(4) Every opinion under this section is governed by the following:

(a) The opinion must be in form and substance as specified in the valuation manual and acceptable to the commissioner.

(b) The opinion must be submitted with the annual statement reflecting the valuation of the reserve liabilities for each year ending on or after the operative date of the valuation manual.

(c) The opinion must apply to all policies and contracts subject to this section, plus other actuarial liabilities as may be specified in the valuation manual.

(d) The opinion must be based on standards adopted from time to time by the actuarial standards board or its suc-

cessor, and on the additional standards as may be prescribed in the valuation manual.

(e) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(f) Except in cases of fraud or willful misconduct, the appointed actuary is not liable for damages to any person, other than the insurance company and the commissioner, for any act, error, omission, decision, or conduct with respect to the appointed actuary's opinion.

(g) Disciplinary action by the commissioner against the company or the appointed actuary must be defined in rule by the commissioner. [2016 c 142 § 6.]

Effective date—2016 c 142: See note following RCW 48.74.010.

48.74.030 Minimum standard for valuation. (1)

Except as provided in subsections (2) and (3) of this section, or in RCW 48.74.090, the minimum standard for the valuation of all such policies and contracts issued prior to July 10, 1982, shall be that provided by the laws in effect immediately prior to such date. Except as otherwise provided in subsections (2) and (3) of this section, or in RCW 48.74.090, the minimum standard for the valuation of all such policies and contracts issued on or after July 10, 1982, shall be the commissioner's reserve valuation methods defined in RCW 48.74.040, 48.74.070, and 48.74.090, three and one-half percent interest, or in the case of life insurance policies and contracts, other than annuity and pure endowment contracts, issued on or after July 16, 1973, four percent interest for such policies issued prior to September 1, 1979, five and one-half percent interest for single premium life insurance policies and four and one-half percent interest for all other such policies issued on and after September 1, 1979, and the following tables:

(a) For ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in such policies—the commissioner's 1941 standard ordinary mortality table for such policies issued prior to the operative date of RCW 48.76.050(5) and the commissioner's 1958 standard ordinary mortality table for such policies issued on or after such operative date and prior to the operative date of RCW 48.76.050(5), except that for any category of such policies issued on female risks, all modified net premiums and present values referred to in this chapter may be calculated according to an age not more than six years younger than the actual age of the insured; and for such policies issued on or after the operative date of RCW 48.76.050(7):

(i) The commissioner's 1980 standard ordinary mortality table;

(ii) At the election of the company for any one or more specified plans of life insurance, the commissioner's 1980 standard ordinary mortality table with ten-year select mortality factors; or

(iii) Any ordinary mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by regulation promulgated by the commissioner for

use in determining the minimum standard of valuation for such policies.

(b) For all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in such policies—the 1941 standard industrial mortality table for such policies issued prior to the operative date of RCW 48.76.050(6), and for such policies issued on or after such operative date of RCW 48.76.050(6), the commissioner's 1961 standard industrial mortality table or any industrial mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by rule of the commissioner for use in determining the minimum standard of valuation for such policies.

(c) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies—the 1937 standard annuity mortality table or, at the option of the company, the annuity mortality table for 1949, ultimate, or any modification of either of these tables approved by the commissioner.

(d) For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies—the group annuity mortality table for 1951, any modification of such table approved by the commissioner, or, at the option of the company, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts.

(e) For total and permanent disability benefits in or supplementary to ordinary policies or contracts—for policies or contracts issued on or after January 1, 1966, the tables of period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 disability study of the Society of Actuaries, with due regard to the type of benefit or any tables of disablement rates and termination rates, adopted after 1980 by the national association of insurance commissioners, that are approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such policies; for policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966, either such tables or, at the option of the company, the class (3) disability table (1926); and for policies issued prior to January 1, 1961, the class (3) disability table (1926). Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(f) For accidental death benefits in or supplementary to policies—for policies issued on or after January 1, 1966, the 1959 accidental death benefits table or any accidental death benefits table, adopted after 1980 by the national association of insurance commissioners, that is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such policies; for policies issued on or after January 1, 1961, and prior to January 1, 1966, either such table or, at the option of the company, the intercompany double indemnity mortality table; and for policies issued prior to January 1, 1961, the intercompany double indemnity mortality table. Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(g) For group life insurance, life insurance issued on the substandard basis and other special benefits—such tables as may be approved by the commissioner.

(2) Except as provided in subsection (3) of this section, the minimum standard valuation for individual annuity and pure endowment contracts issued on or after July 10, 1982, and for all annuities and pure endowments purchased on or after such effective date under group annuity and pure endowment contracts, shall be the commissioner's reserve valuation methods defined in RCW 48.74.040 and the following tables and interest rates:

(a) For individual annuity and pure endowment contracts issued before September 1, 1979, excluding any disability and accidental death benefit in such contracts—the 1971 individual annuity mortality table, or any modification of this table approved by the commissioner, and six percent interest for single premium immediate annuity contracts, and four percent interest for all other individual annuity and pure endowment contracts.

(b) For individual single premium immediate annuity contracts issued on or after September 1, 1979, excluding any disability and accidental death benefits in such contracts—the 1971 individual annuity mortality table or any individual annuity mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the commissioner, and seven and one-half percent interest.

(c) For individual annuity and pure endowment contracts issued on or after September 1, 1979, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts—the 1971 individual annuity mortality table or any individual annuity mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the commissioner, and five and one-half percent interest for single premium deferred annuity and pure endowment contracts and four and one-half percent interest for all other such individual annuity and pure endowment contracts.

(d) For all annuities and pure endowments purchased prior to September 1, 1979, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts—the 1971 group annuity mortality table, or any modification of this table approved by the commissioner, and six percent interest.

(e) For all annuities and pure endowments purchased on or after September 1, 1979, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts—the 1971 group annuity mortality table or any group annuity mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such annuities and pure endowments, or any modification of these tables approved by the commissioner, and seven and one-half percent interest.

After July 16, 1973, any company may file with the commissioner a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1979, which shall be the operative date of this section for

such company. If a company makes no such election, the operative date of this section for such company shall be January 1, 1979.

(3)(a) The interest rates used in determining the minimum standard for the valuation of:

(i) Life insurance policies issued in a particular calendar year, on or after the operative date of RCW 48.76.050(7);

(ii) Individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1982;

(iii) Annuities and pure endowments purchased in a particular calendar year on or after January 1, 1982, under group annuity and pure endowment contracts; and

(iv) The net increase, if any, in a particular calendar year after January 1, 1982, in amounts held under guaranteed interest contracts shall be the calendar year statutory valuation interest rates as defined in this section.

(b) The calendar year statutory valuation interest rates, I, shall be determined as follows and the results rounded to the nearer one-quarter of one percent:

(i) For life insurance:

$$I = .03 + W (R_1 - .03) + W/2 (R_2 - .09);$$

(ii) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options:

$$I = .03 + W (R - .03)$$

where R_1 is the lesser of R and $.09$,

R_2 is the greater of R and $.09$,

R is the reference interest rate defined in this section, and W is the weighting factor defined in this section;

(iii) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in (b)(ii) of this subsection, the formula for life insurance stated in (b)(i) of this subsection shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of ten years and the formula for single premium immediate annuities stated in (b)(ii) of this subsection shall apply to annuities and guaranteed interest contracts with guarantee duration of ten years or less;

(iv) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in (b)(ii) of this subsection shall apply;

(v) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in (b)(ii) of this subsection shall apply.

(c) However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of one percent, the calendar year statutory valuation interest rate for such life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation

tion interest rate for life insurance policies issued in a calendar year shall be determined for 1983 using the reference interest rate defined for 1982 and shall be determined for each subsequent calendar year regardless of when RCW 48.76.050(7) becomes operative.

(d) The weighting factors referred to in the formulas stated in (b) of this subsection are given in the following tables:

(i) Weighting Factors for Life Insurance:

Guarantee Duration (Years)	Weighting Factors
10 or less	.50
More than 10, but not more than 20	.45
More than 20	.35

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed in the original policy;

(ii) Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options: .80;

(iii) Weighting factors for other annuities and for guaranteed interest contracts, except as stated in (d)(ii) of this subsection, shall be as specified in (d)(iii)(A), (B), and (C) of this subsection, according to the rules and definitions in (d)(iii)(D), (E), and (F) of this subsection:

(A) For annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration (Years)	Weighting Factor for Plan Type		
	A	B	C
5 or less:	.80	.60	.50
More than 5, but not more than 10:	.75	.60	.50
More than 10, but not more than 20:	.65	.50	.45
More than 20:	.45	.35	.35

(B) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in (d)(iii)(A) of this subsection increased by:

A	Plan Type	
	B	C
.15	.25	.05

(C) For annuities and guaranteed interest contracts valued on an issue year basis other than those with no cash settlement options which do not guarantee interest on considerations received more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis which do not guarantee interest rates on considerations received more than twelve months beyond the valuation date, the factors shown in (d)(iii)(A) of this sub-

section or derived in (d)(iii)(B) of this subsection increased by:

A	Plan Type	
	B	C
.05	.05	.05

(D) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of twenty years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(E) Plan type as used in the tables in (d)(iii)(A), (B), and (C) of this subsection is defined as follows:

Plan Type A: At any time a policyholder may withdraw funds only: (1) With an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company; or (2) without such adjustment but in installments over five years or more; or (3) as an immediate life annuity; or (4) no withdrawal permitted.

Plan Type B: Before expiration of the interest rate guarantee, a policyholder may withdraw funds only: (1) With adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company; or (2) without such adjustment but in installments over five years or more; or (3) no withdrawal permitted. At the end of the interest rate guarantee, funds may be withdrawn without such adjustment in a single sum or installments over less than five years.

Plan Type C: A policyholder may withdraw funds before expiration of the interest rate guarantee in a single sum or installments over less than five years either: (1) Without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company; or (2) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(F) A company may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue year basis. As used in this section, an issue year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract. The change in fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

(e) The reference interest rate referred to in (b) and (c) of this subsection is defined as follows:

(i) For life insurance, the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June 30th of the calendar year next preceding the year of issue, of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(ii) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of twelve months, ending on June 30th of the calendar year of issue or year of purchase of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(iii) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in (e)(ii) of this subsection, with guarantee duration in excess of ten years, the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June 30th of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(iv) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in (e)(ii) of this subsection, with guarantee duration of ten years or less, the average over a period of twelve months, ending on June 30th of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(v) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of twelve months, ending on June 30th of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(vi) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in (e)(ii) of this subsection, the average over a period of twelve months, ending on June 30th of the calendar year of the change in the fund, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(f) If the monthly average of the composite yield on seasoned corporate bonds is no longer published by Moody's Investors Service, Inc., or if the national association of insurance commissioners determines that the monthly average of the composite yield on seasoned corporate bonds as published by Moody's Investors Service, Inc. is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate, which is adopted by the national association of insurance commissioners and approved by rule adopted by the commissioner, may be substituted. [2016 c 142 § 8; 1993 c 462 § 86; 1982 1st ex.s. c 9 § 3.]

Effective date—2016 c 142: See note following RCW 48.74.010.

48.74.040 Amount of reserves required. (1) Except as otherwise provided in RCW 48.74.040(2), 48.74.070, and 48.74.090, reserves according to the commissioner's reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such policies, over the then present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the policy, of all such modified net premiums shall be equal to the sum of the then present value of such benefits provided for by the policy and the excess of (a) over (b), as follows:

(a) A net level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of such policy on which a premium falls due: PROVIDED HOWEVER, That such net level annual premium shall not exceed the net level annual premium on the nineteen year premium whole life plan for insurance of the same amount at an age one year higher than the age at issue of such policy.

(b) A net one year term premium for such benefits provided for in the first policy year: PROVIDED, That for any life insurance policy issued on or after January 1, 1986, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the reserve according to the commissioner's reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium shall, except as otherwise provided in RCW 48.74.070, be the greater of the reserve as of such policy anniversary calculated as described in the preceding paragraph of this subsection and the reserve as of such policy anniversary calculated as described in that paragraph, but with: (i) The value defined in subparagraph (a) of that paragraph being reduced by fifteen percent of the amount of such excess first year premium; (ii) all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date; (iii) the policy being assumed to mature on such date as an endowment; and (iv) the cash surrender value provided on such date being considered as an endowment benefit. In making the above comparison the mortality and interest bases stated in RCW 48.74.030 (1) and (3) shall be used.

Reserves according to the commissioner's reserve valuation method for life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums, group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation established or maintained by an employer, including a

partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as now or hereafter amended, disability and accidental death benefits in all policies and contracts, and all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts, shall be calculated by a method consistent with the principles of the preceding paragraphs of this subsection.

(2) This section shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as now or hereafter amended.

Reserves according to the commissioner's annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in such contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by such contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of such contract, that become payable prior to the end of such respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate, or rates, specified in such contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values. [1993 c 462 § 87; 1982 1st ex.s. c 9 § 4.]

Additional notes found at www.leg.wa.gov

48.74.050 Minimum aggregate reserves. (1) In no event may a company's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, issued on or after July 10, 1982, be less than the aggregate reserves calculated in accordance with the methods set forth in RCW 48.74.040, 48.74.070, and 48.74.080 and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for such policies.

(2) In no event may the aggregate reserves for all policies, contracts, and benefits be less than the aggregate reserves determined by the appointed actuary to be necessary to render the opinion required under RCW 48.74.025 and 48.74.028. [2016 c 142 § 9; 1993 c 462 § 88; 1982 1st ex.s. c 9 § 5.]

Effective date—2016 c 142: See note following RCW 48.74.010.

Additional notes found at www.leg.wa.gov

48.74.060 Other methods of reserve calculation. (1) Reserves for all policies and contracts issued prior to July 10, 1982, may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for all such policies and contracts than the minimum

reserves required by the laws in effect immediately prior to such date.

(2) Reserves for any category of policies, contracts, or benefits as established by the commissioner, issued on or after July 10, 1982, may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for such category than those calculated according to the minimum standard herein provided, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be greater than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided in the policies or contracts.

(3) A company which adopts at any time any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard under this chapter may, adopt a lower standard of valuation with the approval of the commissioner, but not lower than the minimum provided. For the purposes of this section, the holding of additional reserves previously determined by the appointed actuary to be necessary to render the opinion required under RCW 48.74.025 and 48.74.028 is not to be the adoption of a higher standard of valuation. [2016 c 142 § 10; 1993 c 462 § 89; 1982 1st ex.s. c 9 § 6.]

Effective date—2016 c 142: See note following RCW 48.74.010.

Additional notes found at www.leg.wa.gov

48.74.070 Minimum reserve if gross premium less than valuation net premium. If in any contract year the gross premium charged by a company on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for such policy or contract, or the reserve calculated by the method actually used for such policy or contract but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this section are those standards stated in RCW 48.74.030 (1) and (3): PROVIDED, That for any life insurance policy issued on or after January 1, 1986, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the foregoing provisions of this section shall be applied as if the method actually used in calculating the reserve for such policy were the method described in RCW 48.74.040, ignoring the second paragraph of that section. The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with RCW 48.74.040, including the second paragraph of that section, and the minimum reserve calculated in accordance with this section. [2016 c 142 § 11; 1982 1st ex.s. c 9 § 7.]

Effective date—2016 c 142: See note following RCW 48.74.010.

48.74.080 Procedure when specified methods of reserve determination unfeasible. In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance or annuity which is of such a nature that the minimum reserves cannot be determined by the methods described in RCW 48.74.040 and 48.74.070, the reserves which are held under any such plan must, under regulations promulgated by the commissioner:

(1) Be appropriate in relation to the benefits and the pattern of premiums for that plan; and

(2) Be computed by a method which is consistent with the principles of this standard valuation law. [1982 1st ex.s. c 9 § 8.]

48.74.090 Valuation of disability insurance. For disability insurance contracts issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under RCW 48.74.022. For disability insurance contracts issued on or after July 10, 1982, and prior to the operative date of the valuation manual, the minimum standard of valuation is the standard adopted by the commissioner by rule. [2016 c 142 § 12; 1993 c 462 § 90.]

Effective date—2016 c 142: See note following RCW 48.74.010.

Additional notes found at www.leg.wa.gov

48.74.100 Valuation manual—Operative date—Changes—Required contents—Use—Commissioner's powers. (1) For policies issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under RCW 48.74.022, except as provided under subsection (5) or (7) of this section.

(2) The operative date of the valuation manual is January 1st of the first calendar year following the first July 1st as of which all of the following have occurred:

(a) The valuation manual has been adopted by the NAIC by an affirmative vote of at least forty-two members, or three-fourths of the members voting, whichever is greater.

(b) The standard valuation law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by states representing greater than seventy-five percent of the direct premiums written as reported in the following annual statements submitted for 2008: Life, accident and health annual statements, health annual statements, or fraternal annual statements.

(c) The standard valuation law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least forty-two of the following fifty-five jurisdictions: The fifty states of the United States, American Samoa, the American Virgin Islands, the District of Columbia, Guam, and Puerto Rico.

(3) Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual are effective on January 1st following the date when all of the following have occurred: The change to the valuation manual

has been adopted by the NAIC by an affirmative vote representing:

(a) At least three-fourths of the members of the NAIC voting, but not less than a majority of the total membership; and

(b) Members of the NAIC representing jurisdictions totaling greater than seventy-five percent of the direct premiums written as reported in the following annual statements most recently available prior to the vote in (a) of this subsection: Life, accident and health annual statements, health annual statements, or fraternal annual statements.

(4) The valuation manual must specify all of the following:

(a) Minimum valuation standards for and definitions of the policies or contracts subject to RCW 48.74.022. Such minimum valuation standards shall be:

(i) The commissioner's reserve valuation method for life insurance contracts, other than annuity contracts, subject to RCW 48.74.022;

(ii) The commissioner's annuity reserve valuation method for annuity contracts subject to RCW 48.74.022; and

(iii) Minimum reserves for all other policies or contracts subject to RCW 48.74.022;

(b) Which policies or contracts or types of policies or contracts that are subject to the requirements of a principle-based valuation in RCW 48.74.110(1) and the minimum valuation standards consistent with those requirements;

(c) For policies and contracts subject to a principle-based valuation under RCW 48.74.110:

(i) Requirements for the format of reports to the commissioner under RCW 48.74.110(2)(c) which must include information necessary to determine if the valuation is appropriate and in compliance with this chapter;

(ii) Assumptions must be prescribed for risks over which the company does not have significant control or influence; and

(iii) Procedures for corporate governance and oversight of the actuarial function, and a process for appropriate waiver or modification of such procedures;

(d) For policies not subject to a principle-based valuation under RCW 48.74.110, the minimum valuation standard must either:

(i) Be consistent with the minimum standard of valuation prior to the operative date of the valuation manual; or

(ii) Develop reserves that quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring;

(e) Other requirements, including, but not limited to, those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memorandums, transition rules, and internal controls; and

(f) The data and form of the data required under RCW 48.74.120, with whom the data must be submitted, and may specify other requirements including data analyses and reporting of analyses.

(5) In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual is

not, in the opinion of the commissioner, in compliance with this chapter, then the company must, with respect to such requirements, comply with minimum valuation standards prescribed by the commissioner by rule.

(6) The commissioner may engage a qualified actuary, at the expense of the company, to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any requirement set forth in this chapter. The commissioner may rely upon the opinion, regarding provisions contained within this chapter, of a qualified actuary engaged by the commissioner of another state, district, or territory of the United States. As used in this subsection, "engage" includes employment and contracting.

(7) The commissioner may require a company to change any assumption or method that in the opinion of the commissioner is necessary in order to comply with the requirements of the valuation manual or this chapter; and the company must adjust the reserves as required by the commissioner. The commissioner may take other disciplinary action as permitted under this title. [2016 c 142 § 13.]

Effective date—2016 c 142: See note following RCW 48.74.010.

48.74.110 Reserves—Principle-based valuation. (1) A company must establish reserves, consistent with the commissioner's superseding authority to establish reserves pursuant to RCW 48.74.100(7), using a principle-based valuation that meets the following conditions for policies or contracts as specified in the valuation manual:

(a) Quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts. For policies or contracts with significant tail risk, valuations must reflect conditions appropriately adverse to quantify the tail risk.

(b) Incorporate assumptions, risk analysis methods, and financial models and management techniques that are consistent with, but not necessarily identical to, those utilized within the company's overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods.

(c) Incorporate assumptions that are derived in one of the following manners:

(i) The assumption is prescribed in the valuation manual.

(ii) For assumptions that are not prescribed, the assumptions must:

(A) Be established utilizing the company's available experience, to the extent it is relevant and statistically credible; or

(B) To the extent that company data is not available, relevant, or statistically credible, be established utilizing other relevant, statistically credible experience.

(d) Provide margins for uncertainty including adverse deviation and estimation error, such that the greater the uncertainty the larger the margin and resulting reserve.

(2) A company using a principle-based valuation for one or more policies or contracts subject to this section as specified in the valuation manual must:

(a) Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual.

(b) Provide to the commissioner and the board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation. These controls must be designed to assure that all material risks inherent in the liabilities and associated assets subject to such valuation are included in the valuation, and that valuations are made in accordance with the valuation manual. The certification must be based on the controls in place as of the end of the preceding calendar year.

(c) Develop, and file with the commissioner upon request, a principle-based valuation report that complies with standards prescribed in the valuation manual.

(3) A principle-based valuation may include a prescribed formulaic reserve component. [2016 c 142 § 14.]

Effective date—2016 c 142: See note following RCW 48.74.010.

48.74.120 Submission of data. A company must submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the valuation manual. [2016 c 142 § 15.]

Effective date—2016 c 142: See note following RCW 48.74.010.

48.74.130 Confidentiality of certain information—Exceptions. (1) For purposes of this section, "confidential information" means:

(a) A memorandum in support of an opinion submitted under RCW 48.74.025 and 48.74.028 and any other documents, materials, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the commissioner or any other person in connection with such memorandum;

(b) All documents, materials, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the commissioner or any other person in the course of an examination made under RCW 48.74.100(6). However, if an examination report or other material prepared in connection with an examination made under chapter 48.03 RCW is not held as private and confidential information, an examination report or other material prepared in connection with an examination made under RCW 48.74.100(6) is not "confidential information" to the same extent as if such examination report or other material had been prepared under chapter 48.03 RCW;

(c) Any reports, documents, materials, and other information developed by a company in support of, or in connection with, an annual certification by the company under RCW 48.74.110(2)(b) evaluating the effectiveness of the company's internal controls with respect to a principle-based valuation and any other documents, materials, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the commissioner or any other person in connection with such reports, documents, materials, and other information;

(d) Any principle-based valuation report developed under RCW 48.74.110(2)(c) and any other documents, materials, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or

obtained by or disclosed to the commissioner or any other person in connection with such report; and

(e) Any documents, materials, data, and other information submitted by a company under RCW 48.74.120 (collectively, "experience data") and any other documents, materials, data, and other information, including, but not limited to, all working papers, and copies thereof, created or produced in connection with such experience data, in each case that include any potentially company identifying or personally identifiable [identifying] information, that is provided to or obtained by the commissioner (together with any "experience data," the "experience materials") and any other documents, materials, data, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the commissioner or any other person in connection with such experience materials.

(2)(a) Except as provided in this section, a company's confidential information is confidential by law and privileged, is not subject to chapter 42.56 RCW, is not subject to subpoena, and is not subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the confidential information in the furtherance of any regulatory or legal action brought against the company as a part of the commissioner's official duties.

(b) Neither the commissioner nor any person who received confidential information while acting under the authority of the commissioner is permitted or required to testify in any private civil action concerning any confidential information.

(c) In order to assist in the performance of the commissioner's duties, the commissioner may share confidential information:

(i) With other state, federal, and international regulatory agencies and with the NAIC and its affiliates and subsidiaries;

(ii) In the case of confidential information specified in subsection (1)(a) and (d) of this section only, with the actuarial board for counseling and discipline or its successor upon request stating that the confidential information is required for the purpose of professional disciplinary proceedings and with state, federal, and international law enforcement officials;

(iii) In the case of (c)(i) and (ii) of this subsection, when the recipient agrees, and has the legal authority to agree, to maintain the confidentiality and privileged status of such documents, materials, data, and other information in the same manner and to the same extent as required for the commissioner.

(d) The commissioner may receive documents, materials, data, and other information, including otherwise confidential and privileged documents, materials, data, or information, from the NAIC and its affiliates and subsidiaries, from regulatory or law enforcement officials of other foreign or domestic jurisdictions, and from the actuarial board for counseling and discipline or its successor and shall maintain as confidential or privileged any document, material, data, or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, data, or other information.

(e) The commissioner may enter into agreements governing sharing and use of information consistent with this subsection (2).

(f) No waiver of any applicable privilege or claim of confidentiality in the confidential information may occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in (c) of this subsection.

(g) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection (2) is available and shall be enforced in any proceeding in, and in any court of, this state.

(h) In this section "regulatory agency," "law enforcement agency," and the "NAIC" include, but are not limited to, their employees, agents, consultants, and contractors.

(3) Notwithstanding subsection (2) of this section, any confidential information specified in subsection (1)(a) and (d) of this section:

(a) May be subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under RCW 48.74.025 and 48.74.028 or principle-based valuation report developed under RCW 48.74.110(2)(c) by reason of an action required by this chapter or by rules adopted under this chapter;

(b) May otherwise be released by the commissioner with the written consent of the company; and

(c) Once any portion of a memorandum in support of an opinion submitted under RCW 48.74.025 and 48.74.028 or a principle-based valuation report developed under RCW 48.74.110(2)(c) is cited by the company in its marketing or is publicly volunteered to or before a governmental agency other than a state insurance department or is released by the company to the news media, all portions of such memorandum or report are no longer confidential. [2016 c 142 § 16.]

Effective date—2016 c 142: See note following RCW 48.74.010.

Chapter 48.76 RCW STANDARD NONFORFEITURE LAW FOR LIFE INSURANCE

Sections

48.76.010	Short title—"NAIC" and "operative date of the valuation manual" defined.
48.76.020	Nonforfeiture and cash surrender provisions required.
48.76.030	Amount of cash surrender value.
48.76.040	Nonforfeiture benefit in case of premium default.
48.76.050	Calculation of adjusted premiums—Operative date of section.
48.76.060	Requirements when specified methods of minimum values determination unfeasible.
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48.76.080	Cash surrender value required for policies issued on or after January 1, 1986.
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48.76.900	Construction—Chapter applicable to state registered domestic partnerships—2009 c 521.

48.76.010 Short title—"NAIC" and "operative date of the valuation manual" defined. (1) This chapter may be known and cited as the standard nonforfeiture law for life insurance.

(2) As used in this chapter:

(a) "NAIC" means the national association of insurance commissioners.

(b) "Operative date of the valuation manual" means the January 1st of the first calendar year that the valuation manual as defined in chapter 48.74 RCW is effective. [2016 c 142 § 17; 1982 1st ex.s. c 9 § 10.]

Effective date—2016 c 142: See note following RCW 48.74.010.

48.76.020 Nonforfeiture and cash surrender provisions required. In the case of policies issued on and after the operative date of this chapter as defined in RCW 48.76.100, no policy of life insurance, except as stated in RCW 48.76.090, may be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the commissioner are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements specified in this chapter and are essentially in compliance with RCW 48.76.080:

(1) That, in the event of default in any premium payment, the company will grant, upon proper request not later than sixty days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of such due date, of such amount as may be specified in this chapter. In lieu of such stipulated paid-up nonforfeiture benefit, the company may substitute, upon proper request not later than sixty days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits.

(2) That, upon surrender of the policy within sixty days after the due date of any premium payment in default after premiums have been paid for at least three full years in the case of ordinary insurance or five full years in the case of industrial insurance, the company will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of such amount as may be specified in this chapter.

(3) That a specified paid-up nonforfeiture benefit becomes effective as specified in the policy unless the person entitled to make such election elects another available option not later than sixty days after the due date of the premium in default.

(4) That if the policy has become paid-up by completion of all premium payments or if it is continued under any paid-up nonforfeiture benefit which became effective on or after the third policy anniversary in the case of ordinary insurance or the fifth policy anniversary in the case of industrial insurance, the company will pay, upon surrender of the policy within thirty days after any policy anniversary, a cash surrender value of such amount as may be specified in this chapter.

(5) That policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy. In the case of all other policies, a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each pol-

icy anniversary either during the first twenty policy years or during the term of the policy, whichever is shorter, such values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the company on the policy.

(6) A statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to the insurance law of the state in which the policy is delivered; an explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the company on the policy; if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated therein, a statement that such method of computation has been filed with the insurance supervisory official of the state in which the policy is delivered; and a statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which such values and benefits are consecutively shown in the policy.

Any of the foregoing provisions or portions thereof not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy.

The company shall reserve the right to defer the payment of any cash surrender value for a period of six months after demand therefor with surrender of the policy. [1982 1st ex.s. c 9 § 11.]

48.76.030 Amount of cash surrender value. (1) Subject to subsections (2) and (3) of this section, any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary, whether or not required by RCW 48.76.020, shall be an amount not less than the excess, if any, of the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of the then present value of the adjusted premiums as defined in RCW 48.76.050, corresponding to premiums which would have fallen due on and after such anniversary, and the amount of any indebtedness to the company on the policy.

(2) For any policy issued on or after the operative date of *RCW 48.76.050(4), which provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in subsection (1) of this section shall be an amount not less than the sum of the cash surrender value as defined in such paragraph for an otherwise similar policy issued at the same age without such rider or supplemental policy provision and the cash surrender value as defined in such paragraph for a policy which provides only the benefits otherwise provided by such rider or supplemental policy provision.

(3) For any family policy issued on or after the operative date of *RCW 48.76.050(4), which defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse's age seventy-one, the cash surrender value shall be an amount not less than

the sum of the cash surrender value as defined in this section for an otherwise similar policy issued at the same age without such term insurance on the life of the spouse and the cash surrender value as defined in this section for a policy which provides only the benefits otherwise provided by such term insurance on the life of the spouse.

(4) Any cash surrender value available within thirty days after any policy anniversary under any policy paid-up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, whether or not required by RCW 48.76.020, shall be an amount not less than the present value, on such anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the company on the policy. [1982 1st ex.s. c 9 § 12.]

***Reviser's note:** RCW 48.76.050 was amended by 2016 c 142 § 18, changing subsection (4) to subsection (7), effective January 1, 2017.

48.76.040 Nonforfeiture benefit in case of premium default. Any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment due on any policy anniversary shall be such that its present value as of such anniversary is at least equal to the cash surrender value then provided for by the policy or, if none is provided for, that cash surrender value which would have been required by this chapter in the absence of the condition that premiums shall have been paid for at least a specified period. [1982 1st ex.s. c 9 § 13.]

48.76.050 Calculation of adjusted premiums—Operative date of section. (1) This section does not apply to policies issued on or after the operative date of subsection (7) of this section. Except as provided in subsection (3) of this section, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts stated in the policy as extra premiums to cover impairments or special hazards, that the present value, at the date of issue of the policy, of all such adjusted premiums shall be equal to the sum of:

(a) The then present value of the future guaranteed benefits provided for by the policy;

(b) Two percent of the amount of insurance, if the insurance is uniform in amount, or of the equivalent uniform amount, as defined, if the amount of insurance varies with duration of the policy;

(c) Forty percent of the adjusted premium for the first policy year;

(d) Twenty-five percent of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less.

However, in applying the percentages specified in (c) and (d) of this subsection, no adjusted premium shall be deemed to exceed four percent of the amount of insurance or level amount equivalent thereto. The date of issue of a policy for the purpose of this section shall be the date as of which the rated age of the insured is determined.

(2) In the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent level amount thereof for the purpose of this section shall be deemed to be the level amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the inception of the insurance as the benefits under the policy: PROVIDED HOWEVER, That in the case of a policy providing a varying amount of insurance issued on the life of a child under age ten, the equivalent uniform amount may be computed as though the amount provided by the policy prior to the attainment of age ten were the amount provided by such policy at age ten.

(3) The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to:

(a) The adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits, increased, during the period for which premiums for such term insurance benefits are payable, by

(b) The adjusted premiums for such term insurance, with (a) and (b) of this subsection being calculated separately and as specified in subsections (1) and (2) of this section except that, for the purposes of subsection (1)(b), (c), and (d) of this section, the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in (b) of this subsection shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in (a) of this subsection.

(4) Except as otherwise provided in subsections (5) and (6) of this section, all adjusted premiums and present values referred to in this chapter shall for all policies of ordinary insurance be calculated on the basis of the commissioner's 1941 standard ordinary mortality table: PROVIDED, That for any category of ordinary insurance issued on female risks on or after July 1, 1957, adjusted premiums and present values may be calculated according to an age not more than six years younger than the actual age of the insured and such calculations for all policies of industrial insurance shall be made on the basis of the 1941 standard industrial mortality table. All calculations shall be made on the basis of the rate of interest, not exceeding three and one-half percent per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits: PROVIDED, That in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than one hundred thirty percent of the rates of mortality according to such applicable table: PROVIDED, FURTHER, That for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner.

(5) This subsection does not apply to ordinary policies issued on or after the operative date of subsection (7) of this section. In the case of ordinary policies issued on or after the operative date of this section, all adjusted premiums and present values referred to in this chapter shall be calculated on the

basis of the commissioner's 1958 standard ordinary mortality table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits provided that such rate of interest shall not exceed three and one-half percent per annum except that a rate of interest not exceeding four percent per annum may be used for policies issued on or after July 16, 1973, and before September 1, 1979, and a rate of interest not exceeding five and one-half percent per annum may be used for policies issued on or after September 1, 1979, except that for any single premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half percent per annum may be used and provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than six years younger than the actual age of the insured: PROVIDED, That in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioner's 1958 extended term insurance table: PROVIDED FURTHER, That for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner.

After June 11, 1959, any company may file with the commissioner a written notice of its election to comply with the provisions of this section. After the filing of such notice, then upon such specified date (which shall be the operative date of this section for such company), this subsection shall become operative with respect to the ordinary policies thereafter issued by such company. If a company makes no such election, the operative date of this section for such company shall be January 1, 1966.

(6) This subsection does not apply to industrial policies issued on or after the operative date of subsection (7) of this section. In the case of industrial policies issued on or after the operative date of this chapter, all adjusted premiums and present values referred to in this chapter shall be calculated on the basis of the commissioner's 1961 standard industrial mortality table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits provided that such rate of interest shall not exceed three and one-half percent per annum, except that a rate of interest not exceeding four percent per annum may be used for policies issued on or after July 16, 1973, and prior to September 1, 1979, and a rate of interest not exceeding five and one-half percent per annum may be used for policies issued on or after September 1, 1979, except that for any single premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half percent per annum may be used: PROVIDED, That in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioner's 1961 industrial extended term insurance table: PROVIDED FURTHER, That for insurance issued on a substandard basis, the calculations of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner.

After July 10, 1982, any company may file with the commissioner a written notice of its election to comply with the provisions of this section. After the filing of such notice, then upon such specified date (which shall be the operative date of this section for such company), this subsection shall become operative with respect to the industrial policies thereafter issued by such company. If a company makes no such election, the operative date of this section for such company shall be January 1, 1968.

(7)(a) This subsection applies to all policies issued on or after the operative date of this subsection as defined herein. Except as provided in (g) of this subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of: (i) The then present value of the future guaranteed benefits provided for by the policy; (ii) one percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and (iii) one hundred twenty-five percent of the nonforfeiture net level premium as defined in (b) of this subsection: PROVIDED, That in applying the percentage specified in (a)(iii) of this subsection no nonforfeiture net level premium shall be deemed to exceed four percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years. The date of issue of a policy for the purpose of this section shall be the date as of which the rated age of the insured is determined.

(b) The nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one per annum payable on the date of issue of the policy and on each anniversary of such policy on which a premium falls due.

(c) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any such change in the benefits or premiums the future adjusted premiums, nonforfeiture net level premiums and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

(d) Except as otherwise provided in (g) of this subsection, the recalculated future adjusted premiums for any such policy shall be such uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uni-

form annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all such future adjusted premiums shall be equal to the excess of:

- (i) The sum of
 - (A) The then present value of the then future guaranteed benefits provided for by the policy, and
 - (B) The additional expense allowance, if any, over
- (ii) The then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.
- (e) The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of:
 - (i) One percent of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first ten policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and
 - (ii) One hundred twenty-five percent of the increase, if positive, in the nonforfeiture net level premium.
- (f) The recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing (i) by (ii) where:
 - (i) Equals the sum of:
 - (A) The nonforfeiture net level premium applicable prior to the change times the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of the change on which a premium would have fallen due had the change not occurred; and
 - (B) The present value of the increase in future guaranteed benefits provided for by the policy; and
 - (ii) Equals the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due.
- (g) Notwithstanding any other provisions of this section to the contrary, in the case of a policy issued on a substandard basis which provides reduced graded amounts of insurance so that, in each policy year, such policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis which provides higher uniform amounts of insurance, adjusted premiums and present values for such substandard policy may be calculated as if it were issued to provide such higher uniform amounts of insurance on the standard basis.
- (h) All adjusted premiums and present values referred to in this chapter shall for all policies of ordinary insurance be calculated on the basis of the commissioner's 1980 standard ordinary mortality table or at the election of the company for any one or more specified plans of life insurance, the commissioner's 1980 standard ordinary mortality table with ten-year select mortality factors, shall for all policies of industrial insurance be calculated on the basis of the commissioner's 1961 standard industrial mortality table, and shall for all policies issued in a particular calendar year be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this section, for policies issued in that calendar year, subject to the following provisions:

(i) At the option of the company, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this section, for policies issued in the immediately preceding calendar year.

(ii) Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by RCW 48.76.020, shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any.

(iii) A company may calculate the amount of any guaranteed paid-up nonforfeiture benefit including any paid-up additions under the policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values.

(iv) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioner's 1980 extended term insurance table for policies of ordinary insurance and not more than the commissioner's 1961 industrial extended term insurance table for policies of industrial insurance.

(v) For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on appropriate modifications of the aforementioned tables.

(vi) Any ordinary mortality tables, adopted after 1980 by the national association of insurance commissioners, that are approved by regulation promulgated by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the commissioner's 1980 standard ordinary mortality table with or without ten-year select mortality factors or for the commissioner's 1980 extended term insurance table.

(vii) Any industrial mortality tables, adopted after 1980 by the national association of insurance commissioners, that are approved by regulation promulgated by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the commissioner's 1961 standard industrial mortality table or the commissioner's 1961 industrial extended term insurance table.

(viii) For policies issued prior to the operative date of the valuation manual, any commissioner's standard ordinary mortality tables, adopted after 1980 by the national association of insurance commissioners, that are approved by rules adopted by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the commissioner's 1980 standard ordinary mortality table with or without ten-year select mortality factors or for the commissioner's 1980 extended term insurance table.

For policies issued on or after the operative date of the valuation manual, the valuation manual must provide the commissioner's standard mortality for use in determining the minimum nonforfeiture standard that may be substituted for the commissioner's 1980 standard ordinary mortality table with or without ten-year select mortality factors or for the commissioner's 1980 extended term insurance table. If the commissioner approves by rule any commissioner's standard ordinary mortality table adopted by the national association

of insurance commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then the minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

(ix) For policies issued prior to the operative date of the valuation manual, any commissioners standard industrial mortality tables, adopted after 1980 by the national association of insurance commissioners, that are approved by rule adopted by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the commissioners 1961 standard industrial mortality table or the commissioners 1961 industrial extended term insurance table.

For policies issued on or after the effective date of the valuation manual, the valuation manual must provide the commissioners standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the commissioners 1961 standard industrial mortality table or the commissioners 1961 industrial extended term insurance table. If the commissioner approves by rule any commissioners standard industrial mortality table adopted by the national association of insurance commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

(i)(A) For policies issued prior to the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be equal to one hundred twenty-five percent of the calendar year statutory valuation interest rate for such policy as defined in the standard valuation law (chapter 48.74 RCW), rounded to the nearer one quarter of one percent. However, the nonforfeiture interest rate shall not be less than four percent.

(B) For policies issued on and after the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year must be provided by the valuation manual.

(j) Notwithstanding any other provision in this title to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form which involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of that policy form.

(k) After July 10, 1982, any company may file with the commissioner a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1989, which shall be the operative date of this section for such company. If a company makes no such election, the operative date of this section for such company shall be January 1, 1989. [2016 c 142 § 18; 1982 1st ex.s. c 9 § 14.]

Effective date—2016 c 142: See note following RCW 48.74.010.

48.76.060 Requirements when specified methods of minimum values determination unfeasible. In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future

experience, or in the case of any plan of life insurance which is of such a nature that minimum values cannot be determined by the methods described in RCW 48.76.020 through 48.76.050, then:

(1) The commissioner must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by RCW 48.76.020 through 48.76.050;

(2) The commissioner must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds;

(3) The cash surrender values and paid-up nonforfeiture benefits provided by such plan must not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this chapter, as determined by regulations promulgated by the commissioner. [1982 1st ex.s. c 9 § 15.]

48.76.070 Calculation of cash surrender value and paid-up nonforfeiture benefit. Any cash surrender value and any paid-up nonforfeiture benefit, available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary. All values referred to in RCW 48.76.030 through 48.76.050 may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than paid-up term additions, shall be not less than the amounts used to provide such additions. Notwithstanding the provisions of RCW 48.76.030, additional benefits payable: (1) In the event of death or dismemberment by accident or accidental means; (2) in the event of total and permanent disability; (3) as reversionary annuity or deferred reversionary annuity benefits; (4) as term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this chapter would not apply; (5) as term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if such term insurance expires before the child's age is twenty-six, is uniform in amount after the child's age is one, and has not become paid-up by reason of the death of a parent of the child; and (6) as other policy benefits additional to life insurance and endowment benefits, and premiums for all such additional benefits, shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this chapter, and no such additional benefits shall be required to be included in any paid-up nonforfeiture benefits. [1982 1st ex.s. c 9 § 16.]

48.76.080 Cash surrender value required for policies issued on or after January 1, 1986. (1) This section, in addition to all other applicable sections of this chapter, shall apply to all policies issued on or after January 1, 1986. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall be in an amount which does not differ by more than two-tenths of one percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years, from the sum of: (a) The greater of zero and the basic

cash value specified in subsection (2) of this section; and (b) the present value of any existing paid-up additions less the amount of any indebtedness to the company under the policy.

(2) The basic cash value shall be equal to the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the company, if there had been no default, less the then present value of the nonforfeiture factors, as defined in subsection (3) of this section, corresponding to premiums which would have fallen due on and after such anniversary: PROVIDED, That the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in RCW 48.76.030 or *48.76.050(4), whichever is applicable, shall be the same as are the effects specified in RCW 48.76.030 or *48.76.050(4), whichever is applicable, on the cash surrender values defined in that section.

(3) The nonforfeiture factor for each policy year shall be an amount equal to a percentage of the adjusted premium for the policy year, as defined in *RCW 48.76.050 (1) or (4). Except as is required by the next succeeding sentence of this paragraph, such percentage:

(a) Must be the same percentage for each policy year between the second policy anniversary and the later of: (i) The fifth policy anniversary; and (ii) The first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least two-tenths of one percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and

(b) Must be such that no percentage after the later of the two policy anniversaries specified in subparagraph (a) of this subsection may apply to fewer than five consecutive policy years: PROVIDED, That no basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy, as defined in *RCW 48.76.050 (1) or (4), whichever is applicable, were substituted for the nonforfeiture factors in the calculation of the basic cash value.

(4) All adjusted premiums and present values referred to in this section shall for a particular policy be calculated on the same mortality and interest bases as are used in demonstrating the policy's compliance with the other sections of this chapter. The cash surrender values referred to in this section shall include any endowment benefits provided for by the policy.

(5) Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment shall be determined in manners consistent with the manners specified for determining the analogous minimum amounts in RCW 48.76.020 through 48.76.040, *48.76.050(4), and 48.76.070. The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those listed in RCW 48.76.070 shall conform with the principles of this section. [1982 1st ex.s. c 9 § 17.]

*Reviser's note: RCW 48.76.050 was amended by 2016 c 142 § 18, changing subsection (1) to subsections (1) through (4) and subsection (4) to subsection (7), effective January 1, 2017.

48.76.090 Chapter inapplicable to certain policies.

This chapter does not apply to any of the following:

- (1) Reinsurance;
- (2) Group insurance;
- (3) A pure endowment;
- (4) An annuity or reversionary annuity contract;
- (5) A term policy of a uniform amount, which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of twenty years or less expiring before age seventy-one, for which uniform premiums are payable during the entire term of the policy;
- (6) A term policy of a decreasing amount, which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in RCW 48.76.050, is less than the adjusted premium so calculated, on a term policy of uniform amount, or renewal thereof, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance and for a term of twenty years or less expiring before age seventy-one, for which uniform premiums are payable during the entire term of the policy;
- (7) A policy, which provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit, at the beginning of any policy year, calculated as specified in RCW 48.76.030 through 48.76.050, exceeds two and one-half percent of the amount of insurance at the beginning of the same policy year; nor
- (8) A policy which is delivered outside this state through an insurance producer or other representative of the company issuing the policy.

For purposes of determining the applicability of this chapter, the age at expiration for a joint term life insurance policy is the age at expiration of the oldest life. [2008 c 217 § 66; 1982 1st ex.s. c 9 § 18.]

Additional notes found at www.leg.wa.gov

48.76.100 Operative date of chapter. After July 10, 1982, any company may file with the commissioner a written notice of its election to comply with the provisions of this chapter. After the filing of such notice, then upon such specified date (which shall be the operative date for such company), this chapter becomes operative with respect to the policies thereafter issued by such company. If a company makes no such election, the operative date of this chapter for such company shall be January 1, 1948. [1982 1st ex.s. c 9 § 19.]

48.76.900 Construction—Chapter applicable to state registered domestic partnerships—2009 c 521. For the purposes of this chapter, the terms spouse, marriage, marital, husband, wife, widow, widower, next of kin, and family shall be interpreted as applying equally to state registered domestic partnerships or individuals in state registered domestic partnerships as well as to marital relationships and married persons, and references to dissolution of marriage shall apply equally to state registered domestic partnerships that have been terminated, dissolved, or invalidated, to the extent that

such interpretation does not conflict with federal law. Where necessary to implement chapter 521, Laws of 2009, gender-specific terms such as husband and wife used in any statute, rule, or other law shall be construed to be gender neutral, and applicable to individuals in state registered domestic partnerships. [2009 c 521 § 129.]

Chapter 48.80 RCW HEALTH CARE FALSE CLAIM ACT

Sections

48.80.010	Legislative finding—Short title.
48.80.020	Definitions.
48.80.030	Making false claims, concealing information—Penalty—Exclusions.
48.80.040	Use of circumstantial evidence.
48.80.050	Civil action not limited.
48.80.060	Conviction of provider, notification to regulatory agency.

48.80.010 Legislative finding—Short title. The legislature finds and declares that the welfare of the citizens of this state is threatened by the spiraling increases in the cost of health care. It is further recognized that fraudulent health care claims contribute to these increases in health care costs. In recognition of these findings, it is declared that special attention must be directed at eliminating the unjustifiable costs of fraudulent health care claims by establishing specific penalties and deterrents. This chapter may be known and cited as "the health care false claim act." [1986 c 243 § 1.]

48.80.020 Definitions. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Claim" means any attempt to cause a health care payer to make a health care payment.

(2) "Deceptive" means presenting a claim to a health care payer that contains a statement of fact or fails to reveal a material fact, leading the health care payer to believe that the represented or suggested state of affairs is other than it actually is. For the purposes of this chapter, the determination of what constitutes a material fact is a question of law to be resolved by the court.

(3) "False" means wholly or partially untrue or deceptive.

(4) "Health care payment" means a payment for health care services or the right under a contract, certificate, or policy of insurance to have a payment made by a health care payer for a specified health care service.

(5) "Health care payer" means any insurance company authorized to provide health insurance in this state, any health care service contractor authorized under chapter 48.44 RCW, any health maintenance organization authorized under chapter 48.46 RCW, any legal entity which is self-insured and providing health care benefits to its employees, and any insurer or other person responsible for paying for health care services.

(6) "Person" means an individual, corporation, partnership, association, or other legal entity.

(7) "Provider" means any person lawfully licensed or authorized to render any health service. [1995 c 285 § 25; 1986 c 243 § 2.]

Additional notes found at www.leg.wa.gov

48.80.030 Making false claims, concealing information—Penalty—Exclusions. (1) A person shall not make or present or cause to be made or presented to a health care payer a claim for a health care payment knowing the claim to be false.

(2) No person shall knowingly present to a health care payer a claim for a health care payment that falsely represents that the goods or services were medically necessary in accordance with professionally accepted standards. Each claim that violates this subsection shall constitute a separate offense.

(3) No person shall knowingly make a false statement or false representation of a material fact to a health care payer for use in determining rights to a health care payment. Each claim that violates this subsection shall constitute a separate violation.

(4) No person shall conceal the occurrence of any event affecting his or her initial or continued right under a contract, certificate, or policy of insurance to have a payment made by a health care payer for a specified health care service. A person shall not conceal or fail to disclose any information with intent to obtain a health care payment to which the person or any other person is not entitled, or to obtain a health care payment in an amount greater than that which the person or any other person is entitled.

(5) No provider shall willfully collect or attempt to collect an amount from an insured knowing that to be in violation of an agreement or contract with a health care payer to which the provider is a party.

(6) A person who violates this section is guilty of a class C felony punishable under chapter 9A.20 RCW.

(7) This section does not apply to statements made on an application for coverage under a contract or certificate of health care coverage issued by an insurer, health care service contractor, health maintenance organization, or other legal entity which is self-insured and providing health care benefits to its employees. [1990 c 119 § 11; 1986 c 243 § 3.]

48.80.040 Use of circumstantial evidence. In a prosecution under this chapter, circumstantial evidence may be presented to demonstrate that a false statement or claim was knowingly made. Such evidence may include but shall not be limited to the following circumstances:

(1) Where a claim for a health care payment is submitted with the person's actual, facsimile, stamped, typewritten, or similar signature on the form required for the making of a claim for health care payment; and

(2) Where a claim for a health care payment is submitted by means of computer billing tapes or other electronic means if the person has advised the health care payer in writing that claims for health care payment will be submitted by use of computer billing tapes or other electronic means. [1986 c 243 § 4.]

48.80.050 Civil action not limited. This chapter shall not be construed to prohibit or limit a prosecution of or civil action against a person for the violation of any other law of this state. [1986 c 243 § 5.]

48.80.060 Conviction of provider, notification to regulatory agency. Upon the conviction under this chapter of

any provider, the prosecutor shall provide written notification to the appropriate regulatory or disciplinary agency of such conviction. [1986 c 243 § 6.]

Chapter 48.83 RCW

LONG-TERM CARE INSURANCE COVERAGE—STANDARDS

Sections

48.83.005	Intent.
48.83.010	Application.
48.83.020	Definitions.
48.83.030	Out-of-state policy—Restriction.
48.83.040	Preexisting conditions.
48.83.050	Prohibited policy terms and practices—Field-issued, defined.
48.83.060	Right to return policy or certificate—Refund.
48.83.070	Required documents for prospective and approved applicants—Contents—When due.
48.83.080	Benefit funded through life insurance policy—Acceleration of a death benefit.
48.83.090	Denial of claims—Written explanation.
48.83.100	Rescission of policy or certificate.
48.83.110	Inflation protection features—Rules.
48.83.120	Nonforfeiture benefit option—Offer required—Rules.
48.83.130	Selling, soliciting, or negotiating coverage—Licensed insurance producers—Training—Issuers duties—Rules.
48.83.140	Determining whether coverage is appropriate—Suitability standards—Information protected—Rules.
48.83.150	Prohibited practices.
48.83.160	Violations—Fine.
48.83.170	Rules, generally.
48.83.901	Effective date—2008 c 145.

48.83.005 Intent. The intent of this chapter is to promote the public interest, support the availability of long-term care coverage, establish standards for long-term care coverage, facilitate public understanding and comparison of long-term care contract benefits, protect persons insured under long-term care insurance policies and certificates, protect applicants for long-term care policies from unfair or deceptive sales or enrollment practices, and provide for flexibility and innovation in the development of long-term care insurance coverage. [2008 c 145 § 1.]

48.83.010 Application. This chapter applies to all long-term care insurance policies, contracts, or riders delivered or issued for delivery in this state on or after January 1, 2009. This chapter does not supersede the obligations of entities subject to this chapter to comply with other applicable laws to the extent that they do not conflict with this chapter, except that laws and regulations designed and intended to apply to medicare supplement insurance policies shall not be applied to long-term care insurance.

(1) Coverage advertised, marketed, or offered as long-term care insurance shall comply with the provisions of this chapter. Any coverage, policy, or rider advertised, marketed, or offered as long-term care or nursing home insurance shall comply with the provisions of this chapter.

(2) Individual and group long-term care contracts issued prior to January 1, 2009, remain governed by chapter 48.84 RCW and rules adopted thereunder.

(3) This chapter is not intended to prohibit approval of long-term care funded through life insurance. [2008 c 145 § 2.]

48.83.020 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Applicant" means: (a) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and (b) in the case of a group long-term care insurance policy, the proposed certificate holder.

(2) "Certificate" includes any certificate issued under a group long-term care insurance policy that has been delivered or issued for delivery in this state.

(3) "Commissioner" means the insurance commissioner of Washington state.

(4) "Issuer" includes insurance companies, fraternal benefit societies, health care service contractors, health maintenance organizations, or other entity delivering or issuing for delivery any long-term care insurance policy, contract, or rider.

(5) "Long-term care insurance" means an insurance policy, contract, or rider that is advertised, marketed, offered, or designed to provide coverage for at least twelve consecutive months for a covered person. Long-term care insurance may be on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. Long-term care insurance includes any policy, contract, or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity.

(a) Long-term care insurance includes group and individual annuities and life insurance policies or riders that provide directly or supplement long-term care insurance. However, long-term care insurance does not include life insurance policies that: (i) Accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement; (ii) provide the option of a lump sum payment for those benefits; and (iii) do not condition the benefits or the eligibility for the benefits upon the receipt of long-term care.

(b) Long-term care insurance also includes qualified long-term care insurance contracts.

(c) Long-term care insurance does not include any insurance policy, contract, or rider that is offered primarily to provide coverage for basic medicare supplement, basic hospital expense, basic medical-surgical expense, hospital confinement indemnity, major medical expense, disability income, related income, asset protection, accident only, specified disease, specified accident, or limited benefit health.

(6) "Group long-term care insurance" means a long-term care insurance policy or contract that is delivered or issued for delivery in this state and is issued to:

(a) One or more employers; one or more labor organizations; or a trust or the trustees of a fund established by one or more employers or labor organizations for current or former employees, current or former members of the labor organizations, or a combination of current and former employees or members, or a combination of such employers, labor organizations, trusts, or trustees; or

(b) A professional, trade, or occupational association for its members or former or retired members, if the association:

(i) Is composed of persons who are or were all actively engaged in the same profession, trade, or occupation; and

(ii) Has been maintained in good faith for purposes other than obtaining insurance; or

(c)(i) An association, trust, or the trustees of a fund established, created, or maintained for the benefit of members of one or more associations. Before advertising, marketing, or offering long-term care coverage in this state, the association or associations, or the insurer of the association or associations, must file evidence with the commissioner that the association or associations have at the time of such filing at least one hundred persons who are members and that the association or associations have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws that provide that:

(A) The association or associations hold regular meetings at least annually to further the purposes of the members;

(B) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(C) The members have voting privileges and representation on the governing board and committees of the association.

(ii) Thirty days after filing the evidence in accordance with this section, the association or associations will be deemed to have satisfied the organizational requirements, unless the commissioner makes a finding that the association or associations do not satisfy those organizational requirements; [or]

(d) A group other than as described in (a), (b), or (c) of this subsection subject to a finding by the commissioner that:

(i) The issuance of the group policy is not contrary to the best interest of the public;

(ii) The issuance of the group policy would result in economies of acquisition or administration; and

(iii) The benefits are reasonable in relation to the premiums charged.

(7) "Policy" includes a document such as an insurance policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in this state by an insurer, fraternal benefit society, health care service contractor, health maintenance organization, or any similar entity authorized by the insurance commissioner to transact the business of long-term care insurance.

(8) "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means:

(a) An individual or group insurance contract that meets the requirements of section 7702B(b) of the internal revenue code of 1986, as amended; or

(b) The portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of sections 7702B(b) and (e) of the internal revenue code of 1986, as amended. [2008 c 145 § 3.]

48.83.030 Out-of-state policy—Restriction. A group long-term care insurance policy may not be offered to a resident of this state under a group policy issued in another state to a group described in RCW 48.83.020(6)(d), unless this state or another state having statutory and regulatory long-

term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met. [2008 c 145 § 4.]

48.83.040 Preexisting conditions. (1) A long-term care insurance policy or certificate may not define "preexisting condition" more restrictively than as a condition for which medical advice or treatment was recommended by or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person, unless the policy or certificate applies to group long-term care insurance under RCW 48.83.020(6) (a), (b), or (c).

(2) A long-term care insurance policy or certificate may not exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within six months following the effective date of coverage of an insured person, unless the policy or certificate applies to a group as defined in RCW 48.83.020(6)(a).

(3) The commissioner may extend the limitation periods for specific age group categories in specific policy forms upon finding that the extension is in the best interest of the public.

(4) An issuer may use an application form designed to elicit the complete health history of an applicant and underwrite in accordance with that issuer's established underwriting standards, based on the answers on that application. Unless otherwise provided in the policy or certificate and regardless of whether it is disclosed on the application, a preexisting condition need not be covered until the waiting period expires.

(5) A long-term care insurance policy or certificate may not exclude or use waivers or riders to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period. [2008 c 145 § 5.]

48.83.050 Prohibited policy terms and practices—Field-issued, defined. No long-term care insurance policy may:

(1) Be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder;

(3) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care;

(4) Condition eligibility for any benefits on a prior hospitalization requirement;

(5) Condition eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care;

(6) Condition eligibility for any benefits other than waiver of premium, postconfinement, postacute care, or recuperative benefits on a prior institutionalization requirement;

(7) Include a postconfinement, postacute care, or recuperative benefit unless:

(a) Such requirement is clearly labeled in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits"; and

(b) Such limitations or conditions specify any required number of days of preconfinement or postconfinement;

(8) Condition eligibility for noninstitutional benefits on the prior receipt of institutional care;

(9) A long-term care insurance policy or certificate may be field-issued if the compensation to the field issuer is not based on the number of policies or certificates issued. For purposes of this section, "field-issued" means a policy or certificate issued by a producer or a third-party administrator of the policy pursuant to the underwriting authority by an issuer and using the issuer's underwriting guidelines. [2008 c 145 § 6.]

48.83.060 Right to return policy or certificate—

Refund. (1) Long-term care insurance applicants may return a policy or certificate for any reason within thirty days after its delivery and to have the premium refunded.

(2) All long-term care insurance policies and certificates shall have a notice prominently printed on or attached to the first page of the policy stating that the applicant may return the policy or certificate within thirty days after its delivery and to have the premium refunded.

(3) Refunds or denials of applications must be made within thirty days of the return or denial.

(4) This section shall not apply to certificates issued pursuant to a policy issued to a group defined in RCW 48.83.020(6)(a). [2008 c 145 § 7.]

48.83.070 Required documents for prospective and approved applicants—Contents—When due.

(1) An outline of coverage must be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose.

(a) The commissioner must prescribe a standard format, including style, arrangement, overall appearance, and the content of an outline of coverage.

(b) When an insurance producer makes a solicitation in person, he or she must deliver an outline of coverage before presenting an application or enrollment form.

(c) In a direct response solicitation, the outline of coverage must be presented with an application or enrollment form.

(d) If a policy is issued to a group as defined in RCW 48.83.020(6)(a), an outline of coverage is not required to be delivered, if the information that the commissioner requires to be included in the outline of coverage is in other materials relating to enrollment. Upon request, any such materials must be made available to the commissioner.

(2) If an issuer approves an application for a long-term care insurance contract or certificate, the issuer must deliver the contract or certificate of insurance to the applicant within thirty days after the date of approval. A policy summary must be delivered with an individual life insurance policy that provides long-term care benefits within the policy or by rider. In a direct response solicitation, the issuer must deliver the policy summary, upon request, before delivery of the policy, if the applicant requests a summary.

(2022 Ed.)

(a) The policy summary shall include:

(i) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from any applicable death benefits;

(ii) An illustration of the amount of benefits, the length of benefits, and the guaranteed lifetime benefits if any, for each covered person;

(iii) Any exclusions, reductions, and limitations on benefits of long-term care;

(iv) A statement that any long-term care inflation protection option required by RCW 48.83.110 is not available under this policy; and

(v) If applicable to the policy type, the summary must also include:

(A) A disclosure of the effects of exercising other rights under the policy;

(B) A disclosure of guarantees related to long-term care costs of insurance charges; and

(C) Current and projected maximum lifetime benefits.

(b) The provisions of the policy summary may be incorporated into a basic illustration required under chapter 48.23A RCW, or into the policy summary which is required under rules adopted by the commissioner. [2008 c 145 § 8.]

48.83.080 Benefit funded through life insurance policy—Acceleration of a death benefit.

If a long-term care benefit funded through a life insurance policy by the acceleration of the death benefit is in benefit payment status, a monthly report must be provided to the policyholder. The report must include:

(1) A record of all long-term care benefits paid out during the month;

(2) An explanation of any changes in the policy resulting from paying the long-term care benefits, such as a change in the death benefit or cash values; and

(3) The amount of long-term care benefits that remain to be paid. [2008 c 145 § 9.]

48.83.090 Denial of claims—Written explanation.

All long-term care denials must be made within thirty days after receipt of a written request made by a policyholder or certificate holder, or his or her representative. All denials of long-term care claims by the issuer must provide a written explanation of the reasons for the denial and make available to the policyholder or certificate holder all information directly related to the denial. [2013 c 8 § 1; 2008 c 145 § 10.]

48.83.100 Rescission of policy or certificate. (1) An issuer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim if:

(a) A policy or certificate has been in force for less than six months and upon a showing of misrepresentation that is material to the acceptance for coverage; or

(b) A policy or certificate that has been in force for at least six months but less than two years, upon a showing of misrepresentation that is both material to the acceptance for coverage and that pertains to the condition for which benefits are sought.

(2) After a policy or certificate has been in force for two years it is not contestable upon the grounds of misrepresenta-

tion alone. Such a policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

(3) An issuer's payments for benefits under a long-term care insurance policy or certificate may not be recovered by the issuer if the policy or certificate is rescinded.

(4) This section does not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care that are governed by RCW 48.23.050 the state's life insurance incontestability clause. In all other situations, this section shall apply to life insurance policies that accelerate benefits for long-term care. [2008 c 145 § 11.]

48.83.110 Inflation protection features—Rules. (1) The commissioner must establish minimum standards for inflation protection features.

(2) An issuer must comply with the rules adopted by the commissioner that establish minimum standards for inflation protection features. [2008 c 145 § 12.]

48.83.120 Nonforfeiture benefit option—Offer required—Rules. (1) Except as provided by this section, a long-term care insurance policy may not be delivered or issued for delivery in this state unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate that includes a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. If a policyholder or certificate holder declines the nonforfeiture benefit, the issuer must provide a contingent benefit upon lapse that is available for a specified period of time following a substantial increase in premium rates.

(2) If a group long-term care insurance policy is issued, the offer required in subsection (1) of this section must be made to the group policyholder. However, if the policy is issued as group long-term care insurance as defined in RCW 48.83.020(6)(d) other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificate holder.

(3) The commissioner must adopt rules specifying the type or types of nonforfeiture benefits to be offered as part of long-term care insurance policies and certificates, the standards for nonforfeiture benefits, and the rules regarding contingent benefit upon lapse, including a determination of the specified period of time during which a contingent benefit upon lapse will be available and the substantial premium rate increase that triggers a contingent benefit upon lapse. [2008 c 145 § 13.]

48.83.130 Selling, soliciting, or negotiating coverage—Licensed insurance producers—Training—Issuers duties—Rules. A person may not sell, solicit, or negotiate long-term care insurance unless he or she is appropriately licensed as an insurance producer and has successfully completed long-term care coverage education that meets the requirements of this section.

(1) All long-term care education required by this chapter must meet the requirements of chapter 48.17 RCW and rules adopted by the commissioner.

(2)(a)(i) After January 1, 2009, prior to soliciting, selling, or negotiating long-term care insurance coverage, an

insurance producer must successfully complete a one-time education course consisting of no fewer than eight hours on long-term care coverage, long-term care services, state and federal regulations and requirements for long-term care and qualified long-term care insurance coverage, changes or improvements in long-term care services or providers, alternatives to the purchase of long-term care insurance coverage, the effect of inflation on benefits and the importance of inflation protection, and consumer suitability standards and guidelines.

(ii) In order to continue soliciting, selling, or negotiating long-term care coverage in this state, all insurance producers selling, soliciting, or negotiating long-term care insurance coverage prior to January 1, 2009, must successfully complete the eight-hour, one-time long-term care education and training course no later than July 1, 2009.

(b) In addition to the one-time education and training requirement set forth in (a) of this subsection, insurance producers who engage in the solicitation, sale, or negotiation of long-term care insurance coverage must successfully complete no fewer than four hours every twenty-four months of continuing education specific to long-term care insurance coverage and issues. Long-term care insurance coverage continuing education shall consist of topics related to long-term care insurance, long-term care services, and, if applicable, qualified state long-term care insurance partnership programs, including, but not limited to, the following:

(i) State and federal regulations and requirements and the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services, including medicaid;

(ii) Available long-term care services and providers;

(iii) Changes or improvements in long-term care services or providers;

(iv) Alternatives to the purchase of private long-term care insurance;

(v) The effect of inflation on benefits and the importance of inflation protection;

(vi) This chapter and chapters 48.84 and 48.85 RCW; and

(vii) Consumer suitability standards and guidelines.

(3) The insurance producer education required by this section shall not include training that is issuer or company product-specific or that includes any sales or marketing information, materials, or training, other than those required by state or federal law.

(4) Issuers shall obtain verification that an insurance producer receives training required by this section before that producer is permitted to sell, solicit, or otherwise negotiate the issuer's long-term care insurance products.

(5) Issuers shall maintain records subject to the state's record retention requirements and shall make evidence of that verification available to the commissioner upon request.

(6)(a) Issuers shall maintain records with respect to the training of its producers concerning the distribution of its long-term care partnership policies that will allow the commissioner to provide assurance to the state department of social and health services, medicaid division, that insurance producers engaged in the sale of long-term care insurance contracts have received the training required by this section and any rules adopted by the commissioner, and that produc-

ers have demonstrated an understanding of the partnership policies and their relationship to public and private coverage of long-term care, including medicaid, in this state.

(b) These records shall be maintained in accordance with the state's record retention requirements and shall be made available to the commissioner upon request.

(7) The satisfaction of these training requirements for any state shall be deemed to satisfy the training requirements of this state. [2008 c 145 § 14.]

48.83.140 Determining whether coverage is appropriate—Suitability standards—Information protected—Rules. Issuers and their agents, if any, must determine whether issuing long-term care insurance coverage to a particular person is appropriate, except in the case of a life insurance policy that accelerates benefits for long-term care.

(1) An issuer must:

(a) Develop and use suitability standards to determine whether the purchase or replacement of long-term care coverage is appropriate for the needs of the applicant or insured;

(b) Train its agents in the use of the issuer's suitability standards; and

(c) Maintain a copy of its suitability standards and make the standards available for inspection, upon request.

(2) The following must be considered when determining whether the applicant meets the issuer's suitability standards:

(a) The ability of the applicant to pay for the proposed coverage and any other relevant financial information related to the purchase of or payment for coverage;

(b) The applicant's goals and needs with respect to long-term care and the advantages and disadvantages of long-term care coverage to meet those goals or needs; and

(c) The values, benefits, and costs of the applicant's existing health or long-term care coverage, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

(3) The sale or transfer of any suitability information provided to the issuer or agent by the applicant to any other person or business entity is prohibited.

(4)(a) The commissioner shall adopt, by rule, forms of consumer-friendly personal worksheets that issuers and their agents must use for applications for long-term care coverage.

(b) The commissioner may require each issuer to file its current forms of suitability standards and personal worksheets with the commissioner. [2008 c 145 § 15.]

48.83.150 Prohibited practices. A person engaged in the issuance or solicitation of long-term care coverage shall not engage in unfair methods of competition or unfair or deceptive acts or practices, as such methods, acts, or practices are defined in chapter 48.30 RCW, or as defined by the commissioner. [2008 c 145 § 16.]

48.83.160 Violations—Fine. An issuer or an insurance producer who violates a law or rule relating to the regulation of long-term care insurance or its marketing shall be subject to a fine of up to three times the amount of the commission paid for each policy involved in the violation or up to ten thousand dollars, whichever is greater. [2008 c 145 § 17.]

48.83.170 Rules, generally. (1) The commissioner must adopt rules that include standards for full and fair disclosure setting forth the manner, content, and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definitions of terms. The commissioner must adopt rules establishing loss ratio standards for long-term care insurance policies. The commissioner must adopt rules to promote premium adequacy and to protect policyholders in the event of proposed substantial rate increases, and to establish minimum standards for producer education, marketing practices, producer compensation, producer testing, penalties, and reporting practices for long-term care insurance.

(2) The commissioner must adopt rules establishing standards protecting patient privacy rights, rights to receive confidential health care services, and standards for an issuer's timely review of a claim denial upon request of a covered person.

(3) The commissioner must adopt by rule prompt payment requirements for long-term care insurance. The rules must include a definition of a "claim" and a definition of "clean claim." In adopting the rules the commissioner must consider the prompt payment requirements in long-term care insurance model acts developed by the national association of insurance commissioners.

(4) The commissioner may adopt reasonable rules to effectuate any provision of this chapter in accordance with the requirements of chapter 34.05 RCW. [2013 c 8 § 2; 2008 c 145 § 18.]

48.83.901 Effective date—2008 c 145. This act takes effect January 1, 2009. [2008 c 145 § 24.]

Chapter 48.84 RCW

LONG-TERM CARE INSURANCE ACT

Sections

48.84.010	General provisions, intent.
48.84.020	Definitions.
48.84.030	Rules—Benefits-premiums ratio, coverage limitations.
48.84.040	Policies and contracts—Prohibited provisions.
48.84.050	Disclosure rules—Required provisions in policy or contract.
48.84.060	Prohibited practices.
48.84.070	Separation of data regarding certain policies.
48.84.910	Effective date, application—1986 c 170.

Long-term care insurance plans for eligible public employees: RCW 41.05.065.

48.84.010 General provisions, intent. This chapter may be known and cited as the "long-term care insurance act" and is intended to govern the content and sale of long-term care insurance and long-term care benefit contracts issued before January 1, 2009, as defined in this chapter. This chapter shall be liberally construed to promote the public interest in protecting purchasers of long-term care insurance from unfair or deceptive sales, marketing, and advertising practices. The provisions of this chapter shall apply in addition to

other requirements of Title 48 RCW. [2008 c 145 § 19; 1986 c 170 § 1.]

Additional notes found at www.leg.wa.gov

48.84.020 Definitions. Unless the context requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Long-term care insurance" or "long-term care benefit contract" means any insurance policy or benefit contract primarily advertised, marketed, offered, or designed to provide coverage or services for either institutional or community-based convalescent, custodial, chronic, or terminally ill care. Such terms do not include and this chapter shall not apply to policies or contracts governed by chapter 48.66 RCW and continuing care retirement communities.

(2) "Loss ratio" means the incurred claims plus or minus the increase or decrease in reserves as a percentage of the earned premiums, or the projected incurred claims plus or minus the increase or decrease in projected reserves as a percentage of projected earned premiums, as defined by the commissioner.

(3) "Preexisting condition" means a covered person's medical condition that caused that person to have received medical advice or treatment during the specified time period before the effective date of coverage.

(4) "Medicare" means Title XVIII of the United States social security act, or its successor program.

(5) "Medicaid" means Title XIX of the United States social security act, or its successor program.

(6) "Nursing home" means a nursing home as defined in RCW 18.51.010. [1986 c 170 § 2.]

48.84.030 Rules—Benefits-premiums ratio, coverage limitations. (1) The commissioner shall adopt rules requiring reasonable benefits in relation to the premium or price charged for long-term care policies and contracts which rules may include but are not limited to the establishment of minimum loss ratios.

(2) In addition, the commissioner may adopt rules establishing standards for long-term care coverage benefit limitations, exclusions, exceptions, and reductions and for policy or contract renewability. [1986 c 170 § 3.]

48.84.040 Policies and contracts—Prohibited provisions. No long-term care insurance policy or benefit contract may:

(1) Use riders, waivers, endorsements, or any similar method to limit or reduce coverage or benefits;

(2) Indemnify against losses resulting from sickness on a different basis than losses resulting from accidents;

(3) Be canceled, nonrenewed, or segregated at the time of rating solely on the grounds of the age or the deterioration of the mental or physical health of the covered person;

(4) Exclude or limit coverage for preexisting conditions for a period of more than one year prior to the effective date of the policy or contract or more than six months after the effective date of the policy or contract;

(5) Differentiate benefit amounts on the basis of the type or level of nursing home care provided;

(6) Contain a provision establishing any new waiting period in the event an existing policy or contract is converted

to a new or other form within the same company. [1986 c 170 § 4.]

48.84.050 Disclosure rules—Required provisions in policy or contract. (1) The commissioner shall adopt rules requiring disclosure to consumers of the level, type, and amount of benefits provided and the limitations, exclusions, and exceptions contained in a long-term care insurance policy or contract. In adopting such rules the commissioner shall require an understandable disclosure to consumers of any cost for services that the consumer will be responsible for in utilizing benefits covered under the policy or contract.

(2) Each long-term care insurance policy or contract shall include a provision, prominently displayed on the first page of the policy or contract, stating in substance that the person to whom the policy or contract is sold shall be permitted to return the policy or contract within thirty days of its delivery. In the case of policies or contracts solicited and sold by mail, the person may return the policy or contract within sixty days. Once the policy or contract has been returned, the person may have the premium refunded if, after examination of the policy or contract, the person is not satisfied with it for any reason. An additional ten percent penalty shall be added to any premium refund due which is not paid within thirty days of return of the policy or contract to the insurer or insurance producer. If a person, pursuant to such notice, returns the policy or contract to the insurer at its branch or home office, or to the insurance producer from whom the policy or contract was purchased, the policy or contract shall be void from its inception, and the parties shall be in the same position as if no policy or contract had been issued.

(3) No later than January 1, 2010, or when the insurer has used all of its existing paper long-term care insurance policy forms which were in its possession on July 1, 2009, whichever is earlier, the notice required by subsection (2) of this section shall use the term insurance producer in place of agent. [2008 c 217 § 67; 1986 c 170 § 5.]

Additional notes found at www.leg.wa.gov

48.84.060 Prohibited practices. No insurance producer or other representative of an insurer, contractor, or other organization selling or offering long-term care insurance policies or benefit contracts may: (1) Complete the medical history portion of any form or application for the purchase of such policy or contract; (2) knowingly sell a long-term care policy or contract to any person who is receiving medicaid; or (3) use or engage in any unfair or deceptive act or practice in the advertising, sale, or marketing of long-term care policies or contracts. [2008 c 217 § 68; 1986 c 170 § 6.]

Additional notes found at www.leg.wa.gov

48.84.070 Separation of data regarding certain policies. Commencing with reports for accounting periods beginning on or after January 1, 1988, all insurers, fraternal benefit societies, health care services contractors, and health maintenance organizations shall, for reporting and record-keeping purposes, separate data concerning long-term care insurance policies and contracts from data concerning other insurance policies and contracts. [1986 c 170 § 7.]

48.84.910 Effective date, application—1986 c 170. RCW 48.84.060 shall take effect on November 1, 1986, and the commissioner shall adopt all rules necessary to implement RCW 48.84.060 by its effective date including rules prohibiting particular unfair or deceptive acts and practices in the advertising, sale, and marketing of long-term care policies and contracts. The commissioner shall adopt all rules necessary to implement the remaining sections of this chapter by July 1, 1987, and the remaining sections of this chapter shall apply to policies and contracts issued on or after January 1, 1988. [1986 c 170 § 10.]

Chapter 48.85 RCW

WASHINGTON LONG-TERM CARE PARTNERSHIP

Sections

48.85.010	Washington long-term care partnership program—Generally.
48.85.020	Protection of assets—Federal approval—Rules.
48.85.030	Insurance policy criteria—Rules.
48.85.040	Consumer education program.
48.85.900	Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492.

48.85.010 Washington long-term care partnership program—Generally. The department of social and health services shall, in conjunction with the office of the insurance commissioner, coordinate a long-term care insurance program entitled the Washington long-term care partnership, whereby private insurance and medicaid funds shall be used to finance long-term care. For individuals purchasing a long-term care insurance policy or contract governed by chapter 48.84 or 48.83 RCW and meeting the criteria prescribed in this chapter, and any other terms as specified by the office of the insurance commissioner and the department of social and health services, this program shall allow for the exclusion of some or all of the individual's assets in determination of medicaid eligibility as approved by the centers for medicare and medicaid services. [2012 c 211 § 9; 2008 c 145 § 21; 1995 1st sp.s. c 18 § 76; 1993 c 492 § 458.]

Findings—Intent—1993 c 492: See notes following RCW 43.20.050. Additional notes found at www.leg.wa.gov

48.85.020 Protection of assets—Federal approval—Rules. The department of social and health services shall seek approval from the centers for medicare and medicaid services to allow the protection of an individual's assets as provided in this chapter. The department shall adopt all rules necessary to implement the Washington long-term care partnership program, which rules shall permit the exclusion of all or some of an individual's assets in a manner specified by the department in a determination of medicaid eligibility to the extent that private long-term care insurance provides payment or benefits for services. [2012 c 211 § 10; 1995 1st sp.s. c 18 § 77; 1993 c 492 § 459.]

Findings—Intent—1993 c 492: See notes following RCW 43.20.050. Additional notes found at www.leg.wa.gov

48.85.030 Insurance policy criteria—Rules. (1) The insurance commissioner shall adopt rules defining the criteria that qualified long-term care partnership insurance policies must meet to satisfy the requirements of this chapter. The rules shall incorporate any requirements set forth by chapter

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48.83 RCW and the deficit reduction act of 2005 for qualified long-term care partnership insurance policies purchased for the purposes of this chapter.

(2) Insurers offering long-term care policies for the purposes of this chapter shall demonstrate to the satisfaction of the insurance commissioner that they:

(a) Have procedures to provide notice to each purchaser of the long-term care consumer education program;

(b) Have procedures that provide for the keeping of individual policy records and procedures for the explanation of coverage and benefits identifying those payments or services available under the policy that meet the purposes of this chapter;

(c) Agree to provide the insurance commissioner any required annual report containing information derived from the long-term care partnership long-term care insurance uniform data set as specified by the office of the insurance commissioner. [2011 c 47 § 12; 1995 1st sp.s. c 18 § 78; 1993 c 492 § 460.]

Findings—Intent—1993 c 492: See notes following RCW 43.20.050. Additional notes found at www.leg.wa.gov

48.85.040 Consumer education program. The insurance commissioner shall, with the cooperation of the department of social and health services and members of the long-term care insurance industry, develop a consumer education program designed to educate consumers as to the need for long-term care, methods for financing long-term care, the availability of long-term care insurance, and the availability and eligibility requirements of the asset protection program provided under this chapter. [1995 1st sp.s. c 18 § 79; 1993 c 492 § 461.]

Findings—Intent—1993 c 492: See notes following RCW 43.20.050. Additional notes found at www.leg.wa.gov

48.85.900 Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492. See RCW 43.72.910 through 43.72.915.

Chapter 48.87 RCW

MIDWIVES AND BIRTHING CENTERS—JOINT UNDERWRITING ASSOCIATION

Sections

48.87.010	Intent.
48.87.020	Definitions.
48.87.030	Plan for establishing association—Commissioner's duty—Market assistance plan.
48.87.040	Composition of association.
48.87.050	Midwifery and birth center malpractice insurance—Rating plan modified according to practice volume.
48.87.060	Administering a plan.
48.87.070	Policies written on a claims made basis—Commissioner may not approve without insurer guarantees.
48.87.080	Risk management program—Part of plan.
48.87.100	Rule making.

48.87.010 Intent. Certified nurse midwives and licensed midwives experience a major problem in both the availability and affordability of malpractice insurance. In particular midwives practicing outside hospital settings are unable to obtain malpractice insurance at any price in this state at this time. Licensed midwives have been unable to obtain hospital privileges due in part to the requirement of

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almost all Washington hospitals that professional staff members have liability insurance.

The services performed by midwives are in demand by many women for childbirth and prenatal care. Women often choose to have a home or birth center birth instead of a hospital birth. Women are entitled to the provider of their choice at such a critical life event. Studies document the safety of midwife-attended births and the safety of home births for low-risk women.

At a time when safety, cost-effectiveness, and individual choice are of paramount concern to the citizens of Washington state, midwifery care in a variety of settings must be available to the public. This is essential to the goals of increased access to maternity care and increased cost-effectiveness of care, as well as addressing problems of provider shortage. One of the primary impediments to the availability of maternity services performed by midwives is the lack of available and affordable malpractice liability insurance coverage.

This chapter is intended to increase the availability of cost-effective, high quality maternity care by making malpractice insurance available for midwives. This chapter is implemented by requiring all insurers authorized to write commercial or professional liability insurance to be members of a joint underwriting association created to provide malpractice insurance for midwives. [1993 c 112 § 1.]

48.87.020 Definitions. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Association" means the joint underwriting association established under this chapter.

(2) "Midwifery and birth center malpractice insurance" means insurance coverage against the legal liability of the insured and against loss damage or expense incident to a claim arising out of the death or injury of a person as a result of negligence or malpractice in rendering professional service by a licensee.

(3) "Licensee" means a person or facility licensed to provide midwifery services under chapter 18.50, 18.79, or 18.46 RCW. [2002 c 300 § 1; 1993 c 112 § 2.]

48.87.030 Plan for establishing association—Commissioner's duty—Market assistance plan. The insurance commissioner shall approve by December 31, 1993, a reasonable plan for the establishment of a nonprofit, joint underwriting association for midwifery and birth center malpractice insurance subject to the conditions and limitations contained in this chapter. Such plan shall include a market assistance plan to be used prior to activating a joint underwriting association. [1993 c 112 § 3.]

48.87.040 Composition of association. The association shall be comprised of all insurers possessing a certificate of authority to write and engaged in writing medical malpractice insurance within this state and general casualty companies. Every insurer shall be a member of the association and shall remain a member as a condition of its authority to continue to transact business in this state. Only licensed midwives under chapter 18.50 RCW, certified nurse midwives licensed under chapter 18.79 RCW, or birth centers licensed

under chapter 18.46 RCW may participate in the joint underwriting authority. [2002 c 300 § 2; 1993 c 112 § 4.]

48.87.050 Midwifery and birth center malpractice insurance—Rating plan modified according to practice volume. A licensee may apply to the association to purchase midwifery and birth center malpractice insurance and the association shall offer a policy with liability limits of one million dollars per claim and three million dollars per annual aggregate, or such other minimum level of mandated coverage as determined by the department of health. The insurance commissioner shall require the use of a rating plan for midwifery malpractice insurance that permits rates to be modified according to practice volume. Any rating plan for midwifery malpractice insurance used under this section must be based on sound actuarial principles. Coverage may not exclude midwives who engage in home birth or birth center deliveries. [1994 c 90 § 1; 1993 c 112 § 5.]

Additional notes found at www.leg.wa.gov

48.87.060 Administering a plan. The commissioner may select an insurer to administer a plan established under this chapter. The insurer must be admitted to transact the business of insurance of the state of Washington. [1993 c 112 § 6.]

48.87.070 Policies written on a claims made basis—Commissioner may not approve without insurer guarantees. The insurance commissioner may not approve a policy written on a claims made basis by an insurer doing business in this state unless the insurer guarantees to the commissioner the continued availability of suitable liability protection for midwives subsequent to the discontinuance of professional practice by the midwife or the sooner termination of the insurance policy by the insurer for so long as there is a reasonable probability of a claim for injury for which the health care provider might be liable. [1993 c 112 § 7.]

48.87.080 Risk management program—Part of plan. A risk management program for insureds of the association must be established as a part of the plan. This program must include but not be limited to: Investigation and analysis of frequency, severity, and causes of adverse or untoward outcomes; development of measures to control these injuries; systematic reporting of incidents; investigation and analysis of patient complaints; and education of association members to improve quality of care and risk reduction. [1993 c 112 § 8.]

48.87.100 Rule making. The commissioner may adopt all rules necessary to ensure the efficient, equitable operation of the association, including but not limited to, rules requiring or limiting certain policy provisions. [1993 c 112 § 10.]

Chapter 48.88 RCW

DAY CARE SERVICES—JOINT UNDERWRITING ASSOCIATION

Sections

48.88.010 Intent.
48.88.020 Definitions.

48.88.030 Plan for joint underwriting association.
 48.88.040 Association—Membership.
 48.88.050 Policies—Liability limits—Rating plan.
 48.88.070 Rules.

48.88.010 Intent. Day care service providers have experienced major problems in both the availability and affordability of liability insurance. Premiums for such insurance policies have recently grown as much as five hundred percent and the availability of such insurance in Washington markets has greatly diminished.

The availability of quality day care is essential to achieving such goals as increased workforce productivity, family self-sufficiency, and protection for children at risk due to poverty and abuse. The unavailability of adequate liability insurance threatens to decrease the availability of day care services.

This chapter is intended to remedy the problem of unavailable liability insurance for day care services by requiring all insurers authorized to write commercial or professional liability insurance to be members of a joint underwriting association created to provide liability insurance for day care services. [1986 c 141 § 1.]

48.88.020 Definitions. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Association" means the joint underwriting association established pursuant to the provisions of this chapter.

(2) "Day care insurance" means insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in rendering professional service by any licensee.

(3) "Licensee" means any person or facility licensed to provide day care services pursuant to chapter 74.15 RCW. [1986 c 141 § 2.]

48.88.030 Plan for joint underwriting association. The commissioner shall approve by July 1, 1986, a reasonable plan for the establishment of a nonprofit, joint underwriting association for day care insurance, subject to the conditions and limitations contained in this chapter. [1986 c 141 § 3.]

48.88.040 Association—Membership. The association shall be comprised of all insurers possessing a certificate of authority to write and engage in writing property and casualty insurance within this state on a direct basis, including the liability portion of multiperil policies, but not of ocean marine insurance. Every such insurer shall be a member of the association and shall remain a member as a condition of its authority to continue to transact business in this state. [1986 c 141 § 4.]

48.88.050 Policies—Liability limits—Rating plan. Any licensee may apply to the association to purchase day care insurance, and the association shall offer a policy with liability limits of at least one hundred thousand dollars per occurrence. The commissioner shall require the use of a rating plan for day care insurance that permits rates to be modified for individual licensees according to the type, size and

past loss experience of the licensee including any other difference among licensees that can be demonstrated to have a probable effect upon losses. [1986 c 141 § 5.]

48.88.070 Rules. The commissioner may adopt all rules necessary to ensure the efficient, equitable operation of the association, including but not limited to, rules requiring or limiting certain policy provisions. [1986 c 141 § 7.]

Chapter 48.90 RCW

CHILD DAY CARE CENTERS—SELF-INSURANCE

Sections

48.90.010	Findings and intent.
48.90.020	Definitions.
48.90.030	Authority to self-insure.
48.90.040	Chapter exclusive.
48.90.050	Elements of plan.
48.90.060	Approval of plan.
48.90.070	Contributing trust fund.
48.90.080	Initial implementation of plan—Conditions.
48.90.090	Standard of care in fund management—Fiduciary.
48.90.100	Annual report.
48.90.110	Powers of association.
48.90.120	Contracts—Terms.
48.90.130	Significant modifications in plan, statement on.
48.90.140	Dissolution of plan and association.
48.90.150	Recovery limits.
48.90.160	Suspension of plan—Reconsideration.
48.90.170	Costs of investigation or review of plan.

48.90.010 Findings and intent. (1) Day care providers are facing a major crisis in that adequate and affordable business liability insurance is no longer available within this state for persons who care for children. Many child day care centers have been forced to purchase inadequate coverage at prohibitive premium rates from unregulated foreign surplus line carriers over which the state has minimal control.

(2) There is a danger that a substantial number of child day care centers who cannot afford the escalating premiums will be unable or unwilling to remain in business without adequate coverage. As a result the number of available facilities will be drastically reduced forcing some parents to leave the workforce to care for their children. A corresponding demand upon the state's resources will result in the form of public assistance to unemployed parents and day care providers.

(3) There is a further danger that a substantial number of child day care centers now licensed pursuant to state law, who currently provide specific safeguards for the health and safety of children but are unable to procure insurance, may choose to continue to operate without state approval, avoiding regulation and payment of legitimate taxes, and forcing some parents to place their children in facilities of unknown quality and questionable levels of safety.

(4) Most child day care centers are small business enterprises with limited resources. The state's policies encourage the growth and development of small businesses.

(5)(a) This chapter is intended to remedy the problem of nonexistent or unaffordable liability coverage for child day care centers, and to encourage compliance with state laws protecting children while meeting the state's sound economic policies of encouraging small business development, sustaining an active workforce, and discouraging policies that result in an increased drain on the state's resources through public assistance and other forms of public funding.

(b) This chapter will empower child day care centers to create self-insurance pools, to purchase insurance coverage, and to contract for risk management and administrative services through an association with demonstrated responsible fiscal management.

The intent of this legislation is to allow these associations maximum flexibility to create and administer plans to provide coverage and risk management services to licensed child day care centers. [2003 c 248 § 21; 1986 c 142 § 1.]

48.90.020 Definitions. The definitions in this section apply throughout this chapter.

(1) "Child day care center" means an agency that regularly provides care for one or more children for periods of less than twenty-four hours as defined in *RCW 74.15.020(1)(a).

(2) "Association" means a corporation organized under Title 24 RCW, representative of one or more categories of child day care centers not formed for the sole purpose of establishing and operating a self-insurance program that:

(a) Maintains a roster of current names and addresses of member child day care centers and of former member child day care centers or their representatives, and of all employees of member or former member child day care centers;

(b) Has a membership of a size and stability to ensure that it will be able to provide consistent and responsible fiscal management; and

(c) Maintains a regular newsletter or other periodic communication to member child day care centers.

(3) "Subscriber" means a child day care center that:

(a) Subscribes to a plan created pursuant to this chapter;

(b) Complies with all state licensing requirements;

(c) Is a member in good standing of an association;

(d) Has consistently maintained its license free from revocation for cause, except where the revocation was not later rescinded or vacated by appellate or administrative decision; and

(e) Is prepared to demonstrate the willingness and ability to bear its share of the financial responsibility of its participation in the plan for each applicable contractual period. [2003 c 248 § 22; 1986 c 142 § 2.]

*Reviser's note: RCW 74.15.020 was amended by 2006 c 265 § 401, deleting subsection (1)(a).

48.90.030 Authority to self-insure. Associations meeting the criteria of RCW 48.90.020 are empowered to create and operate self-insurance plans to provide general liability coverage to member child day care centers who choose to subscribe to the plans. [2003 c 248 § 23; 1986 c 142 § 3.]

48.90.040 Chapter exclusive. Except as provided in this chapter, self-insurance plans formed and implemented pursuant to this chapter shall be governed by this chapter and shall be exempt from all other provisions of the insurance laws of this state. [1986 c 142 § 4.]

48.90.050 Elements of plan. Any association desiring to establish a plan pursuant to this chapter shall prepare and submit to the commissioner a proposed plan of organization and operation, including the following elements:

(1) A statement that the association meets the requirements of this chapter.

(2) A financial plan specifying:

(a) The coverage to be offered by the self-insurance pool, setting forth a deductible level and maximum level of claims that the pool will self-insure;

(b) The amount of cash reserves to be maintained for the payment of claims;

(c) The amount of insurance, if any, to be purchased to cover claims in excess of the amount of claims to be satisfied directly from the association's own cash reserves;

(d) The amount of stop-loss coverage to be purchased in the event the joint self-insurance pool's resources are exhausted in a given fiscal period;

(e) A mechanism for determining and assessing the contingent liability of subscribers in the event the assets in the contributing trust fund are at any time insufficient to cover liabilities; and

(f) Certification that all subscribers in the pool are apprised of the limitations of coverage to be provided.

(3) A plan of management setting forth:

(a) The means of fulfilling the requirements in RCW 48.90.050(2);

(b) The names and addresses of board members and their terms of office, and a copy of the corporate bylaws defining the method of election of board members;

(c) The frequency of studies or other evaluation to establish the periodic contribution rates for each of the subscribers;

(d) The responsibilities of subscribers, including procedures for entry into and withdrawal from the pool, the allocation of contingent liabilities and a procedure for immediate assessments if the contributing trust fund falls below the level set in RCW 48.90.050(2)(b);

(e) A plan for monitoring risks and disseminating information with respect to their reduction or elimination;

(f) A contract with a professional insurance management corporation, for the management and operation of any joint self-insurance pool established by the association; and

(g) The corporate address of the association. [1986 c 142 § 5.]

48.90.060 Approval of plan. If the plan submitted complies with RCW 48.90.050 and if the terms of the plan reflect sound financial management, the commissioner shall approve the plan submitted pursuant to RCW 48.90.050. [1986 c 142 § 6.]

48.90.070 Contributing trust fund. All funds contributed for the purpose of the self-insurance plan shall be deposited in a contributing trust fund, which shall at all times be maintained separately from the general funds of the association. The association shall not contribute to or draw upon the contributing trust fund at any time or for any reason other than administration of the trust fund and operation of the plan. All administration and operating costs related to the trust fund shall be drawn from it. [1986 c 142 § 7.]

48.90.080 Initial implementation of plan—Conditions. The initial implementation of the plan shall be conditioned upon establishment of the minimum deposits in the

contributing trust fund at least thirty days prior to the first effective date of the program for its first year of operation. [1986 c 142 § 8.]

48.90.090 Standard of care in fund management—Fiduciary. In managing the assets of the contributing trust fund, the association shall exercise the reasonable judgment and care that ordinary persons of prudence, intelligence, and discretion exercise in the sound management of their affairs, not in regard to speculation but in regard to preservation of their funds with maximum return, given the information reasonably available. The association may delegate this duty to a responsible fiduciary. If the fiduciary has special skills or represents that it has special skills, then the fiduciary is under a duty to use those skills in the management of the fund's assets. [1986 c 142 § 9.]

48.90.100 Annual report. The association shall provide an annual report of the operations of the plan to all subscribers, to the secretary of social and health services, and to the commissioner. This report shall:

- (1) Review claims made, judgments entered, and claims rejected;
- (2) Certify that the current level of the contributing trust fund is sufficient to meet reasonable needs, or provide a plan for establishing such a level within a reasonable time; and
- (3) Make recommendations for specific measures of risk reduction. [1986 c 142 § 10.]

48.90.110 Powers of association. The association shall have the power, in its capacity as plan administrator, to contract for or delegate services as necessary for the efficient management and operation of the plan, including but not limited to:

- (1) Contracting for risk management and loss control services;
- (2) Designing a continuing program of risk reduction, calling for the participation of all subscribers;
- (3) Contracting for legal counsel for the defense of claims and other legal services;
- (4) Consulting with the commissioner, the secretary of social and health services, or other interested state agencies with respect to any matters affecting the provision of day care for the state's children, and related risk problems; and
- (5) Purchasing commercial insurance coverage in the form and amount as the subscribers may by contract agree, including reinsurance, excess coverage, and stop-loss insurance. [1986 c 142 § 11.]

48.90.120 Contracts—Terms. (1) All contracts between subscribers and the association shall be for one-year periods and shall terminate on the first day of the next fiscal year of the association following their signature. Subscribers withdrawing from participation in the plan during any contract period may do so only upon surrender of their licenses to care for children to the department of social and health services.

(2) Premiums should be annual, prorated quarterly in the event any subscriber withdraws, or any new subscriber contracts with the association to become part of the plan during

the fiscal year. Subscribers should not have the power to delegate or assign the responsibility for their assessments.

(3) Contracts should provide for recovery by the association, of any assessments that are not promptly contributed, for methods of collection, and for resolution of related disputes. [1986 c 142 § 12.]

48.90.130 Significant modifications in plan, statement on. Within six months of the beginning of any fiscal year in which significant modifications of the plan are envisioned, the association shall provide the commissioner with a statement of those modifications, setting forth the proposed changes, reasons for the changes, and reasonable alternatives, if any exist. The statement shall specifically include reference to coverage available in the commercial insurance market, together with suggested solutions within the joint self-insurance plan. [1986 c 142 § 13.]

48.90.140 Dissolution of plan and association. (1) If at any time the plan can no longer be operated on a sound financial basis, the association may elect to dissolve the plan, subject to explicit approval by the commissioner of a plan for dissolution. Once a plan operated by an association has been dissolved, that association may not again implement a plan pursuant to this chapter for five calendar years.

(2) At dissolution, the assets of the association represented by the contributing trust fund shall be deposited with the commissioner for a period of twenty-one years, to be made available for claims arising during that period based upon occurrences during the term of coverage. At the time of transfer of the funds, the association shall certify to the commissioner a list of all current subscribers, with their correct mailing addresses, and shall have notified all current subscribers of their obligation to keep the commissioner informed of any changes in their mailing addresses over the twenty-one year period, and that this obligation extends to their representatives, successors, assigns, and to the representatives of their estates. Upon dissolution, the association is required to provide to the commissioner a list of all plan subscribers during all of the years of operation of the plan.

At the end of the twenty-one year period, any funds remaining in the trust account must be distributed to those subscribers who were current subscribers in the most recent year of operation of the plan, with each current subscriber receiving an equal share of the distribution, without regard for the length of time each child day care center was a subscriber.

In the alternative, in the discretion of the association, the balance of the contributing trust fund may be used to purchase similar or more liberal coverage from a commercial insurer. Each subscriber shall, however, be given the option to deposit its share of the fund with the commissioner as provided in this section if it elects not to participate in the proposed commercial insurance. [2003 c 248 § 24; 1986 c 142 § 14.]

48.90.150 Recovery limits. No person with a claim covered by a plan established pursuant to this chapter shall be entitled to recover from the plan any amount in excess of the limits of coverage provided for in the plan. [1986 c 142 § 15.]

48.90.160 Suspension of plan—Reconsideration. The commissioner may disapprove, and require suspension of a plan for failure of the association to comply with any provision of this chapter, for gross mismanagement, or for wilful disregard and neglect of its fiduciary duty. The association shall have the right to request reconsideration of the commissioner's decision within fifteen days of the receipt of the commissioner's written notification of the decision, or to request a hearing according to chapter 48.04 RCW. [1986 c 142 § 16.]

48.90.170 Costs of investigation or review of plan. All reasonable costs of any investigation or review by the commissioner of an association's plan of organization and operation, or any changes or modifications thereof, including the dissolution of a plan, shall be paid by the association before issuance of any approval required under this chapter. [1986 c 142 § 17.]

Chapter 48.92 RCW LIABILITY RISK RETENTION

Sections

48.92.010	Purpose.
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48.92.040	Required acts—Prohibited practices.
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48.92.060	Countersigning not required.
48.92.070	Purchasing groups—Exempt from certain laws.
48.92.080	Purchasing groups—Notice and registration.
48.92.090	Purchasing groups—Dealing with foreign insurers—Deductible or self-insured retention—Aggregate limits.
48.92.095	Premium taxes—Imposition—Obligations—Member's liability.
48.92.100	Authority of commissioner.
48.92.110	Penalties.
48.92.120	Soliciting, negotiating, or procuring liability insurance—License required.
48.92.130	Federal injunctions.
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48.92.010 Purpose. The purpose of this chapter is to regulate the formation and operation of risk retention groups and purchasing groups in this state formed pursuant to the provisions of the federal Liability Risk Retention Act of 1986. [1993 c 462 § 91; 1987 c 306 § 1.]

Additional notes found at www.leg.wa.gov

48.92.020 Definitions. As used in this chapter, the following terms have the meanings indicated unless the context clearly requires otherwise:

(1) "Commissioner" means the insurance commissioner of Washington state or the commissioner, director, or superintendent of insurance in any other state.

(2) "Completed operations liability" means liability arising out of the installation, maintenance, or repair of any product at a site which is not owned or controlled by:

(a) Any person who performs that work; or

(b) Any person who hires an independent contractor to perform that work; but shall include liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability.

(3) "Domicile," for purposes of determining the state in which a purchasing group is domiciled, means:

(a) For a corporation, the state in which the purchasing group is incorporated; and

(b) For an unincorporated entity, the state of its principal place of business.

(4) "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able:

(a) To meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

(b) To pay other obligations in the normal course of business.

(5) "Insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance, and any other arrangement for shifting and distributing risk which is determined to be insurance under the laws of this state.

(6) "Liability" means legal liability for damages including costs of defense, legal costs and fees, and other claims expenses because of injuries to other persons, damage to their property, or other damage or loss to such other persons resulting from or arising out of:

(a) Any business, whether profit or nonprofit, trade, product, services, including professional services, premises, or operations; or

(b) Any activity of any state or local government, or any agency or political subdivision thereof.

"Liability" does not include personal risk liability and an employer's liability with respect to its employees other than legal liability under the federal Employers' Liability Act 45 U.S.C. 51 et seq.

(7) "Personal risk liability" means liability for damages because of injury to any person, damage to property, or other loss or damage resulting from any personal, familial, or household responsibilities or activities, rather than from responsibilities or activities referred to in subsection (6) of this section.

(8) "Plan of operation or a feasibility study" means an analysis which presents the expected activities and results of a risk retention group including, at a minimum:

(a) Information sufficient to verify that its members are engaged in businesses or activities similar or related with respect to the liability to which the members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations;

(b) For each state in which it intends to operate, the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer;

(c) Historical and expected loss experience of the proposed members and national experience of similar exposures;

(d) Pro forma financial statements and projections;

(e) Appropriate opinions by a qualified, independent, casualty actuary, including a determination of minimum premium or participation levels required to commence operations and to prevent a hazardous financial condition;

(f) Identification of management, underwriting and claims procedures, marketing methods, managerial oversight methods, investment policies, and reinsurance agreements;

(g) Identification of each state in which the risk retention group has obtained, or sought to obtain, a charter and license, and a description of its status in each of those states; and

(h) Such other matters as may be prescribed by the commissioner for liability insurance companies authorized by the insurance laws of the state.

(9) "Product liability" means liability for damages because of any personal injury, death, emotional harm, consequential economic damage, or property damage including damages resulting from the loss of use of property arising out of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product, but does not include the liability of any person for those damages if the product involved was in the possession of such a person when the incident giving rise to the claim occurred.

(10) "Purchasing group" means any group which:

(a) Has as one of its purposes the purchase of liability insurance on a group basis;

(b) Purchases the insurance only for its group members and only to cover their similar or related liability exposure, as described in (c) of this subsection;

(c) Is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations; and

(d) Is domiciled in any state.

(11) "Risk retention group" means any corporation or other limited liability association:

(a) Whose primary activity consists of assuming and spreading all, or any portion, of the liability exposure of its group members;

(b) Which is organized for the primary purpose of conducting the activity described under (a) of this subsection;

(c) Which:

(i) Is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or

(ii) Before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before such date, had certified to the insurance commissioner of at least one state that it satisfied the capitalization requirements of such state, except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since that date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability as the terms were defined in the federal Product Liability Risk Retention Act of 1981 before the date of the enactment of the federal Risk Retention Act of 1986;

(d) Which does not exclude any person from membership in the group solely to provide for members of such a group a competitive advantage over such a person;

(e) Which:

(i) Has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by the risk retention group; or

(ii) Has as its sole owner an organization that has:

(A) As its members only persons who comprise the membership of the risk retention group; and

(B) As its owners only persons who comprise the membership of the risk retention group and who are provided insurance by the group;

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(f) Whose members are engaged in businesses or activities similar or related with respect to the liability of which such members are exposed by virtue of any related, similar, or common business trade, product, services, premises, or operations;

(g) Whose activities do not include the provision of insurance other than:

(i) Liability insurance for assuming and spreading all or any portion of the liability of its group members; and

(ii) Reinsurance with respect to the liability of any other risk retention group or any members of such other group which is engaged in businesses or activities so that the group or member meets the requirement described in (f) of this subsection from membership in the risk retention group which provides such reinsurance; and

(h) The name of which includes the phrase "risk retention group."

(12) "State" means any state of the United States or the District of Columbia. [1993 c 462 § 92; 1987 c 306 § 2.]

Additional notes found at www.leg.wa.gov

48.92.030 Requirements for chartering. (1) A risk retention group seeking to be chartered in this state must be chartered and licensed as a liability insurance company authorized by the insurance laws of this state and, except as provided elsewhere in this chapter, must comply with all of the laws, rules, regulations, and requirements applicable to the insurers chartered and licensed in this state and with RCW 48.92.040 to the extent the requirements are not a limitation on laws, rules, regulations, or requirements of this state.

(2) A risk retention group chartered in this state shall file with the department and the National Association of Insurance Commissioners an annual statement in a form prescribed by the National Association of Insurance Commissioners, and in electronic form if required by the commissioner, and completed in accordance with its instructions and the National Association of Insurance Commissioners accounting practices and procedures manual.

(3) Before it may offer insurance in any state, each domestic risk retention group shall also submit for approval to the insurance commissioner of this state a plan of operation or a feasibility study. The risk retention group shall submit an appropriate revision in the event of a subsequent material change in an item of the plan of operation or feasibility study, within ten days of the change. The group may not offer any additional kinds of liability insurance, in this state or in any other state, until a revision of the plan or study is approved by the commissioner.

(4) At the time of filing its application for charter, the risk retention group shall provide to the commissioner in summary form the following information: The identity of the initial members of the group; the identify of those individuals who organized the group or who will provide administrative services or otherwise influence or control the activities of the group; the amount and nature of the initial capitalization; the coverages to be afforded; and the states in which the group intends to operate. Upon receipt of this information, the commissioner shall forward the information to the National Association of Insurance Commissioners. Providing notification to the National Association of Insurance Commissioners is in

addition to and is not sufficient to satisfy the requirements of RCW 48.92.040 or this chapter. [1993 c 462 § 93; 1987 c 306 § 3.]

Additional notes found at www.leg.wa.gov

48.92.040 Required acts—Prohibited practices. Risk retention groups chartered and licensed in states other than this state and seeking to do business as a risk retention group in this state shall comply with the laws of this state as follows:

(1) Before offering insurance in this state, a risk retention group shall submit to the commissioner on a form prescribed by the National Association of Insurance Commissioners:

(a) A statement identifying the state or states in which the risk retention group is chartered and licensed as a liability insurance company, date of chartering, its principal place of business, and any other information including information on its membership, as the commissioner of this state may require to verify that the risk retention group is qualified under RCW 48.92.020(11);

(b) A copy of its plan of operations or a feasibility study and revisions of the plan or study submitted to its state of domicile: PROVIDED, HOWEVER, That the provision relating to the submission of a plan of operation or a feasibility study shall not apply with respect to any line or classification of liability insurance which: (i) Was defined in the federal Product Liability Risk Retention Act of 1981 before October 27, 1986; and (ii) was offered before that date by any risk retention group which had been chartered and operating for not less than three years before that date;

(c) The risk retention group shall submit a copy of any revision to its plan of operation or feasibility study required under RCW 48.92.030(3) at the same time that the revision is submitted to the commissioner of its chartering state; and

(d) A statement of registration which designates the commissioner as its agent for the purpose of receiving service of legal documents or process.

(2) Any risk retention group doing business in this state shall submit to the commissioner:

(a) A copy of the group's financial statement submitted to its state of domicile, which shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American academy of actuaries or a qualified loss reserve specialist under criteria established by the National Association of Insurance Commissioners;

(b) A copy of each examination of the risk retention group as certified by the commissioner or public official conducting the examination;

(c) Upon request by the commissioner, a copy of any information or document pertaining to an outside audit performed with respect to the risk retention group; and

(d) Any information as may be required to verify its continuing qualification as a risk retention group under RCW 48.92.020(11).

(3)(a) A risk retention group is liable for the payment of premium taxes and taxes on premiums of direct business for risks resident or located within this state, and shall report on or before March 1st of each year to the commissioner the direct premiums written for risks resident or located within this state. The risk retention group is subject to taxation, and

applicable fines and penalties related thereto, on the same basis as a foreign admitted insurer.

(b) To the extent insurance producers are utilized under RCW 48.92.120 or otherwise, they shall report to the commissioner the premiums for direct business for risks resident or located within this state that the licensees have placed with or on behalf of a risk retention group not chartered in this state.

(c) To the extent insurance producers are used under RCW 48.92.120 or otherwise, an insurance producer shall keep a complete and separate record of all policies procured from each risk retention group. The record is open to examination by the commissioner, as provided in chapter 48.03 RCW. These records must include, for each policy and each kind of insurance provided thereunder, the following:

(i) The limit of liability;

(ii) The time period covered;

(iii) The effective date;

(iv) The name of the risk retention group that issued the policy;

(v) The gross premium charged; and

(vi) The amount of return premiums, if any.

(4) Any risk retention group, its appointed insurance producers and representatives, shall be subject to any and all unfair claims settlement practices statutes and regulations specifically denominated by the commissioner as unfair claims settlement practices regulations.

(5) Any risk retention group, its appointed insurance producers and representatives, shall be subject to the provisions of chapter 48.30 RCW pertaining to deceptive, false, or fraudulent acts or practices. However, if the commissioner seeks an injunction regarding such conduct, the injunction must be obtained from a court of competent jurisdiction.

(6) Any risk retention group must submit to an examination by the commissioner to determine its financial condition if the commissioner of the jurisdiction in which the group is chartered has not initiated an examination or does not initiate an examination within sixty days after a request by the commissioner of this state. The examination shall be coordinated to avoid unjustified repetition and conducted in an expeditious manner and in accordance with the National Association of Insurance Commissioners' examiner handbook.

(7) Every application form for insurance from a risk retention group and every policy issued by a risk retention group shall contain in ten-point type on the front page and the declaration page, the following notice:

NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

(8) The following acts by a risk retention group are hereby prohibited:

(a) The solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in that group; and

(b) The solicitation or sale of insurance by, or operation of, a risk retention group that is in a hazardous financial condition or is financially impaired.

(9) No risk retention group shall be allowed to do business in this state if an insurance company is directly or indirectly a member or owner of the risk retention group, other than in the case of a risk retention group all of whose members are insurance companies.

(10) The terms of an insurance policy issued by a risk retention group may not provide, or be construed to provide, coverage prohibited generally by statute of this state or declared unlawful by the highest court of this state.

(11) A risk retention group not chartered in this state and doing business in this state shall comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by a state insurance commissioner if there has been a finding of financial impairment after an examination under subsection (6) of this section. [2008 c 217 § 69; 1993 c 462 § 94; 1987 c 306 § 4.]

Additional notes found at www.leg.wa.gov

48.92.050 Insolvency guaranty fund, participation prohibited—Joint underwriting associations, participation required. (1) No risk retention group shall be permitted to join or contribute financially to any insurance insolvency guaranty fund, or similar mechanism, in this state, nor shall any risk retention group, or its insureds or claimants against its insureds, receive any benefit from any such fund for claims arising under the insurance policies issued by a risk retention group.

(2) A risk retention group shall participate in this state's joint underwriting associations and mandatory liability pools or plans required by the commissioners.

(3) When a purchasing group obtains insurance covering its members' risks from an insurer not authorized in this state or a risk retention group, no such risks, wherever resident or located, are covered by an insurance guaranty fund or similar mechanism in this state.

(4) When a purchasing group obtains insurance covering its members' risks from an authorized insurer, only risks resident or located in this state are covered by the state guaranty fund established in chapter 48.32 RCW. [1993 c 462 § 95; 1987 c 306 § 5.]

Additional notes found at www.leg.wa.gov

48.92.060 Countersigning not required. A policy of insurance issued to a risk retention group or any member of that group shall not be required to be countersigned. [1987 c 306 § 6.]

48.92.070 Purchasing groups—Exempt from certain laws. A purchasing group and its insurer or insurers are subject to all applicable laws of this state, except that a purchasing group and its insurer or insurers are exempt, in regard to liability insurance for the purchasing group, from any law that:

- (1) Prohibits the establishment of a purchasing group;
- (2) Makes it unlawful for an insurer to provide or offer to provide insurance on a basis providing, to a purchasing group or its members, advantages based on their loss and expense

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experience not afforded to other persons with respect to rates, policy forms, coverages, or other matters;

(3) Prohibits a purchasing group or its members from purchasing insurance on a group basis described in subsection (2) of this section;

(4) Prohibits a purchasing group from obtaining insurance on a group basis because the group has not been in existence for a minimum period of time or because any member has not belonged to the group for a minimum period of time;

(5) Requires that a purchasing group must have a minimum number of members, common ownership or affiliation, or certain legal form;

(6) Requires that a certain percentage of a purchasing group must obtain insurance on a group basis;

(7) Otherwise discriminates against a purchasing group or any of its members. [1993 c 462 § 96; 1987 c 306 § 7.]

Additional notes found at www.leg.wa.gov

48.92.080 Purchasing groups—Notice and registration. (1) A purchasing group which intends to do business in this state shall furnish, before doing business, notice to the commissioner, on forms prescribed by the National Association of Insurance Commissioners which shall:

- (a) Identify the state in which the group is domiciled;
- (b) Identify all other states in which the group intends to do business;

(c) Specify the lines and classifications of liability insurance which the purchasing group intends to purchase;

(d) Identify the insurance company or companies from which the group intends to purchase its insurance and the domicile of that company or companies;

(e) Specify the method by which, and the person or persons, if any, through whom insurance will be offered to its members whose risks are resident or located in this state;

(f) Identify the principal place of business of the group; and

(g) Provide any other information as may be required by the commissioner to verify that the purchasing group is qualified under RCW 48.92.020(10).

(2) A purchasing group shall, within ten days, notify the commissioner of any changes in any of the items set forth in subsection (1) of this section.

(3) The purchasing group shall register with and designate the commissioner as its agent solely for the purpose of receiving service of legal documents or process, except that this requirement shall not apply in the case of a purchasing group that only purchases insurance that was authorized under the federal Product Liability Risk Retention Act of 1981 and:

- (a) Which in any state of the United States:
 - (i) Was domiciled before April 1, 1986; and
 - (ii) Is domiciled on and after October 27, 1986;
- (b) Which:
 - (i) Before October 27, 1986, purchased insurance from an insurance carrier licensed in any state;
 - (ii) Since October 27, 1986, purchased its insurance from an insurance carrier licensed in any state; or
- (c) Which was a purchasing group under the requirements of the federal Product Liability Risk Retention Act of 1981 before October 27, 1986.

(4) A purchasing group that is required to give notice under subsection (1) of this section shall also furnish such information as may be required by the commissioner to:

(a) Verify that the entity qualifies as a purchasing group;

(b) Determine where the purchasing group is located; and

(c) Determine appropriate tax treatment. [1993 c 462 § 97; 1987 c 306 § 8.]

Additional notes found at www.leg.wa.gov

48.92.090 Purchasing groups—Dealing with foreign insurers—Deductible or self-insured retention—Aggregate limits. (1) A purchasing group may not purchase insurance from a risk retention group that is not chartered in a state or from an insurer not admitted in the state in which the purchasing group is located, unless the purchase is effected through a licensed insurance producer acting pursuant to the surplus lines laws and regulations of that state.

(2) A purchasing group that obtains liability insurance from an insurer not admitted in this state or a risk retention group shall inform each of the members of the group that have a risk resident or located in this state that the risk is not protected by an insurance insolvency guaranty fund in this state, and that the risk retention group or insurer may not be subject to all insurance laws and rules of this state.

(3) No purchasing group may purchase insurance providing for a deductible or self-insured retention applicable to the group as a whole; however, coverage may provide for a deductible or self-insured retention applicable to individual members.

(4) Purchases of insurance by purchasing groups are subject to the same standards regarding aggregate limits that are applicable to all purchases of group insurance. [2008 c 217 § 70; 1993 c 462 § 98; 1987 c 306 § 9.]

Additional notes found at www.leg.wa.gov

48.92.095 Premium taxes—Imposition—Obligations—Member's liability. Premium taxes and taxes on premiums paid for coverage of risks resident or located in this state by a purchasing group or any members of the purchasing groups must be:

(1) Imposed at the same rate and subject to the same interest, fines, and penalties as those applicable to premium taxes and taxes on premiums paid for similar coverage from authorized insurers, as defined under chapter 48.05 RCW, or unauthorized insurers, as defined and provided for under chapter 48.15 RCW, by other insurers; and

(2) The obligation of the insurer; and if not paid by the insurer, then the obligation of the purchasing group; and if not paid by the purchasing group, then the obligation of the insurance producer for the purchasing group; and if not paid by the insurance producer for the purchasing group, then the obligation of each of the purchasing group's members. The liability of each member of the purchasing group is several, not joint, and is limited to the tax due in relation to the premiums paid by that member. [2008 c 217 § 71; 1993 c 462 § 99.]

Additional notes found at www.leg.wa.gov

48.92.100 Authority of commissioner. The commissioner is authorized to make use of any of the powers estab-

lished under Title 48 RCW to enforce the laws of this state so long as those powers are not specifically preempted by the federal Product Liability Risk Retention Act of 1981, as amended by the federal Risk Retention Amendments of 1986. This includes, but is not limited to, the commissioner's administrative authority to investigate, issue subpoenas, conduct depositions and hearings, issue orders, impose penalties, and seek injunctive relief. With regard to any investigation, administrative proceedings, or litigation, the commissioner can rely on the procedural law and regulations of the state. The injunctive authority of the commissioner in regard to risk retention groups is restricted by the requirement that any injunction be issued by a court of competent jurisdiction. [1993 c 462 § 100; 1987 c 306 § 10.]

Additional notes found at www.leg.wa.gov

48.92.110 Penalties. A risk retention group which violates any provision of this chapter shall be subject to fines and penalties applicable to licensed insurers generally, including revocation of its license and/or the right to do business in this state. [1987 c 306 § 11.]

48.92.120 Soliciting, negotiating, or procuring liability insurance—License required. (1) A person may not act or aid in any manner in soliciting, negotiating, or procuring liability insurance in this state from a risk retention group unless the person is licensed as an insurance producer for casualty insurance in accordance with chapter 48.17 RCW and pays the fees designated for the license under RCW 48.14.010.

(2)(a) A person may not act or aid in any manner in soliciting, negotiating, or procuring liability insurance in this state for a purchasing group from an authorized insurer or a risk retention group chartered in a state unless the person is licensed as an insurance producer for casualty insurance in accordance with chapter 48.17 RCW and pays the fees designated for the license under RCW 48.14.010.

(b) A person may not act or aid in any manner in soliciting, negotiating, or procuring liability insurance coverage in this state for a member of a purchasing group under a purchasing group's policy unless the person is licensed as an insurance producer for casualty insurance in accordance with chapter 48.17 RCW and pays the fees designated for the license under RCW 48.14.010.

(c) A person may not act or aid in any manner in soliciting, negotiating, or procuring liability insurance from an insurer not authorized to do business in this state on behalf of a purchasing group located in this state unless the person is licensed as a surplus line broker in accordance with chapter 48.15 RCW and pays the fees designated for the license under RCW 48.14.010.

(3) For purposes of acting as an insurance producer for a risk retention group or purchasing group under subsections (1) and (2) of this section, the requirement of residence in this state does not apply.

(4) Every person licensed under chapters 48.15 and 48.17 RCW, on business placed with risk retention groups or written through a purchasing group, must inform each prospective insured of the provisions of the notice required under RCW 48.92.040(7) in the case of a risk retention group and RCW 48.92.090(2) in the case of a purchasing group.

[2008 c 217 § 72; 2005 c 223 § 31; 1993 c 462 § 101; 1987 c 306 § 12.]

Additional notes found at www.leg.wa.gov

48.92.130 Federal injunctions. An order issued by any district court of the United States enjoining a risk retention group from soliciting or selling insurance, or operating, in any state or in all states or in any territory or possession of the United States, upon a finding that the group is in a hazardous financial or financially impaired condition, shall be enforceable in the courts of the state. [1993 c 462 § 102; 1987 c 306 § 13.]

Additional notes found at www.leg.wa.gov

48.92.140 Rules. The commissioner may establish and from time to time amend the rules relating to risk retention or purchasing groups as may be necessary or desirable to carry out the provisions of this chapter. [1993 c 462 § 103; 1987 c 306 § 14.]

Additional notes found at www.leg.wa.gov

Chapter 48.94 RCW

REINSURANCE INTERMEDIARY ACT

Sections

48.94.005	Definitions.
48.94.010	Acting as a reinsurance intermediary-broker or reinsurance intermediary-manager—Commissioner's powers—Licenses—Attorney exemption.
48.94.015	Written authorization required between a reinsurance intermediary-broker and an insurer—Minimum provisions.
48.94.020	Accounts and records maintained by reinsurance intermediary-broker—Access by insurer.
48.94.025	Restrictions on insurer—Obtaining services—Employees—Financial condition of reinsurance intermediary.
48.94.030	Contract required between a reinsurance intermediary-manager and a reinsurer—Minimum provisions.
48.94.035	Restrictions on reinsurance intermediary-manager—Retrocessions—Syndicates—Licenses—Employees.
48.94.040	Restrictions on reinsurer—Financial condition of reinsurance intermediary-manager—Loss reserves—Retrocessions—Termination of contract—Board of directors.
48.94.045	Examination by commissioner.
48.94.050	Violations of chapter—Penalties—Judicial review.
48.94.055	Rule making.
48.94.900	Short title.
48.94.901	Severability—Implementation—1993 c 462.

48.94.005 Definitions. The definitions set forth in this section apply throughout this chapter:

(1) "Actuary" means a person who is a member in good standing of the American academy of actuaries.

(2) "Controlling person" means a person, firm, association, or corporation who directly or indirectly has the power to direct or cause to be directed, the management, control, or activities of the reinsurance intermediary.

(3) "Insurer" means insurer as defined in RCW 48.01.050.

(4) "Licensed producer" means an insurance producer or reinsurance intermediary licensed under the applicable provisions of this title.

(5) "Reinsurance intermediary" means a reinsurance intermediary-broker or a reinsurance intermediary-manager as these terms are defined in subsections (6) and (7) of this section.

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(6) "Reinsurance intermediary-broker" means a person, other than an officer or employee of the ceding insurer, firm, association, or corporation who solicits, negotiates, or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of the insurer.

(7) "Reinsurance intermediary-manager" means a person, firm, association, or corporation who has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department, or underwriting office, and acts as an insurance producer for the reinsurer whether known as a reinsurance intermediary-manager, manager, or other similar term. Notwithstanding this subsection, the following persons are not considered a reinsurance intermediary-manager, with respect to such reinsurer, for the purposes of this chapter:

(a) An employee of the reinsurer;

(b) A United States manager of the United States branch of an alien reinsurer;

(c) An underwriting manager who, pursuant to contract, manages all the reinsurance operations of the reinsurer, is under common control with the reinsurer, subject to the insurer holding company act, chapter 48.31B RCW, and whose compensation is not based on the volume of premiums written;

(d) The manager of a group, association, pool, or organization of insurers that engages in joint underwriting or joint reinsurance and that are subject to examination by the insurance commissioner of the state in which the manager's principal business office is located.

(8) "Reinsurer" means a person, firm, association, or corporation licensed in this state under this title as an insurer with the authority to assume reinsurance.

(9) "To be in violation" means that the reinsurance intermediary, insurer, or reinsurer for whom the reinsurance intermediary was acting failed to substantially comply with this chapter.

(10) "Qualified United States financial institution" means an institution that:

(a) Is organized or, in the case of a United States office of a foreign banking organization, licensed, under the laws of the United States or any state thereof;

(b) Is regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

(c) Has been determined by either the commissioner, or the securities valuation office of the National Association of Insurance Commissioners, to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner. [2008 c 217 § 73; 1993 c 462 § 23.]

Additional notes found at www.leg.wa.gov

48.94.010 Acting as a reinsurance intermediary-broker or reinsurance intermediary-manager—Commissioner's powers—Licenses—Attorney exemption. (1) No person, firm, association, or corporation may act as a reinsurance intermediary-broker in this state if the person, firm, association, or corporation maintains an office either directly

or as a member or employee of a firm or association, or an officer, director, or employee of a corporation:

(a) In this state, unless the person, firm, association, or corporation is a licensed reinsurance intermediary-broker in this state; or

(b) In another state, unless the person, firm, association, or corporation is a licensed reinsurance intermediary-broker in this state or another state having a regulatory scheme substantially similar to this chapter.

(2) No person, firm, association, or corporation may act as a reinsurance intermediary-manager:

(a) For a reinsurer domiciled in this state, unless the person, firm, association, or corporation is a licensed reinsurance intermediary-manager in this state;

(b) In this state, if the person, firm, association, or corporation maintains an office either directly or as a member or employee of a firm or association, or an officer, director, or employee of a corporation in this state, unless the person, firm, association, or corporation is a licensed reinsurance intermediary-manager in this state;

(c) In another state for a nonresident reinsurer, unless the person, firm, association, or corporation is a licensed reinsurance intermediary-manager in this state or another state having a substantially similar regulatory scheme.

(3) The commissioner may require a reinsurance intermediary-manager subject to subsection (2) of this section to:

(a) File a bond in an amount and from an insurer acceptable to the commissioner for the protection of the reinsurer; and

(b) Maintain an errors and omissions policy in an amount acceptable to the commissioner.

(4) The commissioner may issue a reinsurance intermediary license to a person, firm, association, or corporation who has complied with the requirements of this chapter. Any such license issued to a firm or association authorizes all the members of the firm or association and any designated employees to act as reinsurance intermediaries under the license, and all such persons may be named in the application and any supplements to it. Any such license issued to a corporation authorizes all of the officers, and any designated employees and directors of it, to act as reinsurance intermediaries on behalf of the corporation, and all such persons must be named in the application and any supplements to it.

(5)(a) Each licensed nonresident reinsurance intermediary must appoint the commissioner as the reinsurance intermediary's attorney to receive service of legal process issued against the reinsurance intermediary in this state upon causes of action arising within this state. Service upon the commissioner as attorney constitutes effective legal service upon the reinsurance intermediary.

(b) With the appointment the reinsurance intermediary must designate the person to whom the commissioner must forward legal process so served upon him or her.

(c) The appointment is irrevocable, binds any successor in interest or to the assets or liabilities of the reinsurance intermediary, and remains in effect for as long as there could be any cause of action against the reinsurance intermediary arising out of the reinsurance intermediary's insurance transactions in this state.

(d) The service of process must be accomplished and processed in the manner prescribed under RCW 48.02.200.

(6) The commissioner may refuse to issue a reinsurance intermediary license if, in his or her judgment, the applicant, anyone named on the application, or a member, principal, officer, or director of the applicant, is not trustworthy, or that a controlling person of the applicant is not trustworthy to act as a reinsurance intermediary, or that any of the foregoing has given cause for revocation or suspension of the license, or has failed to comply with a prerequisite for the issuance of such license. Upon written request, the commissioner will furnish a summary of the basis for refusal to issue a license, which document is privileged and not subject to chapter 42.56 RCW.

(7) Licensed attorneys-at-law of this state when acting in their professional capacity as such are exempt from this section. [2011 c 47 § 13; 2005 c 274 § 317; 1993 c 462 § 24.]

48.94.015 Written authorization required between a reinsurance intermediary-broker and an insurer—Minimum provisions. Brokers transactions between a reinsurance intermediary-broker and the insurer it represents in such capacity may be entered into only under a written authorization, specifying the responsibilities of each party. The authorization must, at a minimum, provide that:

(1) The insurer may terminate the reinsurance intermediary-broker's authority at any time.

(2) The reinsurance intermediary-broker shall render accounts to the insurer accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by, or owing, to the reinsurance intermediary-broker, and remit all funds due to the insurer within thirty days of receipt.

(3) All funds collected for the insurer's account must be held by the reinsurance intermediary-broker in a fiduciary capacity in a bank that is a qualified United States financial institution as defined in this chapter.

(4) The reinsurance intermediary-broker will comply with RCW 48.94.020.

(5) The reinsurance intermediary-broker will comply with the written standards established by the insurer for the cession or retrocession of all risks.

(6) The reinsurance intermediary-broker will disclose to the insurer any relationship with any reinsurer to which business will be ceded or retroceded. [1993 c 462 § 25.]

48.94.020 Accounts and records maintained by reinsurance intermediary-broker—Access by insurer. (1) For at least ten years after expiration of each contract of reinsurance transacted by the reinsurance intermediary-broker, the reinsurance intermediary-broker shall keep a complete record for each transaction showing:

(a) The type of contract, limits, underwriting restrictions, classes, or risks and territory;

(b) Period of coverage, including effective and expiration dates, cancellation provisions, and notice required of cancellation;

(c) Reporting and settlement requirements of balances;

(d) Rate used to compute the reinsurance premium;

(e) Names and addresses of assuming reinsurers;

(f) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary-broker;

- (g) Related correspondence and memoranda;
 - (h) Proof of placement;
 - (i) Details regarding retrocessions handled by the reinsurance intermediary-broker including the identity of retrocessionaires and percentage of each contract assumed or ceded;
 - (j) Financial records, including but not limited to, premium and loss accounts; and
 - (k) When the reinsurance intermediary-broker procures a reinsurance contract on behalf of a licensed ceding insurer:
 - (i) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or
 - (ii) If placed through a representative of the assuming reinsurer, other than an employee, written evidence that the reinsurer has delegated binding authority to the representative.
- (2) The insurer has access and the right to copy and audit all accounts and records maintained by the reinsurance intermediary-broker related to its business in a form usable by the insurer. [1993 c 462 § 26.]

48.94.025 Restrictions on insurer—Obtaining services—Employees—Financial condition of reinsurance intermediary. (1) An insurer may not engage the services of a person, firm, association, or corporation to act as a reinsurance intermediary-broker on its behalf unless the person is licensed as required by RCW 48.94.010(1).

(2) An insurer may not employ an individual who is employed by a reinsurance intermediary-broker with which it transacts business, unless the reinsurance intermediary-broker is under common control with the insurer and subject to the insurer holding company act, chapter 48.31B RCW.

(3) The insurer shall annually obtain a copy of statements of the financial condition of each reinsurance intermediary-broker with which it transacts business. [1993 c 462 § 27.]

48.94.030 Contract required between a reinsurance intermediary-manager and a reinsurer—Minimum provisions. Transactions between a reinsurance intermediary-manager and the reinsurer it represents in such capacity may be entered into only under a written contract, specifying the responsibilities of each party, which shall be approved by the reinsurer's board of directors. At least thirty days before the reinsurer assumes or cedes business through the reinsurance intermediary-manager, a true copy of the approved contract must be filed with the commissioner for approval. The contract must, at a minimum, provide that:

(1) The reinsurer may terminate the contract for cause upon written notice to the reinsurance intermediary-manager. The reinsurer may immediately suspend the authority of the reinsurance intermediary-manager to assume or cede business during the pendency of a dispute regarding the cause for termination.

(2) The reinsurance intermediary-manager shall render accounts to the reinsurer accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by, or owing to, the reinsurance intermediary-manager, and remit all funds

due under the contract to the reinsurer on not less than a monthly basis.

(3) All funds collected for the reinsurer's account must be held by the reinsurance intermediary-manager in a fiduciary capacity in a bank that is a qualified United States financial institution. The reinsurance intermediary-manager may retain no more than three months' estimated claims payments and allocated loss adjustment expenses. The reinsurance intermediary-manager shall maintain a separate bank account for each reinsurer that it represents.

(4) For at least ten years after expiration of each contract of reinsurance transacted by the reinsurance intermediary-manager, the reinsurance intermediary-manager shall keep a complete record for each transaction showing:

- (a) The type of contract, limits, underwriting restrictions, classes, or risks and territory;
- (b) Period of coverage, including effective and expiration dates, cancellation provisions, and notice required of cancellation, and disposition of outstanding reserves on covered risks;
- (c) Reporting and settlement requirements of balances;
- (d) Rate used to compute the reinsurance premium;
- (e) Names and addresses of reinsurers;
- (f) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary-manager;

- (g) Related correspondence and memoranda;
- (h) Proof of placement;
- (i) Details regarding retrocessions handled by the reinsurance intermediary-manager, as permitted by RCW 48.94.040(4), including the identity of retrocessionaires and percentage of each contract assumed or ceded;

- (j) Financial records, including but not limited to, premium and loss accounts; and

- (k) When the reinsurance intermediary-manager places a reinsurance contract on behalf of a ceding insurer:

- (i) Directly from an assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

- (ii) If placed through a representative of the assuming reinsurer, other than an employee, written evidence that the reinsurer has delegated binding authority to the representative.

(5) The reinsurer has access and the right to copy all accounts and records maintained by the reinsurance intermediary-manager related to its business in a form usable by the reinsurer.

(6) The reinsurance intermediary-manager may not assign the contract in whole or in part.

(7) The reinsurance intermediary-manager shall comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection, or cession of all risks.

(8) The rates, terms, and purposes of commissions, charges, and other fees that the reinsurance intermediary-manager may levy against the reinsurer are clearly specified.

(9) If the contract permits the reinsurance intermediary-manager to settle claims on behalf of the reinsurer:

- (a) All claims will be reported to the reinsurer in a timely manner;

- (b) A copy of the claim file will be sent to the reinsurer at its request or as soon as it becomes known that the claim:

(i) Has the potential to exceed the lesser of an amount determined by the commissioner or the limit set by the reinsurer;

(ii) Involves a coverage dispute;

(iii) May exceed the reinsurance intermediary-manager's claims settlement authority;

(iv) Is open for more than six months; or

(v) Is closed by payment of the lesser of an amount set by the commissioner or an amount set by the reinsurer;

(c) All claim files are the joint property of the reinsurer and reinsurance intermediary-manager. However, upon an order of liquidation of the reinsurer, the files become the sole property of the reinsurer or its estate; the reinsurance intermediary-manager has reasonable access to and the right to copy the files on a timely basis;

(d) Settlement authority granted to the reinsurance intermediary-manager may be terminated for cause upon the reinsurer's written notice to the reinsurance intermediary-manager or upon the termination of the contract. The reinsurer may suspend the settlement authority during the pendency of a dispute regarding the cause of termination.

(10) If the contract provides for a sharing of interim profits by the reinsurance intermediary-manager, such interim profits will not be paid until one year after the end of each underwriting period for property business and five years after the end of each underwriting period for casualty business, or a later period set by the commissioner for specified lines of insurance, and not until the adequacy of reserves on remaining claims has been verified under RCW 48.94.040(3).

(11) The reinsurance intermediary-manager shall annually provide the reinsurer with a statement of its financial condition prepared by an independent certified accountant.

(12) The reinsurer shall periodically, at least semiannually, conduct an on-site review of the underwriting and claims processing operations of the reinsurance intermediary-manager.

(13) The reinsurance intermediary-manager shall disclose to the reinsurer any relationship it has with an insurer before ceding or assuming any business with the insurer under this contract.

(14) Within the scope of its actual or apparent authority the acts of the reinsurance intermediary-manager are deemed to be the acts of the reinsurer on whose behalf it is acting. [1993 c 462 § 28.]

48.94.035 Restrictions on reinsurance intermediary-manager—Retrocessions—Syndicates—Licenses—Employees. The reinsurance intermediary-manager may not:

(1) Cede retrocessions on behalf of the reinsurer, except that the reinsurance intermediary-manager may cede facultative retrocessions under obligatory automatic agreements if the contract with the reinsurer contains reinsurance underwriting guidelines for the retrocessions. The guidelines must include a list of reinsurers with which the automatic agreements are in effect, and for each such reinsurer, the coverages and amounts or percentages that may be reinsured, and commission schedules.

(2) Commit the reinsurer to participate in reinsurance syndicates.

(3) Appoint a reinsurance intermediary without assuring that the reinsurance intermediary is lawfully licensed to transact the type of reinsurance for which he or she is appointed.

(4) Without prior approval of the reinsurer, pay or commit the reinsurer to pay a claim, net of retrocessions, that exceeds the lesser of an amount specified by the reinsurer or one percent of the reinsurer's policyholder's surplus as of December 31st of the last complete calendar year.

(5) Collect a payment from a retrocessionaire or commit the reinsurer to a claim settlement with a retrocessionaire, without prior approval of the reinsurer. If prior approval is given, a report must be promptly forwarded to the reinsurer.

(6) Jointly employ an individual who is employed by the reinsurer unless the reinsurance intermediary-manager is under common control with the reinsurer subject to the insurer holding company act, chapter 48.31B RCW.

(7) Appoint a subreinsurance intermediary-manager. [1993 c 462 § 29.]

48.94.040 Restrictions on reinsurer—Financial condition of reinsurance intermediary-manager—Loss reserves—Retrocessions—Termination of contract—Board of directors. (1) A reinsurer may not engage the services of a person, firm, association, or corporation to act as a reinsurance intermediary-manager on its behalf unless the person is licensed as required by RCW 48.94.010(2).

(2) The reinsurer shall annually obtain a copy of statements of the financial condition of each reinsurance intermediary-manager that the reinsurer has had prepared by an independent certified accountant in a form acceptable to the commissioner.

(3) If a reinsurance intermediary-manager establishes loss reserves, the reinsurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the reinsurance intermediary-manager. This opinion is in addition to any other required loss reserve certification.

(4) Binding authority for all retrocessional contracts or participation in reinsurance syndicates must rest with an officer of the reinsurer who is not affiliated with the reinsurance intermediary-manager.

(5) Within thirty days of termination of a contract with a reinsurance intermediary-manager, the reinsurer shall provide written notification of the termination to the commissioner.

(6) A reinsurer may not appoint to its board of directors an officer, director, employee, controlling shareholder, or subproducer of its reinsurance intermediary-manager. This subsection does not apply to relationships governed by the insurer holding company act, chapter 48.31B RCW, or, if applicable, the producer-controlled property and casualty insurer act, chapter 48.97 RCW. [2008 c 217 § 74; 1993 c 462 § 30.]

Additional notes found at www.leg.wa.gov

48.94.045 Examination by commissioner. (1) A reinsurance intermediary is subject to examination by the commissioner. The commissioner has access to all books, bank

accounts, and records of the reinsurance intermediary in a form usable to the commissioner.

(2) A reinsurance intermediary-manager may be examined as if it were the reinsurer. [1993 c 462 § 31.]

48.94.050 Violations of chapter—Penalties—Judicial review. (1) A reinsurance intermediary, insurer, or reinsurer found by the commissioner, after a hearing conducted in accordance with chapters 48.17 and 34.05 RCW, to be in violation of any provision of this chapter, shall:

(a) For each separate violation, pay a penalty in an amount not exceeding five thousand dollars;

(b) Be subject to revocation or suspension of its license; and

(c) If a violation was committed by the reinsurance intermediary, make restitution to the insurer, reinsurer, rehabilitator, or liquidator of the insurer or reinsurer for the net losses incurred by the insurer or reinsurer attributable to the violation.

(2) The decision, determination, or order of the commissioner under subsection (1) of this section is subject to judicial review under this title and chapter 34.05 RCW.

(3) Nothing contained in this section affects the right of the commissioner to impose any other penalties provided in this title.

(4) Nothing contained in this chapter is intended to or in any manner limits or restricts the rights of policyholders, claimants, creditors, or other third parties or confer any rights to those persons. [1993 c 462 § 32.]

48.94.055 Rule making. The commissioner may adopt reasonable rules for the implementation and administration of this chapter. [1993 c 462 § 33.]

48.94.900 Short title. This chapter may be known and cited as the reinsurance intermediary act. [1993 c 462 § 22.]

48.94.901 Severability—Implementation—1993 c 462. See RCW 48.31B.901 and 48.31B.902.

Chapter 48.97 RCW

PRODUCER-CONTROLLED PROPERTY AND CASUALTY INSURER ACT

Sections

48.97.005	Definitions.
48.97.010	Application.
48.97.015	Business placed with a controlled insurer—Application of section—Exceptions—Written contract required—Audit committee—Report to commissioner.
48.97.020	Relationship between producer and controlled insurer—Producer's duty to disclose—Subproducers.
48.97.025	Producer's failure to comply with chapter—Commissioner's power—Damages—Penalties.
48.97.900	Short title.
48.97.901	Severability—Implementation—1993 c 462.

48.97.005 Definitions. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Accredited state" means a state in which the insurance department or regulatory agency has qualified as meeting the minimum financial regulatory standards promulgated

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and established from time to time by the National Association of Insurance Commissioners.

(2) "Control" or "controlled by" has the meaning ascribed in RCW 48.31B.005(3).

(3) "Controlled insurer" means a licensed insurer that is controlled, directly or indirectly, by a broker.

(4) "Controlling producer" means a producer who, directly or indirectly, controls an insurer.

(5) "Licensed insurer" or "insurer" means a person, firm, association, or corporation licensed to transact property and casualty insurance business in this state. The following, among others, are not licensed insurers for purposes of this chapter:

(a) Risk retention groups as defined in the Superfund Amendments Reauthorization Act of 1986, P.L. 99-499, 100 Stat. 1613 (1986), the Risk Retention Act, 15 U.S.C. Sec. 3901 et seq. (1982 Supp. 1986), and chapter 48.92 RCW;

(b) Residual market pools and joint underwriting associations; and

(c) Captive insurers. For the purposes of this chapter, captive insurers are insurance companies owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies or, in the case of groups and associations, insurance organizations owned by the insureds whose exclusive purpose is to insure risks to member organizations or group members, or both, and their affiliates.

(6) "Producer" means an insurance broker or brokers or any other person, firm, association, or corporation when, for compensation, commission, or other thing of value, the person, firm, association, or corporation acts or aids in any manner in soliciting, negotiating, or procuring the making of an insurance contract on behalf of an insured other than the person, firm, association, or corporation. [2015 c 122 § 17; 2008 c 217 § 75; 1993 c 462 § 17.]

Effective dates—2015 c 122: See note following RCW 48.31B.005.

Additional notes found at www.leg.wa.gov

48.97.010 Application. This chapter applies to licensed insurers either domiciled in this state or domiciled in a state that is not an accredited state having in effect a substantially similar law. All provisions of the Insurer Holding Company Act, chapter 48.31B RCW, or its successor act, to the extent they are not superseded by this chapter, continue to apply to all parties within the holding company systems subject to this chapter. [1993 c 462 § 18.]

48.97.015 Business placed with a controlled insurer—Application of section—Exceptions—Written contract required—Audit committee—Report to commissioner. (1)(a) This section applies in a particular calendar year if in that calendar year the aggregate amount of gross written premium on business placed with a controlled insurer by a controlling producer is equal to or greater than five percent of the admitted assets of the controlled insurer, as reported in the controlled insurer's quarterly statement filed as of September 30th of the prior year.

(b) Notwithstanding (a) of this subsection, this section does not apply if:

(i) The controlling producer:

(A) Places insurance only with the controlled insurer; or only with the controlled insurer and a member or members of the controlled insurer's holding company system, or the controlled insurer's parent, affiliate, or subsidiary and receives no compensation based upon the amount of premiums written in connection with the insurance; and

(B) Accepts insurance placements only from nonaffiliated subproducers, and not directly from insureds; and

(ii) The controlled insurer, except for business written through a residual market facility such as the assigned risk plan, fair plans, or other such plans, accepts insurance business only from a controlling producer, a producer controlled by the controlled insurer, or a producer that is a subsidiary of the controlled insurer.

(2) A controlled insurer may not accept business from a controlling producer and a controlling producer may not place business with a controlled insurer unless there is a written contract between the controlling producer and the insurer specifying the responsibilities of each party, which contract has been approved by the board of directors of the insurer and contains the following minimum provisions:

(a) The controlled insurer may terminate the contract for cause, upon written notice to the controlling producer. The controlled insurer shall suspend the authority of the controlling producer to write business during the pendency of a dispute regarding the cause for the termination;

(b) The controlling producer shall render accounts to the controlling insurer detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by, or owing to, the controlling producer;

(c) The controlling producer shall remit all funds due under the terms of the contract to the controlling insurer on at least a monthly basis. The due date must be fixed so that premiums or installments collected are remitted no later than ninety days after the effective date of a policy placed with the controlling insurer under this contract;

(d) The controlling producer shall hold all funds collected for the controlled insurer's account in a fiduciary capacity, in one or more appropriately identified bank accounts in banks that are members of the federal reserve system, in accordance with the applicable provisions of this title. However, funds of a controlling producer not required to be licensed in this state must be maintained in compliance with the requirements of the controlling producer's domiciliary jurisdiction;

(e) The controlling producer shall maintain separately identifiable records of business written for the controlled insurer;

(f) The contract shall not be assigned in whole or in part by the controlling producer;

(g) The controlled insurer shall provide the controlling producer with its underwriting standards, rules, and procedures, manuals setting forth the rates to be charged, and the conditions for the acceptance or rejection of risks. The controlling producer shall adhere to the standards, rules, procedures, rates, and conditions that are the same as those applicable to comparable business placed with the controlled insurer by a producer other than the controlling producer;

(h) The rates of the controlling producer's commissions, charges, and other fees must be no greater than those applica-

ble to comparable business placed with the controlled insurer by producers other than controlling producers. For purposes of (g) and (h) of this subsection, examples of comparable business include the same lines of insurance, same kinds of insurance, same kinds of risks, similar policy limits, and similar quality of business;

(i) If the contract provides that the controlling producer, on insurance business placed with the insurer, is to be compensated contingent upon the insurer's profits on that business, then the compensation shall not be determined and paid until at least five years after the premiums on liability insurance are earned and at least one year after the premiums are earned on any other insurance. In no event may the commissions be paid until the adequacy of the controlled insurer's reserves on remaining claims has been independently verified under subsection (3) of this section;

(j) The insurer may establish a different limit on the controlling producer's writings in relation to the controlled insurer's surplus and total writings for each line or subline of business. The controlled insurer shall notify the controlling producer when the applicable limit is approached and may not accept business from the controlling producer if the limit is reached. The controlling producer may not place business with the controlled insurer if it has been notified by the controlled insurer that the limit has been reached; and

(k) The controlling producer may negotiate but may not bind reinsurance on behalf of the controlled insurer on business the controlling producer places with the controlled insurer, except that the controlling producer may bind facultative reinsurance contracts under obligatory facultative agreements if the contract with the controlled insurer contains underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which the automatic agreements are in effect, the coverages and amounts of percentages that may be reinsured, and commission schedules.

(3) Every controlled insurer shall have an audit committee of the board of directors composed of independent directors. The audit committee shall annually meet with management, the insurer's independent certified public accountants, and an independent casualty actuary or other independent loss reserve specialist acceptable to the commissioner to review the adequacy of the insurer's loss reserves.

(4)(a) In addition to any other required loss reserve certification, the controlled insurer shall, annually, on April 1st of each year, file with the commissioner an opinion of an independent casualty actuary, or such other independent loss reserve specialist acceptable to the commissioner, reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of year end, including losses incurred but not reported, on business placed by the producer; and

(b) The controlled insurer shall annually report to the commissioner the amount of commissions paid to the producer, the percentage that amount represents of the net premiums written, and comparable amounts and percentages paid to noncontrolling producers for placements of the same kinds of insurance. [2008 c 217 § 76; 1993 c 462 § 19.]

Additional notes found at www.leg.wa.gov

48.97.020 Relationship between producer and controlled insurer—Producer's duty to disclose—Subproducers. The producer, before the effective date of the policy, shall deliver written notice to the prospective insured disclosing the relationship between the producer and the controlled insurer, except that, if the business is placed through a subproducer who is not a controlling producer, the controlling producer shall retain in his or her records a signed commitment from the subproducer that the subproducer is aware of the relationship between the insurer and the producer and that the subproducer has notified or will notify the insured. [2008 c 217 § 77; 1993 c 462 § 20.]

Additional notes found at www.leg.wa.gov

48.97.025 Producer's failure to comply with chapter—Commissioner's power—Damages—Penalties. (1)(a) If the commissioner believes that the controlling producer has not materially complied with this chapter, or a rule adopted or order issued under this chapter, the commissioner may after notice and opportunity to be heard, order the controlling producer to cease placing business with the controlled insurer; and

(b) If it is found that because of material noncompliance that the controlled insurer or any policyholder thereof has suffered loss or damage, the commissioner may maintain a civil action or intervene in an action brought by or on behalf of the insurer or policyholder for recovery of compensatory damages for the benefit of the insurer or policyholder or other appropriate relief.

(2) If an order for liquidation or rehabilitation of the controlled insurer has been entered under chapter 48.31 RCW, and the receiver appointed under that order believes that the controlling producer or any other person has not materially complied with this chapter, or a rule adopted or order issued under this chapter, and the insurer suffered any loss or damage from the noncompliance, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

(3) Nothing contained in this section alters or affects the right of the commissioner to impose other penalties provided for in this title.

(4) Nothing contained in this section alters or affects the rights of policyholders, claimants, creditors, or other third parties. [2008 c 217 § 78; 1993 c 462 § 21.]

Additional notes found at www.leg.wa.gov

48.97.900 Short title. This chapter may be known and cited as the business transacted with producer-controlled property and casualty insurer act. [2008 c 217 § 79; 1993 c 462 § 16.]

Additional notes found at www.leg.wa.gov

48.97.901 Severability—Implementation—1993 c 462. See RCW 48.31B.901 and 48.31B.902.

Chapter 48.98 RCW

MANAGING GENERAL AGENTS ACT

Sections

48.98.005 Definitions.

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48.98.010 Requirements for managing general agent—License—Bond—Errors and omissions policy.
 48.98.015 Contract required between a managing general agent and an insurer—Minimum provisions.
 48.98.020 Requirements for insurer—Audit, loss reserves, and on-site review of managing general agent—Notice to commissioner—Quarterly review of books and records—Board of director.
 48.98.025 Examinations—Acts of a managing general agent are acts of the insurer.
 48.98.030 Violations of chapter—Penalties—Judicial review.
 48.98.035 Rule making.
 48.98.040 Continued use of a managing general agent—Compliance with chapter.
 48.98.900 Short title.
 48.98.901 Severability—Implementation—1993 c 462.

48.98.005 Definitions. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Actuary" means a person who is a member in good standing of the American academy of actuaries.

(2) "Insurer" means a person having a certificate of authority in this state as an insurance company under RCW 48.01.050.

(3) "Managing general agent" means:

(a) A person who manages all or part of the insurance business of an insurer, including the management of a separate division, department, or underwriting office, and acts as a representative of the insurer whether known as a managing general agent, manager, or other similar term, and who, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross direct written premium equal to or more than five percent of the policyholder surplus as reported in the last annual statement of the insurer in any one quarter or year together with one or more of the following activities related to the business produced:

(i) Adjusts or pays claims in excess of an amount to be determined by the commissioner; or

(ii) Negotiates reinsurance on behalf of the insurer.

(b) Notwithstanding (a) of this subsection, the following persons may not be managing general agents for purposes of this chapter:

(i) An employee of the insurer;

(ii) A United States manager of the United States branch of an alien insurer;

(iii) An underwriting manager who, under a contract, manages all of the insurance operations of the insurer, is under common control with the insurer, subject to the insurer holding company act, chapter 48.31B RCW, and whose compensation is not based on the volume of premiums written; or

(iv) The attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or interinsurance exchange under powers of attorney.

(4) "Underwrite" means to accept or reject risks on behalf of the insurer. [1993 c 462 § 35.]

48.98.010 Requirements for managing general agent—License—Bond—Errors and omissions policy.

(1) No person may act in the capacity of a managing general agent with respect to risks located in this state, for an insurer authorized by this state, unless that person is licensed in this state as an insurance producer, under chapter 48.17 RCW, for

the lines of insurance involved and is designated as a managing general agent and appointed as such by the insurer.

(2) No person may act in the capacity of a managing general agent representing an insurer domiciled in this state with respect to risks located outside this state unless that person is licensed as an insurance producer in this state, under chapter 48.17 RCW, for the lines of insurance involved and is designated as a managing general agent and appointed as such by the insurer.

(3) The commissioner may require a bond for the protection of each insurer.

(4) The commissioner may require the managing general agent to maintain an errors and omissions policy. [2008 c 217 § 80; 1993 c 462 § 36.]

Additional notes found at www.leg.wa.gov

48.98.015 Contract required between a managing general agent and an insurer—Minimum provisions. A managing general agent may not place business with an insurer unless there is in force a written contract between the managing general agent and the insurer that sets forth the responsibilities of each party and, where both parties share responsibility for a particular function, that specifies the division of the responsibilities, and that contains the following minimum provisions:

(1) The insurer may terminate the contract for cause upon written notice to the managing general agent. The insurer may suspend the underwriting authority of the managing general agent during the pendency of a dispute regarding the cause for termination.

(2) The managing general agent shall render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer on not less than a monthly basis.

(3) The managing general agent shall hold funds collected for the account of an insurer in a fiduciary capacity in an FDIC insured financial institution. This account must be used for all payments on behalf of the insurer. The managing general agent may retain no more than three months' estimated claims payments and allocated loss adjustment expenses.

(4) The managing general agent shall maintain separate records of business written for each insurer. The insurer has access to and the right to copy all accounts and records related to its business in a form usable by the insurer, and the commissioner has access to all books, bank accounts, and records of the managing general agent in a form usable to the commissioner. Those records must be retained according to the requirements of this title and rules adopted under it.

(5) The managing general agent may not assign the contract in whole or part.

(6)(a) Appropriate underwriting guidelines must include at least the following: The maximum annual premium volume; the basis of the rates to be charged; the types of risks that may be written; maximum limits of liability; applicable exclusions; territorial limitations; policy cancellation provisions; and the maximum policy period.

(b) The insurer has the right to cancel or not renew any policy of insurance, subject to the applicable laws and rules, including those in chapter 48.18 RCW.

(7) If the contract permits the managing general agent to settle claims on behalf of the insurer:

(a) All claims must be reported to the insurer in a timely manner;

(b) A copy of the claim file must be sent to the insurer at its request or as soon as it becomes known that the claim:

(i) Has the potential to exceed an amount determined by the commissioner, or exceeds the limit set by the insurer, whichever is less;

(ii) Involves a coverage dispute;

(iii) May exceed the managing general agent's claims settlement authority;

(iv) Is open for more than six months; or

(v) Is closed by payment in excess of an amount set by the commissioner or an amount set by the insurer, whichever is less;

(c) All claim files are the joint property of the insurer and the managing general agent. However, upon an order of liquidation of the insurer, those files become the sole property of the insurer or its liquidator or successor. The managing general agent has reasonable access to and the right to copy the files on a timely basis; and

(d) Settlement authority granted to the managing general agent may be terminated for cause upon the insurer's written notice to the managing general agent or upon the termination of the contract. The insurer may suspend the managing general agent's settlement authority during the pendency of a dispute regarding the cause for termination.

(8) When electronic claims files are in existence, the contract must address the timely transmission of the data.

(9) If the contract provides for a sharing of interim profits by the managing general agent, and the managing general agent has the authority to determine the amount of the interim profits by establishing loss reserves or controlling claim payments or in any other manner, interim profits may not be paid to the managing general agent until one year after they are earned for property insurance business and five years after they are earned on casualty business and not until the profits have been verified under RCW 48.98.020.

(10) The managing general agent may not:

(a) Bind reinsurance or retrocessions on behalf of the insurer, except that the managing general agent may bind automatic reinsurance contracts under obligatory automatic agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which the automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules;

(b) Commit the insurer to participate in insurance or reinsurance syndicates;

(c) Use an insurance producer that is not appointed to represent the insurer in accordance with the requirements of chapter 48.17 RCW;

(d) Without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, that may not exceed one percent of the insurer's policyholder surplus as of December 31st of the last-completed calendar year;

(e) Collect a payment from a reinsurer or commit the insurer to a claim settlement with a reinsurer, without prior

approval of the insurer. If prior approval is given, a report must be promptly forwarded to the insurer;

(f) Permit an agent appointed by it to serve on the insurer's board of directors;

(g) Jointly employ an individual who is employed by the insurer; or

(h) Appoint a submanaging general agent. [2008 c 217 § 81; 2005 c 223 § 32; 1993 c 462 § 37.]

Additional notes found at www.leg.wa.gov

48.98.020 Requirements for insurer—Audit, loss reserves, and on-site review of managing general agent—Notice to commissioner—Quarterly review of books and records—Board of director. (1) The insurer shall have on file an independent audited financial statement, in a form acceptable to the commissioner, of each managing general agent with which it is doing or has done business.

(2) If a managing general agent establishes loss reserves, the insurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the managing general agent. This is in addition to any other required loss reserve certification.

(3) The insurer shall periodically, and no less frequently than semiannually, conduct an on-site review of the underwriting and claims processing operations of the managing general agent.

(4) Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates must rest with an officer of the insurer, who may not be affiliated with the managing general agent.

(5) Within thirty days of entering into or terminating a contract with a managing general agent, the insurer shall provide written notification of that appointment or termination to the commissioner. Notices of appointment of a managing general agent must include a statement of duties that the managing general agent is expected to perform on behalf of the insurer, the lines of insurance for which the managing general agent is to be authorized to act, and any other information the commissioner may request. This subsection applies to managing general agents operating in this state.

(6) An insurer shall review its books and records each calendar quarter to determine if any insurance producer has become a managing general agent. If the insurer determines that an insurance producer has become a managing general agent under RCW 48.98.005, the insurer shall promptly notify the insurance producer and the commissioner of that determination, and the insurer and insurance producer shall fully comply with this chapter within thirty days.

(7) An insurer may not appoint to its board of directors an officer, director, employee, subagent, or controlling shareholder of its managing general agents. This subsection does not apply to relationships governed by the insurer holding company act, chapter 48.31B RCW, or, if applicable, the business transacted with broker-controlled property and casualty insurer act, *chapter 48.97 RCW. [2008 c 217 § 82; 1993 c 462 § 38.]

*Reviser's note: Chapter 48.97 RCW was renamed the producer-controlled property and casualty insurer act, effective July 1, 2009.

Additional notes found at www.leg.wa.gov

(2022 Ed.)

48.98.025 Examinations—Acts of a managing general agent are acts of the insurer. The acts of the managing general agent are considered to be the acts of the insurer on whose behalf it is acting. A managing general agent may be examined as if it were the insurer, as provided in chapter 48.03 RCW. [1993 c 462 § 39.]

48.98.030 Violations of chapter—Penalties—Judicial review. (1) Subject to a hearing in accordance with chapters 34.05 and 48.04 RCW, upon a finding by the commissioner that any person has violated any provision of this chapter, the commissioner may order:

(a) For each separate violation, a penalty in an amount of not more than one thousand dollars;

(b) Revocation, or suspension for up to one year, of the managing general agent's license including any insurance producer's licenses held by the managing general agent; and

(c) The managing general agent to reimburse the insurer, the rehabilitator, or liquidator of the insurer for losses incurred by the insurer caused by a violation of this chapter committed by the managing general agent.

(2) The decision, determination, or order of the commissioner under this section is subject to judicial review under chapters 34.05 and 48.04 RCW.

(3) Nothing contained in this section affects the right of the commissioner to impose any other penalties provided for in this title.

(4) Nothing contained in this chapter is intended to or in any manner limits or restricts the rights of policyholders, claimants, and auditors. [2008 c 217 § 83; 1993 c 462 § 40.]

Additional notes found at www.leg.wa.gov

48.98.035 Rule making. The commissioner may adopt rules for the implementation and administration of this chapter, that shall include but are not limited to licensure of managing general agents. [1993 c 462 § 41.]

48.98.040 Continued use of a managing general agent—Compliance with chapter. No insurer may continue to use the services of a managing general agent on and after January 1, 1994, unless that use complies with this chapter. [1993 c 462 § 42.]

48.98.900 Short title. This chapter may be known and cited as the managing general agents act. [1993 c 462 § 34.]

48.98.901 Severability—Implementation—1993 c 462. See RCW 48.31B.901 and 48.31B.902.

Chapter 48.99 RCW

UNIFORM INSURERS LIQUIDATION ACT

Sections

48.99.010	Uniform insurers liquidation act.
48.99.011	Insurer—Self-funded multiple employer welfare arrangement.
48.99.017	Confidentiality of documents, materials, or other information—Commissioner's capacity as a receiver.
48.99.020	Delinquency proceedings—Domestic insurers.
48.99.030	Delinquency proceedings—Foreign insurers.
48.99.040	Claims of nonresidents against domestic insurer.
48.99.050	Claims of residents against foreign insurer.
48.99.060	Priority of certain claims.
48.99.070	Attachment, garnishment, execution stayed.
48.99.080	Severability—Uniformity of interpretation.

48.99.900 Severability—Implementation—1993 c 462.

48.99.010 Uniform insurers liquidation act. This chapter may be known and cited as the uniform insurers liquidation act. For the purposes of this chapter:

(1) "Insurer" means any person, firm, corporation, association, or aggregation of persons doing an insurance business and subject to the insurance supervisory authority of, or to liquidation, rehabilitation, reorganization, or conservation by, the commissioner, or the equivalent insurance supervisory official of another state.

(2) "Delinquency proceeding" means any proceeding commenced against an insurer for the purpose of liquidating, rehabilitating, reorganizing, or conserving such insurer.

(3) "State" means any state of the United States, and also the District of Columbia and Puerto Rico.

(4) "Foreign country" means territory not in any state.

(5) "Domiciliary state" means the state in which an insurer is incorporated or organized, or, in the case of an insurer incorporated or organized in a foreign country, the state in which such insurer, having become authorized to do business in such state, has, at the commencement of delinquency proceedings, the largest amount of its assets held in trust and assets held on deposit for the benefit of its policyholders or policyholders and creditors in the United States; and any such insurer is deemed to be domiciled in such state.

(6) "Ancillary state" means any state other than a domiciliary state.

(7) "Reciprocal state" means any state other than this state in which in substance and effect the provisions of this chapter are in force, including the provisions requiring that the insurance commissioner or equivalent insurance supervisory official be the receiver of a delinquent insurer.

(8) "General assets" means all property, real, personal, or otherwise, not specifically mortgaged, pledged, deposited, or otherwise encumbered for the security or benefit of specified persons or a limited class or classes of persons, and as to such specifically encumbered property the term includes all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets held in trust and assets held on deposit for the security or benefit of all policyholders, or all policyholders and creditors in the United States, shall be deemed general assets.

(9) "Preferred claim" means any claim with respect to which the law of a state or of the United States accords priority of payment from the general assets of the insurer.

(10) "Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any general assets.

(11) "Secured claim" means any claim secured by mortgage, trust, deed, pledge, deposit as security, escrow, or otherwise, but not including special deposit claims or claims against general assets. The term also includes claims which more than four months prior to the commencement of delinquency proceedings in the state of the insurer's domicile have become liens upon specific assets by reason of judicial process.

(12) "Receiver" means receiver, liquidator, rehabilitator, or conservator as the context may require. [1993 c 462 § 78;

1961 c 194 § 12; 1947 c 79 § .31.11; Rem. Supp. 1947 § 45.31.11. Formerly RCW 48.31.110.]

48.99.011 Insurer—Self-funded multiple employer welfare arrangement. A self-funded multiple employer welfare arrangement, as defined in RCW 48.125.010, is an insurer under this chapter. [2004 c 260 § 21.]

Additional notes found at www.leg.wa.gov

48.99.017 Confidentiality of documents, materials, or other information—Commissioner's capacity as a receiver. (1) Documents, materials, or other information that the commissioner obtains under this chapter in the commissioner's capacity as a receiver, are records under the jurisdiction and control of the receivership court. These records are confidential by law and privileged, are not subject to chapter 42.56 or 40.14 RCW, and are not subject to subpoena directed to the commissioner or any person who received documents, materials, or other information while acting under the authority of the commissioner. The commissioner is authorized to use such documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties. The confidentiality and privilege created by this section and RCW 42.56.400(17) is not waived if confidential and privileged information under this section is shared with any person acting under the authority of the commissioner, representatives of insurance guaranty associations that may have statutory obligations as a result of the insolvency of an insurer, the national association of insurance commissioners and its affiliates and subsidiaries, regulatory and law enforcement officials of other states and nations, the federal government, and international authorities.

(2) Neither the commissioner nor any person who received documents, materials, or other information while acting under the authority of the commissioner as receiver is required to testify in any private civil action concerning any confidential and privileged documents, materials, or information subject to subsection (1) of this section.

(3) Any person who can demonstrate a legal interest in the receivership estate or a reasonable suspicion of negligence or malfeasance by the commissioner related to an insurer receivership may file a motion in the receivership matter to allow inspection of private company information or documents not subject to public disclosure under subsection (1) of this section. The court shall conduct an in-camera review after notifying the commissioner and every party that produced the information. The court may order the commissioner to allow the petitioner to have access to the information, provided the petitioner maintains the confidentiality of the information. The petitioner must not disclose the information to any other person, except upon further order of the court. After conducting a hearing, the court may order that the information can be disclosed if the court finds that there is a public interest in the disclosure of the information and the protection of the information from public disclosure is clearly unnecessary to protect any individual's right of privacy, or any company's proprietary information, and the commissioner has not demonstrated that the disclosure would impair any vital governmental function, the receivership estate, or the receiver's ability to manage the estate.

(4) The confidentiality and privilege of documents, materials or other information obtained by the receiver set forth in subsections (1) and (2) of this section does not apply to litigation to which the insurer in receivership is a party. In such instances, discovery is governed by the Washington rules of civil procedure. [2010 c 97 § 2.]

48.99.020 Delinquency proceedings—Domestic insurers. (1) Whenever under the laws of this state a receiver is to be appointed in delinquency proceedings for an insurer domiciled in this state, the court shall appoint the commissioner as such receiver. The court shall direct the commissioner forthwith to take possession of the assets of the insurer and to administer the same under the orders of the court.

(2) As domiciliary receiver the commissioner shall be vested by operation of law with the title to all of the property, contracts, and rights of action, and all of the books and records of the insurer wherever located, as of the date of entry of the order directing him or her to rehabilitate or liquidate a domestic insurer, or to liquidate the United States branch of an alien insurer domiciled in this state, and he or she shall have the right to recover the same and reduce the same to possession; except that ancillary receivers in reciprocal states shall have, as to assets located in their respective states, the rights and powers which are hereinafter prescribed for ancillary receivers appointed in this state as to assets located in this state.

(3) The filing or recording of the order directing possession to be taken, or a certified copy thereof, in the office where instruments affecting title to property are required to be filed or recorded shall impart the same notice as would be imparted by a deed, bill of sale, or other evidence of title duly filed or recorded.

(4) The commissioner as domiciliary receiver shall be responsible on his or her official bond for the proper administration of all assets coming into his or her possession or control. The court may at any time require an additional bond from the commissioner or his or her deputies if deemed desirable for the protection of the assets.

(5) Upon taking possession of the assets of an insurer the domiciliary receiver shall, subject to the direction of the court, immediately proceed to conduct the business of the insurer or to take such steps as are authorized by the laws of this state for the purpose of liquidating, rehabilitating, reorganizing, or conserving the affairs of the insurer.

(6) In connection with delinquency proceedings the commissioner may appoint one or more special deputy commissioners to act for him or her, and may employ such counsel, clerks, and assistants as he or she deems necessary. The compensation of the special deputies, counsel, clerks, or assistants and all expenses of taking possession of the insurer and of conducting the proceedings shall be fixed by the receiver, subject to the approval of the court, and shall be paid out of the funds or assets of the insurer. Within the limits of the duties imposed upon them special deputies shall possess all the powers given to, and, in the exercise of those powers, shall be subject to all of the duties imposed upon the receiver with respect to such proceedings. [2009 c 549 § 7159; 1947 c 79 § .31.12; Rem. Supp. 1947 § 45.31.12. Formerly RCW 48.31.120.]

(2022 Ed.)

48.99.030 Delinquency proceedings—Foreign insurers. (1) Whenever under the laws of this state an ancillary receiver is to be appointed in delinquency proceedings for an insurer not domiciled in this state, the court shall appoint the commissioner as ancillary receiver. The commissioner shall file a petition requesting the appointment (a) if he or she finds that there are sufficient assets of such insurer located in this state to justify the appointment of an ancillary receiver, or (b) if ten or more persons resident in this state having claims against such insurer file a petition with the commissioner requesting the appointment of such ancillary receiver.

(2) The domiciliary receiver for the purpose of liquidating an insurer domiciled in a reciprocal state, shall be vested by operation of law with the title to all of the property, contracts, and rights of action, and all of the books and records of the insurer located in this state, and he or she shall have the immediate right to recover balances due from local insurance producers and surplus line brokers and to obtain possession of any books and records of the insurer found in this state. He or she shall also be entitled to recover the other assets of the insurer located in this state except that upon the appointment of an ancillary receiver in this state, the ancillary receiver shall during the ancillary receivership proceedings have the sole right to recover such other assets. The ancillary receiver shall, as soon as practicable, liquidate from their respective securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in this state, and shall pay the necessary expenses of the proceedings. All remaining assets shall promptly transfer to the domiciliary receiver. Subject to the foregoing provisions the ancillary receiver and his or her deputies shall have the same powers and be subject to the same duties with respect to the administration of such assets, as a receiver of an insurer domiciled in this state.

(3) The domiciliary receiver of an insurer domiciled in a reciprocal state may sue in this state to recover any assets of such insurer to which he or she may be entitled under the laws of this state. [2009 c 162 § 31; 2008 c 217 § 84; 1947 c 79 § .31.13; Rem. Supp. 1947 § 45.31.13. Formerly RCW 48.31.130.]

Additional notes found at www.leg.wa.gov

48.99.040 Claims of nonresidents against domestic insurer. (1) In a delinquency proceeding begun in this state against an insurer domiciled in this state, claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states, or with the domiciliary receiver. All claims must be filed on or before the last date fixed for the filing of claims in the domiciliary delinquency proceedings.

(2) Controverted claims belonging to claimants residing in reciprocal states may either (a) be proved in this state as provided by law, or (b) if ancillary proceedings have been commenced in reciprocal states, be proved in those proceedings. In the event a claimant elects to prove a claim in ancillary proceedings, if notice of the claim and opportunity to appear and be heard is afforded the domiciliary receiver of this state as provided in RCW 48.99.050 with respect to ancillary proceedings in this state, the final allowance of a claim by the courts in the ancillary state must be accepted in this state as conclusive as to its amount, and must also be

accepted as conclusive as to its priority, if any, against special deposits or other security located within the ancillary state. [2003 c 248 § 25; 1947 c 79 § .31.14; Rem. Supp. 1947 § 45.31.14. Formerly RCW 48.31.140.]

48.99.050 Claims of residents against foreign insurer.

(1) In a delinquency proceeding in a reciprocal state against an insurer domiciled in that state, claimants against such insurer, who reside within this state may file claims either with the ancillary receiver, if any, appointed in this state, or with the domiciliary receiver. All such claims must be filed on or before the last date fixed for the filing of claims in the domiciliary delinquency proceeding.

(2) Controverted claims belonging to claimants residing in this state may either (a) be proved in the domiciliary state as provided by the law of that state, or (b) if ancillary proceedings have been commenced in this state, be proved in those proceedings. In the event that any such claimant elects to prove his or her claim in this state, he or she shall file his or her claim with the ancillary receiver in the manner provided by the law of this state for the proving of claims against insurers domiciled in this state, and he or she shall give notice in writing to the receiver in the domiciliary state, either by registered mail or by personal service at least forty days prior to the date set for hearing. The notice shall contain a concise statement of the amount of the claim, the facts on which the claim is based, and the priorities asserted, if any. If the domiciliary receiver, within thirty days after the giving of such notice, shall give notice in writing to the ancillary receiver and to the claimant, either by registered mail or by personal service, of his or her intention to contest such claim, he or she shall be entitled to appear or to be represented in any proceeding in this state involving the adjudication of the claim. The final allowance of the claim by the courts of this state shall be accepted as conclusive as to its amount, and shall also be accepted as conclusive as to its priority, if any, against special deposits or other security located within this state. [2009 c 549 § 7160; 1947 c 79 § .31.15; Rem. Supp. 1947 § 45.31.15. Formerly RCW 48.31.150.]

48.99.060 Priority of certain claims. (1) In a delinquency proceeding against an insurer domiciled in this state, claims owing to residents of ancillary states shall be preferred claims if like claims are preferred under the laws of this state. All such claims whether owing to residents or nonresidents shall be given equal priority of payment from general assets regardless of where such assets are located.

(2) In a delinquency proceeding against an insurer domiciled in a reciprocal state, claims owing to residents of this state shall be preferred if like claims are preferred by the laws of that state.

(3) The owners of special deposit claims against an insurer for which a receiver is appointed in this or any other state shall be given priority against their several special deposits in accordance with the provisions of the statutes governing the creation and maintenance of such deposits. If there is a deficiency in any such deposit so that the claims secured thereby are not fully discharged therefrom, the claimants may share in the general assets, but such sharing shall be deferred until general creditors, and also claimants against other special deposits who have received smaller percentages

from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

(4) The owner of a secured claim against an insurer for which a receiver has been appointed in this or any other state may surrender his or her security and file his or her claim as a general creditor, or the claim may be discharged by resort to the security, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors. If the amount of the deficiency has been adjudicated in ancillary proceedings as provided in this chapter, or if it has been adjudicated by a court of competent jurisdiction in proceedings in which the domiciliary receiver has had notice and opportunity to be heard, such amount shall be conclusive; otherwise the amount shall be determined in the delinquency proceeding in the domiciliary state. [2009 c 549 § 7161; 1993 c 462 § 79; 1947 c 79 § .31.16; Rem. Supp. 1947 § 45.31.16. Formerly RCW 48.31.160.]

48.99.070 Attachment, garnishment, execution stayed. During the pendency of delinquency proceedings in this or any reciprocal state no action or proceeding in the nature of an attachment, garnishment, or execution shall be commenced or maintained in the courts of this state against the delinquent insurer or its assets. Any lien obtained by any such action or proceeding within four months prior to the commencement of any such delinquency proceeding or at any time thereafter shall be void as against any rights arising in such delinquency proceeding. [1947 c 79 § .31.17; Rem. Supp. 1947 § 45.31.17. Formerly RCW 48.31.170.]

48.99.080 Severability—Uniformity of interpretation. (1) If any provision of this chapter or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the chapter which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are declared to be severable.

(2) This uniform insurers liquidation act shall be so interpreted and construed as to effectuate its general purpose to make uniform the law of those states that enact it. To the extent that its provisions, when applicable, conflict with provisions of chapter 48.31 RCW, the provisions of this chapter shall control. [1993 c 462 § 80; 1947 c 79 § .31.18; Rem. Supp. 1947 § 45.31.18. Formerly RCW 48.31.180.]

48.99.900 Severability—Implementation—1993 c 462. See RCW 48.31B.901 and 48.31B.902.

**Chapter 48.102 RCW
LIFE SETTLEMENTS ACT**

Sections

48.102.001	Short title.
48.102.006	Definitions.
48.102.011	Licensing requirements for providers.
48.102.021	Licensing requirements for brokers.
48.102.031	License suspension, revocation, or refusal to renew—Fines.
48.102.041	Contract requirements.
48.102.046	Reporting requirements and record retention.
48.102.051	Privacy.
48.102.061	Examination.

48.102.070	Advertising.
48.102.080	Disclosures to owners.
48.102.090	Disclosure by insurer.
48.102.100	Notice to insured of alternative transactions—Document approved by commissioner.
48.102.110	General rules.
48.102.120	Conflict of laws.
48.102.130	Prohibited practices.
48.102.140	Fraud prevention and control.
48.102.150	Enforcement.
48.102.160	Penalties.
48.102.170	Authority to adopt rules.
48.102.180	Unfair trade practices.
48.102.193	Existing rights or liabilities—July 26, 2009.

48.102.001 Short title. This chapter may be cited as the "life settlements act." [2009 c 104 § 1.]

48.102.006 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Advertisement" means any written, electronic, or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the internet, or similar communications media, including film strips, motion pictures, and videos, published, disseminated, circulated, or placed directly before the public for the purpose of creating an interest in or inducing a person to purchase or sell, assign, devise, bequest, or transfer the death benefit or ownership of a policy or an interest in a policy pursuant to a life settlement contract.

(2) "Broker" means a person who, on behalf of an owner and for a fee, commission, or other valuable consideration, offers or attempts to negotiate life settlement contracts between an owner and providers. A broker represents only the owner and owes a fiduciary duty to the owner to act according to the owner's instructions, and in the best interest of the owner, notwithstanding the manner in which the broker is compensated. A broker does not mean an attorney, certified public accountant, or financial planner retained in the type of practice customarily performed in their professional capacity to represent the owner whose compensation is not paid directly or indirectly by the provider or any other person, except the owner.

(3) "Business of life settlements" means an activity involved in, but not limited to, offering to enter into, soliciting, negotiating, procuring, effectuating, monitoring, or tracking life settlement contracts.

(4) "Chronically ill" means:

(a) Being unable to perform at least two activities of daily living, i.e., eating, toileting, transferring, bathing, dressing, or continence;

(b) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; or

(c) Having a level of disability substantially similar to that described in (a) of this subsection made in a written determination, as existing on July 26, 2009, by the United States secretary of health and human services.

(5) "Commissioner" means the insurance commissioner.

(6)(a) "Financing entity" means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy from a provider, credit enhancer, or any entity that has a direct ownership in a policy that is the subject of a life settlement contract, but:

(i) Whose principal activity related to the transaction is providing funds to effect the life settlement contract or purchase of one or more policies; and

(ii) Who has an agreement in writing with one or more providers to finance the acquisition of life settlement contracts.

(b) "Financing entity" does not mean a nonaccredited investor or purchaser.

(7) "Financing transaction" means a transaction in which a licensed provider obtains financing from a financing entity including, without limitation, any secured or unsecured financing, any securitization transaction, or any securities offering which either is registered or exempt from registration under federal and state securities law.

(8) "Fraudulent life settlement act" includes:

(a) Acts or omissions committed by any person who, knowingly and with intent to defraud, for the purpose of depriving another of property or for pecuniary gain, commits, or permits its employees or its agents to engage in acts including, but not limited to:

(i) Presenting, causing to be presented, or preparing with knowledge and belief that it will be presented to or by a provider, premium finance lender, broker, insurer, insurance producer, or any other person, false material information, or concealing material information, as part of, in support of, or concerning a fact material to one or more of the following:

(A) An application for the issuance of a life settlement contract or policy;

(B) The underwriting of a life settlement contract or policy;

(C) A claim for payment or benefit pursuant to a life settlement contract or policy;

(D) Premiums paid on a policy;

(E) Payments and changes in ownership or beneficiary made in accordance with the terms of a life settlement contract or policy;

(F) The reinstatement or conversion of a policy;

(G) In the solicitation, offer to enter into, or effectuation of a life settlement contract, or policy;

(H) The issuance of written evidence of life settlement contracts or insurance; or

(I) Any application for, or the existence of or any payments related to, a loan secured directly or indirectly by any interest in a policy;

(ii) Entering into any act, practice, or arrangement that involves stranger-originated life insurance;

(iii) Failing to disclose to the insurer where the request for such disclosure has been asked for by the insurer that the prospective insured has undergone a life expectancy evaluation by any person or entity other than the insurer or its authorized representatives in connection with the issuance of the policy;

(iv) Employing any device, scheme, or artifice to defraud in the business of life settlements; or

(v) In the solicitation, application, or issuance of a policy, employing any device, scheme, or artifice in violation of state insurable interest laws.

(b) In the furtherance of a fraud or to prevent the detection of a fraud any person commits or permits its employees or its agents to:

(i) Remove, conceal, alter, destroy, or sequester from the commissioner the assets or records of either a broker or provider, or both or other person engaged in the business of life settlements;

(ii) Misrepresent or conceal the financial condition of either a broker or provider, or both, financing entity, insurer, or other person;

(iii) Transact the business of life settlements in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of life settlements;

(iv) File with the commissioner or the chief insurance regulatory official of another jurisdiction a document containing false information or otherwise concealing information about a material fact from the commissioner;

(v) Engage in embezzlement, theft, misappropriation, or conversion of moneys, funds, premiums, credits, or other property of a provider, insured, owner, or any other person engaged in the business of life settlements;

(vi) Knowingly and with intent to defraud, enter into, broker, or otherwise deal in a life settlement contract, the subject of which is a policy that was obtained by presenting false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information concerning any fact material to the policy, where the owner or the owner's agent intended to defraud the policy's issuer;

(vii) Attempt to commit, assist, aid, or abet in the commission of, or conspiracy to commit, the acts or omissions specified in this subsection; or

(viii) Misrepresent the state of residence of an owner to be a state or jurisdiction that does not have a law substantially similar to this chapter for the purpose of evading or avoiding the provisions of this chapter.

(9) "Insured" means the person covered under the policy being considered for sale in a life settlement contract.

(10) "Life expectancy" means the arithmetic mean of the number of months the insured under the policy to be settled can be expected to live considering medical records and appropriate experiential data.

(11) "Life insurance producer" means any person licensed in this state as a resident or nonresident insurance producer who has received qualification or authority for life insurance coverage or a life line of coverage pursuant to RCW 48.17.170.

(12)(a) "Life settlement contract" means a written agreement entered into between a provider and an owner, establishing the terms under which compensation or any thing of value will be paid, which compensation or thing of value is less than the expected death benefit of the policy, in return for the owner's assignment, transfer, sale, devise, or bequest of the death benefit or any portion of a policy for compensation, provided, however, that the minimum value for a life settlement contract shall be greater than a cash surrender value or accelerated death benefit available at the time of an application for a life settlement contract.

(b) "Life settlement contract" also means the transfer for compensation or value of ownership or beneficial interest in a trust or other entity that owns such policy if the trust or other entity was formed or availed of for the principal purpose of acquiring one or more life insurance contracts, which

life insurance contract insures the life of a person residing in this state.

(c) "Life settlement contract" also means a written agreement for a loan or other lending transaction, secured primarily by a policy or a premium finance loan made for a policy on or before the date of issuance of the policy where:

(i) The loan proceeds are not used solely to pay premiums for the policy and any costs or expenses incurred by the lender or the borrower in connection with the financing;

(ii) The owner receives on the date of the premium finance loan a guarantee of the future life settlement value of the policy; or

(iii) The owner agrees on the date of the premium finance loan to sell the policy or any portion of its death benefit on any date following the issuance of the policy.

(d) "Life settlement contract" does not mean:

(i) A policy loan by a life insurance company pursuant to the terms of the policy or accelerated death provisions contained in the policy, whether issued with the original policy or as a rider;

(ii) A premium finance loan or any loan made by a bank or other licensed financial institution, provided that neither the default on the loan nor the transfer of the policy in connection with such a default is pursuant to an agreement or understanding with any other person for the purpose of evading regulation under this chapter;

(iii) A collateral assignment of a policy by an owner;

(iv) A loan made by a lender that does not violate any provision of this title, provided the loan is not described in (a) of this subsection, and is not otherwise within the definition of life settlement contract;

(v) An agreement where all the parties (A) are closely related to the insured by blood or law, or (B) have a lawful substantial economic interest in the continued life, health, and bodily safety of the person insured, or are trusts established primarily for the benefit of those parties;

(vi) Any designation, consent, or agreement by an insured who is an employee of an employer in connection with the purchase by the employer, or trust established by the employer, of life insurance on the life of the employee;

(vii) A bona fide business succession planning arrangement:

(A) Between one or more shareholders in a corporation or between a corporation and one or more of its shareholders or one or more trusts established by its shareholders;

(B) Between one or more partners in a partnership or between a partnership and one or more of its partners or one or more trusts established by its partners; or

(C) Between one or more members in a limited liability company or between a limited liability company and one or more of its members or one or more trusts established by its members;

(viii) An agreement entered into by a service recipient, or a trust established by the service recipient, and a service provider, or a trust established by the service provider, who performs significant services for the service recipient's trade or business; or

(ix) Any other contract, transaction, or arrangement from the definition of life settlement contract that the commissioner determines is not of the type intended to be regulated by this chapter.

(13) "Net death benefit" means the amount of the policy to be settled less any outstanding debts or liens.

(14)(a) "Owner" means the owner of a policy, with or without a terminal illness, who enters or seeks to enter into a life settlement contract. For the purposes of this chapter, an owner shall not be limited to an owner of a policy that insures the life of an individual with a terminal or chronic illness or condition except where specifically addressed.

(b) "Owner" does not mean:

(i) Any provider or other licensee under this chapter;

(ii) A qualified institutional buyer as defined, as of July 26, 2009, in rule 144A of the federal securities act of 1933, as amended;

(iii) A financing entity;

(iv) A special purpose entity; or

(v) A related provider trust.

(15) "Patient identifying information" means an insured's address, telephone number, facsimile number, electronic mail address, photograph or likeness, employer, employment status, social security number, or any other information that is likely to lead to the identification of the insured.

(16) "Person" means any natural person or legal entity, including but not limited to, a partnership, limited liability company, association, trust, or corporation.

(17) "Policy" means an individual or group life insurance policy, group certificate, contract, or arrangement of life insurance owned by a resident of this state, regardless of whether delivered or issued for delivery in this state.

(18) "Premium finance loan" means a loan made primarily for the purposes of making premium payments on a policy, which loan is secured by an interest in the policy.

(19)(a) "Provider" means a person, other than an owner, who enters into or effectuates a life settlement contract with an owner.

(b) "Provider" does not mean:

(i) Any bank, savings bank, savings and loan association, or credit union;

(ii) A licensed lending institution or creditor or secured party pursuant to a premium finance loan agreement which takes an assignment of a policy as collateral for a loan;

(iii) The insurer of a policy or rider to the extent of providing accelerated death benefits or riders under an approved policy form or cash surrender value;

(iv) Any natural person who enters into or effectuates no more than one agreement in a calendar year for the transfer of a policy, for compensation or anything of value less than the expected death benefit payable under the policy;

(v) A purchaser;

(vi) Any authorized or eligible insurer that provides financial guaranty insurance to a provider, purchaser, financing entity, special purpose entity, or related provider trust;

(vii) A financing entity;

(viii) A special purpose entity;

(ix) A related provider trust;

(x) A broker; or

(xi) An accredited investor or qualified institutional buyer as defined, respectively, in regulation D, rule 501 or rule 144A of the federal securities act of 1933, as amended, who purchases a policy from a provider.

(20) "Purchased policy" means a policy that has been acquired by a provider pursuant to a life settlement contract.

(21) "Purchaser" means a person who pays compensation or anything of value as consideration for a beneficial interest in a trust which is vested with, or for the assignment, transfer, or sale of, an ownership or other interest in a policy which has been the subject of a life settlement contract.

(22) "Related provider trust" means a titling trust or other trust established by a licensed provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. In order to qualify as a related provider trust, the trust must have a written agreement with the licensed provider under which the licensed provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files relating to life settlement transactions available to the commissioner as if those records and files were maintained directly by the licensed provider.

(23) "Settled policy" means a policy that has been acquired by a provider pursuant to a life settlement contract.

(24) "Special purpose entity" means a corporation, partnership, trust, limited liability company, or other legal entity formed solely to provide either directly or indirectly access to institutional capital markets for a financing entity or provider:

(a) In connection with a transaction in which the securities in the special purpose entity are acquired by the owner or by a "qualified institutional buyer" as defined in rule 144 promulgated under the federal securities act of 1933, as amended; or

(b) When the securities pay a fixed rate of return commensurate with established asset-backed institutional capital markets.

(25) "Stranger-originated life insurance" means an act, practice, or arrangement to initiate a policy for the benefit of a third-party investor who, at the time of policy origination, has no insurable interest in the insured under chapter 48.18 RCW. Stranger-originated life insurance practices include, but are not limited to, cases in which life insurance is purchased with resources or guarantees from or through a person or entity who, at the time of policy inception, could not lawfully initiate the policy and where, at the time of inception, there is an arrangement or agreement to directly or indirectly transfer the ownership of the policy or the policy benefits, or both, to a third party. Any trust that is created to give the appearance of insurable interest, and is used to initiate one or more policies for investors, violates chapter 48.18 RCW and the prohibition against wagering on human life. Stranger-originated life insurance arrangements do not include those practices set forth in subsection (12)(d) of this section.

(26) "Terminally ill" means having an illness or sickness that can reasonably be expected to result in death in twenty-four months or less. [2009 c 104 § 2.]

Reviser's note: The definitions in this section have been alphabetized pursuant to RCW 1.08.015(2)(k).

48.102.011 Licensing requirements for providers. (1)

A person, wherever located, may not act as a provider with an owner who is a resident of this state or if there is more than one owner on a single policy and one of the owners is a resi-

dent of this state, without first having obtained a license from the commissioner.

(2) An application for a provider license must be made to the commissioner by the applicant on a form prescribed by the commissioner, and the application must be accompanied by a licensing fee in the amount of two hundred fifty dollars for deposit into the general fund.

(3) All provider licenses continue in force until suspended, revoked, or not renewed. A license is subject to renewal annually on the first day of July upon application of the provider and payment of a renewal fee of two hundred fifty dollars for deposit into the general fund. If not so renewed, the license automatically expires on the renewal date.

(a) If the renewal fee is not received by the commissioner prior to the expiration date, the provider must pay to the commissioner in addition to the renewal fee, a surcharge as follows:

(i) For the first thirty days or part thereof delinquency the surcharge is fifty percent of the renewal fee;

(ii) For the next thirty days or part thereof delinquency the surcharge is one hundred percent of the renewal fee;

(b) If the renewal fee is not received by the commissioner after sixty days but prior to twelve months after the expiration date the payment of the renewal fee is for reinstatement of the license and the provider must pay to the commissioner the renewal fee and a surcharge of two hundred percent.

(4) Subsection (3)(a) and (b) of this section does not exempt any person from any penalty provided by law for transacting a life settlement business without a valid and subsisting license.

(5) The applicant must provide information as the commissioner may require on forms prescribed by the commissioner. The commissioner has the authority, at any time, to require an applicant to fully disclose the identity of its stockholders, partners, officers, and employees, and the commissioner may, in the exercise of the commissioner's sole discretion, refuse to issue a license in the name of any person if not satisfied that any officer, employee, stockholder, or partner thereof who may materially influence the applicant's conduct meets the standards of this chapter.

(6) A license issued to a partnership, corporation, or other entity authorizes all members, officers, and designated employees to act as a licensee under the license, if those persons are named in the application and any supplements to the application.

(7) Upon the filing of an application for a provider's license and the payment of the license fee, the commissioner must make an investigation of each applicant and may issue a license if the commissioner finds that the applicant:

(a) Has provided a detailed plan of operation;

(b) Is competent and trustworthy and intends to transact its business in good faith;

(c) Has a good business reputation and has had experience, training, or education so as to be qualified in the business for which the license is applied;

(d)(i) Has demonstrated evidence of financial responsibility in a form and in an amount prescribed by the commissioner by rule.

(ii) The commissioner may ask for evidence of financial responsibility at any time the commissioner deems necessary;

(e) If the applicant is a legal entity, is formed or organized under the laws of this state, is a foreign legal entity authorized to transact business in this state, or provides a certificate of good standing from the state of its domicile; and

(f) Has provided to the commissioner an antifraud plan that meets the requirements of RCW 48.102.140 and includes:

(i) A description of the procedures for detecting and investigating possible fraudulent acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(ii) A description of the procedures for reporting fraudulent insurance acts to the commissioner;

(iii) A description of the plan for antifraud education and training of its underwriters and other personnel; and

(iv) A written description or chart outlining the arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts and investigating unresolved material inconsistencies between medical records and insurance applications.

(8)(a) A nonresident provider must appoint the commissioner as its attorney to receive service of, and upon whom must be served, all legal process issued against it in this state upon causes of action arising within this state. Service upon the commissioner as attorney constitutes service upon the provider. Service of legal process against the provider can be had only by service upon the commissioner.

(b) With the appointment the provider must designate the person to whom the commissioner must forward legal process so served upon him or her. The provider may change the person by filing a new designation.

(c) The appointment of the commissioner as attorney is irrevocable, binds any successor in interest or to the assets or liabilities of the provider, and remains in effect as long as there is in this state any contract made by the provider or liabilities or duties arising therefrom.

(d) The service of process must be accomplished and processed in the manner prescribed under RCW 48.02.200.

(9) A provider may not use any person to perform the functions of a broker unless the person is authorized to act as a broker under this chapter.

(10) A provider must provide to the commissioner new or revised information about officers, stockholders, partners, directors, members, or designated employees within thirty days of the change. [2011 c 47 § 14; 2010 c 27 § 5; 2009 c 104 § 3.]

48.102.021 Licensing requirements for brokers. (1)

Only a life insurance producer who has been duly licensed as a resident insurance producer with a lifeline of authority in this state or his or her home state for at least one year and is licensed as a nonresident producer in this state is permitted to operate as a broker.

(2) Not later than thirty days from the first day of operating as a broker, the life insurance producer must notify the commissioner that he or she intends acting as a broker on a form prescribed by the commissioner, pay a fee of one hundred dollars, and if a nonresident producer appoint the commissioner as attorney for service of process under RCW

48.02.200. Notification must include an acknowledgment by the life insurance producer that he or she will operate as a broker in accordance with this chapter.

(3) A person licensed as an attorney, certified public accountant, or financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the owner, whose compensation is not paid directly or indirectly by the provider or purchaser, may negotiate life settlement contracts on behalf of the owner without having to obtain a license as a broker.

(4) The authority to act as a broker continues in force until suspended, revoked, or not renewed. The authority to act as a broker automatically expires if not timely renewed. The authority to act as a broker is valid for a time period coincident with the expiration date of the broker's insurance producer license. The authority to act as a broker is renewable at that time, upon payment of a renewal fee in the amount of one hundred dollars and if the payment is received by the commissioner prior to the expiration date, the broker's authority to act as a broker continues in effect.

(a) If the renewal fee is not received by the commissioner prior to the expiration date, the broker must pay to the commissioner in addition to the renewal fee, a surcharge as follows:

(i) For the first thirty days or part thereof of delinquency the surcharge is fifty percent of the renewal fee;

(ii) For the next thirty days or part thereof delinquency the surcharge is one hundred percent of the renewal fee;

(b) If the payment of the renewal fee is not received by the commissioner after sixty days the surcharge is two hundred percent of the renewal fee.

(5) Subsection (4)(a) of this section does not exempt any person from any penalty provided by law for transacting life settlement business without the valid authority to act as a broker.

(6)(a) A nonresident broker must appoint the commissioner as its attorney to receive service of, and upon whom must be served, all legal process issued against it in this state upon causes of action arising within this state. Service upon the commissioner as attorney constitutes service upon the broker. Service of legal process against the broker can be had only by service upon the commissioner.

(b) The appointment of the commissioner as attorney is irrevocable, binds any successor in interest or to the assets or liabilities of the broker, and remains in effect as long as there is in this state any contract made by the broker or liabilities or duties arising therefrom.

(c) The service of process must be accomplished and processed in the manner prescribed in RCW 48.02.200.

(7) A broker may not use any person to perform the functions of a provider unless such a person holds a current, valid license as a provider, and as provided in this chapter. [2011 c 47 § 15; 2009 c 104 § 4.]

48.102.031 License suspension, revocation, or refusal to renew—Fines. (1) If the commissioner finds that a broker:

(a) Committed a fraudulent life settlement act;

(b) Or any officer, partner, member, or director has been guilty of fraudulent or dishonest practices, is subject to a final

administrative action, or is otherwise shown to be untrustworthy or incompetent to act as a licensee;

(c) Or any officer, partner, member, or director has been convicted of a felony, or of any misdemeanor of which criminal fraud is an element; or the licensee has pleaded guilty or nolo contendere with respect to any felony or any misdemeanor of which criminal fraud or moral turpitude is an element, regardless whether a judgment of conviction has been entered by the court; or

(d) Has violated any of the provisions of this chapter or fails to comply with any proper order or regulation of the commissioner;

then such action shall be an additional cause under RCW 48.17.530 to place on probation, suspend, revoke, or refuse to renew the insurance producer's license of the broker.

The procedure to suspend, revoke, or nonrenew the broker's insurance producer license shall be governed by RCW 48.17.540. The suspension, revocation, or nonrenewal of the broker's insurance producer license shall terminate the insurance producer's authority to act as a broker under this chapter.

(2) The commissioner may refuse, suspend, revoke, or refuse to renew a provider's license if the commissioner finds that:

(a) The provider committed a fraudulent life settlement act;

(b) There was any material misrepresentation in the provider's application for its license;

(c) The provider or any officer, partner, member, or director has been guilty of fraudulent or dishonest practices, is subject to a final administrative action, or is otherwise shown to be untrustworthy or incompetent to act as a licensee;

(d) The provider demonstrates a pattern of unreasonably withholding payments to policy owners;

(e) The provider no longer meets the requirements for initial licensure or authority to act as a provider;

(f) The provider or any officer, partner, member, or director has been convicted of a felony, or of any misdemeanor of which criminal fraud is an element; or the provider has pleaded guilty or nolo contendere with respect to any felony or any misdemeanor of which criminal fraud or moral turpitude is an element, regardless whether a judgment of conviction has been entered by the court;

(g) The provider has entered into any life settlement contract that has not been approved under this chapter;

(h) The provider has failed to honor contractual obligations set out in a life settlement contract;

(i) The provider has assigned, transferred, or pledged a settled policy to a person other than a provider licensed in this state, a purchaser, an accredited investor or qualified institutional buyer as defined, respectively, in regulation D, rule 501 or rule 144A of the federal securities act of 1933, as amended, a financing entity, a special purpose entity, or a related provider trust; or

(j) The provider or any officer, partner, member, or key management personnel has violated any of the provisions of this chapter or fails to comply with any proper order or regulation of the commissioner.

(3) The commissioner shall give the provider notice of his or her intention to suspend, revoke, or not renew its license not less than ten days before the order of suspension,

revocation, or nonrenewal is to become effective. The commissioner shall not suspend a provider's license for a period in excess of one year, and the commissioner shall state in the order of suspension the period during which it shall be effective.

(4) After hearing or with the consent of the provider or broker and in addition to or in lieu of the suspension, revocation, or refusal to renew any license, the commissioner may levy a fine upon the provider or broker or its employees in an amount not less than two hundred fifty dollars and not more than ten thousand dollars. The order levying the fine shall specify the period within which the fine shall be fully paid and which period shall not be less than fifteen nor more than thirty days from the date of the order. Upon failure to pay the fine when due the commissioner shall revoke the license of the provider or the insurance producer license of the broker if not already revoked, and the fine shall be recovered in a civil action brought on behalf of the commissioner by the attorney general. Any fine so collected shall be paid by the commissioner to the state treasurer for the account of the general fund. [2009 c 104 § 5.]

48.102.041 Contract requirements. (1) A person may not use any form of life settlement contract in this state unless it has been filed with and approved, if required, by the commissioner in a manner that conforms with the filing procedures and any time restrictions or deeming provisions, if any, for life insurance forms, policies, and contracts.

(2) An insurer may not, as a condition of responding to a request for verification of coverage or in connection with the transfer of a policy pursuant to a life settlement contract, require that the owner, insured, provider, or broker sign any form, disclosure, consent, waiver, or acknowledgment that has not been expressly approved by the commissioner for use in connection with life settlement contracts in this state.

(3) A person shall not use a life settlement contract form or provide to an owner a disclosure statement form in this state unless first filed with and approved by the commissioner. The commissioner shall disapprove a life settlement contract form or disclosure statement form if, in the commissioner's opinion, the contract or provisions contained therein fail to meet the requirements of RCW 48.102.070, 48.102.080, 48.102.110, and 48.102.150 or are unreasonable, contrary to the interests of the public, or otherwise misleading or unfair to the owner. At the commissioner's discretion, the commissioner may require the submission of advertising material. [2009 c 104 § 6.]

48.102.046 Reporting requirements and record retention. (1) Each provider shall file with the commissioner on or before March 1 of each year an annual statement containing such information as the commissioner may prescribe by rule. In addition to any other requirements, for any policy settled within five years of policy issuance, the annual statement shall specify the total number, aggregate face amount, and life settlement proceeds of policies settled during the immediately preceding calendar year, together with a breakdown of the information by policy issue year.

(2) Every provider that fails to file an annual statement as required in this section, or fails to reply within thirty calendar days to a written inquiry by the commissioner in connec-

tion therewith, shall, in addition to other penalties provided by this chapter, be subject, upon due notice and opportunity to be heard, to a penalty of up to fifty dollars per day of delay, not to exceed twenty-five thousand dollars in the aggregate, for each such failure.

(3) Records of all consummated transactions and life settlement contracts shall be maintained by the provider for three years after the death of the insured and shall be available to the commissioner for inspection during reasonable business hours. [2009 c 104 § 7.]

48.102.051 Privacy. (1) Except as otherwise allowed or required by law, a provider, broker, purchaser, insurance company, insurance producer, information bureau, rating agency or company, or any other person with actual knowledge of an insured's identity, shall not disclose the identity of an insured or information that there is a reasonable basis to believe could be used to identify the insured or the insured's financial or medical information to any other person unless the disclosure:

(a) Is necessary to effect a life settlement contract between the owner and a provider and the owner and insured have provided prior written consent to the disclosure;

(b) Is necessary to effectuate the sale of life settlement contracts, or interests therein, as investments, provided (i) the sale is conducted in accordance with applicable state and federal securities law, and (ii) the owner and the insured have both provided prior written consent to the disclosure;

(c) Is provided in response to an investigation or examination by the commissioner or any other governmental officer or agency or pursuant to the requirements of RCW 48.102.061, 48.102.140, and 48.102.150;

(d) Is a term or condition to the transfer of a policy by one provider to another provider, in which case the receiving provider shall be required to comply with the confidentiality requirements of this subsection;

(e) Is necessary to allow the provider or broker or their authorized representatives to make contacts for the purpose of determining health status.

(i) For the purposes of this section, the "authorized representative" does not include any person who has or may have any financial interest in the settlement contract other than a provider, licensed broker, financing entity, related provider trust, or special purpose entity.

(ii) A provider or broker shall require its authorized representative to agree in writing to adhere to the privacy provisions of this chapter; or

(f) Is required to purchase stop loss coverage.

(2) Nonpublic personal information solicited or obtained in connection with a proposed or actual life settlement contract shall be subject to the provisions applicable to financial institutions under the federal Gramm-Leach-Bliley act, P.L. 106-102 (1999).

(3) Names and individual identification data for all owners and insureds shall be considered private and confidential information and shall not be disclosed by the commissioner unless required by law. [2009 c 104 § 8.]

48.102.061 Examination. (1) Any life settlement provider, broker, or person licensed or regulated by this chapter shall be subject to the provisions of chapters 48.03 and 48.37

RCW, except as otherwise explicitly exempted or modified in this chapter.

(2) For the purpose of ascertaining its condition, or compliance with this title, the commissioner may as often as the commissioner finds advisable examine the accounts, records, documents, and transactions of:

(a) Any life settlement provider, broker, or person licensed or regulated under this chapter;

(b) Any person having a contract under which he or she enjoys in fact the exclusive or dominant right to manage or control a provider or broker; and

(c) Any person holding the shares of capital stock of a provider or broker for the purpose of control of its management either as voting trustee or otherwise.

(3) In lieu of an examination or market conduct oversight activity under this chapter of any foreign or alien licensee licensed in this state, the commissioner may, at the commissioner's discretion, accept an examination report or market conduct oversight action on the provider or broker as prepared by the commissioner for the provider's or broker's state of domicile or port-of-entry state.

(4)(a) Every examination, whatsoever, or any part of the examination of any person licensed or regulated under this chapter shall be at the expense of the person examined. RCW 48.03.060 (1) and (2) are not applicable to persons licensed or regulated under this chapter.

(b) When making an examination under this section, the commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners, the cost of which shall be borne by the person who is the subject of the examination.

(c) The person examined and liable therefore shall reimburse the state upon presentation of an itemized statement thereof, for the actual travel expenses of the commissioner's examiners, their reasonable living expense allowance, and their per diem compensation, including salary and the employer's cost of employee benefits, at a reasonable rate approved by the commissioner, incurred on account of the examination. Per diem salary and expenses for employees shall be established by the commissioner on the basis of the national association of insurance commissioner's recommended salary and expense schedule for zone examiners, or the salary schedule established by the Washington personnel resources board and the expense schedule established by the office of financial management, whichever is higher.

(d) The commissioner or the commissioner's examiners shall not receive or accept any additional emolument on account of any examination.

(5) Nothing contained in this section limits the commissioner's authority to terminate or suspend any examination or market conduct oversight activities in order to pursue other legal or regulatory action under the insurance laws of this state. Findings of fact and conclusions made pursuant to any order adopting an examination report are prima facie evidence in any legal or regulatory action. [2009 c 104 § 9.]

48.102.070 Advertising. (1) A broker, or provider licensed pursuant to this chapter, may conduct or participate in advertisements within this state. These advertisements shall comply with all advertising and marketing laws or rules

adopted by the commissioner that are applicable to life insurers or to brokers, and providers licensed pursuant to this chapter.

(2) Advertisements shall be accurate, truthful, and not misleading in fact or by implication.

(3) A person or trust shall not:

(a) Directly or indirectly, market, advertise, solicit, or otherwise promote the purchase of a policy, not previously issued, for the sole purpose of, or with the primary emphasis on, settling the policy; or

(b) Use the words "free," "no cost," or words of similar import in the marketing, advertising, soliciting or otherwise promoting of the purchase of a policy. [2009 c 104 § 10.]

48.102.080 Disclosures to owners. (1) The provider or broker shall provide in writing, or require the broker to provide, in a separate document that is signed by the owner and provider or broker, the following information to the owner no later than the date of application for a life settlement contract:

(a) The fact that possible alternatives to life settlement contracts exist, including, but not limited to, accelerated benefits offered by the issuer of the life insurance policy;

(b) The fact that some or all of the proceeds of a life settlement contract may be taxable and that assistance should be sought from a professional tax advisor;

(c) The fact that the proceeds from a life settlement contract could be subject to the claims of creditors;

(d) The fact that receipt of proceeds from a life settlement contract may adversely affect the recipients' eligibility for public assistance or other government benefits or entitlements and that advice should be obtained from the appropriate agencies;

(e) The fact that the owner has a right to terminate a life settlement contract within fifteen days of the date it is executed by all parties and the owner has received the disclosures required by this section. Rescission, if exercised by the owner, is effective only if both notice of the rescission is given, and the owner repays all proceeds and any premiums, loans, and loan interest paid on account of the provider within the rescission period. If the insured dies during the rescission period, the contract shall be deemed to have been rescinded subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans, and loan interest to the provider;

(f) The fact that proceeds will be sent to the owner within three business days after the provider has received the insurer or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated in accordance with the terms of the life settlement contract;

(g) The fact that entering into a life settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy to be forfeited by the owner and that assistance should be sought from a professional financial advisor;

(h) The date by which the funds will be available to the owner and the transmitter of the funds;

(i) The fact that the commissioner may require delivery of a buyer's guide or a similar consumer advisory package in the form prescribed by the commissioner to owners during the solicitation process;

(j) The disclosure document shall contain the following language:

"All medical, financial, or personal information solicited or obtained by a provider or broker about an insured, including the insured's identity or the identity of family members, a spouse or a significant other may be disclosed as necessary to effect the life settlement contract between the owner and provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years.";

(k) A separate signed fraud warning as follows:

"Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.";

(l) The fact that the insured may be contacted by either the provider or broker or its authorized representative for the purpose of determining the insured's health status or to verify the insured's address. This contact is limited to once every three months if the insured has a life expectancy of more than one year, and no more than once per month if the insured has a life expectancy of one year or less;

(m) The affiliation, if any, between the provider and the issuer of the insurance policy to be settled;

(n) That a broker represents exclusively the owner, and not the insurer or the provider or any other person, and owes a fiduciary duty to the owner, including a duty to act according to the owner's instructions and in the best interest of the owner;

(o) The document shall include the name, address, and telephone number of the provider;

(p) The name, business address, and telephone number of the independent third-party escrow agent, and the fact that the owner may inspect or receive copies of the relevant escrow or trust agreements or documents; and

(q) The fact that a change of ownership could in the future limit the insured's ability to purchase future insurance on the insured's life because there is a limit to how much coverage insurers will issue on one life.

(2) The written disclosures shall be conspicuously displayed in any life settlement contract furnished to the owner by a provider including any affiliations or contractual arrangements between the provider and the broker.

(3) A broker shall provide the owner and the provider with at least the following disclosures no later than the date the life settlement contract is signed by all parties. The disclosures shall be conspicuously displayed in the life settlement contract or in a separate document signed by the owner and provide the following information:

(a) The name, business address, and telephone number of the broker;

(b) A full, complete, and accurate description of all the offers, counter-offers, acceptances, and rejections relating to the proposed life settlement contract;

(c) A written disclosure of any affiliations or contractual arrangements between the broker and any person making an offer in connection with the proposed life settlement contracts;

(d) The name of each broker who receives compensation and the amount of compensation received by that broker, which compensation includes anything of value paid or given to the broker in connection with the life settlement contract;

(e) A complete reconciliation of the gross offer or bid by the provider to the net amount of proceeds or value to be received by the owner. For the purpose of this section, gross offer or bid means the total amount or value offered by the provider for the purchase of one or more life insurance policies, inclusive of commissions and fees; and

(f) The failure to provide the disclosures or rights described in this section is an unfair trade practice pursuant to RCW 48.102.180. [2009 c 104 § 11.]

48.102.090 Disclosure by insurer. In addition to other questions an insurance carrier may lawfully pose to a life insurance applicant, insurance carriers may inquire in the application for insurance whether the proposed owner intends to pay premiums with the assistance of financing from a lender that will use the policy as collateral to support the financing.

(1) If, as described in RCW 48.102.006, the loan provides funds which can be used for a purpose other than paying for the premiums, costs, and expenses associated with obtaining and maintaining the life insurance policy and loan, the application shall be rejected as a violation of the prohibited practices in RCW 48.102.130.

(2) If the financing does not violate RCW 48.102.130 in this manner, the insurance carrier:

(a) May make disclosures, including but not limited to the applicant and the insured, either on the application or an amendment to the application to be completed no later than the delivery of the policy:

"If you have entered into a loan arrangement where the policy is used as collateral, and the policy does change ownership at some point in the future in satisfaction of the loan, the following may be true:

(i) A change of ownership could lead to a stranger owning an interest in the insured's life;

(ii) A change of ownership could in the future limit your ability to purchase future insurance on the insured's life because there is a limit to how much coverage insurers will issue on one life;

(iii) Should there be a change of ownership and you wish to obtain more insurance coverage on the insured's life in the future, the insured's higher issue age, a change in health status, and/or other factors may reduce the ability to obtain coverage and/or may result in significantly higher premiums;

(iv) You should consult a professional advisor, since a change in ownership in satisfaction of the loan may result in tax consequences to the owner, depending on the structure of the loan"; and

(b) May require certifications, such as the following, from the applicant and/or the insured:

"(i) I have not entered into any agreement or arrangement providing for the future sale of this life insurance policy;

(ii) My loan arrangement for this policy provides funds sufficient to pay for some or all of the premiums, costs, and expenses associated with obtaining and maintaining my life insurance policy, but I have not entered into any agreement

by which I am to receive consideration in exchange for procuring this policy; and

(iii) The borrower has an insurable interest in the insured." [2009 c 104 § 12.]

48.102.100 Notice to insured of alternative transactions—Document approved by commissioner. (1) With respect to each policy issued by an insurance company, the insurance company shall notify the owner of an individual life insurance policy when the insured person under such a policy is age sixty or older, or is known to be terminally ill or chronically ill, that there may be alternative transactions available to that owner at the time of each of the following:

(a) When a life insurance company receives from such an owner a request to surrender, in whole or in part, an individual policy;

(b) When a life insurance company receives from such an owner a request to receive an accelerated death benefit under an individual policy;

(c) When a life insurance company sends to such an owner all notices of lapse of an individual policy; or

(d) At any other time that the commissioner may require by rule.

(2)(a) The commissioner shall approve a document calculated to appraise the consumer of his or her rights as an owner of a life insurance policy. The document shall be made available at no cost to all insurance companies and life insurance producers and written in lay terms.

(b) The document shall advise the consumer:

(i) That life insurance is a critical part of a broader financial plan, and that the consumer is encouraged, and has a right, to seek additional financial advice and opinions;

(ii) That possible alternatives to lapse exist; and

(iii) Of the definitions of common industry terms.

(c) In addition to the information described in (a) and (b) of this subsection, the document must contain the following statement in large, bold, or otherwise conspicuous typeface calculated to draw the eye: "Life insurance is a critical part of a broader financial plan. There are many options available, and you have the right to shop around and seek advice from different financial advisers in order to find the option best suited to your needs."

(d) The document may include brief descriptions of common products available from providers. These products must be discussed in general terms for informative purposes only, and not identifiable to any specific provider.

(e) The document will be considered part of the notice required in subsection (1) of this section. [2009 c 104 § 13.]

48.102.110 General rules. (1) A provider entering into a life settlement contract with any owner of a policy, wherein the insured is terminally or chronically ill, shall first obtain:

(a) If the owner is the insured, a written statement from a licensed attending physician that the owner is of sound mind and under no constraint or undue influence to enter into a settlement contract; and

(b) A document in which the insured consents to the release of his or her medical records to a provider, settlement broker, or insurance producer and, if the policy was issued less than two years from the date of application for a settle-

ment contract, to the insurance company that issued the policy.

(2) The insurer shall respond to a request for verification of coverage submitted by a provider, settlement broker, or life insurance producer not later than thirty calendar days of the date the request is received. The request for verification of coverage must be made on a form approved by the commissioner. The insurer shall complete and issue the verification of coverage or indicate in which respects it is unable to respond. In its response, the insurer shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation at this time regarding the validity of the insurance contract.

(3) Before or at the time of execution of the settlement contract, the provider shall obtain a witnessed document in which the owner consents to the settlement contract, represents that the owner has a full and complete understanding of the settlement contract, that the owner has a full and complete understanding of the benefits of the policy and acknowledges that the owner is entering into the settlement contract freely and voluntarily, and, for persons with a terminal or chronic illness or condition, acknowledges that the insured has a terminal or chronic illness and that the terminal or chronic illness or condition was diagnosed after the policy was issued.

(4) The insurer shall not unreasonably delay effecting change of ownership or beneficiary with any life settlement contract lawfully entered into in this state or with a resident of this state.

(5) If a settlement broker or life insurance producer performs any of these activities required of the provider, the provider is deemed to have fulfilled the requirements of this section.

(6) If a broker performs the verification of coverage activities required of the provider, the provider has fulfilled the requirements of RCW 48.102.080(1).

(7) Within twenty days after an owner executes the life settlement contract, the provider shall give written notice to the insurer that issued that insurance policy that the policy has become subject to a life settlement contract. The notice shall be accompanied by the documents required by RCW 48.102.090(2).

(8) All medical information solicited or obtained by any licensee shall be subject to the applicable provision of state law relating to confidentiality of medical information, if not otherwise provided in this chapter.

(9) All life settlement contracts entered into in this state shall provide that the owner may rescind the contract on or before fifteen days after the date it is executed by all parties thereto. Rescission, if exercised by the owner, is effective only if both notice of the rescission is given, and the owner repays all proceeds and any premiums, loans, and loan interest paid on account of the provider within the rescission period. If the insured dies during the rescission period, the contract is considered rescinded subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans, and loan interest to the provider.

(10) Within three business days after receipt from the owner of documents to effect the transfer of the insurance policy, the provider shall pay the proceeds of the settlement to an escrow or trust account managed by a trustee or escrow

agent in a state or federally chartered financial institution pending acknowledgment of the transfer by the issuer of the policy. The trustee or escrow agent shall be required to transfer the proceeds due to the owner within three business days of acknowledgment of the transfer from the insurer.

(11) Failure to tender the life settlement contract proceeds to the owner by the date disclosed to the owner renders the contract voidable by the owner for lack of consideration until the time the proceeds are tendered to and accepted by the owner. A failure to give written notice of the right of rescission under this section tolls the right of rescission until thirty days after the written notice of the right of rescission has been given.

(12) Any fee paid by a provider, party, individual, or an owner to a broker in exchange for services provided to the owner pertaining to a life settlement contract shall be computed as a percentage of the offer obtained, not the face value of the policy. This section does not prohibit a broker from reducing the broker's fee below this percentage if the broker so chooses.

(13) The broker shall disclose to the owner anything of value paid or given to a broker, which relate to a life settlement contract.

(14) A person at any time prior to, or at the time of, the application for, or issuance of, a policy, or during a two-year period commencing with the date of issuance of the policy, shall not enter into a life settlement regardless of the date the compensation is to be provided and regardless of the date the assignment, transfer, sale, devise, bequest, or surrender of the policy is to occur. This prohibition shall not apply if the owner certifies to the provider that:

(a) The policy was issued upon the owner's exercise of conversion rights arising out of a group or individual policy, provided the total of the time covered under the conversion policy plus the time covered under the prior policy is at least twenty-four months. The time covered under a group policy must be calculated without regard to a change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship; or

(b) The owner submits independent evidence to the provider that one or more of the following conditions have been met within the two-year period:

- (i) The owner or insured is terminally or chronically ill;
- (ii) The owner or insured disposes of his or her ownership interests in a closely held corporation, pursuant to the terms of a buyout or other similar agreement in effect at the time the insurance policy was initially issued;
- (iii) The owner's spouse dies;
- (iv) The owner divorces his or her spouse;
- (v) The owner retires from full-time employment;
- (vi) The owner becomes physically or mentally disabled and a physician determines that the disability prevents the owner from maintaining full-time employment; or
- (vii) A final order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor of the owner, adjudicating the owner bankrupt or insolvent, or approving a petition seeking reorganization of the owner or appointing a receiver, trustee, or liquidator to all or a substantial part of the owner's assets;

(c) Copies of the independent evidence required by (b) of this subsection shall be submitted to the insurer when the pro-

vider submits a request to the insurer for verification of coverage. The copies shall be accompanied by a letter of attestation from the provider that the copies are true and correct copies of the documents received by the provider. This section does not prohibit an insurer from exercising its right to contest the validity of any policy;

(d) If the provider submits to the insurer a copy of independent evidence provided for in (b)(i) of this subsection when the provider submits a request to the insurer to effect the transfer of the policy to the provider, the copy is deemed to establish that the settlement contract satisfies the requirements of this section. [2009 c 104 § 14.]

48.102.120 Conflict of laws. (1) If there is more than one owner on a single policy, and the owners are residents of different states, the life settlement contract shall be governed by the law of the state in which the owner having the largest percentage ownership resides or, if the owners hold equal ownership, the state of residence of one owner agreed upon in writing by all of the owners. The law of the state of the insured shall govern in the event that equal owners fail to agree in writing upon a state of residence for jurisdictional purposes.

(2) A provider from this state who enters into a life settlement contract with an owner who is a resident of another state that has enacted statutes or adopted regulations governing life settlement contracts, shall be governed in the effectuation of that life settlement contract by the statutes and regulations of the owner's state of residence. If the state in which the owner is a resident has not enacted statutes or regulations governing life settlement contracts, the provider shall give the owner notice that neither state regulates the transaction upon which he or she is entering. For transactions in those states, however, the provider is to maintain all records required if the transactions were executed in the state of residence. The forms used in those states need not be approved by the commissioner.

(3) If there is a conflict in the laws that apply to an owner and a purchaser in any individual transaction, the laws of the state that apply to the owner shall take precedence and the provider shall comply with those laws. [2009 c 104 § 15.]

48.102.130 Prohibited practices. (1) It is unlawful for any person to:

(a) Enter into a life settlement contract if such person knows or reasonably should have known that the life insurance policy was obtained by means of a false, deceptive or misleading application for such policy;

(b) Engage in any transaction, practice, or course of business if such person knows or reasonably should have known that the intent was to avoid the notice requirements of this chapter;

(c) Engage in any fraudulent act or practice in connection with any transaction relating to any settlement involving an owner who is a resident of this state;

(d) Issue, solicit, market, or otherwise promote the purchase of an insurance policy, not previously issued, for the sole purpose of, or with the primary emphasis on, settling the policy;

(e) If providing premium financing, receive any proceeds, fees, or other consideration from the policy or owner

of the policy that are in addition to the amounts required to pay principal, interest, and any costs or expenses incurred by the lender or borrower in connection with the premium finance agreement, except for the event of a default, unless either the default on such a loan or transfer of the policy occurs pursuant to an agreement or understanding with any other person for the purpose of evading regulation under this chapter. Any payments, charges, fees, or other amounts received by a person providing premium financing in violation of this subsection shall be remitted to the original owner of the policy or to the original owner's estate if the original owner is not living at the time of the determination of overpayment;

(f) With respect to any settlement contract or insurance policy and a broker, knowingly solicit an offer from, effectuate a life settlement contract with, or make a sale to any provider, financing entity, or related provider trust that is controlling, controlled by, or under common control with such broker unless this relationship is disclosed to the owner;

(g) With respect to any life settlement contract or insurance policy and a provider, knowingly enter into a life settlement contract with an owner, if, in connection with such life settlement contract, anything of value will be paid to a broker that is controlling, controlled by, or under common control with such provider or the financing entity or related provider trust that is involved in such settlement contract, unless this relationship is disclosed to the owner;

(h) With respect to a provider, enter into a life settlement contract unless the life settlement promotional, advertising, and marketing materials, as may be prescribed by rule, have been filed with the commissioner. In no event shall any marketing materials expressly reference that the insurance is "free" for any period of time. The inclusion of any reference in the marketing materials that would cause an owner to reasonably believe that the insurance is free for any period of time is a violation of this chapter;

(i) With respect to any life insurance producer, insurance company, broker, or provider make any statement or representation to the applicant or policyholder in connection with the sale or financing of a life insurance policy to the effect that the insurance is free or without cost to the policyholder for any period of time unless provided in the policy; or

(j) With respect to an insurer, engage in any transaction, act, practice, or course of business or dealing which restricts, limits, or impairs in any way the lawful transfer of ownership, change of beneficiary, or assignment of a policy.

(2) A violation of this section constitutes a fraudulent life settlement act. [2009 c 104 § 16.]

48.102.140 Fraud prevention and control. (1)(a) A person shall not commit a fraudulent life settlement act.

(b) A person shall not knowingly and intentionally interfere with the enforcement of this chapter or investigations of suspected or actual violations of this chapter.

(c) A person in the business of life settlements shall not knowingly or intentionally permit any person convicted of a felony involving dishonesty or breach of trust to participate in the business of life settlements.

(2)(a) Life settlement contracts and applications for life settlement contracts, regardless of the form of transmission,

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shall contain the following statement or a substantially similar statement:

"Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison."

(b) The lack of a statement as required in (a) of this subsection does not constitute a defense in any prosecution for a fraudulent life settlement act.

(3)(a) Any person engaged in the business of life settlements having knowledge or a reasonable belief that a fraudulent life settlement act is being, will be, or has been committed shall provide to the commissioner the information required by, and in a manner prescribed by, the commissioner.

(b) Any other person having knowledge or a reasonable belief that a fraudulent life settlement act is being, will be, or has been committed may provide to the commissioner the information required by, and in a manner prescribed by, the commissioner.

(4)(a) Civil liability shall not be imposed on and no cause of action shall arise from a person's furnishing information concerning suspected, anticipated, or completed fraudulent life settlement acts or suspected or completed fraudulent insurance acts, if the information is provided to or received from:

(i) The commissioner or the commissioner's employees, agents, or representatives;

(ii) Federal, state, or local law enforcement or regulatory officials or their employees, agents, or representatives;

(iii) A person involved in the prevention and detection of fraudulent life settlement acts or that person's agents, employees, or representatives;

(iv) Any regulatory body or their employees, agents, or representatives, overseeing life insurance, life settlements, securities, or investment fraud;

(v) The life insurer that issued the life insurance policy covering the life of the insured; or

(vi) Either a broker or provider, or both and any agents, employees, or representatives.

(b) Subsection (4)(a) of this section shall not apply to statements made with actual malice. In an action brought against a person for filing a report or furnishing other information concerning a fraudulent life settlement act or a fraudulent insurance act, the party bringing the action shall plead specifically any allegation that (a) of this subsection does not apply because the person filing the report or furnishing the information did so with actual malice.

(c) A person identified in (a) of this subsection shall be entitled to an award of attorneys' fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of this chapter and the party bringing the action was not substantially justified in doing so. For purposes of this section a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

(d) This section does not abrogate or modify common law or statutory privileges or immunities enjoyed by a person described in (a) of this subsection.

(5)(a) The documents and evidence provided pursuant to subsection (4) of this section or obtained by the commissioner in an investigation of suspected or actual fraudulent life settlement acts shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

(b) Subsection (5)(a) of this section does not prohibit release by the commissioner of documents and evidence obtained in an investigation of suspected or actual fraudulent life settlement acts:

(i) In administrative or judicial proceedings to enforce laws administered by the commissioner;

(ii) To federal, state, or local law enforcement or regulatory agencies, to an organization established for the purpose of detecting and preventing fraudulent life settlement acts, or to the national association of insurance commissioners; or

(iii) At the discretion of the commissioner, to a person in the business of life settlements that is aggrieved by a fraudulent life settlement act.

(c) Release of documents and evidence under (b) of this subsection does not abrogate or modify the privilege granted in (a) of this subsection.

(6) This chapter does not:

(a) Preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine, and prosecute suspected violations of law;

(b) Preempt, supersede, or limit any provision of chapter 21.20 RCW or any rule, order, or notice issued thereunder;

(c) Prevent or prohibit a person from disclosing voluntarily information concerning life settlement fraud to a law enforcement or regulatory agency other than the commissioner; or

(d) Limit the powers granted elsewhere by the laws of this state to the commissioner or an insurance fraud unit to investigate and examine possible violations of law and to take appropriate action against wrongdoers.

(7)(a) Providers and brokers shall have in place antifraud initiatives reasonably calculated to detect, prosecute, and prevent fraudulent life settlement acts. At the discretion of the commissioner, the commissioner may order, or either a broker or provider, or both may request and the commissioner may grant, such modifications of the following required initiatives as necessary to ensure an effective antifraud program. The modifications may be more or less restrictive than the required initiatives so long as the modifications may reasonably be expected to accomplish the purpose of this section. Antifraud initiatives shall include:

(i) Fraud investigators, who may be provider or broker employees or independent contractors; and

(ii) An antifraud plan, which shall be submitted to the commissioner. The antifraud plan shall include, but not be limited to:

(A) A description of the procedures for detecting and investigating possible fraudulent life settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(B) A description of the procedures for reporting possible fraudulent life settlement acts to the commissioner;

(C) A description of the plan for antifraud education and training of underwriters and other personnel; and

(D) A description or chart outlining the organizational arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent life settlement acts and investigating unresolved material inconsistencies between medical records and insurance applications.

(b) Antifraud plans submitted to the commissioner shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action. [2009 c 104 § 17.]

48.102.150 Enforcement. (1) The commissioner may conduct investigations to determine whether any person has violated any provision of this chapter.

(2) If the commissioner has cause to believe that any person is violating or is about to violate any provision of this title or any regulation or order of the commissioner, the commissioner may:

(a) Issue a cease and desist order; and/or

(b) Bring an action in any court of competent jurisdiction to enjoin the person from continuing the violation or doing any action in furtherance thereof. [2009 c 104 § 18.]

48.102.160 Penalties. (1) For the purpose of this section, an act is committed in this state if it is committed, in whole or in part, in the state of Washington, or affects persons or property within this state and relates to or involves a life settlement contract.

(2) It is a violation of this chapter for any person, provider, broker, or any other party related to the business of life settlements, to commit a fraudulent life settlement act.

(3) For criminal liability purposes, a person that knowingly commits a fraudulent life settlement act is guilty of a class B felony punishable under chapter 9A.20 RCW.

(4) Any person who knowingly acts as a life settlement provider without being licensed by the commissioner is guilty of a class B felony punishable under chapter 9A.20 RCW.

(5) Any person who knowingly acts as a life settlement broker without the proper authorization under this chapter is guilty of a class B felony punishable under chapter 9A.20 RCW.

(6) Any criminal penalty imposed under this section is in addition to, and not in lieu of, any other civil or administrative penalty or sanction otherwise authorized under state law.

(7) If the commissioner has cause to believe that any person has:

(a) Knowingly acted as a life settlement provider without being licensed by the commissioner; or

(b) Knowingly acted as a life settlement broker without the proper authorization under RCW 48.102.021; the commissioner may assess a civil penalty of not more than twenty-five thousand dollars for each violation, after providing notice and an opportunity for a hearing in accordance with chapters 34.05 and 48.04 RCW.

(8) Upon failure to pay a civil penalty when due, the attorney general may bring a civil action on behalf of the commissioner to recover the unpaid penalty. Any amounts collected by the commissioner must be paid to the state treasurer for the account of the general fund. [2009 c 104 § 19.]

48.102.170 Authority to adopt rules. The commissioner may adopt rules implementing and administering this chapter including, but not limited to:

- (1) Establishing standards for evaluating reasonableness of payments under life settlement contracts for persons who are terminally ill or chronically ill including, but not limited to, regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise, or bequest of a benefit under a life insurance policy insuring the life of a person that is chronically or terminally ill;
- (2) Requiring a bond or other mechanism for financial accountability for life settlement providers; and
- (3) Governing the activities, relationships, and responsibilities of providers, brokers, insurers, and their agents. [2009 c 104 § 20.]

48.102.180 Unfair trade practices. The legislature finds that the practices covered by this chapter are matters vitally affecting the public interest for the purpose of applying the consumer protection act, chapter 19.86 RCW. A violation of this chapter is not reasonable in relation to the development and preservation of business and is an unfair or deceptive act in trade or commerce and an unfair method of competition for the purpose of applying the consumer protection act, chapter 19.86 RCW. [2009 c 104 § 21.]

48.102.193 Existing rights or liabilities—July 26, 2009. Chapter 104, Laws of 2009 does not affect any existing right acquired or liability or obligation incurred under the sections repealed in chapter 104, Laws of 2009 or under any rule or order adopted under those sections, nor does it affect any proceeding instituted under those sections. [2009 c 104 § 26.]

**Chapter 48.110 RCW
SERVICE CONTRACTS AND PROTECTION
PRODUCT GUARANTEES**

Sections

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48.110.902	Application of chapter to motor vehicle manufacturers or import distributors.
48.110.904	Effective date—2006 c 274.

48.110.010 Finding—Declaration—Purpose. The legislature finds that increasing numbers of businesses are selling service contracts for repair, replacement, and maintenance of motor vehicles, appliances, computers, electronic equipment, and other consumer products. There are risks that contract obligors will close or otherwise be unable to fulfill their contract obligations that could result in unnecessary and preventable losses to citizens of this state. The legislature declares that it is necessary to establish standards that will safeguard the public from possible losses arising from the conduct or cessation of the business of service contract obligors or the mismanagement of funds paid for service contracts. The purpose of this chapter is to create a legal framework within which service contracts may be sold in this state and to set forth requirements for conducting a service contract business. [2006 c 274 § 1; 1999 c 112 § 1.]

48.110.015 Exempt from title—Application of chapter. (1) The following are exempt from this title:

- (a) Warranties;
- (b) Maintenance agreements;
- (c) Service contracts:
 - (i) Paid for with separate and additional consideration;
 - (ii) Issued at the point of sale, or within sixty days of the original purchase date of the property; and
 - (iii) On tangible property when the tangible property for which the service contract is sold has a purchase price of fifty dollars or less, exclusive of sales tax; and
- (d) Agreements whereby a third party contracted by an employer provides mileage reimbursement and incidental maintenance and repairs to the employer's employees for personal vehicles used for business purposes, provided that such agreement does not provide indemnification or repairs for a loss caused by theft, collision, fire, or other peril typically covered in the comprehensive section of an automobile insurance policy.

(2) This chapter does not apply to:

- (a) Vehicle mechanical breakdown insurance;
- (b) Service contracts on tangible personal property purchased by persons who are not consumers; and
- (c) Home heating fuel service contracts offered by home heating energy providers. [2016 c 125 § 1. Prior: 2006 c 274 § 2; 2006 c 36 § 16; 2000 c 208 § 1; 1999 c 112 § 2.]

48.110.017 Application of chapter. This chapter does not prohibit a service contract provider from covering, in whole or in part, residential water, sewer, plumbing, electrical, heating and cooling systems, utilities, or similar systems, including items intended to be attached to or installed in any real property, with or without coverage of appliances, or from sharing contract revenue with local governments or other

third parties for endorsements and marketing services. [2019 c 16 § 1; 2013 c 117 § 2.]

48.110.020 Definitions. The definitions in this section apply throughout this chapter.

(1) "Administrator" means the person who is responsible for the administration of the service contracts, the service contracts plan, or the protection product guarantees.

(2) "Commissioner" means the insurance commissioner of this state.

(3) "Consumer" means an individual who buys any tangible personal property that is primarily for personal, family, or household use.

(4) "Home heating fuel service contract" means a contract or agreement for a separately stated consideration for a specific duration to perform the repair, replacement, or maintenance of a home heating fuel supply system including the fuel tank and all visible pipes, caps, lines, and associated parts or the indemnification for repair, replacement, or maintenance for operational or structural failure due to a defect in materials or workmanship, or normal wear and tear.

(5) "Incidental costs" means expenses specified in the guarantee incurred by the protection product guarantee holder related to damages to other property caused by the failure of the protection product to perform as provided in the guarantee. "Incidental costs" may include, without limitation, insurance policy deductibles, rental vehicle charges, the difference between the actual value of the stolen vehicle at the time of theft and the cost of a replacement vehicle, sales taxes, registration fees, transaction fees, and mechanical inspection fees. Incidental costs may be paid under the provisions of the protection product guarantee in either a fixed amount specified in the protection product guarantee or sales agreement, or by the use of a formula itemizing specific incidental costs incurred by the protection product guarantee holder to be paid.

(6) "Maintenance agreement" means a contract of limited duration that provides for scheduled maintenance only.

(7) "Motor vehicle" means any vehicle subject to registration under chapter 46.16A RCW.

(8) "Person" means an individual, partnership, corporation, incorporated or unincorporated association, joint stock company, reciprocal insurer, syndicate, or any similar entity or combination of entities acting in concert.

(9) "Premium" means the consideration paid to an insurer for a reimbursement insurance policy.

(10) "Protection product" means any protective chemical, substance, device, or system offered or sold with a guarantee to repair or replace another product or pay incidental costs upon the failure of the product to perform pursuant to the terms of the protection product guarantee. Protection product does not include fuel additives, oil additives, or other chemical products applied to the engine, transmission, or fuel system of a motor vehicle.

(11) "Protection product guarantee" means a written agreement by a protection product guarantee provider to repair or replace another product or pay incidental costs upon the failure of the protection product to perform pursuant to the terms of the protection product guarantee. The reimbursement of incidental costs promised under a protection product guarantee must be tied to the purchase of a physical product

that is formulated or designed to make the specified loss or damage from a specific cause less likely to occur.

(12) "Protection product guarantee holder" means a person who is the purchaser or permitted transferee of a protection product guarantee.

(13) "Protection product guarantee provider" means a person who is contractually obligated to the protection product guarantee holder under the terms of the protection product guarantee. Protection product guarantee provider does not include an authorized insurer providing a reimbursement insurance policy.

(14) "Protection product seller" means the person who sells the protection product to the consumer.

(15) "Provider fee" means the consideration paid by a consumer for a service contract.

(16) "Reimbursement insurance policy" means a policy of insurance that is issued to a service contract provider or a protection product guarantee provider to provide reimbursement to the service contract provider or the protection product guarantee provider or to pay on behalf of the service contract provider or the protection product guarantee provider all contractual obligations incurred by the service contract provider or the protection product guarantee provider under the terms of the insured service contracts or protection product guarantees issued or sold by the service contract provider or the protection product guarantee provider.

(17) "Road hazard" means a hazard that is encountered while driving a motor vehicle. Road hazards may include but are not limited to potholes, rocks, wood debris, metal parts, glass, plastic, curbs, or composite scraps.

(18)(a) "Service contract" means a contract or agreement entered into at any time for consideration over and above the lease or purchase price of the property for any specific duration to perform the repair, replacement, or maintenance of property or the indemnification for repair, replacement, or maintenance for operational or structural failure due to a defect in materials or workmanship or normal wear and tear. Service contracts may provide for the repair, replacement, or maintenance of property for damage resulting from power surges and accidental damage from handling, with or without additional provision for incidental payment of indemnity under limited circumstances, including towing, rental, emergency road services, or other expenses relating to the failure of the product or of a component part thereof.

(b) "Service contract" also includes a contract or agreement sold for separately stated consideration for a specific duration to perform any one or more of the following services:

(i) The repair or replacement of tires and/or wheels damaged as a result of coming into contact with road hazards. However, a contract or agreement meeting the definition under this subsection (18)(b) in which the party obligated to perform is either a tire or wheel manufacturer or a motor vehicle manufacturer is exempt from the requirements of this chapter;

(ii) The removal of dents, dings, or creases on a motor vehicle that can be repaired using the process of paintless dent removal without affecting the existing paint finish and without replacing vehicle body panels, sanding, bonding, or painting;

(iii) The repair of chips or cracks in, or the replacement of, motor vehicle windshields as a result of damage caused by road hazards;

(iv) The replacement of a motor vehicle key or key fob in the event that the key or key fob becomes inoperable or is lost or stolen;

(v) Services provided pursuant to a protection product guarantee; and

(vi) Other services approved by rule of the commissioner that are not inconsistent with the provisions of this chapter.

(c) "Service contract" does not include coverage for:

(i) Repair or replacement due to damage to the interior surfaces or to the exterior paint or finish of a vehicle. However, coverage for these types of damage may be offered in connection with the sale of a protection product as defined in this section; or

(ii) Fuel additives, oil additives, or other chemical products applied to the engine, transmission, or fuel system of a motor vehicle.

(19) "Service contract holder" or "contract holder" means a person who is the purchaser or holder of a service contract.

(20) "Service contract provider" means a person who is contractually obligated to the service contract holder under the terms of the service contract.

(21) "Service contract seller" means the person who sells the service contract to the consumer.

(22) "Warranty" means a warranty made solely by the manufacturer, importer, or seller of property or services without consideration; that is not negotiated or separated from the sale of the product and is incidental to the sale of the product; and that guarantees indemnity for defective parts, mechanical or electrical breakdown, labor, or other remedial measures, such as repair or replacement of the property or repetition of services. [2014 c 82 § 1; 2013 c 117 § 1; 2011 c 171 § 104. Prior: 2010 c 89 § 1; prior: 2006 c 274 § 3; 2006 c 36 § 17; 2000 c 208 § 2; 1999 c 112 § 3.]

Intent—Effective date—2011 c 171: See notes following RCW 4.24.210.

48.110.030 Registration required—Application—Required information—Grounds for refusal—Annual renewal. (1) A person may not act as, or offer to act as, or hold himself or herself out to be a service contract provider in this state, nor may a service contract be sold to a consumer in this state, unless the service contract provider has a valid registration as a service contract provider issued by the commissioner.

(2) Applicants to be a service contract provider must make an application to the commissioner upon a form to be furnished by the commissioner. The application must include or be accompanied by the following information and documents:

(a) All basic organizational documents of the service contract provider, including any articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement, bylaws, and other applicable documents, and all amendments to those documents;

(b) The identities of the service contract provider's executive officer or officers directly responsible for the service

contract provider's service contract business, and, if more than fifty percent of the service contract provider's gross revenue is derived from the sale of service contracts, the identities of the service contract provider's directors and stockholders having beneficial ownership of ten percent or more of any class of securities;

(c)(i) For service contract providers relying on RCW 48.110.050(2) (a) or (b) or 48.110.075(2)(a) to assure the faithful performance of its obligations to service contract holders, the most recent audited annual financial statements, if available, or the most recent audited financial statements which prove that the applicant has and maintains a minimum net worth or stockholder's equity of two hundred thousand dollars or more calculated in accordance with RCW 48.110.078 and the ability to pay its debts when debts become due. In lieu of submitting audited financial statements, a service contract provider relying on RCW 48.110.050(2)(a) or 48.110.075(2)(a) to assure the faithful performance of its obligations to service contract holders may comply with the requirements of this subsection (2)(c)(i) by submitting the most recent annual financial statements, if available, or the most recent financial statements of the applicant that are certified as accurate by two or more officers of the applicant; or

(ii) For service contract providers relying on RCW 48.110.050(2)(c) to assure the faithful performance of its obligations to service contract holders, the most recent audited annual financial statements, if available, or the most recent audited financial statements or form 10-K or form 20-F filed with the securities and exchange commission which prove that the applicant has and maintains a net worth or stockholder's equity of one hundred million dollars or more. However, if the service contract provider is relying on its parent company's net worth or stockholder's equity to meet the requirements of RCW 48.110.050(2)(c) and the service contract provider has provided the commissioner with a written guarantee by the parent company in accordance with RCW 48.110.050(2)(c), then the most recent audited annual financial statements, if available, or the most recent audited financial statements or form 10-K or form 20-F filed with the securities and exchange commission of the service contract provider's parent company must be filed and the applicant need not submit its own financial statements or demonstrate a minimum net worth or stockholder's equity; and

(d) An application fee of two hundred fifty dollars, which must be deposited into the general fund.

(3) Each registered service contract provider must appoint the commissioner as the service contract provider's attorney to receive service of legal process issued against the service contract provider in this state upon causes of action arising within this state. Service upon the commissioner as attorney constitutes effective legal service upon the service contract provider.

(a) With the appointment the service contract provider must designate the person to whom the commissioner must forward legal process so served upon him or her.

(b) The appointment is irrevocable, binds any successor in interest or to the assets or liabilities of the service contract provider, and remains in effect for as long as there could be any cause of action against the service contract provider aris-

ing out of any of the service contract provider's contracts or obligations in this state.

(c) The service of process must be accomplished and processed in the manner prescribed under RCW 48.02.200.

(4) The commissioner may refuse to issue a registration if the commissioner determines that the service contract provider, or any individual responsible for the conduct of the affairs of the service contract provider under subsection (2)(b) of this section, is not competent, trustworthy, cannot demonstrate a minimum net worth or stockholder's equity and the ability to pay its debts when debts become due in accordance with the applicable requirements of subsection (2)(c) of this section, or has had a license as a service contract provider or similar license denied or revoked for cause by any state.

(5) A registration issued under this section is valid, unless surrendered, suspended, or revoked by the commissioner, or not renewed for so long as the service contract provider continues in business in this state and remains in compliance with this chapter. A registration is subject to renewal annually on the first day of July upon application of the service contract provider and payment of a fee of two hundred dollars, which must be deposited into the general fund. If not so renewed, the registration expires on the June 30th next preceding.

(6) A service contract provider must keep current the information required to be disclosed in its registration under this section by reporting all material changes or additions within thirty days after the end of the month in which the change or addition occurs. [2019 c 16 § 2; 2016 c 224 § 1; 2014 c 82 § 2; 2011 c 47 § 16; 2006 c 274 § 4; 2005 c 223 § 33; 1999 c 112 § 4.]

48.110.033 Application of RCW 48.110.030—Exceptions. (1) Except for service contract providers or protection product guarantee providers, persons marketing, selling, or offering to sell service contracts or protection products for providers are exempt from the registration requirements of RCW 48.110.030.

(2) The marketing, sale, offering for sale, issuance, making, proposing to make, and administration of service contracts or protection products by service contract providers or protection product guarantee providers and related service contract or protection product sellers, administrators, and other persons complying with this chapter are exempt from the other provisions of this title, except chapters 48.04 and 48.30 RCW and as otherwise provided in this chapter. [2006 c 274 § 19.]

48.110.040 Filing of annual report—Fee—Investigations—Confidentiality. (1)(a) Every registered service contract provider must file an annual report for the preceding calendar year with the commissioner on or before March 1st of each year, or within any extension of time the commissioner for good cause may grant. The report must be in the form and contain those matters as the commissioner prescribes and shall be verified by at least two officers of the service contract provider.

(b)(i) A service contract provider relying on RCW 48.110.050(2)(a) or 48.110.075(2)(a) to assure the faithful performance of its obligations to service contract holders

may not be required to submit audited financial statements of the service contract provider as part of its annual reports. If requested by the commissioner, a service contract provider relying on those provisions must provide a copy of the most recent annual financial statements of the service contract provider or its parent company certified as accurate by two officers of the service contract provider or its parent company.

(ii) A service contract provider relying on its parent company's net worth to meet the requirements of RCW 48.110.050(2)(c) to assure the faithful performance of its obligations to service contract holders must submit as part of its annual report the most recent audited financial statements or form 10-K or form 20-F filed with the United States securities and exchange commission of the service contract provider's parent company if requested by the commissioner but need not submit its own audited financial statements.

(2) At the time of filing the report, the service contract provider must pay a filing fee of twenty dollars which shall be deposited into the general fund.

(3) As part of any investigation by the commissioner, the commissioner may require a service contract provider to file monthly financial reports whenever, in the commissioner's discretion, there is a need to more closely monitor the financial activities of the service contract provider. Monthly financial statements must be filed in the commissioner's office no later than the twenty-fifth day of the month following the month for which the financial report is being filed. These monthly financial reports are the internal financial statements of the service contract provider. The monthly financial reports that are filed with the commissioner constitute information that might be damaging to the service contract provider if made available to its competitors, and therefore shall be kept confidential by the commissioner. This information may not be made public or be subject to subpoena, other than by the commissioner and then only for the purpose of enforcement actions taken by the commissioner. [2016 c 224 § 2; 2006 c 274 § 5; 2005 c 223 § 34; 1999 c 112 § 5.]

48.110.050 Obligations of service contract provider—Limited application. (1) Service contracts shall not be issued, sold, or offered for sale in this state or sold to consumers in this state unless the service contract provider has:

(a) Provided a receipt for, or other written evidence of, the purchase of the service contract to the contract holder; and

(b) Provided a copy of the service contract to the service contract holder within a reasonable period of time from the date of purchase.

(2) In order to either demonstrate its financial responsibility or assure the faithful performance of the service contract provider's obligations to its service contract holders, every service contract provider shall comply with the requirements of one of the following:

(a) Insure all service contracts under a reimbursement insurance policy issued by an insurer holding a certificate of authority from the commissioner or a risk retention group, as defined in 15 U.S.C. Sec. 3901(a)(4), as long as that risk retention group is in full compliance with the federal liability risk retention act of 1986 (15 U.S.C. Sec. 3901 et seq.), is in good standing in its domiciliary jurisdiction, and is properly registered with the commissioner under chapter 48.92 RCW.

The insurance required by this subsection must meet the following requirements:

(i) The insurer or risk retention group must, at the time the policy is filed with the commissioner, and continuously thereafter, maintain surplus as to policyholders and paid-in capital of at least fifteen million dollars and annually file audited financial statements with the commissioner; and

(ii) The commissioner may authorize an insurer or risk retention group that has surplus as to policyholders and paid-in capital of less than fifteen million dollars, but at least equal to ten million dollars, to issue the insurance required by this subsection if the insurer or risk retention group demonstrates to the satisfaction of the commissioner that the company maintains a ratio of direct written premiums, wherever written, to surplus as to policyholders and paid-in capital of not more than three to one;

(b)(i) Maintain a funded reserve account for its obligations under its service contracts issued and outstanding in this state. The reserves shall not be less than forty percent of the gross consideration received, less claims paid, on the sale of the service contract for all in-force contracts. The reserve account shall be subject to examination and review by the commissioner; and

(ii) Place in trust with the commissioner a financial security deposit, having a value of not less than five percent of the gross consideration received, less claims paid, on the sale of the service contract for all service contracts issued and in force, but not less than twenty-five thousand dollars, consisting of one of the following:

(A) A surety bond issued by an insurer holding a certificate of authority from the commissioner;

(B) Securities of the type eligible for deposit by authorized insurers in this state;

(C) Cash;

(D) An irrevocable evergreen letter of credit issued by a qualified financial institution; or

(E) Another form of security prescribed by rule by the commissioner; or

(c)(i) Maintain, or its parent company maintain, a net worth or stockholder's equity of at least one hundred million dollars; and

(ii) Upon request, provide the commissioner with a copy of the service contract provider's or, if using the net worth or stockholder's equity of its parent company to satisfy the one hundred million dollar requirement, the service contract provider's parent company's most recent form 10-K or form 20-F filed with the securities and exchange commission within the last calendar year, or if the company does not file with the securities and exchange commission, a copy of the service contract provider's or, if using the net worth or stockholder's equity of its parent company to satisfy the one hundred million dollar requirement, the service contract provider's parent company's most recent audited financial statements, which shows a net worth of the service contract provider or its parent company of at least one hundred million dollars. If the service contract provider's parent company's form 10-K, form 20-F, or audited financial statements are filed with the commissioner to meet the service contract provider's financial stability requirement, then the parent company shall agree to guarantee the obligations of the service contract provider relating to service contracts sold by the service contract provider

in this state. A copy of the guarantee shall be filed with the commissioner. The guarantee shall be irrevocable as long as there is in force in this state any contract or any obligation arising from service contracts guaranteed, unless the parent company has made arrangements approved by the commissioner to satisfy its obligations under the guarantee.

(3) Service contracts shall require the service contract provider to permit the service contract holder to return the service contract within twenty days of the date the service contract was mailed to the service contract holder or within ten days of delivery if the service contract is delivered to the service contract holder at the time of sale, or within a longer time period permitted under the service contract. Upon return of the service contract to the service contract provider within the applicable period, if no claim has been made under the service contract prior to the return to the service contract provider, the service contract is void and the service contract provider shall refund to the service contract holder, or credit the account of the service contract holder with the full purchase price of the service contract. The right to void the service contract provided in this subsection is not transferable and shall apply only to the original service contract purchaser. A ten percent penalty per month shall be added to a refund of the purchase price that is not paid or credited within thirty days after return of the service contract to the service contract provider.

(4) This section does not apply to service contracts on motor vehicles or to protection product guarantees. [2016 c 224 § 3; 2006 c 274 § 6; 1999 c 112 § 6.]

48.110.055 Protection product guarantee providers—Obligations—Application—Required information—Grounds for refusal—Annual renewal. (1) This section applies to protection product guarantee providers.

(2) A person must not act as, or offer to act as, or hold himself or herself out to be a protection product guarantee provider in this state, nor may a protection product be sold to a consumer in this state, unless the protection product guarantee provider has:

(a) A valid registration as a protection product guarantee provider issued by the commissioner; and

(b) Either demonstrated its financial responsibility or assured the faithful performance of the protection product guarantee provider's obligations to its protection product guarantee holders by insuring all protection product guarantees under a reimbursement insurance policy issued by an insurer holding a certificate of authority from the commissioner or a risk retention group, as defined in 15 U.S.C. Sec. 3901(a)(4), as long as that risk retention group is in full compliance with the federal liability risk retention act of 1986 (15 U.S.C. Sec. 3901 et seq.), is in good standing in its domiciliary jurisdiction, and properly registered with the commissioner under chapter 48.92 RCW. The insurance required by this subsection must meet the following requirements:

(i) The insurer or risk retention group must, at the time the policy is filed with the commissioner, and continuously thereafter, maintain surplus as to policyholders and paid-in capital of at least fifteen million dollars and annually file audited financial statements with the commissioner; and

(ii) The commissioner may authorize an insurer or risk retention group that has surplus as to policyholders and paid-

in capital of less than fifteen million dollars, but at least equal to ten million dollars, to issue the insurance required by this subsection if the insurer or risk retention group demonstrates to the satisfaction of the commissioner that the company maintains a ratio of direct written premiums, wherever written, to surplus as to policyholders and paid-in capital of not more than three to one.

(3) Applicants to be a protection product guarantee provider must make an application to the commissioner upon a form to be furnished by the commissioner. The application must include or be accompanied by the following information and documents:

(a) The names of the protection product guarantee provider's executive officer or officers directly responsible for the protection product guarantee provider's protection product guarantee business and their biographical affidavits on a form prescribed by the commissioner;

(b) The name, address, and telephone number of any administrators designated by the protection product guarantee provider to be responsible for the administration of protection product guarantees in this state;

(c) A copy of the protection product guarantee reimbursement insurance policy or policies;

(d) A copy of each protection product guarantee the protection product guarantee provider proposes to use in this state;

(e) The most recent annual financial statements, if available, or the most recent financial statements certified as accurate by two or more officers of the applicant which prove that the applicant has and maintains a minimum net worth or stockholder's equity of two hundred thousand dollars or more calculated in accordance with RCW 48.110.078 and the ability to pay its debts when debts become due; and

(f) A nonrefundable application fee of two hundred fifty dollars.

(4) Each registered protection product guarantee provider must appoint the commissioner as the protection product guarantee provider's attorney to receive service of legal process issued against the protection product guarantee provider in this state upon causes of action arising within this state. Service upon the commissioner as attorney constitutes effective legal service upon the protection product guarantee provider.

(a) With the appointment the protection product guarantee provider must designate the person to whom the commissioner must forward legal process so served upon him or her.

(b) The appointment is irrevocable, binds any successor in interest or to the assets or liabilities of the protection product guarantee provider, and remains in effect for as long as there could be any cause of action against the protection product guarantee provider arising out of any of the protection product guarantee provider's contracts or obligations in this state.

(c) The service of process must be accomplished and processed in the manner prescribed under RCW 48.02.200.

(5) The commissioner may refuse to issue a registration if the commissioner determines that the protection product guarantee provider, or any individual responsible for the conduct of the affairs of the protection product guarantee provider under subsection (3)(a) of this section, is not competent, trustworthy, cannot demonstrate a minimum net worth

or stockholder's equity in accordance with the applicable requirements of subsection (3)(e) of this section and the ability to pay its debts when debts become due, or has had a license as a protection product guarantee provider or similar license denied or revoked for cause by any state.

(6) A registration issued under this section is valid, unless surrendered, suspended, or revoked by the commissioner, or not renewed for so long as the protection product guarantee provider continues in business in this state and remains in compliance with this chapter. A registration is subject to renewal annually on the first day of July upon application of the protection product guarantee provider and payment of a fee of two hundred fifty dollars. If not so renewed, the registration expires on the June 30th next preceding.

(7) A protection product guarantee provider must keep current the information required to be disclosed in its registration under this section by reporting all material changes or additions within thirty days after the end of the month in which the change or addition occurs. [2019 c 16 § 3; 2016 c 224 § 4; 2011 c 47 § 17; 2006 c 274 § 17.]

48.110.060 Reimbursement insurance policies insuring service contracts or protection product guarantees.

(1) Reimbursement insurance policies insuring service contracts or protection product guarantees issued, sold, or offered for sale in this state or issued or sold to consumers in this state shall state that the insurer that issued the reimbursement insurance policy shall reimburse or pay on behalf of the service contract provider or the protection product guarantee provider all sums the service contract provider or the protection product guarantee provider is legally obligated to pay, including but not limited to the refund of the full purchase price of the service contract to the service contract holder or shall provide the service which the service contract provider or the protection product guarantee provider is legally obligated to perform according to the service contract provider's or protection product guarantee provider's contractual obligations under the service contracts or protection product guarantees issued or sold by the service contract provider or the protection product guarantee provider.

(2) The reimbursement insurance policy shall fully insure the obligations of the service contract provider or protection product guarantee provider, rather than partially insure, or insure only in the event of service contract provider or protection product guarantee provider default.

(3) The reimbursement insurance policy shall state that the service contract holder or protection product guarantee holder is entitled to apply directly to the reimbursement insurance company for payment or performance due. [2006 c 274 § 7; 1999 c 112 § 7.]

48.110.070 Service contracts—Form—Required contents—Limited application.

(1) Service contracts marketed, sold, offered for sale, issued, made, proposed to be made, or administered in this state or sold to residents of this state shall be written, printed, or typed in clear, understandable language that is easy to read, and disclose the requirements set forth in this section, as applicable.

(2) Service contracts insured under a reimbursement insurance policy under RCW 48.110.050(2)(a) and

48.110.060 shall not be issued, sold, or offered for sale in this state or sold to residents of this state unless the service contract conspicuously contains a statement in substantially the following form: "Obligations of the service contract provider under this service contract are insured under a service contract reimbursement insurance policy." The service contract shall also conspicuously state the name and address of the issuer of the reimbursement insurance policy and state that the service contract holder is entitled to apply directly to the reimbursement insurance company.

(3) Service contracts not insured under a reimbursement insurance policy under RCW 48.110.050(2)(a) and 48.110.060 shall contain a statement in substantially the following form: "Obligations of the service contract provider under this contract are backed by the full faith and credit of the service contract provider."

(4) Service contracts shall state the name and address of the service contract provider and shall identify any administrator if different from the service contract provider, the service contract seller, and the service contract holder to the extent that the name of the service contract holder has been furnished by the service contract holder. The identities of such parties are not required to be preprinted on the service contract and may be added to the service contract at the time of sale.

(5) Service contracts shall state the purchase price of the service contract and the terms under which the service contract is sold. The purchase price is not required to be preprinted on the service contract and may be negotiated at the time of sale.

(6) Service contracts shall state the procedure to obtain service or to file a claim, including but not limited to the procedures for obtaining prior approval for repair work, the toll-free telephone number if prior approval is necessary for service, and the procedure for obtaining emergency repairs performed outside of normal business hours or provide for twenty-four-hour telephone assistance.

(7) Service contracts shall state the existence of any deductible amount, if applicable.

(8) Service contracts shall specify the merchandise, parts, and services to be provided and any limitations, exceptions, or exclusions.

(9) Service contracts shall state any restrictions governing the transferability of the service contract, if applicable.

(10) Service contracts shall state the terms, restrictions, or conditions governing cancellation of the service contract prior to the termination or expiration date of the service contract by either the service contract provider or by the service contract holder, which rights can be no more restrictive than provided in RCW 48.110.050(3). The service contract provider of the service contract shall mail a written notice to the service contract holder at the last known address of the service contract holder contained in the records of the service contract provider at least twenty-one days prior to cancellation by the service contract provider. The notice shall state the effective date of the cancellation and the true and actual reason for the cancellation.

(11) Service contracts shall set forth the obligations and duties of the service contract holder, including but not limited to the duty to protect against any further damage and any requirement to follow owner's manual instructions.

(12) Service contracts shall state whether or not the service contract provides for or excludes consequential damages or preexisting conditions.

(13) Service contracts shall state any exclusions of coverage.

(14) Service contracts shall not contain a provision which requires that any civil action brought in connection with the service contract must be brought in the courts of a jurisdiction other than this state. Service contracts that authorize binding arbitration to resolve claims or disputes must allow for arbitration proceedings to be held at a location in closest proximity to the service contract holder's permanent residence.

This section does not apply to service contracts on motor vehicles or to protection product guarantees. [2006 c 274 § 8; 1999 c 112 § 8.]

48.110.073 Service contract forms—Motor vehicles—Reliance on reimbursement insurance policy. (1) If the service contract provider or protection product guarantee provider is using [the] reimbursement insurance policy to satisfy the requirements of RCW 48.110.050(2)(a), 48.110.055(2)(b), or 48.110.075(2)(a), then the reimbursement insurance policy shall be filed with and approved by the commissioner in accordance with and pursuant to the requirements of chapter 48.18 RCW.

(2) All service contracts forms covering motor vehicles must be filed with and approved by the commissioner prior to the service contract forms being used, issued, delivered, sold, or marketed in this state or to residents of this state.

(3) All service contracts forms covering motor vehicles being used, issued, delivered, sold, or marketed in this state or to residents of this state by motor vehicle manufacturers or import distributors or wholly owned subsidiaries thereof must be filed with the commissioner for approval within sixty days after the motor vehicle manufacturer or import distributor or wholly owned subsidiary thereof begins using the service contracts forms.

(4) The commissioner shall disapprove any motor vehicle service contract form if:

(a) The form is in any respect in violation of, or does not comply with, this chapter or any applicable order or regulation of the commissioner issued under this chapter;

(b) The form contains or incorporates by reference any inconsistent, ambiguous, or misleading clauses, or exceptions and conditions;

(c) The form has any title, heading, or other indication of its provisions that is misleading; or

(d) The purchase of the contract is being solicited by deceptive advertising. [2006 c 274 § 20.]

48.110.075 Service contracts on motor vehicles—Obligations of provider—Contract requirements. (1) This section applies to service contracts on motor vehicles.

(2) Service contracts shall not be issued, sold, or offered for sale in this state or sold to consumers in this state unless:

(a) The service contract provider has either demonstrated its financial responsibility or assured the faithful performance of the service contract provider's obligations to its service contract holders by insuring all service contracts under a reimbursement insurance policy issued by an insurer holding

a certificate of authority from the commissioner or a risk retention group, as defined in 15 U.S.C. Sec. 3901(a)(4), as long as that risk retention group is in full compliance with the federal liability risk retention act of 1986 (15 U.S.C. Sec. 3901 et seq.), is in good standing in its domiciliary jurisdiction, and properly registered with the commissioner under chapter 48.92 RCW. The insurance required by this subsection must meet the following requirements:

(i) The insurer or risk retention group must, at the time the policy is filed with the commissioner, and continuously thereafter, maintain surplus as to policyholders and paid-in capital of at least fifteen million dollars and annually file audited financial statements with the commissioner; and

(ii) The commissioner may authorize an insurer or risk retention group that has surplus as to policyholders and paid-in capital of less than fifteen million dollars, but at least equal to ten million dollars, to issue the insurance required by this subsection if the insurer or risk retention group demonstrates to the satisfaction of the commissioner that the company maintains a ratio of direct written premiums, wherever written, to surplus as to policyholders and paid-in capital of not more than three to one;

(b) The service contract conspicuously states that the obligations of the provider to the service contract holder are guaranteed under the reimbursement insurance policy, the name and address of the issuer of the reimbursement insurance policy, the applicable policy number, and the means by which a service contract holder may file a claim under the policy;

(c) The service contract conspicuously and unambiguously states the name and address of the service contract provider and identifies any administrator if different from the service contract provider, the service contract seller, and the service contract holder. The identity of the service contract seller and the service contract holder are not required to be preprinted on the service contract and may be added to the service contract at the time of sale;

(d) The service contract states the purchase price of the service contract and the terms under which the service contract is sold. The purchase price is not required to be preprinted on the service contract and may be negotiated at the time of sale;

(e) The contract contains a conspicuous statement that has been initialed by the service contract holder and dis-closes:

(i) Any material conditions that the service contract holder must meet to maintain coverage under the contract including, but not limited to, any maintenance schedule to which the service contract holder must adhere, any requirement placed on the service contract holder for documenting repair or maintenance work, any duty to protect against any further damage, and any procedure to which the service contract holder must adhere for filing claims;

(ii) The work and parts covered by the contract;

(iii) Any time or mileage limitations;

(iv) That the implied warranty of merchantability on the motor vehicle is not waived if the contract has been purchased within ninety days of the purchase date of the motor vehicle from a provider or service contract seller who also sold the motor vehicle covered by the contract;

(v) Any exclusions of coverage; and

(vi) The contract holder's right to return the contract for a refund, which right can be no more restrictive than provided for in subsection (4) of this section;

(f) The service contract states the procedure to obtain service or to file a claim, including but not limited to the procedures for obtaining prior approval for repair work, the toll-free telephone number if prior approval is necessary for service, and the procedure for obtaining emergency repairs performed outside of normal business hours or for obtaining twenty-four-hour telephone assistance;

(g) The service contract states the existence of any deductible amount, if applicable;

(h) The service contract states any restrictions governing the transferability of the service contract, if applicable; and

(i) The service contract states whether or not the service contract provides for or excludes consequential damages or preexisting conditions.

(3) Service contracts shall not contain a provision which requires that any civil action brought in connection with the service contract must be brought in the courts of a jurisdiction other than this state. Service contracts that authorize binding arbitration to resolve claims or disputes must allow for arbitration proceedings to be held at a location in closest proximity to the service contract holder's permanent residence.

(4)(a) At a minimum, every provider shall permit the service contract holder to return the contract within thirty days of its purchase if no claim has been made under the contract, and shall refund to the holder the full purchase price of the contract unless the service contract holder returns the contract ten or more days after its purchase, in which case the provider may charge a cancellation fee not exceeding twenty-five dollars.

(b) If no claim has been made and a contract holder returns the contract after thirty days, the provider shall refund the purchase price pro rata based upon either elapsed time or mileage computed from the date the contract was purchased and the mileage on that date, less a cancellation fee not exceeding twenty-five dollars.

(c) A ten percent penalty shall be added to any refund that is not paid within thirty days of return of the contract to the provider.

(d) If a contract holder returns the contract under this subsection, the contract is void from the beginning and the parties are in the same position as if no contract had been issued.

(e) If a service contract holder returns the contract in accordance with this section, the insurer issuing the reimbursement insurance policy covering the contract shall refund to the provider the full premium by the provider for the contract if canceled within thirty days or a pro rata refund if canceled after thirty days.

(5) A service contract provider shall not deny a claim for coverage based upon the service contract holder's failure to properly maintain the vehicle, unless the failure to maintain the vehicle involved the failed part or parts.

(6) A contract provider has only sixty days from the date of the sale of the service contract to the holder to determine whether or not the vehicle qualifies under the provider's program for that vehicle. After sixty days the vehicle qualifies for the service contract that was issued and the service contract provider may not cancel the contract and is fully obli-

gated under the terms of the contract sold to the service contract holder. [2006 c 274 § 18.]

48.110.078 Calculation of minimum net worth or stockholder's equity—Accounting principles. (1) A service contract provider relying on RCW 48.110.050(2)(a) or 48.110.075(2)(a) to assure the faithful performance of its obligations to service contract holders shall calculate the minimum net worth or stockholder's equity required by this chapter in accordance with generally accepted accounting principles as set forth by the financial accounting standards board. A service contract provider must follow generally accepted accounting principles, as set forth by the financial accounting standards board, in regard to either unearned service contract fees or expected service contract claims, or both, when determining its net worth. A service contract provider relying on RCW 48.110.050(2)(a) or 48.110.075(2)(a) may elect to use statutory accounting principles in lieu of generally accepted accounting principles if it so chooses.

(2) A service contract provider relying on RCW 48.110.050(2) (b) or (c) to assure the faithful performance of its obligations to service contract holders shall calculate the minimum net worth or stockholder's equity required by this chapter in accordance with generally accepted accounting principles as set forth by the financial accounting standards board but must exclude from its assets all intangible assets including, but not limited to, goodwill, franchises, customer lists, patents or trademarks, and receivables from or advances to officers, directors, employees, salesmen [salespersons], and affiliated companies when calculating net worth or stockholder's equity. However, a service contract provider relying on RCW 48.110.050(2) (b) or (c) may include receivables from affiliated companies if the affiliated company provides a written irrevocable guarantee to assure repayment of all receivables to the service contract provider and the guaranteeing organization has a net worth or stockholder's equity in excess of one hundred million dollars and submits a statement from a certified public accountant attesting that the net worth or stockholder's equity of the guaranteeing organization meets or exceeds the requirements of this subsection.

(3) A protection product guarantee provider that has elected to assure the faithful performance of its obligations to its protection product guarantee holders by insuring all protection product guarantees under a reimbursement insurance policy in accordance with RCW 48.110.055(2)(b) shall calculate the minimum net worth or stockholder's equity required by this chapter in accordance with generally accepted accounting principles as set forth by the financial accounting standards board. A protection product guarantee provider will follow generally accepted accounting principles, as set forth by the financial accounting standards board, in regard to either unearned protection product guarantee contract fees or expected protection product guarantee contract claims, or both, when determining net worth. A protection product guarantee provider may elect to use statutory accounting principles in lieu of generally accepted accounting principles. [2019 c 16 § 6.]

48.110.080 Name of service contract provider or protection product guarantee provider—Use of legal name—False or misleading statements—Restrictions on require-

ment to purchase service contract. (1) A service contract provider or protection product guarantee provider shall not use in its name the words insurance, casualty, guaranty, surety, mutual, or any other words descriptive of the insurance, casualty, guaranty, or surety business; or a name deceptively similar to the name or description of any insurance or surety corporation, or to the name of any other service contract provider or protection product guarantee provider. This subsection does not apply to a company that was using any of the prohibited language in its name prior to January 1, 1999. However, a company using the prohibited language in its name shall conspicuously disclose in its service contracts or protection product guarantees the following statement: "This agreement is not an insurance contract."

(2) Every service contract provider or protection product guarantee provider shall conduct its business in its own legal name, unless the commissioner has approved the use of another name.

(3) A service contract provider or protection product guarantee provider or their representatives shall not in their service contracts or protection product guarantees or literature make, permit, or cause to be made any false or misleading statement, or deliberately omit any material statement that would be considered misleading if omitted.

(4) A person, such as a bank, savings and loan association, lending institution, manufacturer, or seller shall not require the purchase of a service contract or protection product as a condition of a loan or a condition for the sale of any property. [2006 c 274 § 9; 1999 c 112 § 9.]

48.110.090 Recordkeeping of service contract provider or protection product guarantee provider—Requirements—Duration—Form. (1) The service contract provider or protection product guarantee provider shall keep accurate accounts, books, and records concerning transactions regulated under this chapter.

(2) The service contract provider's or protection product guarantee provider's accounts, books, and records shall include the following:

(a) Copies of each type of service contract or protection product guarantees offered, issued, or sold;

(b) The name and address of each service contract holder or protection product guarantee holder, to the extent that the name and address have been furnished by the service contract holder or protection product guarantee holder;

(c) A list of the locations where the service contracts or protection products are marketed, sold, or offered for sale; and

(d) Written claim files that contain at least the dates, amounts, and descriptions of claims related to the service contracts or protection products.

(3) Except as provided in subsection (5) of this section, the service contract provider or protection product guarantee provider shall retain all records required to be maintained by subsection (1) of this section for at least six years after the specified coverage has expired.

(4) The records required under this chapter may be, but are not required to be, maintained on a computer disk or other recordkeeping technology. If the records are maintained in other than hard copy, the records shall be capable of duplication to legible hard copy.

(5) A service contract provider or protection product guarantee provider discontinuing business in this state shall maintain its records until it furnishes the commissioner satisfactory proof that it has discharged all obligations to service contract holders or protection product guarantee holders in this state. [2006 c 274 § 10; 1999 c 112 § 10.]

48.110.100 Termination of reimbursement insurance policy. As applicable, an insurer that issued a reimbursement insurance policy shall not terminate the policy until a notice of termination in accordance with RCW 48.18.290 has been given to the service contract provider or protection product guarantee provider and has been delivered to the commissioner. The termination of a reimbursement insurance policy does not reduce the issuer's responsibility for service contracts issued by service contract providers or protection product guarantees issued by protection product guarantee providers prior to the effective date of the termination. [2006 c 274 § 11; 1999 c 112 § 11.]

48.110.110 Service contract provider or protection product guarantee provider—Agent of insurer which issued reimbursement insurance policy. (1) Service contract providers or protection product guarantee providers are considered to be the agent of the insurer which issued the reimbursement insurance policy for purposes of obligating the insurer to service contract holders or protection product guarantee holders in accordance with the service contract or protection product guarantee holders and this chapter. Payment of the provider fee by the consumer to the service contract seller, service contract provider, or administrator or payment of consideration for the protection product to the protection product seller constitutes payment by the consumer to the service contract provider or protection product guarantee provider and to the insurer which issued the reimbursement insurance policy. In cases where a service contract provider or protection product guarantee provider is acting as an administrator and enlists other service contract providers or protection product guarantee providers, the service contract provider or protection product guarantee provider acting as the administrator shall notify the insurer of the existence and identities of the other service contract providers or protection product guarantee providers.

(2) This chapter does not prevent or limit the right of an insurer which issued a reimbursement insurance policy to seek indemnification or subrogation against a service contract provider or protection product guarantee provider if the issuer pays or is obligated to pay the service contract holder or protection product guarantee holder sums that the service contract provider or protection product guarantee provider was obligated to pay under the provisions of the service contract or protection product guarantee. [2006 c 274 § 12; 1999 c 112 § 12.]

48.110.120 Commissioner may conduct investigations. (1) The commissioner may conduct investigations of service contract providers or protection product guarantee providers, administrators, service contract sellers or protection product sellers, insurers, and other persons to enforce this chapter and protect service contract holders or protection product guarantee holders in this state. Upon request of the

commissioner, the service contract provider or protection product guarantee provider shall make all accounts, books, and records concerning service contracts or protection products offered, issued, or sold by the service contract provider or protection product guarantee provider available to the commissioner which are necessary to enable the commissioner to determine compliance or noncompliance with this chapter.

(2) The commissioner may take actions under RCW 48.02.080 or 48.04.050 which are necessary or appropriate to enforce this chapter and the commissioner's rules and orders, and to protect service contract holders or protection product guarantee holders in this state. [2006 c 274 § 13; 1999 c 112 § 13.]

48.110.130 Denial, suspension, or revocation of registration—Immediate suspension without notice or hearing—Fine. (1) The commissioner may, subject to chapter 48.04 RCW, deny, suspend, or revoke the registration of a service contract provider or protection product guarantee provider if the commissioner finds that the service contract provider or protection product guarantee provider:

(a) Has violated this chapter or the commissioner's rules and orders;

(b) Has refused to be investigated or to produce its accounts, records, and files for investigation, or if any of its officers have refused to give information with respect to its affairs or refused to perform any other legal obligation as to an investigation, when required by the commissioner;

(c) Has, without just cause, refused to pay proper claims or perform services arising under its contracts or has, without just cause, caused service contract holders or protection product guarantee holders to accept less than the amount due them or caused service contract holders or protection product guarantee holders to employ attorneys or bring suit against the service contract provider or protection product guarantee provider to secure full payment or settlement of claims;

(d) Is affiliated with or under the same general management or interlocking directorate or ownership as another service contract provider or protection product guarantee provider which unlawfully transacts business in this state without having a registration;

(e) At any time fails to meet any qualification for which issuance of the registration could have been refused had such failure then existed and been known to the commissioner;

(f) Has been convicted of, or has entered a plea of guilty or nolo contendere to, a felony;

(g) Is under suspension or revocation in another state with respect to its service contract business or protection product business;

(h) Has made a material misstatement in its application for registration;

(i) Has obtained or attempted to obtain a registration through misrepresentation or fraud;

(j) Has, in the transaction of business under its registration, used fraudulent, coercive, or dishonest practices;

(k) Has failed to pay any judgment rendered against it in this state regarding a service contract or protection product guarantee within sixty days after the judgment has become final; or

(l) Has failed to respond promptly to any inquiry from the insurance commissioner relative to service contract or protection product business. A lack of response within fifteen business days from receipt of an inquiry is untimely. A response must be in writing, unless otherwise indicated in the inquiry.

(2)(a) The commissioner may, without advance notice or hearing thereon, immediately suspend the registration of a service contract provider or protection product guarantee provider if the commissioner finds that any of the following circumstances exist:

(i) The provider either does not maintain the minimum net worth required by this chapter or cannot pay its debts when debts become due, or both;

(ii) A proceeding for receivership, conservatorship, rehabilitation, or other delinquency proceeding regarding the service contract provider or protection product guarantee provider has been commenced in any state; or

(iii) The business practices of the service contract provider or protection product guarantee provider otherwise pose an imminent threat to the public health, safety, or welfare of the residents of this state.

(b) However, nothing in this subsection shall in any way be construed to limit the authority of the commissioner to take action against a service contract provider or a protection product guarantee provider granted by this chapter.

(3) If the commissioner finds that grounds exist for the suspension or revocation of a registration issued under this chapter, the commissioner may, in lieu of suspension or revocation, impose a fine upon the service contract provider or protection product guarantee provider in an amount not more than two thousand dollars per violation. [2019 c 16 § 4; 2006 c 274 § 14; 1999 c 112 § 14.]

48.110.140 Application of consumer protection act.

The legislature finds that the practices covered by this chapter are matters vitally affecting the public interest for the purpose of applying the consumer protection act, chapter 19.86 RCW. Violations of this chapter are not reasonable in relation to the development and preservation of business. A violation of this chapter is an unfair or deceptive act or practice in the conduct of trade or commerce and an unfair method of competition, as specifically contemplated by RCW 19.86.020, and is a violation of the consumer protection act, chapter 19.86 RCW. Any service contract holder or protection product guarantee holder injured as a result of a violation of a provision of this chapter shall be entitled to maintain an action pursuant to chapter 19.86 RCW against the service contract provider or protection product guarantee provider and the insurer issuing the applicable service contract or protection product guarantee reimbursement insurance policy and shall be entitled to all of the rights and remedies afforded by that chapter. [2006 c 274 § 15; 1999 c 112 § 15.]

48.110.150 Rules. The commissioner may adopt rules to implement and administer this chapter. [1999 c 112 § 16.]

48.110.900 Date of application to service contracts.

This chapter applies to all service contracts, other than on motor vehicles, sold or offered for sale ninety or more days after July 25, 1999. This chapter applies to all service con-

tracts on motor vehicles and protection products sold or offered for sale after September 30, 2006. [2006 c 274 § 16; 1999 c 112 § 17.]

48.110.902 Application of chapter to motor vehicle manufacturers or import distributors.

(1) RCW 48.110.030 (2)(a) and (b), (3), and (4), 48.110.040, 48.110.060, 48.110.100, 48.110.110, 48.110.075 (2)(a) and (b) and (4)(e), and 48.110.073 (1) and (2) do not apply to motor vehicle service contracts issued by a motor vehicle manufacturer or import distributor covering vehicles manufactured or imported by the motor vehicle manufacturer or import distributor.

(2) RCW 48.110.030(2)(c) does not apply to a publicly traded motor vehicle manufacturer or import distributor.

(3) RCW 48.110.030 (2)(a) through (c), (3), and (4), 48.110.040, and 48.110.073(2) do not apply to wholly owned subsidiaries of motor vehicle manufacturers or import distributors. For purposes of this subsection, a company is considered a wholly owned subsidiary as long as it is ultimately owned, directly or indirectly, one hundred percent by single or multiple motor vehicle manufacturers or import distributors.

(4) The adoption of chapter 274, Laws of 2006 does not imply that a vehicle protection product warranty was insurance prior to October 1, 2006.

(5) For purposes of this section, "motor vehicle service contract" includes a contract or agreement sold for separately stated consideration for a specific duration to perform any of the services set forth in RCW 48.110.020(18)(b). [2019 c 16 § 5; 2016 c 224 § 5; 2006 c 274 § 21.]

48.110.904 Effective date—2006 c 274. This act takes effect October 1, 2006. [2006 c 274 § 24.]

Chapter 48.111 RCW

HOME HEATING FUEL SERVICE CONTRACTS

Sections

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48.111.005 Findings—Purpose. The legislature finds that certain service contracts involving providers of home heating fuel and homeowners are in the public interest. The legislature further finds that the existing statutory provisions

regulating service contracts are more burdensome than is necessary to safeguard homeowners from the risk that a contract obligor will close or be unable to fulfill their contract obligations. The legislature declares that it is necessary to establish separate standards that will safeguard certain homeowners from possible losses arising from the cessation of business of a home heating fuel company or the mismanagement of funds paid for home heating fuel service contracts. The purpose of this chapter is to create a legal framework within which home heating fuel service contracts may be sold in this state and set forth requirements for conducting a service contract business. [2006 c 36 § 1.]

48.111.010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Administrator" means the person who is responsible for the administration of the service contracts or the service contracts plan.

(2) "Commissioner" means the insurance commissioner of this state.

(3) "Consumer" means an individual who buys any tangible personal property that is primarily for personal, family, or household use.

(4) "Home heating fuel service contract" means a contract or agreement for a separately stated consideration for a specific duration to perform the repair, replacement, or maintenance of a customer-owned home heating fuel supply system including the fuel tank and all visible pipes, caps, lines, and associated parts or the indemnification for repair, replacement, or maintenance for operational or structural failure due to a defect in materials or workmanship, or normal wear and tear.

(5) "Person" means an individual, partnership, corporation, incorporated or unincorporated association, joint stock company, reciprocal insurer, syndicate, or any similar entity or combination of entities acting in concert.

(6) "Premium" means the consideration paid to an insurer for a reimbursement insurance policy.

(7) "Provider fee" means the consideration paid by a consumer for a home heating fuel service contract.

(8) "Reimbursement insurance policy" means a policy of insurance that is issued to a service contract provider to provide reimbursement to the service contract provider or to pay on behalf of the service contract provider all contractual obligations incurred by the service contract provider under the terms of the insured service contracts issued or sold by the service contract provider.

(9) "Home heating fuel service contract holder" or "contract holder" means a person who is the purchaser or holder of a home heating fuel service contract.

(10) "Home heating fuel service contract provider" or "contract provider" means a person who is providing home heating fuel delivery services to the customer and is contractually obligated to the home heating fuel service contract holder under the terms of the service contract.

(11) "Home heating fuel service contract seller" means the person who sells the home heating fuel service contract to the consumer.

(12) "Warranty" means a warranty made solely by the manufacturer, importer, or seller of property or services with-

out consideration; that is not negotiated or separated from the sale of the product and is incidental to the sale of the product; and that guarantees indemnity for defective parts, mechanical or electrical breakdown, labor, or other remedial measures, such as repair or replacement of the property or repetition of services. [2006 c 36 § 2.]

48.111.020 Registration required—Application—Required information—Grounds for refusal—Annual renewal. (1) A person shall not act as, or offer to act as, or hold himself or herself out to be a home heating fuel service contract provider in this state, nor may a home heating fuel service contract be sold to a consumer in this state, unless the contract provider has a valid registration as a home heating fuel service contract provider issued by the commissioner.

(2) Applicants to be a home heating fuel service contract provider shall make an application to the commissioner upon a form to be furnished by the commissioner. The application must include or be accompanied by the following information and documents:

(a) All basic organizational documents of the home heating fuel service contract provider, including any articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement, bylaws, and other applicable documents, and all amendments to those documents;

(b) The identities of the contract provider's executive officer or officers directly responsible for the contract provider's home heating fuel service contract business;

(c) Annual financial statements or other financial reports acceptable to the commissioner for the two most recent years which prove that the applicant is solvent and any information the commissioner may require in order to review the current financial condition of the applicant;

(d) An application fee of one hundred dollars, which must be deposited into the general fund; and

(e) Any other pertinent information required by the commissioner.

(3) The commissioner may refuse to issue a registration if the commissioner determines that the home heating fuel service contract provider, or any individual responsible for the conduct of the affairs of the contract provider under subsection (2)(b) of this section, is not competent, trustworthy, or financially responsible.

(4) A registration issued under this section is valid, unless surrendered, suspended, or revoked by the commissioner, or not renewed for so long as the service contract provider continues in business in this state and remains in compliance with this chapter. A registration is subject to renewal annually on July 1st upon application of the home heating fuel service contract provider and payment of a fee of twenty-five dollars, which must be deposited into the general fund. If not so renewed, the registration expires on June 30th next preceding.

(5) A home heating fuel service contract provider shall keep current the information required to be disclosed in its registration under this section by reporting all material changes or additions within thirty days after the end of the month in which the change or addition occurs. [2007 c 80 § 1; 2006 c 36 § 3.]

48.111.030 Filing of reports—Investigations—Confidentiality. (1) Every registered home heating fuel service contract provider that is assuring its faithful performance of its obligations to its contract holders by complying with RCW 48.111.040(2)(b) shall file an annual report for the preceding calendar year with the commissioner on or before March 1st of each year, or within any extension of time the commissioner for good cause may grant. The report must be in the form and contain those matters as the commissioner prescribes and must be verified by at least two officers of the home heating fuel service contract provider.

(2) As part of an investigation by the commissioner, the commissioner may require a home heating fuel service contract provider to file monthly financial reports whenever, in the commissioner's discretion, there is a need to more closely monitor the financial activities of the service contract provider. Monthly financial statements must be filed in the commissioner's office no later than the twenty-fifth day of the month following the month for which the financial report is being filed. These monthly financial reports must be the internal financial statements of the service contract provider. The monthly financial reports that are filed with the commissioner constitute information that might be damaging to the service contract provider if made available to its competitors, and therefore shall be kept confidential by the commissioner. This information may not be made public or be subject to subpoena, other than by the commissioner and then only for the purpose of enforcement actions taken by the commissioner. [2006 c 36 § 4.]

48.111.040 Obligations of contract provider. (1) Home heating fuel service contracts may not be issued, sold, or offered for sale in this state or sold to consumers in this state unless the contract provider has:

(a) Provided a receipt for, or other written evidence of, the purchase of the home heating fuel service contract to the contract holder; and

(b) Provided a copy of the home heating fuel service contract to the service contract holder within a reasonable period of time from the date of purchase.

(2) In order to assure the faithful performance of a home heating fuel service contract provider's obligations to its contract holders, every home heating fuel service contract provider is responsible for complying with the requirements of one of the following:

(a) Insure all home heating fuel service contracts under a reimbursement insurance policy issued by an insurer holding a certificate of authority from the commissioner; or

(b)(i) Maintain a funded reserve account for its obligations under its home heating service contracts issued and outstanding in this state. The reserves may not be less than forty percent of the gross consideration received, less claims paid, on the sale of the home heating fuel service contract for all in-force contracts. The reserve account is subject to examination and review by the insurance commissioner; and

(ii) Place in trust with the commissioner a financial security deposit, having a value of not less than five percent of the gross consideration received, less claims paid, on the sale of the service contract for all service contracts issued and in force, but not less than ten thousand dollars, consisting of one of the following:

(A) A surety bond issued by an insurer holding a certificate of authority from the commissioner;

(B) Securities of the type eligible for deposit by authorized insurers in this state;

(C) Cash;

(D) An evergreen letter of credit issued by a qualified financial institution;

(E) A pledged certificate of deposit issued by a qualified financial institution; or

(F) Another form of security prescribed by rule by the commissioner.

(3) Home heating fuel service contracts must require the contract provider to permit the contract holder to return the home heating fuel service contract within thirty days of the date the home heating fuel service contract was delivered to the contract holder, or within a longer time period permitted under the home heating fuel service contract. Upon return of the home heating fuel service contract to the contract provider within the applicable period, if no claim has been made under the home heating fuel service contract prior to the return to the contract provider, the home heating fuel service contract is void and the contract provider shall refund to the contract holder, or credit the account of the contract holder with the full purchase price of the home heating fuel service contract. The right to void the home heating fuel service contract provided in this subsection is not transferable and applies only to the original contract purchaser. A ten percent penalty per month must be added to a refund of the purchase price that is not paid or credited within thirty days after return of the home heating fuel service contract to the contract provider.

(4) Except for home heating fuel service contract providers, persons marketing, selling, or offering to sell home heating service contracts for providers are exempt from the registration requirements of this chapter.

(5) The marketing, sale, offering for sale, issuance, making, proposing to make, and administration of home heating fuel service contracts by contract providers and related contract sellers, administrators, and other persons complying with this chapter are exempt from the other provisions of this title, except chapter 48.04 RCW and as otherwise provided in this chapter. [2006 c 36 § 5.]

48.111.050 Reimbursement insurance policies insuring home heating fuel service contracts. (1) Reimbursement insurance policies insuring home heating fuel service contracts issued, sold, or offered for sale in this state or sold to consumers in this state must state that the insurer that issued the reimbursement insurance policy shall reimburse or pay on behalf of the contract provider all sums the contract provider is legally obligated to pay, including but not limited to the refund of the full purchase price of the contract to the contract holder or shall provide the service which the contract provider is legally obligated to perform according to the contract provider's contractual obligations under the home heating fuel service contracts issued or sold by the contract provider.

(2) The reimbursement insurance policy must fully insure the obligations of the contract provider, rather than partially insure, or insure only in the event of contract provider default.

(3) The reimbursement insurance policy must state that the contract holder is entitled to apply directly to the reimbursement insurance company. [2006 c 36 § 6.]

48.111.053 Termination of reimbursement insurance policies. As applicable, an insurer that issued a reimbursement insurance policy shall not terminate the policy until a notice of termination in accordance with RCW 48.18.290 has been given to the home heating fuel service contract provider and has been delivered to the commissioner. The termination of a reimbursement insurance policy does not reduce the issuer's responsibility for home heating fuel service contracts issued by contract providers prior to the effective date of the termination. [2006 c 36 § 10.]

48.111.055 Insurer issuing reimbursement insurance policy—Contract provider is agent. (1) Home heating fuel service contract providers are the agent of the insurer that issued the reimbursement insurance policy for purposes of obligating the insurer to contract holders in accordance with the home heating fuel service contract and this chapter. Payment of the provider fee by the consumer to the home heating fuel service contract seller, contract provider, or administrator constitutes payment by the consumer to the home heating fuel service contract provider and to the insurer that issued the reimbursement insurance policy. In cases when a contract provider is acting as an administrator and enlists other contract providers, the contract provider acting as the administrator shall notify the insurer of the existence and identities of the other contract providers.

(2) This chapter does not prevent or limit the right of an insurer that issued a reimbursement insurance policy to seek indemnification or subrogation against a home heating fuel service contract provider if the issuer pays or is obligated to pay the contract holder sums that the contract provider was obligated to pay under the provisions of the home heating fuel service contract. [2006 c 36 § 11.]

48.111.060 Home heating fuel service contracts—Form—Required contents. (1) Home heating fuel service contracts marketed, sold, offered for sale, issued, made, proposed to be made, or administered in this state or sold to residents of this state must be written, printed, or typed in clear, understandable language that is easy to read, and disclose the requirements set forth in this section, as applicable.

(2) Home heating fuel service contracts insured under a reimbursement insurance policy must not be issued, sold, or offered for sale in this state or sold to residents of this state unless the home heating fuel service contract conspicuously contains a statement in substantially the following form: "Obligations of the home heating fuel service contract provider under this contract are insured under a contract reimbursement insurance policy." The home heating fuel service contract must also conspicuously state the name and address of the issuer of the reimbursement insurance policy and state that the contract holder is entitled to apply directly to the reimbursement insurance company.

(3) Service contracts not insured under a reimbursement insurance policy must contain a statement in substantially the following form: "Obligations of the home heating fuel service contract provider under this contract are backed by the

full faith and credit of the home heating fuel service contract provider."

(4) Home heating fuel service contracts must state the name and address of the contract provider and must identify any administrator if different from the contract provider, the contract seller, and the contract holder to the extent that the name of the contract holder has been furnished by the contract holder. The identities of the parties are not required to be preprinted on the home heating fuel service contract and may be added to the home heating fuel service contract at the time of sale.

(5) Home heating fuel service contracts must state the purchase price of the contract and the terms under which the home heating fuel service contract is sold. The purchase price is not required to be preprinted on the home heating fuel service contract and may be negotiated at the time of sale.

(6) Home heating fuel service contracts must state the procedure to obtain service or to file a claim, including but not limited to the procedures for obtaining prior approval for repair work, the toll-free telephone number if prior approval is necessary for service, and the procedure for obtaining emergency repairs performed outside of normal business hours or provide for twenty-four hour telephone assistance.

(7) Home heating fuel service contracts must state the existence of any deductible amount, if applicable.

(8) Home heating fuel service contracts must specify the merchandise and services to be provided and any limitations, exceptions, or exclusions.

(9) Home heating fuel service contracts must state any restrictions governing the transferability of the service contract, if applicable.

(10) Home heating fuel service contracts must state the terms, restrictions, or conditions governing cancellation of the home heating fuel service contract prior to the termination or expiration date of the home heating fuel service contract by either the contract provider or by the contract holder, which rights can be no more restrictive than provided in RCW 48.111.040. The contract provider of the home heating fuel service contract shall mail a written notice to the contract holder at the last known address of the contract holder contained in the records of the contract provider at least twenty-one days prior to cancellation by the contract provider. The notice must state the effective date of the cancellation and the true and actual reason for the cancellation.

(11) Home heating fuel service contracts must set forth the obligations and duties of the contract holder, including but not limited to the duty to protect against any further damage and any requirement to follow owner's manual instructions.

(12) Home heating fuel service contracts must state whether or not the home heating fuel service contract provides for or excludes consequential damages or preexisting conditions.

(13) Home heating fuel service contracts must not contain a provision that requires that any civil action brought in connection with the home heating fuel service contract must be brought in the courts of a jurisdiction other than this state. Home heating service contracts that authorize binding arbitration to resolve claims or disputes may allow for arbitration proceedings to be held at a location in closest proximity to the contract holder's permanent residence. [2006 c 36 § 7.]

48.111.070 Name of contract provider—Use of legal name—False or misleading statements—Restrictions on requirement to purchase service contracts. (1) A home heating fuel service contract provider shall not use in its name the words insurance, casualty, guaranty, surety, mutual, or any other words descriptive of the insurance, casualty, guaranty, or surety business; or a name deceptively similar to the name or description of any insurance or surety corporation, or to the name of any other home heating fuel service contract provider. This subsection does not apply to a company that was using any of the prohibited language in its name prior to June 7, 2006. However, a company using the prohibited language in its name shall conspicuously disclose in its home heating fuel service contracts the following statement: "This agreement is not an insurance contract."

(2) Every home heating fuel service contract provider shall conduct its business in its own legal name, unless the commissioner has approved the use of another name.

(3) A home heating fuel service contract provider or its representative shall not in its contracts or literature make, permit, or cause to be made any false or misleading statement, or deliberately omit any material statement that would be considered misleading if omitted.

(4) A person, such as a bank, savings and loan association, lending institution, manufacturer, or seller shall not require the purchase of a home heating fuel service contract as a condition of a loan or a condition for the sale of any property. [2006 c 36 § 8.]

48.111.080 Recordkeeping of contract provider—Requirements—Form. (1) The home heating fuel service contract provider shall keep accurate accounts, books, and records concerning transactions regulated under this chapter.

(2) The contract provider's accounts, books, and records must include the following:

(a) Copies of each type of home heating fuel service contract sold;

(b) The name and address of each contract holder, to the extent that the name and address have been furnished by the contract holder; and

(c) Written claim files that contain at least the dates, amounts, and descriptions of claims related to the service contracts.

(3) The records required under this chapter may be, but are not required to be, maintained on a computer disk or other recordkeeping technology. If the records are maintained in other than hard copy, the records must be capable of duplication to legible hard copy.

(4) A home heating fuel service contract provider discontinuing business in this state shall maintain its records until it furnishes the commissioner satisfactory proof that it has discharged all obligations to service contract holders in this state. [2006 c 36 § 9.]

48.111.090 Commissioner may conduct investigations. (1) The commissioner may conduct investigations of home heating fuel service contract providers, administrators, home heating fuel service contract sellers, insurers, and other persons to enforce this chapter and protect home heating fuel service contract holders in this state. Upon request of the commissioner, the contract provider shall make all accounts,

books, and records concerning home heating fuel service contracts sold by the contract provider available to the commissioner that are necessary to enable the commissioner to determine compliance or noncompliance with this chapter.

(2) The commissioner may take actions under RCW 48.02.080 or 48.04.050 that are necessary or appropriate to enforce this chapter and the commissioner's rules and orders, and to protect home heating fuel service contract holders in this state. [2006 c 36 § 12.]

48.111.100 Denial, suspension, or revocation of registration—Immediate suspension without notice or hearing—Fine. (1) The commissioner may, subject to chapter 48.04 RCW, deny, suspend, or revoke the registration of a home heating fuel service contract provider if the commissioner finds that the contract provider:

(a) Has violated this chapter or the commissioner's rules and orders;

(b) Has refused to be investigated or to produce its accounts, records, and files for investigation, or if any of its officers have refused to give information with respect to its affairs or refused to perform any other legal obligation as to an investigation, when required by the commissioner;

(c) Has, without just cause, refused to pay proper claims or perform services arising under its contracts or has, without just cause, caused home heating fuel service contract holders to accept less than the amount due them or caused home heating fuel service contract holders to employ attorneys or bring suit against the contract provider to secure full payment or settlement of claims;

(d) Is affiliated with or under the same general management or interlocking directorate or ownership as another home heating fuel service contract provider that unlawfully transacts business in this state without having a registration;

(e) At any time fails to meet any qualification for which issuance of the registration could have been refused had that failure then existed and been known to the commissioner;

(f) Is under suspension or revocation in another state with respect to its home heating fuel service contract business;

(g) Has made a material misstatement in its application for registration;

(h) Has obtained or attempted to obtain a registration through misrepresentation or fraud;

(i) Has, in the transaction of business under its registration, used fraudulent, coercive, or dishonest practices;

(j) Has failed to pay any judgment rendered against it in this state regarding a home heating fuel service contract within sixty days after the judgment has become final; or

(k) Has been convicted of, or has entered a plea of guilty or nolo contendere to, a property or finance-related felony.

(2) The commissioner may, without advance notice or hearing thereon, immediately suspend the registration of a home heating fuel service contract provider if the commissioner finds that any of the following circumstances exist:

(a) The provider is insolvent;

(b) A proceeding for receivership, conservatorship, rehabilitation, or other delinquency proceeding regarding the home heating fuel service contract provider has been commenced in any state; or

(c) The financial condition or business practices of the home heating fuel service contract provider otherwise pose an imminent threat to the public health, safety, or welfare of the residents of this state.

(3) If the commissioner finds that grounds exist for the suspension or revocation of a registration issued under this chapter, the commissioner may, in lieu of suspension or revocation, impose a fine upon the home heating fuel service contract provider in an amount not more than one thousand dollars per violation. [2006 c 36 § 13.]

48.111.110 Rules. The commissioner may adopt rules to implement and administer this chapter. [2006 c 36 § 14.]

48.111.900 Application. This chapter applies to all home heating fuel service contracts sold or offered for sale after October 1, 2006. [2006 c 36 § 15.]

Chapter 48.115 RCW RENTAL CAR INSURANCE

Sections

48.115.001	Short title.
48.115.005	Definitions.
48.115.010	License required.
48.115.015	Licensing rental car companies as rental car insurance producers.
48.115.020	Rental car insurance producer endorsee—Duties of rental car insurance producer—Training—Transaction records.
48.115.025	Restrictions on offer, sale, or solicitation—Consumer information.
48.115.030	Rental car insurance producer prohibitions.
48.115.035	Enforcement—Commissioner may revoke, suspend, or refuse to issue or renew license.
48.115.040	Treatment of moneys collected from renters purchasing insurance.
48.115.045	Rule making.

48.115.001 Short title. This chapter may be known and cited as the rental car specialty insurance producer license act. [2008 c 217 § 85; 2002 c 273 § 1.]

Additional notes found at www.leg.wa.gov

48.115.005 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Endorsee" means an unlicensed employee or agent of a rental car insurance producer who meets the requirements of this chapter.

(2) "Person" means an individual or a business entity.

(3) "Rental agreement" means any written master, corporate, group, or individual agreement setting forth the terms and conditions governing the use of a rental car rented or leased by a rental car company.

(4) "Rental car" means any motor vehicle that is intended to be rented or leased for a period of thirty consecutive days or less by a driver who is not required to possess a commercial driver's license to operate the motor vehicle and the motor vehicle is either of the following:

(a) A private passenger motor vehicle, including a passenger van, recreational vehicle, minivan, or sports [sport] utility vehicle; or

(b) A cargo vehicle, including a cargo van, pickup truck, or truck with a gross vehicle weight of less than twenty-six thousand pounds.

(5) "Rental car insurance producer" means any rental car company that is licensed to offer, sell, or solicit rental car insurance under this chapter.

(6) "Rental car company" means any person in the business of renting rental cars to the public, including a franchisee.

(7) "Rental car insurance" means insurance offered, sold, or solicited in connection with and incidental to the rental of rental cars, whether at the rental office or by preselection of coverage in master, corporate, group, or individual agreements that: (a) Is nontransferable; (b) applies only to the rental car that is the subject of the rental agreement; and (c) is limited to the following kinds of insurance:

(i) Personal accident insurance for renters and other rental car occupants, for accidental death or dismemberment, and for medical expenses resulting from an accident that occurs with the rental car during the rental period;

(ii) Liability insurance, including uninsured or underinsured motorist coverage, whether offered separately or in combination with other liability insurance, that provides protection to the renters and to other authorized drivers of a rental car for liability arising from the operation of the rental car during the rental period;

(iii) Personal effects insurance that provides coverage to renters and other vehicle occupants for loss of, or damage to, personal effects in the rental car during the rental period; and

(iv) Roadside assistance and emergency sickness protection insurance.

(8) "Renter" means any person who obtains the use of a vehicle from a rental car company under the terms of a rental agreement. [2008 c 217 § 86; 2002 c 273 § 2.]

Additional notes found at www.leg.wa.gov

48.115.010 License required. (1) A rental car company, or officer, director, employee, or agent of a rental car company, may not offer, sell, or solicit the purchase of rental car insurance unless that person is licensed under chapter 48.17 RCW or is in compliance with this chapter.

(2) The commissioner may issue a license to a rental car company that is in compliance with this chapter authorizing the rental car company to act as a rental car insurance producer under this chapter, in connection with and incidental to rental agreements, on behalf of any insurer authorized to write rental car insurance in this state. [2008 c 217 § 87; 2002 c 273 § 3.]

Additional notes found at www.leg.wa.gov

48.115.015 Licensing rental car companies as rental car insurance producers. A rental car company may apply to be licensed as a rental car insurance producer under, and if in compliance with, this chapter by filing the following documents with the commissioner:

(1) A written application for licensure, signed by the applicant or by an officer of the applicant, in the form prescribed by the commissioner that includes a listing of all locations at which the rental car company intends to offer, sell, or solicit rental car insurance; and

(2)(a) A certificate by the insurer that is to be named in the rental car insurance producer license, stating that: (i) The insurer has satisfied itself that the named applicant is trustworthy and competent to act as its rental car insurance producer

ducer, limited to this purpose; (ii) the insurer has reviewed the endorsee training and education program required by RCW 48.115.020(4) and believes that it satisfies the statutory requirements; and (iii) the insurer will appoint the applicant to act as its rental car insurance producer to offer, sell, or solicit rental car insurance, if the license for which the applicant is applying is issued by the commissioner.

(b) The certification shall be subscribed by an authorized representative of the insurer on a form prescribed by the commissioner. [2008 c 217 § 88; 2002 c 273 § 4.]

Additional notes found at www.leg.wa.gov

48.115.020 Rental car insurance producer endorsees—Duties of rental car insurance producer—Training—Transaction records. (1) An employee or agent of a rental car insurance producer may be an endorsee authorized to offer, sell, or solicit rental car insurance under the authority of the rental car insurance producer license, if all of the following conditions have been satisfied:

(a) The employee or agent is eighteen years of age or older;

(b) The employee or agent is a trustworthy person and has not committed any act set forth in RCW 48.17.530;

(c) The employee or agent has completed a training and education program;

(d) The rental car company, at the time it submits its rental car insurance producer license application, also submits a list of the names of all endorsees to its rental car insurance producer license on forms prescribed by the commissioner. The list shall be updated and submitted to the commissioner quarterly on a calendar year basis. Each list shall be retained by the rental car company for a period of three years from submission; and

(e) The rental car company or its agent submits to the commissioner with its initial rental car insurance producer license application, and annually thereafter, a certification subscribed by an officer of the rental car company on a form prescribed by the commissioner, stating all of the following:

(i) No person other than an endorsee offers, sells, or solicits rental car insurance on its behalf or while working as an employee or agent of the rental car insurance producer; and

(ii) All endorsees have completed the training and education program under subsection (4) of this section.

(2) A rental car insurance producer's endorsee may only act on behalf of the rental car insurance producer in the offer, sale, or solicitation of a rental car insurance. A rental car insurance producer is responsible for, and must supervise, all actions of its endorsees related to the offering, sale, or solicitation of rental car insurance. The conduct of an endorsee acting within the scope of his or her employment or agency is the same as the conduct of the rental car insurance producer for purposes of this chapter.

(3) The manager at each location of a rental car insurance producer, or the direct supervisor of the rental car insurance producer's endorsees at each location, must be an endorsee of that rental car insurance producer and is responsible for the supervision of each additional endorsee at that location. Each rental car insurance producer shall identify the endorsee who is the manager or direct supervisor at each location in the

endorsee list that it submits under subsection (1)(d) of this section.

(4) Each rental car insurance producer shall provide a training and education program for each endorsee prior to allowing an endorsee to offer, sell, or solicit rental car insurance. Details of the program must be submitted to the commissioner, along with the license application, for approval prior to use, and resubmitted for approval of any changes prior to use. This training program shall meet the following minimum standards:

(a) Each endorsee shall receive instruction about the kinds of insurance authorized under this chapter that may be offered for sale to prospective renters; and

(b) Each endorsee shall receive training about the requirements and limitations imposed on rental car insurance producers and endorsees under this chapter. The training must include specific instruction that the endorsee is prohibited by law from making any statement or engaging in any conduct express or implied, that would lead a consumer to believe that the:

(i) Purchase of rental car insurance is required in order for the renter to rent a motor vehicle;

(ii) Renter does not have insurance policies in place that already provide the coverage being offered by the rental car company under this chapter; or

(iii) Endorsee is qualified to evaluate the adequacy of the renter's existing insurance coverages.

(5) The training and education program submitted to the commissioner is approved if no action is taken within thirty days of its submission.

(6) An endorsee's authorization to offer, sell, or solicit rental car insurance expires when the endorsee's employment with the rental car company is terminated.

(7) The rental car insurance producer shall retain for a period of one year from the date of each transaction records which enable it to identify the name of the endorsee involved in each rental transaction when a renter purchases rental car insurance. [2008 c 217 § 89; 2002 c 273 § 5.]

Additional notes found at www.leg.wa.gov

48.115.025 Restrictions on offer, sale, or solicitation—Consumer information. Insurance may not be offered, sold, or solicited under this section, unless:

(1) The rental period of the rental car agreement is thirty consecutive days or less;

(2) At every location where rental agreements are executed, the rental car insurance producer or endorsee provides brochures or other written materials to each renter who purchases rental car insurance that clearly, conspicuously, and in plain language:

(a) Summarize, clearly and correctly, the material terms, exclusions, limitations, and conditions of coverage offered to renters, including the identity of the insurer;

(b) Describe the process for filing a claim in the event the renter elects to purchase coverage, including a toll-free telephone number to report a claim;

(c) Provide the rental car insurance producer's name, address, telephone number, and license number, as well as the commissioner's consumer hotline number;

(d) Inform the consumer that the rental car insurance offered, sold, or solicited by the rental car insurance producer

may provide a duplication of coverage already provided by a renter's personal automobile insurance policy, homeowners' insurance policy, or by another source of coverage;

(e) Inform the consumer that the purchase by the renter of the rental car insurance is not required in order to rent a rental car from the rental car insurance producer; and

(f) Inform the consumer that the rental car insurance producer and the rental car insurance producer's endorsees are not qualified to evaluate the adequacy of the renter's existing insurance coverages;

(3) The purchaser of rental car insurance acknowledges in writing the receipt of the brochures or written materials required by subsection (2) of this section;

(4) Evidence of the rental car insurance coverage is stated on the face of the rental agreement;

(5) All costs for the rental car insurance are separately itemized in the rental agreement;

(6) When the rental car insurance is not the primary source of coverage, the consumer is informed in writing in the form required by subsection (2) of this section that their personal insurance will serve as the primary source of coverage; and

(7) For transactions conducted by electronic means, the rental car insurance producer must comply with the requirements of this section, and the renter must acknowledge in writing or by electronic signature the receipt of the following disclosures:

(a) The insurance policies offered by the rental car insurance producer may provide a duplication of coverage already provided by a renter's personal automobile insurance policy, homeowners' insurance policy, or by another source of coverage;

(b) The purchase by the renter of rental car insurance is not required in order to rent a rental car from the rental car insurance producer; and

(c) The rental car insurance producer and the rental car insurance producer's endorsees are not qualified to evaluate the adequacy of the renter's existing insurance coverages. [2008 c 217 § 90; 2002 c 273 § 6.]

Additional notes found at www.leg.wa.gov

48.115.030 Rental car insurance producer prohibitions. A rental car insurance producer may not:

(1) Offer, sell, or solicit the purchase of insurance except in conjunction with and incidental to rental car agreements;

(2) Advertise, represent, or otherwise portray itself or any of its employees or agents as licensed insurers or insurance producers;

(3) Pay any person, including a rental car insurance producer endorsee, any compensation, fee, or commission that is dependent primarily on the placement of insurance under the license issued under this chapter;

(4) Make any statement or engage in any conduct, express or implied, that would lead a customer to believe that the:

(a) Insurance policies offered by the rental car insurance producer do not provide a duplication of coverage already provided by a renter's personal automobile insurance policy, homeowners' insurance policy, or by another source of coverage;

(b) Purchase by the renter of rental car insurance is required in order to rent a rental car from the rental car insurance producer; and

(c) Rental car insurance producer or the rental car insurance producer's endorsees are qualified to evaluate the adequacy of the renter's existing insurance coverages. [2008 c 217 § 91; 2002 c 273 § 7.]

Additional notes found at www.leg.wa.gov

48.115.035 Enforcement—Commissioner may revoke, suspend, or refuse to issue or renew license. (1) Every rental car insurance producer licensed under this chapter shall promptly reply in writing to an inquiry of the commissioner relative to the business of rental car insurance.

(2)(a) In the event of a violation of this chapter by a rental car insurance producer, the commissioner may revoke, suspend, or refuse to issue or renew any rental car insurance producer's license that is issued or may be issued under this chapter for any cause specified in any other provision of this title, or for any of the following causes:

(i) For any cause that the issuance of this license could have been refused had it then existed and been known to the commissioner;

(ii) If the licensee or applicant willfully violates or knowingly participates in a violation of this title or any proper order or rule of the commissioner;

(iii) If the licensee or applicant has obtained or attempted to obtain a license through willful misrepresentation or fraud;

(iv) If the licensee or applicant has misappropriated or converted funds that belong to, or should be paid to, another person as a result of, or in connection with, a rental car or insurance transaction;

(v) If the licensee or applicant has, with intent to deceive, materially misrepresented the terms or effects of any insurance contract, or has engaged, or is about to engage, in any fraudulent transaction;

(vi) If the licensee or applicant or officer of the licensee or applicant has been convicted by final judgment of a felony;

(vii) If the licensee or applicant is shown to be, and is determined by the commissioner, incompetent or untrustworthy, or a source of injury and loss to the public; and

(viii) If the licensee has dealt with, or attempted to deal with, insurances, or has exercised powers relative to insurance outside the scope of the rental car insurance producer license or other insurance licenses.

(b) If any natural person named under a firm or corporate rental car insurance producer license, or application therefore, commits or has committed any act, or fails or has failed to perform any duty, that constitutes grounds for the commissioner to revoke, suspend, or refuse to issue or renew the license or application for license, the commissioner may revoke, suspend, refuse to renew, or refuse to issue the license or application for a license of the corporation or firm.

(c) Any conduct of an applicant or licensee that constitutes grounds for disciplinary action under this title may be addressed under this section regardless of where the conduct took place.

(d) The holder of any license that has been revoked or suspended shall surrender the license to the commissioner at the commissioner's request.

(e) After notice and hearing the commissioner may impose other penalties, including suspending the transaction of insurance at specific rental locations where violations of this section have occurred and imposing fines on the manager or supervisor at each location responsible for the supervision and conduct of each endorsee, as the commissioner determines necessary or convenient to carry out the purpose of this chapter.

(3) The commissioner may suspend, revoke, or refuse to renew any rental car insurance producer license by an order served by mail or personal service upon the licensee not less than fifteen days prior to its effective date. The order is subject to the right of the licensee to a hearing under chapter 48.04 RCW.

(4) The commissioner may temporarily suspend a license by an order served by mail or personal service upon the licensee not less than three days prior to its effective date. However, the order must contain a notice of revocation and include a finding that the public safety or welfare imperatively requires emergency action. These suspensions may continue only until proceedings for revocation are concluded. The commissioner may also temporarily suspend a license in cases when proceedings for revocation are pending if it is found that the public safety or welfare imperatively requires emergency action.

(5) Service by mail under this section means posting in the United States mail, addressed to the licensee at the most recent address shown in the commissioner's licensing records for the licensee. Service by mail is complete upon deposit in the United States mail.

(6) If any person sells insurance in connection with or incidental to rental car agreements, or holds himself or herself or a company out as a rental car insurance producer, without satisfying the requirements of this chapter, the commissioner is authorized to issue a cease and desist order. [2008 c 217 § 92; 2002 c 273 § 8.]

Additional notes found at www.leg.wa.gov

48.115.040 Treatment of moneys collected from renters purchasing insurance. A rental car insurance producer is not required to treat moneys collected from renters purchasing rental car insurance as funds received in a fiduciary capacity, if:

(1) The charges for rental car insurance coverage are itemized and ancillary to a rental transaction; and

(2) The insurer has consented in writing, signed by an officer of the insurer, that premiums need not be segregated from funds received by the rental car insurance producer. [2008 c 217 § 93; 2002 c 273 § 9.]

Additional notes found at www.leg.wa.gov

48.115.045 Rule making. The commissioner may adopt rules necessary to implement this chapter, including rules establishing licensing fees to defray the cost of administering this chapter. [2002 c 273 § 10.]

(2022 Ed.)

Chapter 48.120 RCW

SPECIALTY PRODUCER LICENSES—PORTABLE ELECTRONICS OR SERVICES

Sections

48.120.005	Definitions.
48.120.010	License required—Application.
48.120.015	Scope of license—Authorization—Portable electronics.
48.120.020	Issuance of insurance—Restrictions—Portable electronics—Conduct of employees and authorized representatives.
48.120.025	Statutes governing vendor misconduct—Rules necessary to implement chapter.

48.120.005 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Appointing insurer" means the insurer appointing the vendor as its agent under a specialty producer license.

(2) "Customer" means a person that enters into a portable electronics transaction with a vendor.

(3) "Federal securities law" means the securities act of 1933, the securities exchange act of 1934, and the investment company act of 1940.

(4) "Location" means any physical locale in this state and any website, call center site, or similar site directed to residents of this state.

(5) "Portable electronics" means personal, self-contained, easily carried by an individual, battery-operated electronic communication, viewing, listening, recording, gaming, computing or global positioning devices and other similar devices and their accessories, and service related to the use of such devices.

(6) "Portable electronics insurance program" means an insurance program as described in RCW 48.120.015.

(7) "Portable electronics transaction" means the sale or lease of portable electronics or the sale of a service related to the use of portable electronics by a vendor to a customer.

(8) "Specialty producer license" means a license issued under RCW 48.120.010 that authorizes a vendor to offer or sell insurance as provided in RCW 48.120.015.

(9) "Supervising person" means a licensed insurer or an appointed insurance producer licensed under RCW 48.17.090 who provides training as described in RCW 48.120.020 and is appointed by an insurer to supervise the administration of a portable electronics insurance program.

(10) "Vendor" means a person in the business of, directly or indirectly, engaging in portable electronics transactions. [2012 c 154 § 1; 2008 c 217 § 94; 2002 c 357 § 1.]

Reviser's note: The definitions in this section have been alphabetized pursuant to RCW 1.08.015(2)(k).

Additional notes found at www.leg.wa.gov

48.120.010 License required—Application. (1) A vendor that intends to offer insurance under RCW 48.120.015 must file a specialty producer license application with the commissioner. Before the commissioner issues such a license, the vendor must be appointed as the insurance producer of one or more authorized appointing insurers under a vendor's specialty producer license.

(2) Upon receipt of an application, if the commissioner is satisfied that the application is complete, the commissioner may issue a specialty producer license to the vendor.

(3) An application for licensure pursuant to this section must conform to the requirements of chapter 48.17 RCW. However, information with respect to an applicant's officers, directors, and shareholders of record having beneficial ownership of ten percent or more of any class of securities registered under federal securities law may only be required if the vendor derives more than fifty percent of its revenue from the sale of portable electronics insurance. [2012 c 154 § 2; 2008 c 217 § 95; 2002 c 357 § 2.]

Additional notes found at www.leg.wa.gov

48.120.015 Scope of license—Authorization—Portable electronics. (1) A specialty producer license authorizes a vendor and its employees and authorized representatives to offer and sell to, enroll in, and bill and collect premiums from customers for insurance covering portable electronics on a master, corporate, group commercial inland marine policy, or on an individual policy basis on a month-to-month or other periodic basis at each location at which the vendor engages in portable electronics transactions. However:

(a) The supervising person must maintain a list of a vendor's locations that are authorized to sell or solicit portable electronics insurance coverage; and

(b) The list under (a) of this subsection must be provided to the commissioner within ten days of a request by the commissioner.

(2) An employee or authorized representative of a vendor may sell or offer portable electronics insurance to the vendor's customers without being individually licensed as an insurance producer if the vendor is licensed under this chapter and is acting in compliance with this chapter and any rules adopted by the commissioner.

(3) A vendor billing and collecting premiums from customers for portable electronics insurance coverage is not required to maintain these funds in a segregated account if the vendor:

(a) Is authorized by the insurer to hold the funds in an alternative manner; and

(b) Remits the funds to the supervising person within sixty days of receipt.

(4) All funds received by a vendor from an enrolled customer for the sale of portable electronics insurance are considered funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer.

(5) Any charge to the enrolled customer for coverage that is not included in the cost associated with the purchase or lease of portable electronics or related services must be separately itemized on the enrolled customer's bill.

(6) If portable electronics insurance coverage is included with the purchase or lease of portable electronics or related services, the vendor must clearly and conspicuously disclose to the enrolled customer that the portable electronics insurance coverage is included with the portable electronics or related services.

(7) Vendors may receive compensation for billing and collection services. [2013 c 152 § 4; 2012 c 154 § 3; 2002 c 357 § 3.]

48.120.020 Issuance of insurance—Restrictions—Portable electronics—Conduct of employees and authorized representatives. (1) A vendor issued a specialty pro-

ducer license may not issue insurance under RCW 48.120.015 unless:

(a) At every location where customers are enrolled in portable electronics insurance programs, written material regarding the program is made available to prospective customers that:

(i) Discloses that portable electronics insurance may provide a duplication of coverage already provided by a customer's homeowner's insurance policy, renter's insurance policy, or other source of coverage;

(ii) States that the enrollment by the customer in a portable electronics insurance program is not required in order to purchase or lease portable electronics or services;

(iii) Summarizes the material terms of the insurance coverage, including the identity of the insurer, the identity of the supervising person, the amount of any applicable deductible and how it is to be paid, benefits of the coverage, and key terms and conditions of coverage, such as whether portable electronics may be replaced with a similar make and model or reconditioned make and model or repaired with nonoriginal manufacturer parts or equipment;

(iv) Summarizes the process for filing a claim, including a description of how to return portable electronics and the maximum fee applicable in the event the customer fails to comply with any equipment return requirements;

(v) States that an enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time and the person paying the premium will receive a refund or credit of any applicable unearned premium; and

(vi) Discloses with specificity under what circumstances and subject to what limitations an insurer may cancel, terminate, modify, or otherwise change the terms and conditions of a policy of portable electronics insurance; and

(b) The portable electronics insurance program is operated with the participation of a supervising person who, with authorization and approval from the appointing insurer, supervises a training program for employees of the licensed vendor. The training must comply with the following:

(i) The training must be delivered to employees and authorized representatives of vendors who are directly engaged in the activity of selling or offering portable electronics insurance;

(ii) The training may be provided in electronic form. However, if conducted in an electronic form, the supervising person must implement a supplemental education program regarding the portable electronics insurance product that is conducted and overseen by licensed employees of the supervising person; and

(iii) Each employee and authorized representative must receive basic instruction about the portable electronics insurance offered to customers and the disclosures required under this section.

(2) No employee or authorized representative of a vendor of portable electronics may advertise, represent, or otherwise hold himself or herself out as a nonlimited lines licensed insurance producer.

(3) Employees and authorized representatives of a vendor issued a specialty producer license may only act on behalf of the vendor in the offer, sale, solicitation, or enrollment of customers in a portable electronics insurance program. The

conduct of these employees and authorized representatives within the scope of their employment or agency is the same as conduct of the vendor for purposes of this title. [2013 c 152 § 6; (2013 c 152 § 5 expired July 1, 2015); 2012 c 154 § 4; 2002 c 357 § 4.]

Effective date—2013 c 152 § 6: "Section 6 of this act takes effect July 1, 2015." [2013 c 152 § 10.]

Expiration date—2013 c 152 § 5: "Section 5 of this act expires July 1, 2015." [2013 c 152 § 9.]

48.120.025 Statutes governing vendor misconduct—Rules necessary to implement chapter. (1) A vendor issued a specialty producer license under this chapter is subject to RCW 48.17.530 through 48.17.560.

(2) The commissioner may adopt rules necessary for the implementation of this chapter, including, but not limited to, rules governing:

(a) The specialty producer license application process, including any forms required to be used;

(b) The standards for approval and the required content of written materials required under RCW 48.120.020(1)(a);

(c) The approval and required content of training materials required under RCW 48.120.020(1)(c);

(d) Establishing license fees to defray the cost of administering the specialty producer licensure program;

(e) Establishing requirements for the remittance of premium funds to the supervising agent under authority from the program insurer; and

(f) Determining the applicability or nonapplicability of other provisions of this title to this chapter. [2013 c 152 § 7; 2002 c 357 § 5.]

Chapter 48.125 RCW

SELF-FUNDED MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

Sections

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48.125.901	Effective date—2004 c 260.

48.125.003 Short title. This chapter may be cited as the "self-funded multiple employer welfare arrangement regulation act." [2004 c 260 § 1.]

48.125.005 Purposes. The purposes of this chapter are to:

(1) Provide for the authorization and registration of self-funded multiple employer welfare arrangements;

(2) Regulate self-funded multiple employer welfare arrangements in order to ensure the financial integrity of the arrangements;

(3) Provide reporting requirements for self-funded multiple employer welfare arrangements; and

(4) Provide for sanctions against self-funded multiple employer welfare arrangements organized, operated, providing benefits, or maintained in this state that do not comply with this chapter. [2004 c 260 § 2.]

48.125.010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Bona fide association" means an association of employers that has been in existence for a period of not less than ten years prior to sponsoring a self-funded multiple employer welfare arrangement, during which time the association has engaged in substantial activities relating to the common interests of member employers, and that continues to engage in substantial activities in addition to sponsoring an arrangement. However, an association that was formed and began sponsoring an arrangement prior to October 1, 1995, is not subject to the requirement that the association be in existence for ten years prior to sponsoring an arrangement.

(2) "Employer" means any person, firm, corporation, partnership, business trust, legal representative, or other business entity which engages in any business, industry, profession, or activity in this state and employs one or more other persons or who contracts with one or more persons, the essence of which is the personal labor of that person or persons.

(3) "Health care service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

(4) "Incurred claims" means the value of all amounts paid or payable under a multiple employer welfare arrangement determined by contract to be a liability with an incurred claims date during the valuation period. It includes all payments during the valuation period plus a reasonable estimate of unpaid claims liabilities.

(5) "Multiple employer welfare arrangement" means a multiple employer welfare arrangement as defined by 29 U.S.C. Sec. 1002, but does not include an arrangement, plan, program, or interlocal agreement of or between any political subdivisions of this state, any federal agencies, or any contractors or subcontractors with federal agencies at a federal government facility within this state.

(6) "Qualified actuary" means an individual who:

(a) Is a member in good standing of the American academy of actuaries; and

(b) Is qualified to sign statements of actuarial opinion for health annual statements in accordance with the American academy of actuaries qualification standards for actuaries signing the statements.

(7) "Self-funded multiple employer welfare arrangement" or "arrangement" means a multiple employer welfare arrangement that does not provide for payment of benefits under the arrangement solely through a policy or policies of

insurance issued by one or more insurance companies licensed under this title.

(8) "Surplus" means the excess of the assets of a self-funded multiple employer welfare arrangement over the liabilities of the arrangement. The assets and liabilities should be determined in accordance with the accounting practices and procedures manuals as adopted by the national association of insurance commissioners, unless otherwise provided by law. [2004 c 260 § 3.]

48.125.020 Certificate of authority required. (1) Except as provided in subsection (3) of this section, a person may not establish, operate, provide benefits, or maintain a self-funded multiple employer welfare arrangement in this state unless the arrangement first obtains a certificate of authority from the commissioner.

(2) An arrangement is considered to be established, operated, providing benefits, or maintained in this state if (a) one or more of the employer members participating in the arrangement is either domiciled in or maintains a place of business in this state, or (b) the activities of the arrangement or employer members fall under the scope of RCW 48.01.020.

(3) An arrangement established, operated, providing benefits, or maintained in this state prior to December 31, 2003, has until April 1, 2005, to file a substantially complete application for a certificate of authority. An arrangement that files a substantially complete application for a certificate of authority by that date is allowed to continue to operate without a certificate of authority until the commissioner approves or denies the arrangement's application for a certificate of authority. [2004 c 260 § 4.]

48.125.030 Certificate of authority—Requirements for issuance. The commissioner may not issue a certificate of authority to a self-funded multiple employer welfare arrangement unless the arrangement establishes to the satisfaction of the commissioner that the following requirements have been satisfied by the arrangement:

(1) The employers participating in the arrangement are members of a bona fide association;

(2) The employers participating in the arrangement exercise control over the arrangement, as follows:

(a) Subject to (b) of this subsection, control exists if the board of directors of the bona fide association or the employers participating in the arrangement have the right to elect at least seventy-five percent of the individuals designated in the arrangement's organizational documents as having control over the operations of the arrangement and the individuals designated in the arrangement's organizational documents in fact exercise control over the operation of the arrangement; and

(b) The use of a third-party administrator to process claims and to assist in the administration of the arrangement is not evidence of the lack of exercise of control over the operation of the arrangement;

(3) In this state, the arrangement provides only health care services;

(4) In this state, the arrangement provides or arranges benefits for health care services in compliance with those provisions of this title that mandate particular benefits or

offerings and with provisions that require access to particular types or categories of health care providers and facilities;

(5) In this state, the arrangement provides or arranges benefits for health care services in compliance with RCW 48.43.500 through 48.43.535, 48.43.545, and 48.43.550;

(6) The arrangement provides health care services to not less than twenty employers and not less than seventy-five employees;

(7) The arrangement may not solicit participation in the arrangement from the general public. However, the arrangement may employ licensed insurance producers who receive a commission, unlicensed individuals who do not receive a commission, and may contract with a licensed insurance producer who may be paid a commission or other remuneration, for the purpose of enrolling and renewing the enrollments of employers in the arrangement;

(8) The arrangement has been in existence and operated actively for a continuous period of not less than ten years as of December 31, 2003, except for an arrangement that has been in existence and operated actively since December 31, 2000, and is sponsored by an association that has been in existence more than twenty-five years; and

(9) The arrangement is not organized or maintained solely as a conduit for the collection of premiums and the forwarding of premiums to an insurance company. [2008 c 217 § 96; 2004 c 260 § 5.]

Additional notes found at www.leg.wa.gov

48.125.040 Certificate of authority—Continued compliance with certain conditions—Commissioner's discretion. (1) In addition to the requirements under RCW 48.125.030, self-funded multiple employer welfare arrangements are subject to the following requirements:

(a) Arrangements must maintain a calendar year for operations and reporting purposes;

(b) Arrangements must satisfy one of the following requirements:

(i)(A) The arrangement must deposit two hundred thousand dollars with the commissioner to be used for the payment of claims in the event that the arrangement becomes insolvent; and

(B) The arrangement must submit to the commissioner a written plan of operation that, in the reasonable discretion of the commissioner, ensures the financial integrity of the arrangement; or

(ii) The arrangement demonstrates to the reasonable satisfaction of the commissioner the ability of the arrangement to remain financially solvent, for which purpose the commissioner may consider:

(A) The pro forma financial statements of the arrangement;

(B) The types and levels of excess of loss insurance coverage, including the attachment points of the coverage and whether the points are reflected as annual or monthly levels;

(C) Whether a deposit is required for each employee covered under the arrangement equal to at least one month's cost of providing benefits under the arrangement;

(D) The experience of the individuals who will be involved in the management of the arrangement, including employees, independent contractors, and consultants; and

(E) Other factors as reasonably determined by the commissioner to be relevant to a determination of whether the arrangement is able to operate in a financially solvent manner.

(2) The commissioner may require that the articles, bylaws, agreements, trusts, or other documents or instruments describing the rights and obligations of the employers, employees, and beneficiaries of the arrangement provide that employers participating in the arrangement are subject to pro rata assessment for all liabilities of the arrangement.

(3) Self-funded multiple employer welfare arrangements with fewer than one thousand covered persons are required to have aggregate stop loss coverage, with an attachment point of one hundred twenty-five percent of expected claims. If the arrangement is allowed to assess the participating employers to cover actual or projected claims in excess of plan assets, then the attachment point shall be increased by the amount of the allowable assessments. If the required attachment point exceeds one hundred seventy-five percent of expected claims, aggregate stop loss coverage shall be waived. Arrangements with one thousand covered persons or more are not required to have aggregate stop loss coverage.

(4) The arrangement must demonstrate continued compliance with respect to the conditions set forth in this section as a condition of receiving and maintaining a certificate of authority. The commissioner may waive continued compliance with respect to the conditions in this section at any time after the commissioner has granted a certificate of authority to an arrangement. [2004 c 260 § 6.]

48.125.050 Certificate of authority—Application—Form—Documentation. A self-funded multiple employer welfare arrangement must apply for a certificate of authority on a form prescribed by the commissioner and must submit the application, together with the following documents, to the commissioner:

(1) A copy of all articles, bylaws, agreements, trusts, or other documents or instruments describing the rights and obligations of the employers, employees, and beneficiaries of the arrangement;

(2) A copy of the summary plan description or summary plan descriptions of the arrangement, including those filed or required to be filed with the United States department of labor, together with any amendments to the description;

(3) Evidence of coverage of or letters of intent to participate executed by at least twenty employers providing allowable benefits to at least seventy-five employees;

(4) A copy of the arrangement's most recent year's financial statements that must include, at a minimum, a balance sheet, an income statement, a statement of changes in financial position, and an actuarial opinion signed by a qualified actuary stating that the unpaid claim liability of the arrangement satisfies the standards under this title;

(5) Proof that the arrangement maintains or will maintain fidelity bonds required by the United States department of labor under the employee retirement income security act of 1974, 29 U.S.C. Sec. 1001 et seq.;

(6) A copy of any excess of loss insurance coverage policies maintained or proposed to be maintained by the arrangement;

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(7) Biographical reports on forms prescribed by the national association of insurance commissioners evidencing the general trustworthiness and competence of each individual who is serving or who will serve as an officer, director, trustee, employee, or fiduciary of the arrangement;

(8) Third-party verification reports from a vendor authorized by the national association of insurance commissioners to perform a state, national, and international criminal background history check of any person who exercises control over the financial dealings and operations of the self-funded multiple employer welfare arrangement, including collection of employer contributions, investment of assets, payment of claims, rate setting, and claims adjudication. The third-party verification reports and any additional information must be submitted to the office of the insurance commissioner. The results may be disseminated to any governmental agency or entity authorized to receive them; and

(9) A statement executed by a representative of the arrangement certifying, to the best knowledge and belief of the representative, that:

(a) The arrangement is in compliance with RCW 48.125.030;

(b) The arrangement is in compliance with the requirements of the employee retirement income security act of 1974, 29 U.S.C. Sec. 1001 et seq., or a statement of any requirements with which the arrangement is not in compliance and a statement of proposed corrective actions; and

(c) The arrangement is in compliance with RCW 48.125.060 and 48.125.070. [2012 c 211 § 11; 2004 c 260 § 7.]

48.125.060 Surplus required—Amount—Enforcement. Self-funded multiple employer welfare arrangements must maintain continuously a surplus equal to at least ten percent of the next twelve months projected incurred claims or two million dollars, whichever is greater. The commissioner may proceed against self-funded multiple employer welfare arrangements that fail to maintain the level of surplus required by this section in any manner that the commissioner is authorized to proceed against a health care service contractor that failed to maintain minimum net worth. [2004 c 260 § 8.]

48.125.070 Contribution rates. A self-funded multiple employer welfare arrangement must establish and maintain contribution rates for participation under the arrangement that satisfy either of the following requirements:

(1) Contribution rates must equal or exceed the sum of projected incurred claims for the year, plus all projected costs of operation of the arrangement for the year, plus an amount equal to any deficiency in the surplus of the arrangement for the prior year, minus an amount equal to the surplus of the arrangement in excess of the minimum required level of surplus; or

(2) Contribution rates must equal or exceed a funding level established by a report prepared by a qualified actuary. [2004 c 260 § 9.]

48.125.080 Certificate of authority—Granting or denying application. (1) The commissioner shall grant or deny an application for a certificate of authority within one

hundred eighty days of the date that a completed application, together with the items designated in RCW 48.125.050, is submitted to the commissioner.

(2) The commissioner shall grant the application of an arrangement that satisfies the applicable requirements of RCW 48.125.030 through 48.125.070.

(3) The commissioner shall deny the application of an arrangement that does not satisfy the applicable requirements of RCW 48.125.030 through 48.125.070. Denial of an application for a certificate of authority is subject to appeal under chapter 34.05 RCW.

(4) A certificate of authority granted to an arrangement is effective unless revoked by the commissioner under RCW 48.125.100. [2004 c 260 § 10.]

48.125.090 Reporting requirements. (1) A self-funded multiple employer welfare arrangement must comply with the reporting requirements of this section.

(2) Every arrangement holding a certificate of authority from the commissioner must file its financial statements as required by this title and by the commissioner in accordance with the accounting practices and procedures manuals as adopted by the national association of insurance commissioners, unless otherwise provided by law.

(3) Every arrangement must comply with the provisions of chapters 48.12 and 48.13 RCW.

(4) Every domestic arrangement holding a certificate of authority shall annually, on or before the first day of March, file with the commissioner a true statement of its financial condition, transactions, and affairs as of the thirty-first day of December of the preceding year. The statement forms must be those forms approved by the national association of insurance commissioners for health insurance. The statement must be verified by the oaths of at least two officers of the arrangement. Additional information may be required by this title or by the request of the commissioner.

(5) Every arrangement must report their annual and other statements in the same manner required of other insurers by rule of the commissioner.

(6) The arrangement must file with the commissioner a copy of the arrangement's internal revenue service form 5500 together with all attachments to the form, at the time required for filing the form. [2006 c 25 § 10; 2004 c 260 § 11.]

48.125.100 Failure to comply with chapter—Sanctions. (1) The commissioner may impose sanctions against a self-funded multiple employer welfare arrangement that fails to comply with this chapter. The maximum fine may not exceed ten thousand dollars for each violation.

(2) The commissioner may issue a notice of intent to revoke the certificate of authority of a self-funded multiple employer welfare arrangement that fails to comply with RCW 48.125.060, 48.125.070, or 48.125.090. If, within sixty days of receiving notice under this subsection, the arrangement fails to file with the commissioner a plan to bring the arrangement into compliance with RCW 48.125.060, 48.125.070, or 48.125.090, the commissioner may revoke the arrangement's certificate of authority. A revocation of a certificate of authority is subject to appeal under chapter 34.05 RCW.

(3) An arrangement that fails to maintain the level of surplus required by RCW 48.125.060 is subject to the sanctions authorized in RCW 48.44.160 through 48.44.166. [2004 c 260 § 12.]

48.125.110 Certificate of authority—Failure to obtain. A self-funded multiple employer welfare arrangement organized, operated, providing benefits, or maintained in this state without a certificate of authority is in violation of this title. [2004 c 260 § 13.]

48.125.120 Policy must contain specific notice. Each policy issued by a self-funded multiple employer welfare arrangement must contain, in ten-point type on the front page and the declaration page, the following notice:

"NOTICE

This policy is issued by a self-funded multiple employer welfare arrangement. A self-funded multiple employer welfare arrangement may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for a self-funded multiple employer welfare arrangement." [2004 c 260 § 14.]

48.125.130 Additional compliance requirements. A self-funded multiple employer welfare arrangement is subject to RCW 48.43.300 through 48.43.370, the rehabilitation provisions under chapter 48.31 RCW, and chapter 48.99 RCW. [2004 c 260 § 15.]

48.125.140 Examination of operations—Commissioner's powers—Definition of affiliate. (1) The commissioner may make an examination of the operations of any self-funded multiple employer welfare arrangement as often as he or she deems necessary in order to carry out the purposes of this chapter.

(2) Every self-funded multiple employer welfare arrangement shall submit its books and records relating to its operation for financial condition and market conduct examinations and in every way facilitate them. For the purpose of examinations, the commissioner may issue subpoenas, administer oaths, and examine the officers and principals of the self-funded multiple employer welfare arrangement.

(3) The commissioner may elect to accept and rely on audit reports made by an independent certified public accountant for the self-funded multiple employer welfare arrangement in the course of that part of the commissioner's examination covering the same general subject matter as the audit. The commissioner may incorporate the audit report in his or her report of the examination.

(4)(a) The commissioner may also examine any affiliate of the self-funded multiple employer welfare arrangement. An examination of an affiliate is limited to the activities or operations of the affiliate that may impact the financial position of the arrangement.

(b) For the purposes of this section, "affiliate" has the same meaning as defined in RCW 48.31B.005.

(5) Whenever an examination is made, all of the provisions of chapter 48.03 RCW not inconsistent with this chapter shall be applicable. In lieu of making an examination himself or herself, the commissioner may, in the case of a foreign

self-funded multiple employer welfare arrangement, accept an examination report of the applicant by the regulatory official in its state of domicile. In the case of a domestic self-funded multiple employer welfare arrangement, the commissioner may accept an examination report of the applicant by the regulatory official of a state that has already licensed the arrangement. [2015 c 122 § 18; 2004 c 260 § 16.]

Effective dates—2015 c 122: See note following RCW 48.31B.005.

48.125.150 Chapter not applicable. This chapter does not apply to:

- (1) Single employer entities;
- (2) Taft-Hartley plans; or
- (3) Self-funded multiple employer welfare arrangements that do not provide coverage for health care services. [2004 c 260 § 17.]

48.125.160 Taxable amounts—Participant contributions. Participant contributions used to determine the taxable amounts in this state under RCW 48.14.0201 shall be determined in the same manner as premiums taxable in this state are determined under RCW 48.14.090. [2004 c 260 § 18.]

48.125.200 Prostate cancer screening. (1) Each self-funded multiple employer welfare arrangement established, operated, providing benefits, or maintained in this state after December 31, 2006, that provides coverage for hospital or medical expenses shall provide coverage for prostate cancer screening, provided that the screening is delivered upon the recommendation of the patient's physician, advanced registered nurse practitioner, or physician assistant.

(2) This section shall not be construed to prevent the application of standard policy provisions applicable to other benefits, such as deductible or copayment provisions. This section does not limit the authority of a self-funded multiple employer welfare arrangement to negotiate rates and contract with specific providers for the delivery of prostate cancer screening services. [2006 c 367 § 6.]

48.125.901 Effective date—2004 c 260. This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [March 31, 2004]. [2004 c 260 § 29.]

Chapter 48.130 RCW INTERSTATE INSURANCE PRODUCT REGULATION COMPACT

Sections

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48.130.020	Commission created.
48.130.030	Commission's powers.
48.130.040	Commission membership—Management and legislative committees—Liability.
48.130.050	Commission actions—Voting.
48.130.060	Commission rule making—Uniform standards and operating procedures—States may opt out.
48.130.070	Commission rule making—Confidentiality of information and records—Compliance with compact.
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48.130.120	Compact, commission, compact amendments—When effective.
48.130.130	Withdrawal from compact, how—Default by state—Dissolution of compact.
48.130.140	Effect of compact—Other state laws—Binding on compacting states, when.
48.130.901	Construction—2005 c 92.

48.130.005 Purposes—Insurance commissioner represents state. Under the terms and conditions of this chapter, the state of Washington seeks to join with other states and establish the interstate insurance product regulation compact and thus become a member of the interstate insurance product regulation commission. The insurance commissioner is hereby designated to serve as the representative of this state to the commission. The purposes of the compact under this chapter are, through means of joint and cooperative action among the compacting states:

- (1) To promote and protect the interest of consumers of individual and group annuity, life insurance, disability income, and long-term care insurance products;
- (2) To develop uniform standards for insurance products covered under the compact;
- (3) To establish a central clearinghouse to receive and provide prompt review of insurance products covered under the compact and, in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one or more compacting states;
- (4) To give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard;
- (5) To improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the compact;
- (6) To create the interstate insurance product regulation commission; and
- (7) To perform these and such other related functions as may be consistent with the state regulation of the business of insurance. [2005 c 92 § 1.]

48.130.010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

- (1) "Advertisement" means any material designed to create public interest in a product, or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace, or retain a policy, as more specifically defined in the rules and operating procedures of the commission.
- (2) "Bylaws" means those bylaws established by the commission for its governance, or for directing or controlling the commission's actions or conduct.
- (3) "Compact" means the compact set forth in this chapter.
- (4) "Compacting state" means any state which has enacted the compact and which has not withdrawn under RCW 48.130.130(1) or been terminated under RCW 48.130.130(2).
- (5) "Commission" means the interstate insurance product regulation commission established in RCW 48.130.020.
- (6) "Commissioner" means the insurance commissioner or the chief insurance regulatory official of a state including

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but not limited to commissioner, superintendent, director, or administrator.

(7) "Domiciliary state" means the state in which an insurer is incorporated or organized; or, in the case of an alien insurer, its state of entry.

(8) "Insurer" means any entity licensed by a state to issue contracts of insurance for any of the lines of insurance covered by the compact.

(9) "Member" means the person chosen by a compacting state as its representative to the commission, or his or her designee.

(10) "Noncompacting state" means any state which is not at the time a compacting state.

(11) "Operating procedures" mean procedures adopted by the commission implementing a rule, uniform standard, or a provision of the compact.

(12) "Product" means the form of a policy or contract, including any application, endorsement, or related form which is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability income, or long-term care insurance product that an insurer is authorized to issue.

(13) "Rule" means a statement of general or particular applicability and future effect adopted by the commission, including a uniform standard developed under RCW 48.130.060, designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of the commission, which shall have the force and effect of law in the compacting states.

(14) "State" means any state, district, or territory of the United States of America.

(15) "Third-party filer" means an entity that submits a product filing to the commission on behalf of an insurer.

(16) "Uniform standard" means a standard adopted by the commission for a product line, under RCW 48.130.060, and includes all of the product requirements in aggregate. However, each uniform standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading, or ambiguous provisions in a product and the form of the product made available to the public shall not be unfair, inequitable, or against public policy as determined by the commission. [2005 c 92 § 2.]

48.130.020 Commission created. (1) The compacting states hereby create and establish a joint public agency known as the interstate insurance product regulation commission. Under RCW 48.130.030, the commission will have the power to develop uniform standards for product lines, receive and provide prompt review of products filed therewith, and give approval to those product filings satisfying applicable uniform standards. However, it is not intended for the commission to be the exclusive entity for receipt and review of insurance product filings. This section does not prohibit any insurer from filing its product in any state wherein the insurer is licensed to conduct the business of insurance; and any such filing shall be subject to the laws of the state where filed.

(2) The commission is a body corporate and politic, and an instrumentality of the compacting states.

(3) The commission is solely responsible for its liabilities except as otherwise specifically provided in the compact.

(4) Venue is proper and judicial proceedings by or against the commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the commission is located. [2005 c 92 § 3.]

48.130.030 Commission's powers. The commission shall have the following powers:

(1) To adopt rules, under RCW 48.130.060, which shall have the force and effect of law and shall be binding in the compacting states to the extent and in the manner provided in the compact;

(2) To exercise its rule-making authority and establish reasonable uniform standards for products covered under the compact, and advertisement related thereto, which shall have the force and effect of law and shall be binding in the compacting states, but only for those products filed with the commission. However, a compacting state shall have the right to opt out of such uniform standard under RCW 48.130.060, to the extent and in the manner provided in this compact. Any uniform standard established by the commission for long-term care insurance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the national association of insurance commissioners' long-term care insurance model act and long-term care insurance model regulation, respectively, adopted as of 2001. The commission shall consider whether any subsequent amendments to the long-term care insurance model act or long-term care insurance model regulation adopted by the national association of insurance commissioners require amending of the uniform standards established by the commission for long-term care insurance products;

(3) To receive and review in an expeditious manner products filed with the commission, and rate filings for disability income and long-term care insurance products, and give approval of those products and rate filings that satisfy the applicable uniform standard, where such approval shall have the force and effect of law and be binding on the compacting states to the extent and in the manner provided in the compact;

(4) To receive and review in an expeditious manner advertisement relating to long-term care insurance products for which uniform standards have been adopted by the commission, and give approval to all advertisement that satisfies the applicable uniform standard. For any product covered under this compact, other than long-term care insurance products, the commission shall have the authority to require an insurer to submit all or any part of its advertisement with respect to that product for review or approval prior to use, if the commission determines that the nature of the product is such that an advertisement of the product could have the capacity or tendency to mislead the public. The actions of the commission as provided in this section shall have the force and effect of law and shall be binding in the compacting states to the extent and in the manner provided in the compact;

(5) To exercise its rule-making authority and designate products and advertisement that may be subject to a self-certification process without the need for prior approval by the commission;

(6) To adopt operating procedures, under RCW 48.130.060, which shall be binding in the compacting states to the extent and in the manner provided in the compact;

(7) To bring and prosecute legal proceedings or actions in its name as the commission. However, the standing of any state insurance department to sue or be sued under applicable law shall not be affected;

(8) To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence;

(9) To establish and maintain offices;

(10) To purchase and maintain insurance and bonds;

(11) To borrow, accept, or contract for services of personnel, including, but not limited to, employees of a compacting state;

(12) To hire employees, professionals, or specialists, and elect or appoint officers, and to fix their compensation, define their duties, and give them appropriate authority to carry out the purposes of the compact, and determine their qualifications; and to establish the commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation, and qualifications of personnel;

(13) To accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services, and to receive, utilize, and dispose of the same. However, the commission shall strive to avoid any appearance of impropriety;

(14) To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve, or use, any property, real, personal, or mixed. However, the commission shall strive to avoid any appearance of impropriety;

(15) To sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;

(16) To remit filing fees to compacting states as may be set forth in the bylaws, rules, or operating procedures;

(17) To enforce compliance by compacting states with rules, uniform standards, operating procedures, and bylaws;

(18) To provide for dispute resolution among compacting states;

(19) To advise compacting states on issues relating to insurers domiciled or doing business in noncompacting jurisdictions, consistent with the purposes of the compact;

(20) To provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state insurance departments;

(21) To establish a budget and make expenditures;

(22) To borrow money;

(23) To appoint committees, including advisory committees comprising members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and such other interested persons as may be designated in the bylaws;

(24) To provide and receive information from, and to cooperate with, law enforcement agencies;

(25) To adopt and use a corporate seal; and

(26) To perform such other functions as may be necessary or appropriate to achieve the purposes of the compact consistent with the state regulation of the business of insurance. [2005 c 92 § 4.]

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48.130.040 Commission membership—Management and legislative committees—Liability. (1)(a) Each compacting state shall have and be limited to one member. Each member shall be qualified to serve in that capacity pursuant to applicable law of the compacting state. Any member may be removed or suspended from office as provided by the law of the state from which he or she shall be appointed. Any vacancy occurring in the commission shall be filled in accordance with the laws of the compacting state wherein the vacancy exists. This section does not affect the manner in which a compacting state determines the election or appointment and qualification of its own commissioner.

(b) Each member shall be entitled to one vote and shall have an opportunity to participate in the governance of the commission in accordance with the bylaws. Notwithstanding any provision in this chapter to the contrary, no action of the commission with respect to the adoption of a uniform standard shall be effective unless two-thirds of the members vote in favor thereof.

(c) The commission shall, by a majority of the members, prescribe bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes, and exercise the powers, of the compact, including, but not limited to:

(i) Establishing the fiscal year of the commission;

(ii) Providing reasonable procedures for appointing and electing members, as well as holding meetings, of the management committee;

(iii) Providing reasonable standards and procedures for: (A) The establishment and meetings of other committees; and (B) governing any general or specific delegation of any authority or function of the commission;

(iv) Providing reasonable procedures for calling and conducting meetings of the commission that consists [consist] of a majority of commission members, ensuring reasonable advance notice of each such meeting and providing for the right of citizens to attend each such meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' proprietary information, including trade secrets. The commission may meet in camera only after a majority of the entire membership votes to close a meeting. As soon as practicable, the commission must make public: (A) A copy of the vote to close the meeting revealing the vote of each member with no proxy votes allowed; and (B) votes taken during such meeting;

(v) Establishing the titles, duties, and authority and reasonable procedures for the election of the officers of the commission;

(vi) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the commission. Notwithstanding any civil service or other similar laws of any compacting state, the bylaws shall exclusively govern the personnel policies and programs of the commission;

(vii) Adopting a code of ethics to address permissible and prohibited activities of commission members and employees; and

(viii) Providing a mechanism for winding up the operations of the commission and the equitable disposition of any surplus funds that may exist after the termination of the compact and after the payment or reserving of all of its debts and obligations.

(d) The commission shall publish its bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto with the appropriate agency or officer in each of the compacting states.

(2)(a) A management committee comprising no more than fourteen members shall be established as follows:

(i) One member from each of the six compacting states with the largest premium volume for individual and group annuities, life, disability income, and long-term care insurance products, determined from the records of the national association of insurance commissioners for the prior year;

(ii) Four members from those compacting states with at least two percent of the market based on the premium volume described under (a)(i) of this subsection, other than the six compacting states with the largest premium volume, selected on a rotating basis as provided in the bylaws; and

(iii) Four members from those compacting states with less than two percent of the market, based on the premium volume described under (a)(i) of this subsection, with one selected from each of the four zone regions of the national association of insurance commissioners as provided in the bylaws.

(b) The management committee shall have such authority and duties as may be set forth in the bylaws, including but not limited to:

(i) Managing the affairs of the commission in a manner consistent with the bylaws and purposes of the commission;

(ii) Establishing and overseeing an organizational structure within, and appropriate procedures for, the commission to provide for the creation of uniform standards and other rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a compacting state to opt out of a uniform standard. However, a uniform standard shall not be submitted to the compacting states for adoption unless approved by two-thirds of the members of the management committee;

(iii) Overseeing the offices of the commission; and

(iv) Planning, implementing, and coordinating communications and activities with other state, federal, and local government organizations in order to advance the goals of the commission.

(c) The commission shall elect annually officers from the management committee, with each having such authority and duties, as may be specified in the bylaws.

(d) The management committee may, subject to the approval of the commission, appoint or retain an executive director for such period, upon such terms and conditions and for such compensation as the commission may deem appropriate. The executive director shall serve as secretary to the commission, but shall not be a member of the commission. The executive director shall hire and supervise such other staff as may be authorized by the commission.

(3)(a) A legislative committee comprising state legislators or their designees shall be established to monitor the operations of, and make recommendations to, the commission, including the management committee. However, the manner of selection and term of any legislative committee member shall be as set forth in the bylaws. Prior to the adoption by the commission of any uniform standard, revision to the bylaws, annual budget, or other significant matter as may

be provided in the bylaws, the management committee shall consult with and report to the legislative committee.

(b) The commission shall establish two advisory committees, one of which shall comprise consumer representatives independent of the insurance industry, and the other comprising insurance industry representatives.

(c) The commission may establish additional advisory committees as its bylaws may provide for the carrying out of its functions.

(4) The commission shall maintain its corporate books and records in accordance with the bylaws.

(5)(a) The members, officers, executive director, employees, and representatives of the commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities. However, this subsection (5)(a) does not protect any such person from suit or liability for any damage, loss, injury or liability caused by the intentional or willful and wanton misconduct of that person.

(b) The commission shall defend any member, officer, executive director, employee, or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities. However, this subsection (5)(b) does not prohibit that person from retaining his or her own counsel. Also, the actual or alleged act, error, or omission may not have resulted from that person's intentional or willful and wanton misconduct.

(c) The commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities. However, the actual or alleged act, error, or omission may not have resulted from the intentional or willful and wanton misconduct of that person. [2005 c 92 § 5.]

48.130.050 Commission actions—Voting. (1) The commission shall meet and take such actions as are consistent with the provisions of the compact and the bylaws.

(2) Each member of the commission shall have the right and power to cast a vote to which that compacting state is entitled and to participate in the business and affairs of the commission. A member shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for members' participation in meetings by telephone or other means of communication.

(3) The commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws. [2005 c 92 § 6.]

48.130.060 Commission rule making—Uniform standards and operating procedures—States may opt out. (1) The commission shall adopt reasonable rules, including uniform standards, and operating procedures in order to effectively and efficiently achieve the purposes of the compact. In the event the commission exercises its rule-making authority in a manner that is beyond the scope of the purposes of this chapter, then such an action by the commission shall be invalid and have no force and effect.

(2) Rules and operating procedures shall be made pursuant to a rule-making process that conforms to the model state administrative procedure act of 1981 as amended, as may be appropriate to the operations of the commission. Before the commission adopts a uniform standard, the commission shall give written notice to the relevant state legislative committees in each compacting state responsible for insurance issues of its intention to adopt the uniform standard. The commission in adopting a uniform standard shall consider fully all submitted materials and issue a concise explanation of its decision.

(3) A uniform standard shall become effective ninety days after its adoption by the commission or such later date as the commission may determine. However, a compacting state may opt out of a uniform standard as provided in this section. "Opt out" means any action by a compacting state to decline to adopt or participate in an adopted uniform standard. All other rules and operating procedures, and amendments thereto, shall become effective as of the date specified in each rule, operating procedure, or amendment.

(4)(a) A compacting state may opt out of a uniform standard, either by legislation or regulation adopted by the insurance department under the compacting state's administrative procedure act. If a compacting state elects to opt out of a uniform standard by rule, it must: (i) Give written notice to the commission no later than ten business days after the uniform standard is adopted, or at the time the state becomes a compacting state; and (ii) find that the uniform standard does not provide reasonable protections to the citizens of the state, given the conditions in the state.

(b) The commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the state which warrant a departure from the uniform standard and determining that the uniform standard would not reasonably protect the citizens of the state. The commissioner must consider and balance the following factors and find that the conditions in the state and needs of the citizens of the state outweigh: (i) The intent of the legislature to participate in, and the benefits of, an interstate agreement to establish national uniform consumer protections for the products subject to this chapter; and (ii) the presumption that a uniform standard adopted by the commission provides reasonable protections to consumers of the relevant product.

(c) A compacting state may, at the time of its enactment of the compact, prospectively opt out of all uniform standards involving long-term care insurance products by expressly providing for such opt out in the enacted compact, and such

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an opt out shall not be treated as a material variance in the offer or acceptance of any state to participate in the compact. Such an opt out shall be effective at the time of enactment of the compact by the compacting state and shall apply to all existing uniform standards involving long-term care insurance products and those subsequently promulgated.

(5) If a compacting state elects to opt out of a uniform standard, the uniform standard shall remain applicable in the compacting state electing to opt out until such time the opt out legislation is enacted into law or the regulation opting out becomes effective. Once the opt out of a uniform standard by a compacting state becomes effective as provided under the laws of that state, the uniform standard shall have no further force and effect in that state unless and until the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the state. If a compacting state opts out of a uniform standard after the uniform standard has been made effective in that state, the opt out shall have the same prospective effect as provided under RCW 48.130.130 for withdrawals.

(6) If a compacting state has formally initiated the process of opting out of a uniform standard by regulation, and while the regulatory opt out is pending, the compacting state may petition the commission, at least fifteen days before the effective date of the uniform standard, to stay the effectiveness of the uniform standard in that state. The commission may grant a stay if it determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the commission, the stay or extension thereof may postpone the effective date by up to ninety days, unless affirmatively extended by the commission. However, a stay may not be permitted to remain in effect for more than one year unless the compacting state can show extraordinary circumstances which warrant a continuance of the stay, including, but not limited to, the existence of a legal challenge which prevents the compacting state from opting out. A stay may be terminated by the commission upon notice that the rule-making process has been terminated.

(7) Not later than thirty days after a rule or operating procedure is adopted, any person may file a petition for judicial review of the rule or operating procedure. However, the filing of such a petition shall not stay or otherwise prevent the rule or operating procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the commission consistent with applicable law and shall not find the rule or operating procedure to be unlawful if the rule or operating procedure represents a reasonable exercise of the commission's authority. [2005 c 92 § 7.]

48.130.070 Commission rule making—Confidentiality of information and records—Compliance with compact. (1) The commission shall adopt rules establishing conditions and procedures for public inspection and copying of its information and official records, except such information and records involving the privacy of individuals and insurers' trade secrets. The commission may adopt additional rules under which it may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into

agreements with such agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

(2) Except as to privileged records, data, and information, the laws of any compacting state pertaining to confidentiality or nondisclosure shall not relieve any compacting state commissioner of the duty to disclose any relevant records, data or information to the commission. However, disclosure to the commission does not waive or otherwise affect any confidentiality requirement. Also, except as otherwise expressly provided in this chapter, the commission shall not be subject to the compacting state's laws pertaining to confidentiality and nondisclosure with respect to records, data, and information in its possession. Confidential information of the commission shall remain confidential after such information is provided to any commissioner.

(3) The commission shall monitor compacting states for compliance with duly adopted bylaws, rules, including uniform standards, and operating procedures. The commission shall notify any noncomplying compacting state in writing of its noncompliance with commission bylaws, rules or operating procedures. If a noncomplying compacting state fails to remedy its noncompliance within the time specified in the notice of noncompliance, the compacting state shall be deemed to be in default as set forth in RCW 48.130.130.

(4) The commissioner of any state in which an insurer is authorized to do business, or is conducting the business of insurance, shall continue to exercise his or her authority to oversee the market regulation of the activities of the insurer in accordance with the provisions of the state's law. The commissioner's enforcement of compliance with the compact is governed by the following provisions:

(a) With respect to the commissioner's market regulation of a product or advertisement that is approved or certified to the commission, the content of the product or advertisement shall not constitute a violation of the provisions, standards, or requirements of the compact except upon a final order of the commission, issued at the request of a commissioner after prior notice to the insurer and an opportunity for hearing before the commission.

(b) Before a commissioner may bring an action for violation of any provision, standard, or requirement of the compact relating to the content of an advertisement not approved or certified to the commission, the commission, or an authorized commission officer or employee, must authorize the action. However, authorization under this subsection (4)(b) does not require notice to the insurer, opportunity for hearing, or disclosure of requests for authorization or records of the commission's action on such requests. [2005 c 92 § 8.]

48.130.080 Dispute resolution. The commission shall attempt, upon the request of a member, to resolve any disputes or other issues that are subject to this compact and which may arise between two or more compacting states, or between compacting states and noncompacting states, and the commission shall adopt an operating procedure providing for resolution of such disputes. [2005 c 92 § 9.]

48.130.090 Commission approval of product—Filing—Rule making. (1) Insurers and third-party filers seeking to have a product approved by the commission shall file

the product with, and pay applicable filing fees to, the commission. This chapter does not restrict or otherwise prevent an insurer from filing its product with the insurance department in any state wherein the insurer is licensed to conduct the business of insurance, and such filing shall be subject to the laws of the states where filed.

(2) The commission shall establish appropriate filing and review processes and procedures pursuant to commission rules and operating procedures. The commission shall adopt rules to establish conditions and procedures under which the commission will provide public access to product filing information. In establishing such rules, the commission shall consider the interests of the public in having access to such information, as well as protection of personal medical and financial information and trade secrets, that may be contained in a product filing or supporting information.

(3) Any product approved by the commission may be sold or otherwise issued in those compacting states for which the insurer is legally authorized to do business. [2005 c 92 § 10.]

48.130.100 Commission disapproval of product—Appeal. (1) Not later than thirty days after the commission has given notice of a disapproved product or advertisement filed with the commission, the insurer or third-party filer whose filing was disapproved may appeal the determination to a review panel appointed by the commission. The commission shall adopt rules to establish procedures for appointing such review panels and provide for notice and hearing. An allegation that the commission, in disapproving a product or advertisement filed with the commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with RCW 48.130.020(4).

(2) The commission shall have authority to monitor, review, and reconsider products and advertisement subsequent to their filing or approval upon a finding that the product does not meet the relevant uniform standard. Where appropriate, the commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in subsection (1) of this section. [2005 c 92 § 11.]

48.130.110 Commission expenses—Budget—Tax exempt—Accounting. (1) The commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the commission may accept contributions and other forms of funding from the national association of insurance commissioners, compacting states, and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the commission concerning the performance of its duties shall not be compromised.

(2) The commission shall collect a filing fee from each insurer and third-party filer filing a product with the commission to cover the cost of the operations and activities of the commission and its staff in a total amount sufficient to cover the commission's annual budget.

(3) The commission's budget for a fiscal year shall not be approved until it has been subject to notice and comment as set forth in RCW 48.130.060.

(4) The commission shall be exempt from all taxation in and by the compacting states.

(5) The commission shall not pledge the credit of any compacting state, except by and with the appropriate legal authority of that compacting state.

(6) The commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all funds under its control. The internal financial accounts of the commission shall be subject to the accounting procedures established under its bylaws. The financial accounts and reports including the system of internal controls and procedures of the commission shall be audited annually by an independent certified public accountant. Upon the determination of the commission, but no less frequently than every three years, the review of the independent auditor shall include a management and performance audit of the commission. The commission shall make an annual report to the governor and legislature of the compacting states, which shall include a report of the independent audit. The commission's internal accounts shall not be confidential and such materials may be shared with the commissioner of any compacting state upon request. However, any work papers related to any internal or independent audit and any information regarding the privacy of individuals and insurers' proprietary information, including trade secrets, shall remain confidential.

(7) A compacting state does not have any claim to or ownership of any property held by or vested in the commission or to any commission funds held under this chapter. [2005 c 92 § 12.]

48.130.120 Compact, commission, compact amendments—When effective. (1) Any state is eligible to become a compacting state.

(2) The compact shall become effective and binding upon legislative enactment of the compact into law by two compacting states. However, the commission shall become effective for purposes of adopting uniform standards for, reviewing, and giving approval or disapproval of products filed with the commission that satisfy applicable uniform standards only after twenty-six states are compacting states or, alternatively, by states representing greater than forty percent of the premium volume for life insurance, annuity, disability income, and long-term care insurance products, based on records of the national association of insurance commissioners for the prior year. Thereafter, it shall become effective and binding as to any other compacting state upon enactment of the compact into law by that state.

(3) Amendments to the compact may be proposed by the commission for enactment by the compacting states. An amendment does not become effective and binding upon the commission and the compacting states unless and until all compacting states enact the amendment into law. [2005 c 92 § 13.]

48.130.130 Withdrawal from compact, how—Default by state—Dissolution of compact. (1)(a) Once effective, the compact shall continue in force and remain binding upon each and every compacting state. However, a compacting state may withdraw from the compact by enact-

ing a statute specifically repealing the statute which enacted the compact into law.

(b) The effective date of withdrawal is the effective date of the repealing statute. However, the withdrawal shall not apply to any product filings approved or self-certified, or any advertisement of such products, on the date the repealing statute becomes effective, except by mutual agreement of the commission and the withdrawing state unless the approval is rescinded by the withdrawing state as provided in (e) of this subsection.

(c) The commissioner of the withdrawing state shall immediately notify the management committee in writing upon the introduction of legislation repealing the compact in the withdrawing state.

(d) The commission shall notify the other compacting states of the introduction of such legislation within ten days after its receipt of notice thereof.

(e) The withdrawing state is responsible for all obligations, duties, and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the commission and the withdrawing state. The commission's approval of products and advertisement prior to the effective date of withdrawal shall continue to be effective and be given full force and effect in the withdrawing state, unless formally rescinded by the withdrawing state in the same manner as provided by the laws of the withdrawing state for the prospective disapproval of products or advertisement previously approved under state law.

(f) Reinstatement following withdrawal of any compacting state shall occur upon the effective date of the withdrawing state reenacting the compact.

(2)(a) If the commission determines that any compacting state has at any time defaulted in the performance of any of its obligations or responsibilities under the compact, the bylaws, or adopted rules or operating procedures, then, after notice and hearing as set forth in the bylaws, all rights, privileges, and benefits conferred by the compact on the defaulting state shall be suspended from the effective date of default as fixed by the commission. The grounds for default include, but are not limited to, failure of a compacting state to perform its obligations or responsibilities, and any other grounds designated in commission rules. The commission shall immediately notify the defaulting state in writing of the defaulting state's suspension pending a cure of the default. The commission shall stipulate the conditions and the time period within which the defaulting state must cure its default. If the defaulting state fails to cure the default within the time period specified by the commission, the defaulting state shall be terminated from the compact and all rights, privileges, and benefits conferred by the compact shall be terminated from the effective date of termination.

(b) Product approvals by the commission or product self-certifications, or any advertisement in connection with such product, that are in force on the effective date of termination shall remain in force in the defaulting state in the same manner as if the defaulting state had withdrawn voluntarily under subsection (1) of this section.

(c) Reinstatement following termination of any compacting state requires a reenactment of the compact.

(3)(a) The compact dissolves effective upon the date of the withdrawal or default of the compacting state which reduces membership in the compact to one compacting state.

(b) Upon the dissolution of the compact, the compact becomes null and void and shall be of no further force or effect, and the business and affairs of the commission shall be wound up and any surplus funds shall be distributed in accordance with the bylaws. [2005 c 92 § 14.]

48.130.140 Effect of compact—Other state laws—Binding on compacting states, when. (1)(a) The compact does not prevent the enforcement of any other law of a compacting state, except as provided in (b) of this subsection.

(b) For any product approved or certified to the commission, the rules, uniform standards, and any other requirements of the commission shall constitute the exclusive provisions applicable to the content, approval, and certification of such products. For advertisement that is subject to the commission's authority, any rule, uniform standard, or other requirement of the commission which governs the content of the advertisement shall constitute the exclusive provision that a commissioner may apply to the content of the advertisement. However, no action taken by the commission shall abrogate or restrict: (i) The access of any person to state courts; (ii) remedies available under state law related to breach of contract, tort, or other laws not specifically directed to the content of the product; (iii) state law relating to the construction of insurance contracts; or (iv) the authority of the attorney general of the state, including but not limited to maintaining any actions or proceedings, as authorized by law.

(c) All insurance products filed with individual states shall be subject to the laws of those states.

(2)(a) All lawful actions of the commission, including all rules and operating procedures adopted by the commission, are binding upon the compacting states.

(b) All agreements between the commission and the compacting states are binding in accordance with their terms.

(c) Upon the request of a party to a conflict over the meaning or interpretation of commission actions, and upon a majority vote of the compacting states, the commission may issue advisory opinions regarding the meaning or interpretation in dispute.

(d) In the event any provision of the compact exceeds the constitutional limits imposed on the legislature of any compacting state, the obligations, duties, powers, or jurisdiction sought to be conferred by that provision upon the commission shall be ineffective as to that compacting state, and those obligations, duties, powers, or jurisdiction shall remain in the compacting state and shall be exercised by the agency thereof to which those obligations, duties, powers, or jurisdiction are delegated by law in effect at the time the compact becomes effective. [2005 c 92 § 15.]

48.130.901 Construction—2005 c 92. This chapter shall be liberally construed. [2005 c 92 § 17.]

Chapter 48.135 RCW INSURANCE FRAUD PROGRAM

Sections

48.135.005	Purpose.
48.135.007	When chapter not applicable.
48.135.010	Definitions.
48.135.020	Insurance fraud program established—Commissioner's powers and duties.
48.135.030	Program operating costs.
48.135.040	Program implementation—Commissioner's authority—Limited authority peace officers.
48.135.050	Furnishing and disclosing insurance fraud knowledge and information.
48.135.060	Disclosure of documents, materials, or other information—Exemptions.
48.135.070	Insurance company as victim—Restitution.
48.135.080	Required statement on all insurance applications and claim forms.
48.135.090	Insurance fraud advisory board—Membership.
48.135.100	Program report—Contents.
48.135.110	Rules.
48.135.901	Effective date—2006 c 284.

48.135.005 Purpose. The purpose of this chapter and sections 14 through 17, chapter 284, Laws of 2006 is to confront the problem of insurance fraud in this state by making a concerted effort to detect insurance fraud, reduce the occurrence of fraud through criminal enforcement and deterrence, require restitution of fraudulently obtained insurance benefits and expenses incurred by an insurer in investigating fraudulent claims, and reduce the amount of premium dollars used to pay fraudulent claims. The primary focus of the insurance fraud program is on organized fraudulent activities committed against insurance companies. [2006 c 284 § 1.]

48.135.007 When chapter not applicable. This chapter does not:

(1) Preempt the authority or relieve the duty of any other general authority law enforcement agencies to investigate, examine, and prosecute suspected violations of law;

(2) Prevent or prohibit a person from voluntarily disclosing any information concerning insurance fraud to any law enforcement agency other than the commissioner; or

(3) Limit any of the powers granted elsewhere in this title to the commissioner to investigate and examine possible violations of the law and to take appropriate action. [2006 c 284 § 9.]

48.135.010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Insurance fraud" means an act or omission committed by a person who, knowingly, and with intent to defraud, commits, or conceals any material information concerning, one or more of the following:

(a) Presenting, causing to be presented, or preparing with knowledge or belief that it will be presented to or by an insurer, insurance producer, or surplus line broker, false information as part of, in support of, or concerning a fact material to one or more of the following:

(i) An application for the issuance or renewal of an insurance policy;

(ii) The rating of an insurance policy or contract;

(iii) A claim for payment or benefit pursuant to an insurance policy;

- (iv) Premiums paid on an insurance policy;
 - (v) Payments made in accordance with the terms of an insurance policy; or
 - (vi) The reinstatement of an insurance policy;
- (b) Willful embezzlement, abstracting, purloining, or conversion of moneys, funds, premiums, credits, or other property of an insurer or person engaged in the business of insurance; or
- (c) Attempting to commit, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this subsection.

The definition of insurance fraud is for illustrative purposes only under this chapter to describe the nature of the behavior to be reported and investigated, and is not intended in any manner to create or modify the definition of any existing criminal acts nor to create or modify the burdens of proof in any criminal prosecution brought as a result of an investigation under this chapter.

(2) "Insurer" means an insurance company authorized under chapter 48.05 RCW, a health care service contractor registered under chapter 48.44 RCW, and a health care maintenance organization registered under chapter 48.46 RCW. [2009 c 162 § 32; 2008 c 217 § 97; 2006 c 284 § 2.]

Additional notes found at www.leg.wa.gov

48.135.020 Insurance fraud program established—Commissioner's powers and duties. (1) There is established an insurance fraud program within the office of the insurance commissioner. The commissioner may employ supervisory, legal, and investigative personnel for the program, who must be qualified by training and experience in the areas of detection, investigation, or prosecution of fraud in which the insurance industry is a victim. The chief of the fraud program is a full-time position that is appointed by the commissioner. The chief serves at the pleasure of the commissioner. The commissioner shall provide office space, equipment, supplies, investigators, clerical staff, and other staff that are necessary for the program to carry out its duties and responsibilities under this chapter.

(2) The commissioner may fund one or more state patrol officers to work with the insurance fraud program and the funding for the officers must be paid out of the budget of the insurance fraud program.

(3) The commissioner may fund one or more assistant attorneys general and support staff to work with the insurance fraud program and the funding for the assistant attorneys general and support staff must be paid out of the budget of the insurance fraud program.

(4) The commissioner may make grants to or reimburse local prosecuting attorneys to assist in the prosecution of insurance fraud. The grants must be paid out of the budget of the insurance fraud program. The commissioner may investigate and seek prosecution of crimes involving insurance fraud upon the request of or with the concurrence of the county prosecuting attorney of the jurisdiction in which the offense has occurred. Before such a prosecution, the commissioner and the county in which the offense occurred shall reach an agreement regarding the payment of all costs, including expert witness fees, and defense attorneys' fees associated with any such prosecution.

(5) Staff levels for this program, until June 30, 2010, shall not exceed 8.0 full-time equivalents. [2006 c 284 § 3.]

48.135.030 Program operating costs. The annual cost of operating the fraud program is funded from the insurance commissioner's regulatory account under RCW 48.02.190 subject to appropriation by the legislature. [2006 c 284 § 4.]

48.135.040 Program implementation—Commissioner's authority—Limited authority peace officers. (1) The commissioner may:

(a) Employ and train personnel to achieve the purposes of this chapter and to employ legal counsel, investigators, auditors, and clerical support personnel and other personnel as the commissioner determines necessary from time to time to accomplish the purposes of this chapter;

(b) Initiate inquiries and conduct investigations when the commissioner has cause to believe that insurance fraud has been, is being, or is about to be committed;

(c) Conduct independent examinations of alleged insurance fraud;

(d) Review notices, reports, or complaints of suspected insurance fraud activities from federal, state, and local law enforcement and regulatory agencies, persons engaged in the business of insurance, and any other person to determine whether the reports require further investigation;

(e) Share records and evidence with federal, state, or local law enforcement or regulatory agencies, and enter into interagency agreements;

(f) Conduct investigations outside this state. If the information the commissioner seeks to obtain is located outside this state, the person from whom the information is sought may make the information available to the commissioner to examine at the place where the information is located. The commissioner may designate representatives, including officials of the state in which the matter is located, to inspect the information on behalf of the commissioner, and the commissioner may respond to similar requests from officials of other states;

(g) Administer oaths and affirmations, subpoena witnesses, compel their attendance, take evidence, and require the production of any books, papers, correspondence, memoranda, agreements, or other documents or records that the commissioner deems relevant or material to an inquiry concerning insurance fraud;

(h) Report incidents of alleged insurance fraud disclosed by its investigations to the appropriate prosecutorial authority, including but not limited to the attorney general and to any other appropriate law enforcement, administrative, regulatory, or licensing agency;

(i) Assemble evidence, prepare charges, and work closely with any prosecutorial authority having jurisdiction to pursue prosecution of insurance fraud; and

(j) Undertake independent studies to determine the extent of fraudulent insurance acts.

(2) The fraud program investigators who have obtained certification as a peace officer under RCW 43.101.095 have the powers and status of a limited authority Washington peace officer. [2006 c 284 § 5.]

48.135.050 Furnishing and disclosing insurance fraud knowledge and information. (1) Any insurer or licensee of the commissioner that has reasonable belief that an act of insurance fraud which is or may be a crime under Washington law has been, is being, or is about to be committed shall furnish and disclose the knowledge and information to the commissioner or the national insurance crime bureau, the national association of insurance commissioners, or similar organization, who shall disclose the information to the commissioner, and cooperate fully with any investigation conducted by the commissioner.

(2) Any person that has a reasonable belief that an act of insurance fraud which is or may be a crime under Washington law has been, is being, or is about to be committed; or any person who collects, reviews, or analyzes information concerning insurance fraud which is or may be a crime under Washington law may furnish and disclose any information in its possession concerning such an act to the commissioner or to an authorized representative of an insurer that requests the information for the purpose of detecting, prosecuting, or preventing insurance fraud. [2006 c 284 § 6.]

48.135.060 Disclosure of documents, materials, or other information—Exemptions. (1) Documents, materials, or other information as described in subsection (3), (4), or both of this section are exempt from public inspection and copying under chapters *42.17 and 42.56 RCW. The commissioner is authorized to use such documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties.

(2) The commissioner:

(a) May share documents, materials, or other information, including the documents, materials, or information subject to subsection (1) of this section, with (i) the national association of insurance commissioners and its affiliates and subsidiaries, (ii) regulatory and law enforcement officials of other states and nations, the federal government, and international authorities, (iii) the national insurance crime bureau, and (iv) an insurer with respect to whom the suspected fraudulent claim may be perpetrated;

(b) May receive documents, materials, or information from (i) the national association of insurance commissioners and its affiliates and subsidiaries, (ii) regulatory and law enforcement officials of other states and nations, the federal government, and international authorities, (iii) the national insurance crime bureau, and (iv) an insurer with respect to whom the suspected fraudulent claim may be perpetrated and any such documents, materials, or information as described in subsection (3), (4), or both of this section are exempt from public inspection and copying; and

(c) May enter into agreements governing the sharing and use of information consistent with this subsection.

(3) Specific intelligence information and specific investigative records compiled by investigative, law enforcement, and penology agencies, the fraud program of the office of the insurance commissioner, and state agencies vested with the responsibility to discipline members of any profession, the nondisclosure of which is essential to effective law enforcement or for the protection of any person's right to privacy, are exempt under subsection (1) of this section.

(4) Information revealing the identity of persons who are witnesses to or victims of crime or who file complaints with investigative, law enforcement, and penology agencies, or the fraud program of the office of the insurance commissioner, if disclosure would endanger any person's life, physical safety, or property, is exempt under subsection (1) of this section. If at the time a complaint is filed the complainant, victim, or witness indicates a desire for disclosure or nondisclosure, such desire shall govern.

(5) No waiver of an existing privilege or claim of confidentiality in the documents, materials, or information may occur as a result of disclosure to the commissioner under this section or as a result of sharing documents, materials, or information as authorized in subsection (2) of this section.

(6) Documents, materials, or other information that is in the possession of persons other than the commissioner that would otherwise not be confidential by law or privileged do not become confidential by law or privileged by providing the documents, materials, or other information to the commissioner. [2006 c 284 § 7.]

**Reviser's note:* Provisions in chapter 42.17 RCW relating to public disclosure were recodified in chapter 42.56 RCW by 2005 c 274.

48.135.070 Insurance company as victim—Restitution. In a criminal prosecution for any crime under Washington law in which the insurance company is a victim, the insurance company is entitled to be considered as a victim in any restitution ordered by the court under RCW 9.94A.753, as part of the criminal penalty imposed against the defendant convicted for such a violation. [2006 c 284 § 8.]

48.135.080 Required statement on all insurance applications and claim forms. No later than six months after July 1, 2006, or when the insurer has used all its existing paper application and claim forms which were in its possession on July 1, 2006, whichever is later, all applications for insurance, and all claim forms regardless of the form of transmission provided and required by an insurer or required by law as condition of payment of a claim, must contain a statement, permanently affixed to the application or claim form, that clearly states in substance the following:

"It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits."

The lack of a statement required in this section does not constitute a defense in any criminal prosecution nor any civil action. [2006 c 284 § 10.]

48.135.090 Insurance fraud advisory board—Membership. The commissioner shall appoint an insurance fraud advisory board. The board shall consist of ten members. Five members shall be representatives from the insurance industry doing business in this state, at least one of which shall be from a Washington domestic insurer, two members shall represent consumers, one member shall represent the national insurance crime bureau or successor organization, one member shall represent prosecutors, and one member shall represent other law enforcement agencies. The members of the board serve four-year terms and until their successors are appointed and qualified. Three of the original members must

be appointed to serve an initial term of four years, three must be appointed to serve an initial term of three years, two must be appointed to serve an initial term of two years, and two must be appointed to serve an initial term of one year. The members of the board receive no compensation. The board shall advise the commissioner and the legislature with respect to the effectiveness, resources allocated to the fraud program, the source of the funding for the program, and before June 30, 2010, if the staffing level restriction in RCW 48.135.020(5) should be renewed. [2006 c 284 § 11.]

48.135.100 Program report—Contents. The commissioner shall prepare a periodic report of the activities of the fraud program. The report shall, at a minimum, include information as to the number of cases reported to the commissioner, the number of cases referred for prosecution, the number of convictions obtained, the amount of money recovered, and any recommendations of the insurance advisory board. [2006 c 284 § 12.]

48.135.110 Rules. The commissioner may adopt rules to implement and administer this chapter. [2006 c 284 § 13.]

48.135.901 Effective date—2006 c 284. This act takes effect July 1, 2006. [2006 c 284 § 21.]

Chapter 48.140 RCW

MEDICAL MALPRACTICE CLOSED CLAIM REPORTING

Sections

48.140.010	Definitions.
48.140.020	Closed claim reporting requirements.
48.140.030	Closed claim reports—Information requirements.
48.140.040	Statistical summaries.
48.140.050	Annual report.
48.140.060	Rules.
48.140.070	Model statistical reporting standards—Report to legislature.
48.140.080	Reporting requirements under RCW 48.19.370 not affected.
48.140.900	Findings—Intent—Part headings and subheadings not law—Severability—2006 c 8.

48.140.010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Claim" means a demand for monetary damages for injury or death caused by medical malpractice, and a voluntary indemnity payment for injury or death caused by medical malpractice made in the absence of a demand for monetary damages.

(2) "Claimant" means a person, including a decedent's estate, who is seeking or has sought monetary damages for injury or death caused by medical malpractice.

(3) "Closed claim" means a claim that has been settled or otherwise disposed of by the insuring entity, self-insurer, facility, or provider. A claim may be closed with or without an indemnity payment to a claimant.

(4) "Commissioner" means the insurance commissioner.

(5) "Economic damages" has the same meaning as in RCW 4.56.250(1)(a).

(6) "Health care facility" or "facility" means a clinic, diagnostic center, hospital, laboratory, mental health center, nursing home, office, surgical facility, treatment facility, or

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similar place where a health care provider provides health care to patients, and includes entities described in RCW 7.70.020(3).

(7) "Health care provider" or "provider" has the same meaning as in RCW 7.70.020 (1) and (2).

(8) "Insuring entity" means:

(a) An insurer;

(b) A joint underwriting association;

(c) A risk retention group; or

(d) An unauthorized insurer that provides surplus lines coverage.

(9) "Medical malpractice" means an actual or alleged negligent act, error, or omission in providing or failing to provide health care services that is actionable under chapter 7.70 RCW.

(10) "Noneconomic damages" has the same meaning as in RCW 4.56.250(1)(b).

(11) "Self-insurer" means any health care provider, facility, or other individual or entity that assumes operational or financial risk for claims of medical malpractice. [2006 c 8 § 201.]

48.140.020 Closed claim reporting requirements. (1)

For claims closed on or after January 1, 2008:

(a) Every insuring entity or self-insurer that provides medical malpractice insurance to any facility or provider in Washington state must report each medical malpractice closed claim to the commissioner.

(b) If a claim is not covered by an insuring entity or self-insurer, the facility or provider named in the claim must report it to the commissioner after a final claim disposition has occurred due to a court proceeding or a settlement by the parties.

Instances in which a claim may not be covered by an insuring entity or self-insurer include, but are not limited to, situations in which the:

(i) Facility or provider did not buy insurance or maintained a self-insured retention that was larger than the final judgment or settlement;

(ii) Claim was denied by an insuring entity or self-insurer because it did not fall within the scope of the insurance coverage agreement; or

(iii) Annual aggregate coverage limits had been exhausted by other claim payments.

(c) If a facility or provider is insured by a risk retention group and the risk retention group refuses to report closed claims and asserts that the federal liability risk retention act (95 Stat. 949; 15 U.S.C. Sec. 3901 et seq.) preempts state law, the facility or provider must report all data required by this chapter on behalf of the risk retention group.

(d) If a facility or provider is insured by an unauthorized insurer and the unauthorized insurer refuses to report closed claims and asserts a federal exemption or other jurisdictional preemption, the facility or provider must report all data required by this chapter on behalf of the unauthorized insurer.

(2) Beginning in 2009, reports required under subsection (1) of this section must be filed by March 1st, and include data for all claims closed in the preceding calendar year and any adjustments to data reported in prior years. The commissioner may adopt rules that require insuring entities, self-

insurers, facilities, or providers to file closed claim data electronically.

(3) The commissioner may impose a fine of up to two hundred fifty dollars per day against any insuring entity, except a risk retention group, that violates the requirements of this section.

(4) The department of health, department of licensing, or department of social and health services may require a provider or facility to take corrective action to assure compliance with the requirements of this section. [2007 c 32 § 1; 2006 c 8 § 202.]

48.140.030 Closed claim reports—Information requirements. Reports required under RCW 48.140.020 must contain the following information in a form and coding protocol prescribed by the commissioner that, to the extent possible and still fulfill the purposes of this chapter, are consistent with the format for data reported to the national practitioner data bank:

- (1) Claim and incident identifiers, including:
 - (a) A claim identifier assigned to the claim by the insuring entity, self-insurer, facility, or provider; and
 - (b) An incident identifier if companion claims have been made by a claimant. For the purposes of this section, "companion claims" are separate claims involving the same incident of medical malpractice made against other providers or facilities;
- (2) The medical specialty of the provider who was primarily responsible for the incident of medical malpractice that led to the claim;
- (3) The type of health care facility where the medical malpractice incident occurred;
- (4) The primary location within a facility where the medical malpractice incident occurred;
- (5) The geographic location, by city and county, where the medical malpractice incident occurred;
- (6) The injured person's sex and age on the incident date;
- (7) The severity of malpractice injury using the national practitioner data bank severity scale;
- (8) The dates of:
 - (a) The incident that was the proximate cause of the claim;
 - (b) Notice to the insuring entity, self-insurer, facility, or provider;
 - (c) Suit, if filed;
 - (d) Final indemnity payment, if any; and
 - (e) Final action by the insuring entity, self-insurer, facility, or provider to close the claim;
- (9) Settlement information that identifies the timing and final method of claim disposition, including:
 - (a) Claims settled by the parties;
 - (b) Claims disposed of by a court, including the date disposed; or
 - (c) Claims disposed of by alternative dispute resolution, such as arbitration, mediation, private trial, and other common dispute resolution methods; and
 - (d) Whether the settlement occurred before or after trial, if a trial occurred;
- (10) Specific information about the indemnity payments and defense expenses, as follows:

(a) For claims disposed of by a court that result in a verdict or judgment that itemizes damages:

- (i) The total verdict or judgment;
- (ii) If there is more than one defendant, the total indemnity paid by or on behalf of this facility or provider;
- (iii) Economic damages;
- (iv) Noneconomic damages; and
- (v) Allocated loss adjustment expense, including but not limited to court costs, attorneys' fees, and costs of expert witnesses; and

(b) For claims that do not result in a verdict or judgment that itemizes damages:

- (i) The total amount of the settlement;
- (ii) If there is more than one defendant, the total indemnity paid by or on behalf of this facility or provider;
- (iii) Paid and estimated economic damages; and
- (iv) Allocated loss adjustment expense, including but not limited to court costs, attorneys' fees, and costs of expert witnesses;

(11) The reason for the medical malpractice claim. The reporting entity must use the same allegation group and act or omission codes used for mandatory reporting to the national practitioner data bank; and

(12) Any other claim-related data the commissioner determines to be necessary to monitor the medical malpractice marketplace, if such data are reported:

- (a) To the national practitioner data bank; or
- (b) Voluntarily by members of the physician insurers association of America as part of the association's data-sharing project. [2006 c 8 § 203.]

48.140.040 Statistical summaries. 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. [2006 c 8 § 204.]

**Reviser's note:* RCW 42.56.400 was amended by 2007 c 197 § 7, changing subsection (11) to subsection (10).

48.140.050 Annual report. Beginning in 2010, the commissioner must prepare an annual report that summarizes and analyzes the closed claim reports for medical malpractice filed under RCW 48.140.020 and 7.70.140 and the annual financial reports filed by authorized insurers 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.

(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);

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

(i) An analysis of the financial reports of the authorized insurers with a combined market share of at least ninety 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 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 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 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. [2006 c 8 § 205.]

***Reviser's note:** RCW 42.56.400 was amended by 2007 c 197 § 7, changing subsection (11) to subsection (10).

48.140.060 Rules. The commissioner must adopt all rules needed to implement this chapter. The rules must:

(1) Identify which insuring entity or self-insurer has the primary obligation to report a closed claim when more than one insuring entity or self-insurer is providing medical malpractice liability coverage to a single health care provider or a single health care facility that has been named in a claim;

(2) Protect information that, alone or in combination with other data, could result in the ability to identify a claimant, health care provider, health care facility, or self-insurer involved in a particular claim or collection of claims; and

(3) Specify standards and methods for the reporting by claimants, insuring entities, self-insurers, facilities, and providers. [2006 c 8 § 206.]

48.140.070 Model statistical reporting standards—Report to legislature. (1) If the national association of insurance commissioners adopts revised model statistical reporting standards for medical malpractice insurance, the commissioner must analyze the new reporting standards and report this information to the legislature, as follows:

(a) An analysis of any differences between the model reporting standards and:

(i) RCW 48.140.010 through 48.140.060; and

(ii) Any statistical plans that the commissioner has adopted under RCW 48.19.370; and

(b) Recommendations, if any, about legislative changes necessary to implement the model reporting standards.

(2) The commissioner must submit the report required under subsection (1) of this section to the following legislative committees by the first day of December in the year after the national association of insurance commissioners adopts new model medical malpractice reporting standards:

(a) The house of representatives committees on health care; financial institutions and insurance; and judiciary; and

(b) The senate committees on health and long-term care; financial institutions, housing and consumer protection; and judiciary. [2006 c 8 § 207.]

48.140.080 Reporting requirements under RCW 48.19.370 not affected. This chapter does not amend or modify the statistical reporting requirements that apply to insurers under RCW 48.19.370. [2006 c 8 § 208.]

48.140.900 Findings—Intent—Part headings and subheadings not law—Severability—2006 c 8. See notes following RCW 5.64.010.

Chapter 48.150 RCW

DIRECT PATIENT-PROVIDER PRIMARY HEALTH CARE

Sections

48.150.005	Public policy.
48.150.010	Definitions.
48.150.020	Prohibition on discrimination.
48.150.030	Direct fee—Monthly basis—Designated contact person.
48.150.040	Prohibited and authorized practices.
48.150.050	Acceptance or discontinuation of patients—Third-party payments.
48.150.060	Direct practices are not insurers.
48.150.070	Conduct of business—Prohibitions.
48.150.080	Misrepresenting the terms of a direct agreement.
48.150.090	Chapter violations.
48.150.100	Annual statements—Commissioner's report.
48.150.110	Direct agreement requirements—Disclaimer.

48.150.005 Public policy. It is the public policy of Washington to promote access to medical care for all citizens and to encourage innovative arrangements between patients and providers that will help provide all citizens with a medical home.

Washington needs a multipronged approach to provide adequate health care to many citizens who lack adequate access to it. Direct patient-provider practices, in which patients enter into a direct relationship with medical practitioners and pay a fixed amount directly to the health care provider for primary care services, represent an innovative, affordable option which could improve access to medical care, reduce the number of people who now lack such access, and cut down on emergency room use for primary care purposes, thereby freeing up emergency room facilities to treat true emergencies. [2007 c 267 § 1.]

48.150.010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Direct agreement" means a written agreement entered into between a direct practice and an individual direct patient, or the parent or legal guardian of the direct patient or a family of direct patients, whereby the direct practice charges a direct fee as consideration for being available to provide and providing primary care services to the individual direct patient. A direct agreement must (a) describe the specific health care services the direct practice will provide; and (b) be terminable at will upon written notice by the direct patient.

(2) "Direct fee" means a fee charged by a direct practice as consideration for being available to provide and providing primary care services as specified in a direct agreement.

(3) "Direct patient" means a person who is party to a direct agreement and is entitled to receive primary care services under the direct agreement from the direct practice.

(4) "Direct patient-provider primary care practice" and "direct practice" means a provider, group, or entity that meets the following criteria in (a), (b), (c), and (d) of this subsection:

(a)(i) A health care provider who furnishes primary care services through a direct agreement;

(ii) A group of health care providers who furnish primary care services through a direct agreement; or

(iii) An entity that sponsors, employs, or is otherwise affiliated with a group of health care providers who furnish only primary care services through a direct agreement, which entity is wholly owned by the group of health care providers or is a nonprofit corporation exempt from taxation under section 501(c)(3) of the internal revenue code, and is not otherwise regulated as a health care service contractor, health maintenance organization, or disability insurer under Title 48 RCW. Such entity is not prohibited from sponsoring, employing, or being otherwise affiliated with other types of health care providers not engaged in a direct practice;

(b) Enters into direct agreements with direct patients or parents or legal guardians of direct patients;

(c) Does not accept payment for health care services provided to direct patients from any entity subject to regulation under Title 48 RCW or plans administered under chapter 41.05, 70.47, or *70.47A RCW; and

(d) Does not provide, in consideration for the direct fee, services, procedures, or supplies such as prescription drugs except as provided in RCW 48.150.040(2)(b)(i)(B), hospitalization costs, major surgery, dialysis, high level radiology (CT, MRI, PET scans or invasive radiology), rehabilitation services, procedures requiring general anesthesia, or similar advanced procedures, services, or supplies.

(5) "Health care provider" or "provider" means a person regulated under Title 18 RCW or chapter 70.127 RCW to practice health or health-related services or otherwise practicing health care services in this state consistent with state law.

(6) "Health carrier" or "carrier" has the same meaning as in RCW 48.43.005.

(7) "Network" means the group of participating providers and facilities providing health care services to a particular health carrier's health plan or to plans administered under chapter 41.05, 70.47, or *70.47A RCW.

(8) "Primary care" means routine health care services, including screening, assessment, diagnosis, and treatment for the purpose of promotion of health, and detection and management of disease or injury. [2013 c 126 § 1. Prior: 2009 c 552 § 1; 2007 c 267 § 3.]

**Reviser's note:* Chapter 70.47A RCW was repealed in its entirety by 2017 3rd sp.s. c 25 § 9.

48.150.020 Prohibition on discrimination. Except as provided in RCW 48.150.050, no direct practice shall decline to accept any person solely on account of race, religion, national origin, the presence of any sensory, mental, or physical disability, education, economic status, or sexual orientation. [2007 c 267 § 4.]

48.150.030 Direct fee—Monthly basis—Designated contact person. (1) A direct practice must charge a direct fee on a monthly basis. The fee must represent the total amount due for all primary care services specified in the direct agreement and may be paid by the direct patient or on his or her behalf by others.

(2) A direct practice must:

(a) Maintain appropriate accounts and provide data regarding payments made and services received to direct patients upon request; and

(b) Either:

(i) Bill patients at the end of each monthly period; or

(ii) If the patient pays the monthly fee in advance, promptly refund to the direct patient all unearned direct fees following receipt of written notice of termination of the direct agreement from the direct patient. The amount of the direct fee considered earned shall be a proration of the monthly fee as of the date the notice of termination is received.

(3) If the patient chooses to pay more than one monthly direct fee in advance, the funds must be held in a trust account and paid to the direct practice as earned at the end of each month. Any unearned direct fees held in trust following receipt of termination of the direct agreement shall be promptly refunded to the direct patient. The amount of the direct fee earned shall be a proration of the monthly fee for the then current month as of the date the notice of termination is received.

(4) The direct fee schedule applying to an existing direct patient may not be increased over the annual negotiated

amount more frequently than annually. A direct practice shall provide advance notice to existing patients of any change within the fee schedule applying to those existing direct patients. A direct practice shall provide at least sixty days' advance notice of any change in the fee.

(5) A direct practice must designate a contact person to receive and address any patient complaints.

(6) Direct fees for comparable services within a direct practice shall not vary from patient to patient based on health status or sex. [2007 c 267 § 5.]

48.150.040 Prohibited and authorized practices. (1)

Direct practices may not:

(a) Enter into a participating provider contract as defined in RCW 48.44.010 or 48.46.020 with any carrier or with any carrier's contractor or subcontractor, or plans administered under chapter 41.05, 70.47, or *70.47A RCW, to provide health care services through a direct agreement except as set forth in subsection (2) of this section;

(b) Submit a claim for payment to any carrier or any carrier's contractor or subcontractor, or plans administered under chapter 41.05, 70.47, or *70.47A RCW, for health care services provided to direct patients as covered by their agreement;

(c) With respect to services provided through a direct agreement, be identified by a carrier or any carrier's contractor or subcontractor, or plans administered under chapter 41.05, 70.47, or *70.47A RCW, as a participant in the carrier's or any carrier's contractor or subcontractor network for purposes of determining network adequacy or being available for selection by an enrollee under a carrier's benefit plan; or

(d) Pay for health care services covered by a direct agreement rendered to direct patients by providers other than the providers in the direct practice or their employees, except as described in subsection (2)(b) of this section.

(2) Direct practices and providers may:

(a) Enter into a participating provider contract as defined by RCW 48.44.010 and 48.46.020 or plans administered under chapter 41.05, 70.47, or *70.47A RCW for purposes other than payment of claims for services provided to direct patients through a direct agreement. Such providers shall be subject to all other provisions of the participating provider contract applicable to participating providers including but not limited to the right to:

(i) Make referrals to other participating providers;

(ii) Admit the carrier's members to participating hospitals and other health care facilities;

(iii) Prescribe prescription drugs; and

(iv) Implement other customary provisions of the contract not dealing with reimbursement of services;

(b)(i) Pay for charges associated with:

(A) The provision of routine lab and imaging services; and

(B) The dispensing, at no additional cost to the direct patient, of an initial supply, not to exceed thirty days, of generic prescription drugs prescribed by the direct provider.

(ii) In aggregate payments made under (b)(i)(A) and (B) of this subsection per year per direct patient are not to exceed fifteen percent of the total annual direct fee charged that direct patient. Exceptions to this limitation may occur with respect to routine lab and imaging services in the event of

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short-term equipment failure if such failure prevents the provision of care that should not be delayed; and

(c) Charge an additional fee to direct patients for supplies, medications, and specific vaccines provided to direct patients that are specifically excluded under the agreement, provided the direct practice notifies the direct patient of the additional charge, prior to their administration or delivery. [2013 c 126 § 2; 2009 c 552 § 2; 2007 c 267 § 6.]

*Reviser's note: Chapter 70.47A RCW was repealed in its entirety by 2017 3rd sp.s. c 25 § 9.

48.150.050 Acceptance or discontinuation of patients—Third-party payments. (1)

Direct practices may not decline to accept new direct patients or discontinue care to existing patients solely because of the patient's health status. A direct practice may decline to accept a patient if the practice has reached its maximum capacity, or if the patient's medical condition is such that the provider is unable to provide the appropriate level and type of health care services in the direct practice. So long as the direct practice provides the patient notice and opportunity to obtain care from another physician, the direct practice may discontinue care for direct patients if: (a) The patient fails to pay the direct fee under the terms required by the direct agreement; (b) the patient has performed an act that constitutes fraud; (c) the patient repeatedly fails to comply with the recommended treatment plan; (d) the patient is abusive and presents an emotional or physical danger to the staff or other patients of the direct practice; or (e) the direct practice discontinues operation as a direct practice.

(2) Subject to the restrictions established in this chapter, direct practices may accept payment of direct fees directly or indirectly from third parties. A direct practice may accept a direct fee paid by an employer on behalf of an employee who is a direct patient. However, a direct practice shall not enter into a contract with an employer relating to direct practice agreements between the direct practice and employees of that employer, other than to establish the timing and method of the payment of the direct fee by the employer. [2009 c 552 § 3; 2007 c 267 § 7.]

48.150.060 Direct practices are not insurers. Direct practices, as defined in RCW 48.150.010, who comply with this chapter are not insurers under RCW 48.01.050, health carriers under chapter 48.43 RCW, health care service contractors under chapter 48.44 RCW, or health maintenance organizations under chapter 48.46 RCW. [2007 c 267 § 8.]

48.150.070 Conduct of business—Prohibitions. A person shall not make, publish, or disseminate any false, deceptive, or misleading representation or advertising in the conduct of the business of a direct practice, or relative to the business of a direct practice. [2007 c 267 § 9.]

48.150.080 Misrepresenting the terms of a direct agreement. A person shall not make, issue, or circulate, or cause to be made, issued, or circulated, a misrepresentation of the terms of any direct agreement, or the benefits or advantages promised thereby, or use the name or title of any direct agreement misrepresenting the nature thereof. [2007 c 267 § 10.]

48.150.090 Chapter violations. Violations of this chapter constitute unprofessional conduct enforceable under RCW 18.130.180. [2007 c 267 § 11.]

48.150.100 Annual statements—Commissioner's report. (1) Direct practices must submit annual statements, beginning on October 1, 2007, to the office of [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.

(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 initial report shall be due December 1, 2009. [2007 c 267 § 12.]

48.150.110 Direct agreement requirements—Disclaimer. (1) A direct agreement must include the following disclaimer: "This agreement does not provide comprehensive health insurance coverage. It provides only the health care services specifically described." The direct agreement may not be sold to a group and may not be entered with a group of subscribers. It must be an agreement between a direct practice and an individual direct patient. Nothing prohibits the presentation of marketing materials to groups of potential subscribers or their representatives.

(2) A comprehensive disclosure statement shall be distributed to all direct patients with their participation forms. Such disclosure must inform the direct patients of their financial rights and responsibilities to the direct practice as provided for in this chapter, encourage that direct patients obtain and maintain insurance for services not provided by the direct practice, and state that the direct practice will not bill a carrier for services covered under the direct agreement. The disclosure statement shall include contact information for the office of the insurance commissioner. [2007 c 267 § 13.]

Chapter 48.155 RCW

HEALTH CARE DISCOUNT PLAN ORGANIZATION ACT

Sections

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48.155.001 Short title. This chapter may be known and cited as the Washington health care discount plan organization act. [2009 c 175 § 1.]

48.155.003 Purpose. The purposes of this chapter are to promote the public interest by establishing standards for discount plan organizations, to protect consumers from unfair or deceptive marketing, sales, or enrollment practices, and to facilitate consumer understanding of the role and function of discount plan organizations in providing discounts on charges for health care services. [2009 c 175 § 2.]

48.155.007 Rules. The commissioner may adopt rules to implement this chapter. [2009 c 175 § 18.]

48.155.010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Affiliate" means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(2) "Commissioner" means the Washington state insurance commissioner.

(3)(a) "Control" or "controlled by" or "under common control with" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person.

(b) Control exists when any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent or more of the voting securities of any other person. A presumption of control may be rebutted by a showing made in the manner provided by RCW 48.31B.005(3) and 48.31B.025(11) that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(4)(a) "Discount plan" means a business arrangement or contract in which a person or organization, in exchange for fees, dues, charges, or other consideration, provides or purports to provide discounts to its members on charges by providers for health care services.

(b) "Discount plan" does not include:

(i) A plan that does not charge a membership or other fee to use the plan's discount card;

(ii) A patient access program as defined in this chapter;

(iii) A medicare prescription drug plan as defined in this chapter; or

(iv) A discount plan offered by a health carrier authorized under chapter 48.20, 48.21, 48.44, or 48.46 RCW.

(5)(a) "Discount plan organization" means a person that, in exchange for fees, dues, charges, or other consideration, provides or purports to provide access to discounts to its members on charges by providers for health care services. "Discount plan organization" also means a person or organization that contracts with providers, provider networks, or other discount plan organizations to offer discounts on health care services to its members. This term also includes all persons that determine the charge to or other consideration paid by members.

(b) "Discount plan organization" does not mean:

(i) Pharmacy benefit managers;

(ii) Health care provider networks, when the network's only involvement in discount plans is contracting with the plan to provide discounts to the plan's members;

(iii) Marketers who market the discount plans of discount plan organizations which are licensed under this chapter as long as all written communications of the marketer in connection with a discount plan clearly identify the licensed discount plan organization as the responsible entity; or

(iv) Health carriers, if the discount on health care services is offered by a health carrier authorized under chapter 48.20, 48.21, 48.44, or 48.46 RCW.

(6) "Health care facility" or "facility" has the same meaning as in *RCW 48.43.005(22).

(7) "Health care provider" or "provider" has the same meaning as in *RCW 48.43.005(23).

(8) "Health care provider network," "provider network," or "network" means any network of health care providers, including any person or entity that negotiates directly or indirectly with a discount plan organization on behalf of more than one provider to provide health care services to members.

(9) "Health care services" has the same meaning as in *RCW 48.43.005(24).

(10) "Health carrier" or "carrier" has the same meaning as in *RCW 48.43.005(25).

(11) "Marketer" means a person or entity that markets, promotes, sells, or distributes a discount plan, including a contracted marketing organization and a private label entity that places its name on and markets or distributes a discount plan pursuant to a marketing agreement with a discount plan organization.

(12) "Medicare prescription drug plan" means a plan that provides a medicare part D prescription drug benefit in accordance with the requirements of the federal medicare prescription drug improvement and modernization act of 2003.

(13) "Member" means any individual who pays fees, dues, charges, or other consideration for the right to receive the benefits of a discount plan, but does not include any individual who enrolls in a patient access program.

(14) "Patient access program" means a voluntary program sponsored by a pharmaceutical manufacturer, or a consortium of pharmaceutical manufacturers, that provides free or discounted health care products for no additional consideration directly to low-income or uninsured individuals either through a discount card or direct shipment.

(15) "Person" means an individual, a corporation, a governmental entity, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the persons listed in this subsection.

(16)(a) "Pharmacy benefit manager" means a person that performs pharmacy benefit management for a covered entity.

(b) For purposes of this subsection, a "covered entity" means an insurer, a health care service contractor, a health maintenance organization, or a multiple employer welfare arrangement licensed, certified, or registered under the provisions of this title. "Covered entity" also means a health program administered by the state as a provider of health coverage, a single employer that provides health coverage to its employees, or a labor union that provides health coverage to its members as part of a collective bargaining agreement. [2015 c 122 § 19; 2010 c 27 § 4; 2009 c 175 § 3.]

***Reviser's note:** RCW 48.43.005 was alphabetized pursuant to RCW 1.08.015(2)(k), changing subsections (22), (23), (24), and (25) to subsections (23), (24), (25), and (26), and effective January 1, 2020, changing subsections (22), (23), (24), and (25) to subsections (25), (26), (27), and (28). RCW 48.43.005 was alphabetized pursuant to RCW 1.08.015(2)(k), changing subsections (25), (26), (27), and (28) to subsections (27), (28), (29), and (30).

Effective dates—2015 c 122: See note following RCW 48.31B.005.

48.155.015 Application of chapter. (1) This chapter applies to all discount plans and all discount plan organizations doing business in or from this state or that affect subjects located wholly or in part or to be performed within this state, and all persons having to do with this business.

(2) A discount plan organization that is a health carrier, as defined under RCW 48.43.005, with a license, certificate of authority, or registration:

(a) Is not required to obtain a license under RCW 48.155.020, except that any of its affiliates that operate as a discount plan organization in this state must obtain a license under RCW 48.155.020 and comply with all other provisions of this chapter;

(b) Is required to comply with RCW 48.155.060 through 48.155.090 and report, in the form and manner as the commissioner may require, any of the information described in RCW 48.155.110(2) (b), (c), or (d) that is not otherwise already reported; and

(c) Is subject to RCW 48.155.130 and 48.155.140. [2015 c 122 § 20; 2009 c 175 § 4.]

Effective dates—2015 c 122: See note following RCW 48.31B.005.

48.155.020 License required—Application—Review—Annual renewal—Required disclosures. (1) Before conducting discount plan business to which this chapter applies, a person must obtain a license from the commissioner to operate as a discount plan organization.

(2) Except as provided in subsection (4) of this section, each application for a license to operate as a discount plan organization:

(a) Must be in a form prescribed by the commissioner and verified by an officer or authorized representative of the applicant; and

(b) Must demonstrate, set forth, or be accompanied by the following:

(i) The two hundred fifty dollar application fee, which must be deposited into the general fund;

(ii) A copy of the organization documents of the applicant, such as the articles of incorporation, including all amendments;

(iii) A copy of the applicant's bylaws or other enabling documents that establish organizational structure;

(iv) The applicant's federal identification number, business address, and mailing address;

(v)(A) A list of names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant's affairs, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire ten percent or more of the voting securities of the applicant; and

(B) A disclosure in the listing of the extent and nature of any contracts or arrangements between any individual who is responsible for conducting the applicant's affairs and the discount plan organization, including all possible conflicts of interest;

(vi) A complete biographical statement, on forms prescribed by the commissioner, with respect to each individual identified under (b)(v) of this subsection;

(vii) A statement generally describing the applicant, its facilities and personnel, and the health care services for which a discount will be made available under the discount plan;

(viii) A copy of the form of all contracts made or to be made between the applicant and any health care providers or health care provider networks regarding the provision of health care services to members and discounts to be made available to members;

(ix) A copy of the form of any contract made or arrangement to be made between the applicant and any individual listed in (b)(v) of this subsection;

(x) A list identifying by name, address, telephone number, and email address all persons who will market each discount plan offered by the applicant. If the person who will market a discount plan is an entity, only the entity must be identified. This list must be maintained and updated within sixty days of any change in the information. An updated list must be sent to the commissioner as part of the discount plan organization's renewal application under (b)(vii) of this subsection;

(xi) A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function, including marketing, administration, enrollment, and subcontracting for the provision of health care services to members and discounts to be made available to members;

(xii) A copy of the applicant's most recent financial statements audited by an independent certified public accountant, except that, subject to the approval of the commissioner, an applicant that is an affiliate of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity may submit the audited financial statement of the parent entity and a written guaranty that the minimum capital requirements required under RCW 48.155.030 will be met by the parent

entity instead of the audited financial statement of the applicant;

(xiii) A description of the proposed methods of marketing including, but not limited to, describing the use of marketers, use of the internet, sales by telephone, electronic mail, or facsimile machine, and use of salespersons to market the discount plan benefits;

(xiv) A description of the member complaint procedures which must be established and maintained by the applicant;

(xv) If domiciled in this state, the name and address of the applicant's Washington statutory agent for service of process, notice, or demand; and

(xvi) Any other information the commissioner may reasonably require.

(3)(a) If the applicant is not domiciled in this state, the applicant must appoint the commissioner as the discount plan organization's attorney to receive service of legal process issued against the discount plan organization in this state upon causes of action arising within this state. Service upon the commissioner as attorney constitutes effective legal service upon the discount plan organization.

(b) With the appointment the discount plan organization must designate by name, email address, and address the person to whom the commissioner must forward legal process so served upon him or her. The discount plan organization may change the person by filing a new designation.

(c) The discount plan organization must keep the designation, address, and email address filed with the commissioner current.

(d) The appointment is irrevocable, binds any successor in interest or to the assets or liabilities of the discount plan organization, and remains in effect for as long as there could be any cause of action against the discount plan organization arising out of the discount plan organization's transactions in this state.

(e) The service of process must be accomplished and processed in the manner prescribed under RCW 48.02.200.

(4)(a) Upon application to and approval by the commissioner and payment of the applicable fees, a discount plan organization that holds a current license or other form of authority from another state to operate as a discount plan organization, at the commissioner's discretion, may not be required to submit the information required under subsection (2) of this section in order to obtain a license under this section if the commissioner is satisfied that the other state's requirements, at a minimum, are equivalent to those required under subsection (2) of this section or the commissioner is satisfied that the other state's requirements are sufficient to protect the interests of the residents of this state.

(b) Whenever the discount plan organization loses its license or other form of authority in that other state to operate as a discount plan organization, or is the subject of any disciplinary administrative proceeding related to the organization's operating as a discount plan organization in that other state, the discount plan organization must immediately notify the commissioner.

(5) After the receipt of an application filed under subsection (2) or (4) of this section, the commissioner must review the application and notify the applicant of any deficiencies in the application.

(6)(a) Within ninety days after the date of receipt of a completed application, the commissioner must:

(i) Issue a license if the commissioner is satisfied that the applicant has met the following:

(A) The applicant has fulfilled the requirements of this section and the minimum capital requirements in accordance with RCW 48.155.030; and

(B) The persons who own, control, and manage the applicant are competent and trustworthy and possess managerial experience that would make the proposed operation of the discount plan organization beneficial to discount plan members; or

(ii) Disapprove the application and state the grounds for disapproval.

(b) In making a determination under (a) of this subsection, the commissioner may consider, for example, whether the applicant or an officer or manager of the applicant: (i) Is not financially responsible; (ii) does not have adequate expertise or experience to operate a medical discount plan organization; or (iii) is not of good character. Among the factors that the commissioner may consider in making the determination is whether the applicant or an affiliate or a business formerly owned or managed by the applicant or an officer or manager of the applicant has had a previous application for a license, or other authority, to operate as any entity regulated by the commissioner denied, revoked, suspended, or terminated for cause, or is under investigation for or has been found in violation of a statute or regulation in another jurisdiction within the previous five years.

(7) Prior to licensure by the commissioner, each discount plan organization must establish an internet website in order to conform to the requirements of RCW 48.155.070(2).

(8)(a) A license is effective for up to one year, unless prior to its expiration the license is renewed in accordance with this subsection or suspended or revoked in accordance with subsection (9) of this section. Licenses issued or renewed on or after July 1, 2010, will be subject to renewal annually on July 1st. If not so renewed, the license will automatically expire on the renewal date.

(b) At least ninety days before a license expires, the discount plan organization must submit:

(i) A renewal application form; and

(ii) A two hundred dollar renewal application fee for deposit into the general fund.

(c) The commissioner must renew the license of each holder that meets the requirements of this chapter and pays the appropriate renewal fee required.

(9)(a) The commissioner may suspend the authority of a discount plan organization to enroll new members or refuse to renew or revoke a discount plan organization's license if the commissioner finds that any of the following conditions exist:

(i) The discount plan organization is not operating in compliance with this chapter;

(ii) The discount plan organization does not have the minimum net worth as required under RCW 48.155.030;

(iii) The discount plan organization has advertised, merchandised, or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading, or unfair practices with respect to advertising or merchandising;

(iv) The discount plan organization is not fulfilling its obligations as a discount plan organization; or

(v) The continued operation of the discount plan organization would be hazardous to its members.

(b) If the commissioner has cause to believe that grounds for the nonrenewal, suspension, or revocation of a license exists, the commissioner must notify the discount plan organization in writing specifically stating the grounds for the refusal to renew or suspension or revocation and may also pursue a hearing on the matter under chapter 48.04 RCW.

(c) When the license of a discount plan organization is nonrenewed, surrendered, or revoked, the discount plan organization must immediately upon the effective date of the order of revocation or, in the case of a nonrenewal, the date of expiration of the license, stop any further advertising, solicitation, collecting of fees, or renewal of contracts, and proceed to wind up its affairs transacted under the license.

(d)(i) When the commissioner suspends a discount plan organization's authority to enroll new members, the suspension order must specify the period during which the suspension is to be in effect and the conditions, if any, that must be met by the discount plan organization prior to reinstatement of its license to enroll members.

(ii) The commissioner may rescind or modify the order of suspension prior to the expiration of the suspension period.

(iii) The license of a discount plan organization may not be reinstated unless requested by the discount plan organization. The commissioner may not grant the request for reinstatement if the commissioner finds that the circumstances for which the suspension occurred still exist or are likely to recur.

(10) Each licensed discount plan organization must notify the commissioner immediately whenever the discount plan organization's license, or other form of authority to operate as a discount plan organization in another state, is suspended, revoked, or nonrenewed in that state.

(11) A health care provider who provides discounts to his or her own patients without any cost or fee of any kind to the patient is not required to obtain and maintain a license under this chapter as a discount plan organization. [2011 c 47 § 18; 2010 c 27 § 6; 2009 c 175 § 5.]

48.155.030 Minimum net worth. (1) Except under subsection (3) of this section, before the commissioner issues a license to any person required to obtain a license under RCW 48.155.020, the person seeking to operate a discount plan organization must have a net worth of at least one hundred fifty thousand dollars.

(2) At all times, except under subsection (3) of this section, each discount plan organization must maintain a net worth of at least one hundred fifty thousand dollars.

(3) By rule of the commissioner, the amounts in subsections (1) and (2) of this section may be adjusted annually for inflation. [2009 c 175 § 6.]

48.155.040 Surety bond—Deposit in lieu of bond. (1) Each licensed discount plan organization shall continuously maintain in force a surety bond in its own name in an amount not less than thirty-five thousand dollars to be used in the discretion of the commissioner to protect the financial interest of

Washington members. The bond must be issued by an insurance company licensed to do business in this state.

(2) In lieu of the bond specified in subsection (1) of this section, a licensed discount plan organization may deposit and maintain deposited with the commissioner, or at the discretion of the commissioner, with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that are acceptable to the commissioner which always have a market value of not less than thirty-five thousand dollars.

(3) All income from a deposit made under subsection (2) of this section is an asset of the discount plan organization.

(4) Except for the commissioner, the assets or securities held in this state as a deposit under subsection (1) or (2) of this section are not subject to levy by a judgment creditor or other claimant of the discount plan organization. [2009 c 175 § 7.]

48.155.050 Investigations by commissioner—Organization must maintain detailed books and records. (1) The commissioner may conduct investigations to determine whether any person has violated any provision of this chapter and may, if the commissioner has a reason to believe that the discount plan organization is not complying with the requirements of this chapter, examine the business and affairs of any discount plan organization.

(2) An examination conducted under subsection (1) of this section must be performed in accordance with chapter 48.03 RCW, except that RCW 48.03.060 (1) and (2) shall not be applicable to the examination of persons registered under this chapter.

(3) The commissioner may:

(a) Order any discount plan organization or applicant that operates a discount plan organization to produce any records, books, files, advertising, and solicitation materials or other information; and

(b) Gather evidence and take statements under oath to determine whether the discount plan organization or applicant is in violation of the law or is acting contrary to the public interest.

(4) The discount plan organization or applicant that is the subject of the examination or investigation shall pay the expenses incurred in conducting the examination or investigation. Failure by the discount plan organization or applicant to pay the expenses is grounds for denial or revocation of a license to operate as a discount plan organization.

(5) All discount plan organizations or applicants that are subject to examinations, investigations, or annual reporting requirements under this chapter shall maintain detailed books and records of the following:

(a) Records documenting all Washington transactions, showing all funds received and all funds disbursed to Washington members, prospective members, providers, and provider networks;

(b) All contracts or agreements with providers of the services under a discount plan offered in Washington or sold to Washington residents; and

(c) Telephone scripts for marketing activities to which this chapter applies.

The discount plan organization shall maintain the books and records described in this section, in addition to the books and records required to be maintained under RCW 48.155.070, for a period of at least two years. [2009 c 175 § 8.]

48.155.060 Charges and fees—When writing is required—Cancellation. (1) A discount plan organization may charge a periodic charge as well as a reasonable one-time processing fee of no more than thirty dollars for a discount plan, or such other amount as established by rule, but may not require payment of these or any other charges or fees by direct debit from a banking, credit, or debit card account unless that method of payment is clearly and conspicuously disclosed to the prospective member. All charges and fees must be provided in writing to the member when the member first joins the plan.

(2) When a marketer or discount plan organization solicits a discount plan in conjunction with any other product, all charges that a member or prospective member must pay for each discount plan must be provided in writing as a separate item to the member or prospective member, unless the entire amount of the periodic charge which includes the periodic discount plan charge will be refunded if the member cancels his or her membership in the discount plan organization within the first thirty days after the date of receipt of the written documents for the discount plan as provided in subsection (3) of this section.

(3)(a)(i) If a member cancels his or her membership in the discount plan organization within the first thirty days after the date of receipt of the written documents for the discount plan described in RCW 48.155.090(4), the member must receive a reimbursement of all periodic charges upon return of the discount plan card to the discount plan organization.

(ii)(A) Cancellation occurs when notice of cancellation is given to the discount plan organization.

(B) Notice of cancellation is given when delivered by hand or deposited in a mailbox, properly addressed and postage prepaid to the mailing address of the discount plan organization, or emailed to the email address of the discount plan organization.

(iii) A discount plan organization shall return in full any periodic charge charged or collected after the member has given the discount plan organization notice of cancellation.

(b) If the discount plan organization cancels a membership for any reason other than nonpayment of charges by the member, the discount plan organization shall make a pro rata reimbursement of all periodic charges to the member. [2009 c 175 § 9.]

48.155.070 Written health care provider agreements required—Terms—Internet website. (1)(a) A discount plan organization shall have a written health care provider agreement with all health care providers for whose health care services it provides access to a discount to its members. The written health care provider agreement may be entered into directly with the health care provider or indirectly with a health care provider network to which the health care provider belongs.

(b) A health care provider agreement between a discount plan organization and a health care provider must provide the following:

(i) A list of the health care services and products to be provided at a discount;

(ii) The amount or amounts of the discounts or, alternatively, a fee schedule that reflects the health care provider's discounted rates; and

(iii) That the health care provider may not charge members more than the discounted rates.

(c) A health care provider agreement between a discount plan organization and a health care provider network must require that the health care provider network have written agreements with its health care providers that:

(i) Contain the provisions described in (b) of this subsection;

(ii) Authorize the health care provider network to contract with the discount plan organization on behalf of the health care provider; and

(iii) Require the health care provider network to maintain an up-to-date list of its contracted health care providers and to provide the list on a monthly basis to the discount plan organization.

(d) A health care provider agreement between a discount plan organization and an entity that contracts with a health care provider network must require that the entity, in its contract with the health care provider network, require the health care provider network to have written agreements with its health care providers that comply with (c) of this subsection.

(e) The discount plan organization shall maintain a copy of each health care provider agreement into which it has entered and shall promptly furnish a copy of each agreement to the commissioner when requested.

(2)(a) Each discount plan organization shall maintain on an internet website a list of the names and addresses of the health care providers with which it has a current provider agreement directly or through a health care provider network. This list must be updated every thirty days. The internet website address must be prominently displayed on all of its advertisements, marketing materials, brochures, and discount plan cards.

(b) This subsection applies to those health care providers with which the discount plan organization has a current provider agreement directly as well as those health care providers that are members of a health care provider network with which the discount plan organization has a current provider agreement. [2009 c 175 § 10.]

48.155.080 Marketing products—Directly to consumers—By contract with marketers. (1) A discount plan organization may market its products directly to consumers or contract with marketers for the distribution of its discount plans.

(2)(a) The discount plan organization shall have an executed written agreement with a marketer prior to the marketer's marketing, promoting, selling, or distributing the discount plan organization's discount plans.

(b) The agreement between the discount plan organization and the marketer must prohibit the marketer from using advertising, marketing materials, brochures, and discount

plan cards without first having the discount plan organization's approval in writing.

(c) The discount plan organization is bound by and responsible for the activities of a marketer that are within the scope of the marketer's agency relationship with the organization.

(3) A discount plan organization shall approve in writing all advertisements, marketing materials, brochures, and discount cards used by marketers to market, promote, sell, or distribute the discount plan prior to their use.

(4) Upon request, a discount plan organization shall submit to the commissioner all advertising, marketing materials, and brochures used or to be used in connection with the organization's discount plans. [2009 c 175 § 11.]

48.155.090 Communications with regulators and consumers—Restrictions—Required general disclosures.

(1)(a) All advertisements, marketing efforts, promotions, marketing materials, discount plan documents, brochures, discount plan cards, and any other communications of a discount plan organization provided to prospective members and members must be truthful and not misleading in fact or in implication.

(b) Any advertisement, marketing material, discount plan document, brochure, discount plan card, or other communication is misleading in fact or in implication if it has a capacity or tendency to mislead or deceive based on the overall impression that it may reasonably be expected to create within the segment of the public to which it is directed.

(c) A discount plan organization shall conduct its business in its own legal name and all written communications from a discount plan to regulators and consumers must prominently display the discount plan organization's full legal name.

(2) A discount plan organization shall not:

(a) Except as otherwise provided in this chapter or as a disclaimer of any relationship between discount plan benefits and insurance, or as a description of an insurance product connected with a discount plan, use in its advertisements, marketing efforts, promotions, marketing materials, discount plan documents, brochures, and discount plan cards the term "insurance";

(b) Describe or characterize the discount plan as being insurance whenever a discount plan is bundled with an insured product and the insurance benefits are incidental to the discount plan benefits;

(c) Use in its advertisements, marketing efforts, promotions, marketing materials, discount plan documents, brochures, and discount plan cards words or phrases that are commonly associated with the business of insurance, such as the terms "health plan," "coverage," "copay," "copayments," "deductible," "preexisting conditions," "guaranteed issue," "premium," "PPO," "preferred provider organization," or similar terms, in a manner that could reasonably mislead an individual into believing that the discount plan is health insurance;

(d) Use language in its advertisements, marketing efforts, promotions, marketing material, discount plan documents, brochures, and discount plan cards with respect to being licensed by the insurance commissioner's office in a manner that could reasonably mislead an individual into

believing that the discount plan is insurance or has been endorsed by the insurance commissioner's office;

(e) Make misleading, deceptive, or fraudulent representations regarding the discount or range of discounts offered by the discount plan or the access to any range of discounts offered by the discount plan;

(f) Have restrictions on access to discount plan providers including, except for hospital services, waiting periods and notification periods; or

(g) Pay health care providers any fees for health care services or collect or accept money from a member to pay a health care provider for health care services provided under the discount plan, unless the discount plan organization has an active certificate of authority or registration in Washington.

(3)(a) Each discount plan organization shall make the following general disclosures in not less than twelve-point type on the first content page of any advertisements, marketing materials, or brochures made available to the public relating to a discount plan, along with any enrollment forms given to a prospective member:

(i) That the plan is a discount plan and is not insurance coverage;

(ii) If true, that the range of discounts for health care services provided under the plan will vary depending on the type of health care provider and health care service received;

(iii) That the discount plan organization does not make payments to providers for the health care services received under the discount plan, unless the discount plan organization has an active certificate of authority or registration, as described in subsection (2)(g) of this section;

(iv) That the plan member is obligated to pay for all health care services, but will receive the stated discount from those health care providers that have a current provider agreement with the discount plan organization; and

(v) The toll-free telephone number and internet website address for the licensed discount plan organization for prospective members and members to obtain additional information about and assistance with the discount plan and up-to-date lists of health care providers participating in the discount plan.

(b) If the initial contact with a prospective member is by telephone, the disclosures required under (a) of this subsection must be made orally and included in the initial written materials that describe the benefits under the discount plan provided to the prospective or new member.

(4)(a) In addition to the general disclosures required under subsection (3) of this section, each discount plan organization shall send to:

(i) Each prospective member, at their request, information that describes the terms and conditions of the discount plan, including any limitations or restrictions on the refund of any processing fees or periodic charges associated with the discount plan. The written materials presented must not be dependent upon the requestor first making any form of payment or enrolling in the plan; and

(ii) Each new member, within fourteen calendar days of enrollment, written documents that contain all terms and conditions of the discount plan.

(b) The written documents required under (a)(ii) of this subsection must be clear and include the following information:

(i) The name of the member;

(ii) The benefits to be provided under the discount plan;

(iii) Any processing fees and periodic charges associated with the discount plan, including any limitations or restrictions on the refund of any processing fees and periodic charges;

(iv) The mode of payment of any processing fees and periodic charges, such as monthly or quarterly, and procedures for changing the mode of payment;

(v) Any limitations, exclusions, or exceptions regarding the receipt of discount plan benefits;

(vi) Any waiting periods for receiving discounts on hospital services under the discount plan;

(vii) Procedures for obtaining discounts under the discount plan, such as requiring members to contact the discount plan organization to make an appointment with a health care provider on the member's behalf;

(viii) Cancellation procedures, including information on the member's thirty-day cancellation rights and refund requirements and procedures for obtaining refunds;

(ix) Renewal, termination, and cancellation terms and conditions;

(x) Procedures for adding new members to a family discount plan, if applicable;

(xi) Procedures for filing complaints under the discount plan organization's complaint system and information that, if the member remains dissatisfied after completing the organization's complaint system, the plan member may contact the office of the insurance commissioner; and

(xii) The name, telephone number, internet website address, and mailing address of the licensed discount plan organization or other entity where the member can make inquiries about the plan, or send cancellation notices and file complaints. [2009 c 175 § 12.]

48.155.100 Organization changes require notice to commissioner. Each discount plan organization shall provide the commissioner at least thirty days' advance notice of any change in the discount plan organization's name, address, principal business address, mailing address, toll-free telephone number, or internet website address. [2009 c 175 § 13.]

48.155.110 Annual report required—Fee—Contents—Failure to file. (1) If the information required in subsection (2) of this section is not provided at the time of renewal of a license under RCW 48.155.020, a discount plan organization shall file an annual report with the commissioner in the form prescribed by the commissioner no later than March 31st of the following year.

(2) The annual report must be filed with the commissioner, accompanied by the twenty dollar annual reporting fee to be deposited into the general fund. The annual report must include:

(a) Audited financial statements prepared in accordance with generally accepted accounting principles certified by an independent certified public accountant, including the organization's balance sheet, income statement, and statement of

changes in cash flow for the preceding year. However, subject to the approval of the commissioner, an organization that is an affiliate of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity may submit the audited financial statement of the parent entity and a written guaranty that the minimum capital requirements required under RCW 48.155.030 will be met by the parent entity instead of the audited financial statement of the organization;

(b) If different from the initial application for a license, or at the time of renewal of a license, or the last annual report, as appropriate, a list of the names and residence addresses of all persons responsible for the conduct of the organization's affairs, together with a disclosure of the extent and nature of any contracts or arrangements with these persons and the discount plan organization, including any possible conflicts of interest;

(c) The number of current members the discount plan organization has in the state; and

(d) Any other information relating to the performance of the discount plan organization that may be required by the commissioner.

(3) Any discount plan organization that fails to file an annual report in the form and within the time required by this section is subject to the following:

(a) Monetary penalties of:

(i) Up to five hundred dollars each day for the first ten days during which the violation continues; and

(ii) Up to one thousand dollars each day after the first ten days during which the violation continues; and

(b) Upon notice by the commissioner, loss, suspension, or revocation of its license and authority to enroll new members or to do business in this state while the violation continues. [2009 c 175 § 14.]

48.155.120 Designation of compliance officer. Each discount plan organization shall designate and provide the commissioner with the name, address, and telephone number of the organization's compliance officer responsible for ensuring compliance with this chapter. [2009 c 175 § 15.]

48.155.130 Violation of chapter—Commissioner's authority—Penalties—Criminal sanctions—Civil action for recovery of damages. (1) In lieu of or in addition to suspending or revoking a discount plan organization's license under *RCW 48.155.020(8), whenever the commissioner has cause to believe that any person is violating or is about to violate any provision of this chapter or any rules adopted under this chapter or any order of the commissioner, the commissioner may:

(a) Issue a cease and desist order; and

(b) After hearing or with the consent of the discount plan organization and in addition to or in lieu of the suspension, revocation, or refusal to renew any license, impose a monetary penalty of not less than one hundred dollars for each violation and not more than ten thousand dollars for each violation.

(2) A person that willfully operates as or aids and abets another operating as a discount plan organization in violation of RCW 48.155.020(1) commits insurance fraud and is subject to RCW 48.15.020 and 48.15.023, as if the unlicensed

discount plan organization were an unauthorized insurer, and the fees, dues, charges, or other consideration collected from the members by the unlicensed discount plan organization or marketer were insurance premiums.

(3) A person that collects fees for purported membership in a discount plan but willfully fails to provide the promised benefits commits a theft and upon conviction is subject to the provisions of Title 9A RCW. In addition, upon conviction, the person shall pay restitution to persons aggrieved by the violation of this chapter.

(4) Any person damaged by acts that violate this chapter may maintain an action for the recovery of damages caused by that act or acts.

(a) An action for violation of this section may be brought:

(i) In the county where the plaintiff resides;

(ii) In the county where the plaintiff conducts business;

or

(iii) In the county where the discount plan was sold, marketed, promoted, advertised, or otherwise distributed.

(b) The acceptance or use of any discount plan or discount plan card does not operate as a waiver of any civil, criminal, or administrative claim that may be asserted under this chapter. [2009 c 175 § 16.]

**Reviser's note:* RCW 48.155.020 was amended by 2011 c 47 § 18, changing subsection (8) to subsection (9).

48.155.140 Temporary and permanent injunctive relief—When authorized. (1)(a) In addition to the penalties and other enforcement provisions of this chapter, the commissioner may seek both temporary and permanent injunctive relief when:

(i) A discount plan is being operated by a person or entity that is not licensed under this chapter; or

(ii) Any person, entity, or discount plan organization has engaged in any activity prohibited by this chapter or any rule adopted under this chapter.

(b) The venue for any court proceeding brought under this section is Thurston county.

(2) The commissioner's authority to seek injunctive relief is not conditioned on having conducted any proceeding under chapter 34.05 RCW. [2009 c 175 § 17.]

Chapter 48.160 RCW

GUARANTEED ASSET PROTECTION WAIVERS

Sections

48.160.001	Purpose—Application.
48.160.005	Guaranteed asset protection waiver account.
48.160.010	Definitions.
48.160.020	Waivers limited to motor vehicle financing—Registration, when required—Application.
48.160.030	Waivers—Requirements for offering, selling, or providing—Terms—Insuring obligations—Funds—Assignment.
48.160.040	Insuring waiver obligations—Contractual liability or other insurance policies.
48.160.050	Required disclosures.
48.160.060	Cancellations—Refunds—Free look period—Disclosure required.
48.160.070	Commissioner's authority to enforce chapter—Rules.
48.160.080	Failure to register when required—Criminal and civil penalties—Personal liability.
48.160.900	Date of application—2009 c 334.

48.160.001 Purpose—Application. (1) The purpose of this chapter is to provide a framework within which guaranteed asset protection waivers are defined and may be offered within this state.

(2) This chapter does not apply to:

(a) An insurance policy offered by an insurer under this title; or

(b) A federally regulated financial institution operating under 12 C.F.R. Part 37 of the office of the comptroller of the currency regulations or credit unions operating under 12 C.F.R. 721.3(g) of the national credit union administration regulations, or state regulated banks, credit unions, financial institutions operating pursuant to chapter 63.14 RCW, and consumer loan companies operating pursuant to chapter 31.04 RCW. However, an exempt federal or state chartered bank, credit union, or financial institution may elect to offer a guaranteed asset protection waiver that complies with this section, RCW 48.160.010, and 48.160.030 through 48.160.060.

(3) Guaranteed asset protection waivers are governed under this chapter and are exempt from all other provisions of this title, except RCW 48.02.060 and 48.02.080, chapter 48.04 RCW, and as provided in this chapter. [2009 c 334 § 1.]

48.160.005 Guaranteed asset protection waiver account. The guaranteed asset protection waiver account is created in the custody of the state treasurer. The fees and fines collected under this chapter must be deposited into the account. Expenditures from the account may be used to implement, administer, and enforce this chapter. Only the commissioner or the commissioner's designee may authorize expenditures from the account. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures. [2009 c 334 § 10.]

48.160.010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Administrator" means a person, other than an insurer or creditor that performs administrative or operational functions pursuant to guaranteed asset protection waiver programs.

(2) "Borrower" means a debtor, retail buyer, or lessee, under a finance agreement, or a person who receives a loan or enters into a retail installment contract to purchase or lease a motor vehicle or vessel under chapter 63.14 RCW.

(3) "Creditor" means:

(a) The lender in a loan or credit transaction;

(b) The lessor in a lease transaction;

(c) Any retail seller of motor vehicles that provides credit to retail buyers of motor vehicles provided the seller complies with this chapter;

(d) The seller in commercial retail installment transactions; or

(e) The assignees of any creditor under this subsection to whom the credit obligation is payable.

(4) "Finance agreement" means a loan, lease, or retail installment sales contract for the purchase or lease of a motor vehicle.

(5) "Free look period" means the period of time from the effective date of the waiver until the date the borrower may cancel the waiver without penalty, fees, or costs to the borrower. This period of time must not be shorter than thirty days.

(6) "Guaranteed asset protection waiver" or "waiver" means a contractual agreement wherein a creditor agrees for a separate charge to cancel or waive all or part of amounts due 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, which agreement must be part of, or a separate addendum to, the finance agreement.

(7) "Insurer" means an insurance company licensed, registered, or otherwise authorized to do business under the insurance laws of this state.

(8) "Motor vehicle" means self-propelled or towed vehicles designed for personal or commercial use, including but not limited to automobiles, trucks, motorcycles, recreational vehicles, all-terrain vehicles, snowmobiles, campers, boats, personal watercraft, and motorcycle, boat, camper, and personal watercraft trailers.

(9) "Motor vehicle dealer" has the same meaning as "vehicle dealer" in RCW 46.70.011.

(10) "Person" includes an individual, company, association, organization, partnership, business trust, corporation, and every form of legal entity.

(11) "Retail buyer" means a person who buys or agrees to buy a motor vehicle or obtain motor vehicle services or agrees to have motor vehicle services rendered or furnished from a retail seller.

(12) "Retail seller" means a person engaged in the business of selling motor vehicles or motor vehicle services to retail buyers.

(13) "Unregistered marketers" means persons who offer for sale and sell guaranteed asset protection waivers who are not registered under this chapter and who are not otherwise exempt under this chapter. [2009 c 334 § 2.]

48.160.020 Waivers limited to motor vehicle financing—Registration, when required—Application. (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 percent of guaranteed asset protection waiver agreements within thirty 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 percent of guaranteed asset protection waiver agreements within forty-five 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, which shall be deposited into the guaranteed asset protection waiver account;

(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 days after the end of the month in which the change occurs. [2009 c 334 § 3.]

48.160.030 Waivers—Requirements for offering, selling, or providing—Terms—Insuring obligations—Funds—Assignment. (1) Waivers may be offered, sold, or provided to borrowers in this state in compliance with this chapter.

(2) Waivers may, at the option of the creditor, be sold for a single payment or may be offered with a monthly or periodic payment option.

(3) Notwithstanding any other provision of law, any cost to the borrower for a guaranteed asset protection waiver entered into in compliance with the truth in lending act (15 U.S.C. Sec. 1601 et seq.) and its implementing regulations, as amended, must be separately stated and is not to be considered a finance charge or interest.

(4) Nothing in this chapter prohibits a person who is registered, or is otherwise exempt from registration or exempt from this chapter, from insuring its waiver obligation through the purchase of a contractual liability policy or other insurance policy issued by an insurer authorized to transact such insurance in this state.

(5) The waiver remains a part of the finance agreement upon the assignment, sale, or transfer of the finance agreement by the creditor.

(6) Neither the extension of credit, the term of credit, nor the term of the related motor vehicle sale or lease may be conditioned upon the purchase of a waiver.

(7) Any creditor that offers a waiver must report the sale of, and forward funds received on, all waivers to the designated party, if any, as prescribed in any applicable administrative services agreement, contractual liability policy, other insurance policy, or other specified program documents.

(8) Funds received or held by a creditor or administrator and belonging to an insurer, creditor, or administrator, under the terms of a written agreement, must be held by that creditor or administrator in a fiduciary capacity.

(9) If the guaranteed asset protection waiver is assigned, the name and address of the assignee must be mailed to the borrower within thirty days of the assignment. If at any time the name and address provided to the borrower by the initial creditor are no longer the valid point of contact to apply for

waiver benefits, written notice will be mailed to the borrower within thirty days of the change stating the new name and address of the person or entity the borrower should contact to apply for waiver benefits. No waiver may be assigned to an entity that is not registered pursuant to this chapter, unless such entity is exempt from registration or unless the commissioner specifically authorizes such assignment.

(10) No person shall knowingly make, publish, or disseminate any false, deceptive, or misleading representation or advertising in the conduct of, or relative to, waiver business. Nor shall any person make, issue, or circulate, or cause to be made, issued, or circulated any misrepresentation of the terms or benefits of any waiver.

(11) A person or entity engaged in the guaranteed asset protection waiver business in this state may not refuse to sell or issue any guaranteed asset protection waiver because of the sex, marital status, or sexual orientation as defined in RCW 49.60.040, or the presence of any sensory, mental, or physical disability of the borrower or prospective borrower. The type of benefits, or any term, rate, condition, or type of coverage may not be restricted, modified, excluded, increased, or reduced on the basis of the presence of any sensory, mental, or physical disability of the borrower or prospective borrower. [2009 c 334 § 4.]

48.160.040 Insuring waiver obligations—Contractual liability or other insurance policies. (1) Contractual liability or other insurance policies insuring waivers must state the obligation of the insurer to reimburse or pay to the creditor any sums the creditor is legally obligated to waive under the waivers issued by the creditor and purchased or held by the borrower. Contractual liability insurance or other insurance policies insuring waivers must not be purchased by the creditor as part of, or a rider to, vendor single-interest or collateral protection coverages as defined in RCW 48.22.110(4).

(2) Coverage under a contractual liability or other insurance policy insuring a waiver must also cover any subsequent assignee upon the assignment, sale, or transfer of the finance agreement.

(3) Coverage under a contractual liability or other insurance policy insuring a waiver must remain in effect unless canceled or terminated in compliance with applicable insurance laws of this state.

(4) The cancellation or termination of a contractual liability or other insurance policy must not reduce the insurer's responsibility for waivers issued by the creditor prior to the date of cancellation or termination and for which a premium has been received by the insurer. [2009 c 334 § 5.]

48.160.050 Required disclosures. Guaranteed asset protection waivers must disclose, as applicable, in writing and in clear, understandable language that is easy to read, the following:

(1) The name and address of the initial creditor and the borrower at the time of sale, and the identity of any administrator if different from the creditor;

(2) The purchase price and the terms of the waiver, including without limitation, the requirements for protection, conditions, or exclusions associated with the waiver;

(3) That the borrower may cancel the waiver within a free look period as specified in the waiver, and will be entitled to a full refund of the purchase price, so long as no benefits have been provided; or in the event benefits have been provided, the borrower may receive a full or partial refund pursuant to the terms of the waiver;

(4) The procedure the borrower must follow, if any, to obtain waiver benefits under the terms and conditions of the waiver, including a telephone number and address where the borrower may apply for waiver benefits;

(5) Whether or not the waiver is cancellable after the free look period and the conditions under which it may be canceled or terminated including the procedures for requesting any refund due;

(6) That in order to receive any refund due in the event of a borrower's cancellation of the waiver agreement or early termination of the finance agreement after the free look period of the waiver, the borrower, in accordance with terms of the waiver, must provide a written request to cancel to the creditor, administrator, or such other party, within ninety days of the occurrence of the event terminating the finance agreement;

(7) The methodology for calculating any refund of the unearned purchase price of the waiver due, in the event of cancellation of the waiver or early termination of the finance agreement;

(8) That any refund of the purchase price for a waiver that was included in the financing of the motor vehicle or vessel may be applied by the creditor as a reduction of the overall amount owed under the finance agreement, rather than applying the refund strictly to the purchase price of the waiver. This disclosure must be conspicuously presented prior to the purchase of the waiver;

(9) That neither the extension of credit, the terms of the credit, nor the terms of the related motor vehicle sale or lease, may be conditioned upon the purchase of the waiver;

(10) That the guaranteed asset protection waiver is not credit insurance, nor does it eliminate the borrower's obligation to insure the motor vehicle as provided by laws of this state. Purchasing a guaranteed asset protection waiver does not eliminate the borrower's rights and obligations under the vendor single-interest and collateral protection coverage laws of this state. [2009 c 334 § 6.]

48.160.060 Cancellations—Refunds—Free look period—Disclosure required. (1) Guaranteed asset protection waiver agreements may be cancellable or noncancellable after the free look period. Waivers must provide that if a borrower cancels a waiver within the free look period, the borrower will be entitled to a full refund of the purchase price, so long as no benefits have been provided; or in the event benefits have been provided, the borrower may receive a full or partial refund pursuant to the terms of the waiver.

(2) In the event of a borrower's cancellation of the waiver or early termination of the finance agreement, after the agreement has been in effect beyond the free look period, the borrower may be entitled to a refund of any unearned portion of the purchase price of the waiver unless the waiver provides otherwise. In order to receive a refund, the borrower, in accordance with any applicable terms of the waiver, must provide a written request to the creditor, administrator, or

other party, within ninety days of the event terminating the finance agreement.

(3) If the cancellation of a waiver occurs as a result of a default under the finance agreement or the repossession of the motor vehicle associated with the finance agreement, any refund due may be paid directly to the creditor or administrator and applied as set forth in subsection (4) of this section.

(4) Any cancellation refund under this section may be applied by the creditor as a reduction of the overall amount owed under the finance agreement, if the cost of the guaranteed asset protection waiver was included in the financing of the motor vehicle or vessel.

(5) Disclosure of how the refund may be applied by the creditor or administrator must be made in accordance with the provisions of RCW 48.160.050(8). [2009 c 334 § 7.]

48.160.070 Commissioner's authority to enforce chapter—Rules. (1) The commissioner may, subject to chapter 48.04 RCW, take action that is necessary or appropriate to enforce this chapter and to protect guaranteed asset protection waiver holders in this state, which includes:

(a) Suspending, revoking, or refusing to issue the registration of a person or entity if the registrant fails to comply with any provision of this chapter or fails to comply with any proper order or rule of the commissioner; and

(b) After hearing or with the consent of the registrant, and in addition to or in lieu of the suspension, revocation, or refusal to issue any registration, imposing a penalty of not more than two thousand dollars for each violation of this chapter.

(2) The commissioner may adopt rules to implement this chapter. [2009 c 334 § 8.]

48.160.080 Failure to register when required—Criminal and civil penalties—Personal liability. (1) Any person who markets, offers for sale or sells a guaranteed asset protection waiver, or acts as an obligor for a guaranteed asset protection waiver without a registration, unless otherwise exempt from registration or exempt from this chapter, is acting in violation of this section and is subject to the provisions of RCW 48.160.070. In addition, any person who knowingly violates this section is guilty of a class B felony punishable under chapter 9A.20 RCW.

(2) Any criminal penalty imposed under this section is in addition to, and not in lieu of, any other civil or administrative penalty or sanction otherwise authorized under state law.

(3) If the commissioner has cause to believe that any person has violated this section, the commissioner may assess a civil penalty of not more than twenty-five thousand dollars for each violation, after providing notice and an opportunity for a hearing in accordance with chapter 48.04 RCW. Upon failure to pay this civil penalty when due, the attorney general may bring a civil action on behalf of the commissioner to recover the unpaid penalty.

(4) A person or entity that should have been registered at the time of the sale of a waiver who was not so registered pursuant to this chapter is personally liable for performance of the waiver. Any waiver sold by a person or entity that should have been registered at the time of the sale is voidable, except at the instance of the person or entity who sold the waiver. [2009 c 334 § 9.]

48.160.900 Date of application—2009 c 334. Chapter 334, Laws of 2009 is applicable to all guaranteed asset protection waiver agreements entered into on or after January 1, 2010. [2009 c 334 § 13.]

Chapter 48.165 RCW
UNIFORM ADMINISTRATIVE PROCEDURES—
HEALTH CARE SERVICES

Sections

48.165.005	Findings—Intent.
48.165.010	Definitions.
48.165.030	Designation of lead organizations—Coordination responsibility—Qualifications—Lead organization's duties—Commissioner's duties.
48.165.0301	Prior authorization requirements—Lead organization and work group to develop recommendations—Rules.
48.165.035	Lead organization tasks—Uniform electronic process.
48.165.040	Lead organization tasks—Uniform standard companion document and data set.
48.165.045	Lead organization tasks—Implementation guidelines—Code development and standardization—Denial review process.
48.165.050	Lead organization tasks—Develop and promote uniform practices—Medical management protocols.

48.165.005 Findings—Intent. The legislature finds that:

(1) The health care system in the nation and in Washington state costs nearly twice as much per capita as other industrialized nations.

(2) The fragmentation and variation in administrative processes prevalent in our health care system contribute to the high cost of health care, putting it increasingly beyond the reach of small businesses and individuals in Washington.

(3) In 2006, the legislature's blue ribbon commission on health care costs and access requested the office of the insurance commissioner to conduct a study of administrative costs and recommendations to reduce those costs. Findings in the report included:

(a) In Washington state approximately thirty cents of every dollar received by hospitals and doctors' offices is consumed by the administrative expenses of public and private payors and the providers;

(b) Before the doctors and hospitals receive the funds for delivering the care, approximately fourteen percent of the insurance premium has already been consumed by payor administration. The payor's portion of expense totals approximately four hundred fifty dollars per insurance member per year in Washington state;

(c) Over thirteen percent of every dollar received by a physician's office is devoted to interactions between the provider and payor;

(d) Between 1997 and 2005, billing and insurance related costs for hospitals in Washington grew at an average pace of nineteen percent per year; and

(e) The greatest opportunity for improved efficiency and administrative cost reduction in our health care system would involve standardizing and streamlining activities between providers and payors.

(4) To address these inefficiencies, constrain health care inflation, and make health care more affordable for Washingtonians, the legislature seeks to establish streamlined and uniform procedures for payors and providers of health care services in the state. It is the intent of the legislature to foster a continuous quality improvement cycle to simplify health care

administration. This process should involve leadership in the health care industry and health care purchasers, with regulatory oversight from the office of the insurance commissioner. [2009 c 298 § 1.]

48.165.010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Commissioner" means the insurance commissioner as established under chapter 48.02 RCW.

(2) "Health care provider" or "provider" has the same meaning as in RCW 48.43.005 and, for the purposes of chapter 298, Laws of 2009, shall include facilities licensed under chapter 70.41 RCW.

(3) "Lead organization" means a private sector organization or organizations designated by the commissioner to lead development of processes, guidelines, and standards to streamline health care administration and to be adopted by payors and providers of health care services operating in the state.

(4) "Medical management" means administrative activities established by the payor to manage the utilization of services through preservice or postservice reviews. "Medical management" includes, but is not limited to:

- (a) Prior authorization or preauthorization of services;
- (b) Precertification of services;
- (c) Postservice review;
- (d) Medical necessity review; and
- (e) Benefits advisory.

(5) "Payor" means public purchasers, as defined in this section, carriers licensed under chapters 48.20, 48.21, 48.44, 48.46, and 48.62 RCW, and the Washington state health insurance pool established in chapter 48.41 RCW.

(6) "Public purchaser" means the department of social and health services, the department of labor and industries, and the health care authority.

(7) "Secretary" means the secretary of the department of health.

(8) "Third-party payor" has the same meaning as in RCW 70.02.010. [2009 c 298 § 2.]

48.165.030 Designation of lead organizations—Coordination responsibility—Qualifications—Lead organization's duties—Commissioner's duties. (1) The commissioner shall designate one or more lead organizations to coordinate development of processes, guidelines, and standards to streamline health care administration and to be adopted by payors and providers of health care services operating in the state. The lead organization designated by the commissioner for chapter 298, Laws of 2009 shall:

- (a) Be representative of providers and payors across the state;
- (b) Have expertise and knowledge in the major disciplines related to health care administration; and
- (c) Be able to support the costs of its work without recourse to public funding.

(2) The lead organization shall:

- (a) In collaboration with the commissioner, identify and convene work groups, as needed, to define the processes, guidelines, and standards required in RCW 48.165.035, 18.122.165, and 48.165.040 through 48.165.050;

(b) In collaboration with the commissioner, promote the participation of representatives of health care providers, payors of health care services, and others whose expertise would contribute to streamlining health care administration;

(c) Conduct outreach and communication efforts to maximize adoption of the guidelines, standards, and processes developed by the lead organization;

(d) Submit regular updates to the commissioner on the progress implementing the requirements of chapter 298, Laws of 2009; and

(e) With the commissioner, report to the legislature annually through December 1, 2012, on progress made, the time necessary for completing tasks, and identification of future tasks that should be prioritized for the next improvement cycle.

(3) The commissioner shall:

(a) Participate in and review the work and progress of the lead organization, including the establishment and operation of work groups for chapter 298, Laws of 2009;

(b) Adopt into rule, or submit as proposed legislation, the guidelines, standards, and processes set forth in chapter 298, Laws of 2009 if:

(i) The lead organization fails to timely develop or implement the guidelines, standards, and processes set forth in RCW 48.165.035, 18.122.165, and 48.165.040 through 48.165.050; or

(ii) It is unlikely that there will be widespread adoption of the guidelines, standards, and processes developed under chapter 298, Laws of 2009;

(c) Consult with the office of the attorney general to determine whether an antitrust safe harbor is necessary to enable licensed carriers and providers to develop common rules and standards; and, if necessary, take steps, such as implementing rules or requesting legislation, to establish such safe harbor; and

(d) Convene an executive level work group with broad payor and provider representation to advise the commissioner regarding the goals and progress of implementation of the requirements of chapter 298, Laws of 2009. [2009 c 298 § 5.]

48.165.0301 Prior authorization requirements—Lead organization and work group to develop recommendations—Rules. (1) The insurance commissioner must reauthorize the efforts with the lead organization established in RCW 48.165.030, and establish a new work group to develop recommendations for prior authorization requirements. The focus of the prior authorization efforts must include the full scope of health care services including pharmacy issues. The work group must submit recommendations to the commissioner by October 31, 2014.

(2) The lead organization and work group established to review prior authorization requirements must consider the following areas in their efforts:

(a) Requiring carriers and pharmacy benefit managers to provide a listing of prior authorization requirements electronically on a website. The listing of requirements for any procedure, supply, or service requiring preauthorization must include criteria needed by the carrier specific to that medical or procedural code, to allow a provider's office to submit all information needed on the initial request for prior authorization, along with instructions for submitting that information;

(b) Requiring a carrier or pharmacy benefit manager to issue an acknowledgment of receipt or reference number for prior authorization within a specified time frame, such as two business days of receipt of a prior authorization request from a provider;

(c) Recommendations for the best practices for exchanging information, including alternatives to fax requests;

(d) Recommendations for the best practices if the acknowledgment has not been received by the provider or pharmacy benefit manager within the specified time frame, such as two business days;

(e) Recommendations if the carrier or pharmacy benefit manager fails to approve, deny, or respond to the request for authorization within the specified time frame and options for deeming approval;

(f) Recommendations to refine the time frames in current rule; and

(g) Recommendations specific to pharmacy services, including communication between the pharmacy to the carrier or pharmacy benefit manager, communications between the carrier or pharmacy benefit manager with the provider's office, communication of the authorization number, posting of the criteria for pharmacy related prior authorization on a website and other recommended alternatives; and options for prior authorizations involving urgent and emergent care with short-term prescription fill, such as a three-day supply, while the authorization is obtained.

(3) In preparing the recommendations, the work group must consider the opportunities to align with national mandates and regulatory guidance in the health insurance portability and accountability act and the patient protection and affordable care act, and use information technologies and electronic health records to increase efficiencies in health care and reengineer and automate age-old practices to improve business functions and ensure timely access to care for patients.

(4) The commissioner shall adopt rules implementing the recommendations of the work group. The rules adopted under this subsection may only implement, and may not expand or limit, the recommendations of the work group. [2014 c 141 § 1.]

48.165.035 Lead organization tasks—Uniform electronic process. By December 31, 2010, the lead organization shall:

(1) Develop a uniform electronic process for collecting and transmitting the necessary provider-supplied data to support credentialing, admitting privileges, and other related processes that:

(a) Reduces the administrative burden on providers;

(b) Improves the quality and timeliness of information for hospitals and payors;

(c) Is interoperable with other relevant systems;

(d) Enables use of the data by authorized participants for other related applications; and

(e) Serves as the sole source of credentialing information required by hospitals and payors from providers for data elements included in the electronic process, except this shall not prohibit:

(i) A hospital, payor, or other credentialing entity subject to the requirements of this section from seeking clarification

of information obtained through use of the uniform electronic process, if such clarification is reasonably necessary to complete the credentialing process; or

(ii) A hospital, payor, other credentialing entity, or a university from using information not provided by the uniform process for the purpose of credentialing, admitting privileges, or faculty appointment of providers, including peer review and coordinated quality improvement information, that is obtained from sources other than the provider;

(2) Promote widespread adoption of such process by payors and hospitals, their delegates, and subcontractors in the state that credential health professionals and by such health professionals as soon as possible thereafter; and

(3) Work with the secretary to assure that data used in the uniform electronic process can be electronically exchanged with the department of health professional licensing process under chapter 18.122 RCW. [2009 c 298 § 6.]

48.165.040 Lead organization tasks—Uniform standard companion document and data set. The lead organization shall:

(1) Establish a uniform standard companion document and data set for electronic eligibility and coverage verification. Such a companion guide will:

(a) Be based on nationally accepted ANSI X12 270/271 standards for eligibility inquiry and response and, wherever possible, be consistent with the standards adopted by nationally recognized organizations, such as the centers for medicare and medicaid services;

(b) Enable providers and payors to exchange eligibility requests and responses on a system-to-system basis or using a payor supported web browser;

(c) Provide reasonably detailed information on a consumer's eligibility for health care coverage, scope of benefits, limitations and exclusions provided under that coverage, cost-sharing requirements for specific services at the specific time of the inquiry, current deductible amounts, accumulated or limited benefits, out-of-pocket maximums, any maximum policy amounts, and other information required for the provider to collect the patient's portion of the bill; and

(d) Reflect the necessary limitations imposed on payors by the originator of the eligibility and benefits information;

(2) Recommend a standard or common process to the commissioner to protect providers and hospitals from the costs of, and payors from claims for, services to patients who are ineligible for insurance coverage in circumstances where a payor provides eligibility verification based on best information available to the payor at the date of the request; and

(3) Complete, disseminate, and promote widespread adoption by payors of such document and data set by December 31, 2010. [2009 c 298 § 8.]

48.165.045 Lead organization tasks—Implementation guidelines—Code development and standardization—Denial review process. (1) By December 31, 2010, the lead organization shall develop implementation guidelines and promote widespread adoption of such guidelines for:

(a) The use of the national correct coding initiative code edit policy by payors and providers in the state;

(b) Publishing any variations from component codes, mutually exclusive codes, and status b codes by payors in a manner that makes for simple retrieval and implementation by providers;

(c) Use of health insurance portability and accountability act standard group codes, reason codes, and remark codes by payors in electronic remittances sent to providers;

(d) The processing of corrections to claims by providers and payors; and

(e) A standard payor denial review process for providers when they request a reconsideration of a denial of a claim that results from differences in clinical edits where no single, common standards body or process exists and multiple conflicting sources are in use by payors and providers.

(2) By October 31, 2010, the lead organization shall develop a proposed set of goals and work plan for additional code standardization efforts for 2011 and 2012.

(3) Nothing in this section or in the guidelines developed by the lead organization shall inhibit an individual payor's ability to employ, and not disclose to providers, temporary code edits for the purpose of detecting and deterring fraudulent billing activities. Though such temporary code edits are not required to be disclosed to providers, the guidelines shall require that:

(a) Each payor disclose to the provider its adjudication decision on a claim that was denied or adjusted based on the application of such an edit; and

(b) The provider have access to the payor's review and appeal process to challenge the payor's adjudication decision, provided that nothing in this subsection (3)(b) shall be construed to modify the rights or obligations of payors or providers with respect to procedures relating to the investigation, reporting, appeal, or prosecution under applicable law of potentially fraudulent billing activities. [2009 c 298 § 9.]

48.165.050 Lead organization tasks—Develop and promote uniform practices—Medical management protocols. (1) By December 31, 2010, the lead organization shall:

(a) Develop and promote widespread adoption by payors and providers of guidelines to:

(i) Ensure payors do not automatically deny claims for services when extenuating circumstances make it impossible for the provider to: (A) Obtain a preauthorization before services are performed; or (B) notify a payor within twenty-four hours of a patient's admission; and

(ii) Require payors to use common and consistent time frames when responding to provider requests for medical management approvals. Whenever possible, such time frames shall be consistent with those established by leading national organizations and be based upon the acuity of the patient's need for care or treatment;

(b) Develop, maintain, and promote widespread adoption of a single common website where providers can obtain payors' preauthorization, benefits advisory, and preadmission requirements;

(c) Establish guidelines for payors to develop and maintain a website that providers can employ to:

(i) Request a preauthorization, including a prospective clinical necessity review;

(ii) Receive an authorization number; and

(iii) Transmit an admission notification.

(2) By October 31, 2010, the lead organization shall propose to the commissioner a set of goals and work plan for the development of medical management protocols, including whether to develop evidence-based medical management practices addressing specific clinical conditions and make its recommendation to the commissioner, who shall report the lead organization's findings and recommendations to the legislature. [2009 c 298 § 10.]

Chapter 48.170 RCW SELF-SERVICE STORAGE INSURANCE PRODUCERS

Sections

48.170.005	Definitions.
48.170.007	Rules.
48.170.010	License required.
48.170.020	Application for a license—Requirements.
48.170.030	Licensee exempt from continuing education requirements.
48.170.040	Authority conveyed by license.
48.170.050	Preconditions to soliciting insurance.
48.170.060	Required written disclosure material—Contents.
48.170.070	Employee acting under authority of license—Conditions— Limitations.
48.170.900	Effective date—2009 c 119.

48.170.005 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Commissioner" means the insurance commissioner of this state.

(2) "Occupant" means a person, or his or her sublessee, successor, or assign, who is entitled to the use of the storage space at a self-service storage facility under a rental agreement, to the exclusion of others.

(3) "Owner" means the owner, operator, property management company, lessor, or sublessor of a self-service storage facility. "Owner" does not mean an occupant.

(4) "Personal property" means movable property not affixed to land, and includes, but is not limited to, goods, merchandise, furniture, and household items.

(5) "Self-service storage facility" or "facility" means any real property designed and used for the purpose of renting or leasing individual storage space to occupants who are to have access to the space for the purpose of storing and removing personal property on a self-service basis, but does not include a garage or other storage area in a private residence.

(6) "Self-service storage insurance" is insurance that in connection with and incidental to the rental of space at a facility provides coverage to occupants at the facility for the loss of or damage to stored personal property that occurs at that facility.

(7) "Self-service storage insurance producer" means any owner of a facility that is licensed as a specialty lines insurance producer under chapter 48.17 RCW to offer, sell, or solicit self-service storage insurance under this chapter. [2009 c 119 § 1.]

Reviser's note: The definitions in this section have been alphabetized pursuant to RCW 1.08.015(2)(k).

48.170.007 Rules. The commissioner may adopt rules necessary to implement and administer this chapter. [2009 c 119 § 9.]

48.170.010 License required. (1) An owner; or officer, director, or employee of an owner; may not offer, sell, or solicit the purchase of self-service storage insurance unless that person is:

(a) Licensed as an insurance producer with a property line of authority under chapter 48.17 RCW; or

(b) Licensed as a self-service storage insurance producer under chapter 48.17 RCW and is in compliance with this chapter.

(2) If the owner is licensed as a self-service storage insurance producer under chapter 48.17 RCW and is in compliance with this chapter, then an employee of the owner who is in compliance with RCW 48.170.070(1) is not required to be individually licensed.

(3) The commissioner may issue a specialty line insurance producer license to an owner that is in compliance with this chapter authorizing the owner to act as a self-service storage insurance producer under this chapter, in connection with and incidental to rental agreements, on behalf of any insurer authorized to write self-service storage insurance in this state. [2009 c 119 § 2.]

48.170.020 Application for a license—Requirements.

An owner may apply to be licensed as a self-service storage insurance producer under, and if in compliance with, this chapter by filing the following documents with the commissioner:

(1) A written application for licensure, signed by the applicant or by an officer of the applicant, in the form prescribed by the commissioner that includes a listing of all locations at which the owner intends to offer, sell, or solicit self-service storage insurance; and

(2)(a) A certificate by the insurer that is to be named in self-service storage insurance producer license, stating that the insurer:

(i) Has satisfied itself that the named applicant is trustworthy and competent to act as its self-service storage insurance producer, limited to this purpose;

(ii) Has reviewed the employee training and education program required by RCW 48.170.070(1)(c) and that it satisfies the statutory requirements; and

(iii) Will appoint the applicant to act as its self-service storage insurance producer to offer, sell, or solicit self-service storage insurance, if the license for which the applicant is applying is issued by the commissioner.

(b) The certification shall be subscribed by an authorized representative of the insurer on a form prescribed by the commissioner. [2009 c 119 § 3.]

48.170.030 Licensee exempt from continuing education requirements. An owner issued a self-service storage insurance producer license under this chapter is not subject to the precicensure or continuing education requirements in chapter 48.17 RCW. [2009 c 119 § 4.]

48.170.040 Authority conveyed by license. (1) A self-service storage insurance producer license authorizes a self-service storage insurance producer and its employees to offer and sell to, enroll in, and bill and collect premiums from occupants for insurance covering the loss of or damage to

personal property stored at a facility on a master, corporate, group, or individual policy basis.

(2) A self-service storage insurance producer is not required to treat moneys collected from occupants purchasing insurance under this chapter as funds received in a fiduciary capacity, if:

(a) The insurer represented by the self-service storage insurance producer has consented in writing, signed by an officer of the insurer, that the premiums need not be segregated from funds received by the self-service storage insurance producer; and

(b) The charges for insurance coverage are itemized and ancillary to the rental agreement.

(3) An owner is not required to be licensed pursuant to this section merely to display and make available to prospective occupants brochures and other promotional materials created by or on behalf of an authorized insurer, provided that either the owner or its employees, or both, are not paid a commission or other consideration. [2009 c 119 § 5.]

48.170.050 Preconditions to soliciting insurance. A self-service storage insurance producer may not solicit insurance under RCW 48.170.010 unless:

(1) At every location where occupants are enrolled in self-service storage insurance programs, written disclosure material regarding the program is made available to prospective occupants; and

(2) All employees who offer and sell to, enroll in, and bill and collect premiums from occupants for insurance have completed a training program for employees of the licensed self-service storage insurance producer as approved by the commissioner. [2009 c 119 § 6.]

48.170.060 Required written disclosure material—Contents. The written disclosure material required in RCW 48.170.050(1) must:

(1) Summarize the material terms of insurance coverage offered to occupants, including the name, address, telephone number of the insurer, price, benefits, exclusions, and conditions;

(2) Prominently and conspicuously disclose that the policies offered by the self-service storage insurance producer may provide a duplication of coverage already provided by an occupant's homeowner's insurance policy, renter's insurance policy, vehicle insurance policy, watercraft insurance policy, or other source of property insurance coverage;

(3) State that if self-service storage insurance is required as a condition of rental, the requirement may be satisfied by the occupant purchasing the insurance being offered to the occupant by the owner or by presenting evidence of other applicable insurance coverage;

(4) Describe the process for filing a claim;

(5) State in writing all costs related to the insurance; and

(6) Disclose any other information required by rule by the commissioner. [2009 c 119 § 7.]

48.170.070 Employee acting under authority of license—Conditions—Limitations. (1) An employee of a self-service storage insurance producer may be authorized to offer, sell, or solicit self-service storage insurance under the

authority of the self-service storage insurance producer's license, if all of the following conditions have been satisfied:

(a) The employee is eighteen years of age or older;

(b) The employee is a trustworthy person and has not committed any act set forth in RCW 48.17.530;

(c) The employee has completed a training and education program;

(d) The self-service storage insurance producer, at the time it submits its self-service storage insurance producer license application, also submits a list of the names of all employees to its self-service storage insurance producer license on forms prescribed by the commissioner. The list shall be submitted to the commissioner annually and kept current by reporting all changes, deletions, or additions within thirty days after the change, deletion, or addition occurred. Each list shall be retained by the self-service storage insurance producer for a period of three years from submission; and

(e) The self-service storage insurance producer submits to the commissioner with its initial self-service storage insurance producer license application, and annually thereafter, a certification subscribed by an officer of the self-service storage insurance producer on a form prescribed by the commissioner, stating all of the following:

(i) No person other than an employee offers, sells, or solicits self-service storage insurance on its behalf or while working as an employee of the self-service storage insurance producer; and

(ii) All employees have completed the training and education program under subsection (4) of this section.

(2) A self-service storage insurance producer's employee may only act on behalf of the self-service storage insurance producer in the offer, sale, or solicitation of self-service storage insurance. A self-service storage insurance producer is responsible for, and must supervise, all actions of its employees related to the offering, sale, or solicitation of self-service storage insurance. The conduct of an employee is the same as the conduct of the self-service storage insurance producer for purposes of this chapter.

(3) The manager at each location of a self-service storage insurance producer, or the direct supervisor of the self-service storage insurance producer's employees at each location, must be an employee of that self-service storage insurance producer and is responsible for the supervision of each additional employee at that location. Each self-service storage insurance producer shall identify the employee who is the manager or direct supervisor at each location in the employee list that it submits under subsection (1)(d) of this section.

(4) Each self-service storage insurance producer shall provide a training and education program for each employee prior to allowing an employee to offer, sell, or solicit self-service storage insurance. Details of the program must be submitted to the commissioner, along with the license application, for approval prior to use, and resubmitted for approval of any changes prior to use. This training program shall meet the following minimum standards:

(a) Each employee shall receive instruction about the insurance authorized under this chapter that may be offered for sale to prospective occupants; and

(b) Each employee shall receive training about the requirements and limitations imposed on self-service storage

insurance producer and employees under this chapter. The training must include specific instruction that the employee is prohibited by law from making any statement or engaging in any conduct express or implied, that would lead a consumer to believe that the:

(i) Occupant does not have insurance policies in place that already provide the coverage being offered by the self-service storage producer under this chapter; or

(ii) Employee is qualified to evaluate the adequacy of the occupant's existing insurance coverages.

(5) The training and education program submitted to the commissioner is approved if no action is taken within thirty days of its submission.

(6) An employee's authorization to offer, sell, or solicit self-service storage insurance expires when the employee's employment with the self-service storage insurance producer is terminated.

(7) The self-service storage insurance producer shall retain for a period of one year from the date of each transaction records which enable it to identify the name of the employee involved in each rental transaction when an occupant purchases self-service storage insurance. [2009 c 119 § 8.]

48.170.900 Effective date—2009 c 119. This act takes effect July 1, 2010. [2009 c 119 § 13.]

Chapter 48.175 RCW PERSONAL VEHICLE SHARING PROGRAMS

Sections

48.175.005	Definitions.
48.175.010	Requirements of program.
48.175.020	Program's liabilities—Owner's insurance policy.
48.175.030	Private passenger motor vehicle not a commercial or for-hire motor vehicle—Criteria.
48.175.900	Application—2012 c 108.

48.175.005 Definitions. (Effective until January 1, 2023.) For the purposes of this chapter, unless the context otherwise requires:

(1) "Owner's insurance policy" means an automobile liability insurance policy, as defined in RCW 48.22.005, that includes:

(a) All coverage necessary to comply with the requirements of chapter 46.30 RCW; and

(b) Any optional coverage selected by the registered owner, including:

(i) Personal injury protection coverage as defined in RCW 48.22.005;

(ii) Underinsured coverage as defined in RCW 48.22.030;

(iii) Comprehensive property damage coverage for the vehicle; and

(iv) Collision property damage coverage for the vehicle.

(2) "Personal vehicle sharing" means the operation and use of a private passenger motor vehicle, by persons other than the vehicle's registered owner in connection with a personal vehicle sharing program.

(3) "Personal vehicle sharing program" or "program" means a legal entity qualified to do business in this state engaged in the business of facilitating the sharing of private

passenger motor vehicles for noncommercial use by individuals within this state. For the purposes of this subsection, "noncommercial use" means use other than that for a "commercial vehicle" as defined in RCW 46.04.140.

(4) "Private passenger motor vehicle" means a four-wheel passenger motor vehicle insured under an automobile liability insurance policy covering a single individual or individuals residing in the same household as the named insured.

(5) "Program insurance policy" means an automobile liability insurance policy that is obtained by the personal vehicle sharing program and that:

(a) Includes all coverage needed to comply with the requirements of chapter 46.30 RCW;

(b) Includes the following optional coverages:

(i) Comprehensive property damage coverage for the vehicle; and

(ii) Collision property damage coverage for the vehicle;

(c) Offers to the named insured on the program policy underinsured coverage as defined in RCW 48.22.030;

(d) Offers to the named insured on the program policy *underinsured coverage as defined in RCW 48.22.005; and

(e) Does not include any other optional coverage selected by the owner of the vehicle and included in the owner's insurance policy. [2012 c 108 § 1.]

***Reviser's note:** The reference to underinsured coverage appears erroneous. Personal injury protection was apparently intended.

48.175.010 Requirements of program. (Effective until January 1, 2023.) For each vehicle that the program facilitates the use of, a program must:

(1) Provide a program insurance policy with coverage for the vehicle and all persons who, with the consent of the program, use the motor vehicle insured while in control of the vehicle in the program. The limits for any coverage included in the program insurance policy may not provide liability coverage that is less than three times the limits specified in chapter 46.30 RCW and may not provide collision or comprehensive coverage that is less than the actual cash value of the vehicle;

(2) Prior to the first use of a vehicle in a program, and upon renewal, cancellation, or change in insurance by the program, provide the vehicle's registered owner with a proof of compliance with the insurance requirements of this section and the requirements of chapter 46.30 RCW, underinsured motorist coverage elections made by the sharing program under RCW 48.22.030 and personal injury protection coverage elections made by the sharing program under RCW 48.22.085. A copy of the proof of compliance must be maintained in the vehicle by the vehicle's registered owner at all times when the vehicle is operated by any person other than the vehicle's registered owner pursuant to the program;

(3) Collect, maintain, and make available to the vehicle's registered owner, the vehicle's registered owner's primary automobile liability insurer, and any government agency as required by law, at the cost of the program, the following:

(a) Verifiable records that identify the date and duration that the vehicle is under the control of a person other than the vehicle's registered owner pursuant to the program. For vehicles with an electronic tracking device, verifiable electronic records of the time, initial and final locations of the vehicle, and miles driven when the vehicle is under the control of a

person other than the vehicle's registered owner pursuant to the program; and

(b) In instances where an insurance claim has been filed, any and all information, including payments to the registered owner by the program, concerning accidents, damages, or injuries arising out of personal vehicle sharing pursuant to the program;

(4) Not knowingly permit the vehicle to be operated as a commercial vehicle by a personal vehicle sharing user while engaged in personal vehicle sharing. For the purposes of this subsection, "commercial vehicle" has the meaning given that term in RCW 46.04.140;

(5) Ensure that the vehicle is a private passenger motor vehicle;

(6) Facilitate the installation, operation, and maintenance of its own signage and computer hardware and software, if and when requested by the vehicle owner, necessary for the vehicle to be used in the program;

(7) Indemnify and hold harmless the vehicle's registered owner for the cost of damage or theft of equipment installed by the program under subsection (6) of this section and any damage caused to the vehicle by the installation, operation, or maintenance of the equipment;

(8)(a) Prior to the first use of a vehicle in a program, and upon renewal, cancellation, or change in insurance by the program, provide the vehicle's registered owner and any person operating the vehicle pursuant to the program with a disclosure that contains:

(i) Information explaining the requirements of this section;

(ii) Full and clear disclosure of the coverages and coverage limits provided under the program insurance policy;

(iii) Notice that the vehicle owner's insurer has no duty to defend or indemnify any person or organization for liability for any loss that occurs during use of the vehicle pursuant to a program; and

(iv) Notice that the vehicle owner or any person operating the vehicle pursuant to the program may have liability for claims that exceed the limits of the program insurance policy.

(b) The information in (a) of this subsection must be made available to the vehicle owner's insurer upon the insurer's request. [2012 c 108 § 2.]

48.175.020 Program's liabilities—Owner's insurance policy. (Effective until January 1, 2023.) (1) Notwithstanding any provision in the owner's insurance policy and notwithstanding chapter 46.29 RCW, in the event of any loss or injury that occurs at any time when the vehicle is under the operation or control of a person, other than the vehicle's registered owner, pursuant to a program, or is otherwise under the control of a program, the program shall assume all liability of the vehicle owner and shall be considered the vehicle owner for all purposes.

(2) Nothing in subsection (1) of this section:

(a) Limits the liability of a program for any acts or omissions by the program that result in injury to any persons as a result of the use or operation of the program; or

(b) Limits the ability of the program to, by contract, seek indemnification from the vehicle's registered owner for any claims paid by the program for any loss or injury resulting from fraud or material intentional misrepresentation by the

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vehicle's registered owner, provided that the vehicle sharing program disclose in the contract that:

(i) The program is entitled to seek indemnification in these circumstances; and

(ii) The registered owner's insurance policy does not provide defense or indemnification for any loss or injury resulting from fraud or material intentional misrepresentation.

(3) A program continues to be liable under subsection (1) of this section until:

(a) The vehicle is returned to a location designated by the program, as set forth in the contract between the registered owner and the program; and

(b)(i) The expiration of the time period established for the vehicle occurs;

(ii) The intent to terminate the vehicle's personal vehicle sharing use is verifiably communicated to the program, as set forth in the contract between the registered owner and the program; or

(iii) The vehicle's registered owner takes possession and control of the vehicle.

(4)(a) A program shall assume liability, including the costs of defense and indemnification, for a claim in which a dispute exists as to who was in control of a private passenger motor vehicle when the loss giving rise to the claim occurred.

(b) The insurer of the vehicle shall indemnify the program to the extent of the insurer's obligation under the owner's insurance policy, if it is determined that the vehicle's registered owner was in control of the vehicle at the time of the loss.

(5) If a private passenger motor vehicle's registered owner is named as a defendant in a civil action for any loss or injury that occurs at any time when the vehicle is under the operation or control of a person, other than the vehicle's registered owner, pursuant to a program, or is otherwise under the control of a program, the program shall have the duty to defend and indemnify the vehicle's registered owner.

(6)(a) Notwithstanding any provision in the owner's insurance policy, while the vehicle is under the operation or control of a person, other than the vehicle's registered owner, pursuant to a program, or is otherwise under the control of a program:

(i) The insurer providing coverage to the owner of a private passenger motor vehicle may exclude any and all coverage afforded under the owner's insurance policy; and

(ii) A primary or excess insurer of the vehicle owner may notify an insured that the insurer has no duty to defend or indemnify any person or organization for liability for any loss that occurs during use of the vehicle pursuant to a program;

(b) In order to exclude such coverage, the exclusion allowed in (a)(i) of this subsection and the notification required in (a)(ii) of this subsection are not required for a policy that otherwise does not provide such coverages.

(7) An owner's insurance policy for a private passenger motor vehicle may not be canceled, voided, terminated, rescinded, or nonrenewed solely on the basis that the vehicle has been made available for personal vehicle sharing pursuant to a program that is in compliance with the provisions of this chapter. [2012 c 108 § 3.]

48.175.030 Private passenger motor vehicle not a commercial or for-hire motor vehicle—Criteria. (Effec-

tive until January 1, 2023.) A private passenger motor vehicle insured by the vehicle's registered owner under an owner's insurance policy may not be classified as a commercial motor vehicle or for-hire motor vehicle solely because the vehicle's registered owner allows the vehicle to be used for personal vehicle sharing if:

(1) The personal vehicle sharing is conducted under a program;

(2) The annual revenue received by the vehicle's registered owner that was generated by the personal vehicle sharing does not exceed the annual expenses of owning and operating the vehicle, including depreciation, interest, lease payments, motor vehicle loan payments, insurance, maintenance, parking, fuel, cleaning, automobile repair and costs associated with personal vehicle sharing, including but not limited to the installation, operation, and maintenance of computer hardware and software, signage identifying the vehicle as a personal vehicle sharing vehicle, and any fees charged by a program. [2012 c 108 § 4.]

48.175.900 Application—2012 c 108. (Effective until January 1, 2023.) This act applies to automobile liability insurance policies issued or renewed on or after January 1, 2013. [2012 c 108 § 6.]

Chapter 48.177 RCW

COMMERCIAL TRANSPORTATION SERVICES

Sections

48.177.005 Definitions.

48.177.005 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Commercial transportation services" or "services" means all times the driver is logged in to a commercial transportation services provider's digital network or software application or until the passenger has left the personal vehicle, whichever is later. The term does not include services provided either directly or under contract with a political subdivision or other entity exempt from federal income tax under 26 U.S.C. Sec. 115 of the federal internal revenue code.

(2) "Commercial transportation services provider" means a corporation, partnership, sole proprietorship, or other entity, operating in Washington, that uses a digital network or software application to connect passengers to drivers for the purpose of providing a prearranged ride. However, a commercial transportation services provider is not a taxicab company under chapter 81.72 RCW, a charter party or excursion service carrier under chapter 81.70 RCW, an auto transportation company under chapter 81.68 RCW, a private, nonprofit transportation provider under chapter 81.66 RCW, a limousine carrier under chapter 46.72A RCW, or a commuter ride-sharing or flexible commuter ride-sharing arrangement under chapter 46.74 RCW. A commercial transportation services provider is not deemed to own, control, operate, or manage the personal vehicles used by commercial transportation services providers. A commercial transportation services provider does not include a political subdivision or other entity exempt from federal income tax under 26 U.S.C. Sec. 115 of the federal internal revenue code.

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(3) "Commercial transportation services provider driver" or "driver" means an individual who uses a personal vehicle to provide services for passengers matched through a commercial transportation services provider's digital network or software application.

(4) "Commercial transportation services provider passenger" or "passenger" means a passenger in a personal vehicle for whom transport is provided, including:

(a) An individual who uses a commercial transportation services provider's digital network or software application to connect with a driver to obtain services in the driver's vehicle for the individual and anyone in the individual's party; or

(b) Anyone for whom another individual uses a commercial transportation services provider's digital network or software application to connect with a driver to obtain services in the driver's vehicle.

(5) "Personal vehicle" means a vehicle that is used by a commercial transportation services provider driver in connection with providing services for a commercial transportation services provider and that is authorized by the commercial transportation services provider.

(6) "Prearranged ride" means a route of travel between points chosen by the passenger and arranged with a driver through the use of a commercial transportation services provider's digital network or software application. The ride begins when a driver accepts a requested ride through a digital network or software application, continues while the driver transports the passenger in a personal vehicle, and ends when the passenger departs from the personal vehicle. [2016 c 21 § 1. Prior: 2015 c 236 § 1.]

Chapter 48.180 RCW

NONPROFIT CORPORATIONS—JOINT SELF-INSURANCE PROGRAMS

Sections

48.180.005 Intent—Liberal construction.

48.180.010 Definitions.

48.180.015 Agreement to form joint self-insurance program—Authorized activities—State risk manager as attorney for receipt of service.

48.180.020 When chapter does not apply.

48.180.025 Rules by state risk manager—Requirements.

48.180.030 Program approval required from state risk manager—Management and operations plan—Contents of plan.

48.180.035 Participation by nonprofit corporations from other states—Requirements.

48.180.040 Approval or disapproval by state risk manager—Within one hundred twenty days—Risk manager's powers and duties—Program's obligations.

48.180.045 Treasurer may be designated by resolution—Bond—Program's interest and earnings.

48.180.050 Prohibition on receiving anything of value for services rendered.

48.180.055 Program exempt from certain taxes and fees.

48.180.060 Investigation fee—Use—Failure to pay.

48.180.065 Immunity from liability—Person who files, reports, or furnishes information—State risk manager and agents or employees.

48.180.005 Intent—Liberal construction. This chapter is intended to provide authority for two or more nonprofit corporations to participate in a joint self-insurance program covering property or liability risks. This chapter provides nonprofit corporations with the authority to jointly self-insure property and liability risks, jointly purchase insurance or reinsurance, and contract for risk management, claims, and

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administrative services with other nonprofit corporations. This chapter must be liberally construed to grant nonprofit corporations maximum flexibility in jointly self-insuring to the extent the self-insurance programs are operated in a safe and sound manner. This chapter is intended to require prior approval for the establishment of every joint self-insurance program. In addition, this chapter is intended to require every joint self-insurance program for nonprofit corporations established under this chapter to notify the state of the existence of the program and to comply with the regulatory and statutory standards governing the management and operation of the programs as provided in this chapter. This chapter is not intended to authorize or regulate self-insurance of unemployment compensation under chapter 50.44 RCW or industrial insurance under chapter 51.14 RCW. [2015 c 109 § 5.]

48.180.010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Nonprofit corporation" or "corporation" has the same meaning as defined in RCW 24.03A.010.

(2) "Property and liability risks" includes the risk of property damage or loss sustained by a nonprofit corporation and the risk of claims arising from the tortious or negligent conduct or any error or omission of the entity, its officers, employees, agents, or volunteers as a result of a claim that may be made against the entity.

(3) "Self-insurance" means a formal program of advance funding and management of entity financial exposure to a risk of loss that is not transferred through the purchase of an insurance policy or contract.

(4) "State risk manager" means the risk manager of the office of risk management within the department of enterprise services. [2021 c 176 § 5230; 2015 c 109 § 6.]

Effective date—2021 c 176: See note following RCW 24.03A.005.

48.180.015 Agreement to form joint self-insurance program—Authorized activities—State risk manager as attorney for receipt of service. (1) The governing body of a nonprofit corporation may join or form a self-insurance program together with one or more other nonprofit corporations, and may jointly purchase insurance or reinsurance with one or more other nonprofit corporations for property and liability risks only as permitted under this chapter. Nonprofit corporations may contract for or hire personnel to provide risk management, claims, and administrative services in accordance with this chapter.

(2) The agreement to form a joint self-insurance program may include the organization of a separate legal or administrative entity with powers delegated to the entity. The entity may include or create a nonprofit corporation as defined in RCW 48.62.021.

(3) If provided for in the organizational documents, a joint self-insurance program may, in conformance with this chapter:

(a) Contract or otherwise provide for risk management and loss control services;

(b) Contract or otherwise provide legal counsel for the defense of claims and other legal services;

(c) Consult with the state insurance commissioner and the state risk manager;

(d) Jointly purchase insurance and reinsurance coverage in a form and amount as provided for in the organizational documents;

(e) Obligate the program's participants to pledge funds or revenues to secure the obligations or pay the expenses of the program, including the establishment of a reserve fund for coverage, including an additional assessment if the reserve fund or the program's revenue or assets are insufficient to cover the program's liabilities; and

(f) Possess any other powers and perform all other functions reasonably necessary to carry out the purposes of this chapter.

(4) Every joint self-insurance program governed by this chapter must appoint the state risk manager as its attorney to receive service of, and upon whom must be served, all legal process issued against the program in this state upon causes of action arising in this state.

(a) Service upon the state risk manager as attorney constitutes service upon the program. Service upon joint self-insurance programs subject to this chapter may only occur by service upon the state risk manager. At the time of service, the plaintiff shall pay to the state risk manager a fee to be set by the state risk manager, taxable as costs in the action.

(b) With the initial filing for approval with the state risk manager, each joint self-insurance program must designate by name and address the person to whom the state risk manager must forward legal process that is served upon him or her. The joint self-insurance program may change this person by filing a new designation.

(c) The appointment of the state risk manager as attorney is irrevocable, binds any successor in interest or to the assets or liabilities of the joint self-insurance program, and remains in effect as long as there is in force in this state any contract made by the joint self-insurance program or liabilities or duties arising from the contract.

(d) The state risk manager shall keep a record of the day and hour of service upon him or her of all legal process. A copy of the process, by registered mail with return receipt requested, must be sent by the state risk manager to the person designated to receive legal process by the joint self-insurance program in its most recent designation filed with the state risk manager. Proceedings may not commence against the joint self-insurance program, and the program is not required to appear, plead, or answer, until the expiration of forty days after the date of service upon the state risk manager.

(e) For any legal process issued against the program for causes of action arising outside of this state, the program shall provide the state risk manager a copy of such claim.

(5) A nonprofit joint self-insurance program previously established under chapter 48.62 RCW may continue its operations without interruption. All previously approved operating documents under chapter 48.62 RCW including, but not limited to, applications, state-granted authorities, approvals to operate, certificates of incorporation, articles of incorporation, membership documents, executed contracts, and other applicable items or authorities remain in effect without reapproval.

(6) A nonprofit joint self-insurance program previously established under and governed by chapter 48.62 RCW is not required to reapply for authority to operate as previously

approved by the state risk manager in its original application. [2015 c 109 § 7.]

48.180.020 When chapter does not apply. This chapter does not apply to a nonprofit corporation that:

- (1) Individually self-insures for property and liability risks;
- (2) Participates in a risk pooling arrangement, including a risk retention group or a risk purchasing group, regulated under chapter 48.92 RCW, or is a captive insurer authorized in its state of domicile;
- (3) Comprises only units of local government or is a group that comprises local governments joined by an interlocal agreement authorized by chapter 39.34 RCW; or
- (4) Is a hospital licensed under chapter 70.41 RCW, or an entity owned, operated, controlled by, or affiliated with such a hospital that participates in a self-insurance risk pool or other risk pooling arrangement. [2015 c 109 § 8.]

48.180.025 Rules by state risk manager—Requirements. The state risk manager shall adopt rules governing the management and operation of joint self-insurance programs for nonprofit corporations that cover property or liability risks. All rules must be appropriate for the type of program and class of risk covered. The state risk manager's rules must include:

- (1) Standards for the management, operation, and solvency of joint self-insurance programs, including the necessity and frequency of actuarial analyses and claims audits;
- (2) Standards for claims management procedures;
- (3) Standards for contracts between joint self-insurance programs and private businesses, including standards for contracts between third-party administrators and programs; and
- (4) Standards requiring pool verification of each member's nonprofit status in their state of domicile. [2015 c 109 § 9.]

48.180.030 Program approval required from state risk manager—Management and operations plan—Contents of plan. Before the establishment of a joint self-insurance program covering property or liability risks by nonprofit corporations, the entities must obtain the approval of the state risk manager. The entities proposing the creation of a joint self-insurance program requiring prior approval shall submit a plan of management and operation to the state risk manager that provides at least the following information:

- (1) The risk or risks to be covered, including any coverage definitions, terms, conditions, and limitations;
- (2) The amount and method of funding the covered risks, including the initial capital and proposed rates and projected premiums;
- (3) The proposed claim reserving practices;
- (4) The proposed purchase and maintenance of insurance or reinsurance in excess of the amounts retained by the joint self-insurance program;
- (5) The legal form of the program including, but not limited to, any articles of incorporation, bylaws, charter, or trust agreement or other agreement among the participating entities;

(6) The agreements with participants in the program defining the responsibilities and benefits of each participant and management;

(7) The proposed accounting, depositing, and investment practices of the program;

(8) The proposed time when actuarial analysis will be first conducted and the frequency of future actuarial analysis;

(9) A designation of the individual to whom service of process must be forwarded by the state risk manager on behalf of the program;

(10) All contracts between the program and private persons providing risk management, claims, or other administrative services;

(11) A professional analysis of the feasibility of the creation and maintenance of the program;

(12) A legal analysis or an internal revenue service opinion on the federal income tax exposure or liability of the program; and

(13) Any other information required by rule of the state risk manager that is necessary to determine the probable financial and management success of the program or that is necessary to determine compliance with this chapter. [2015 c 109 § 10.]

48.180.035 Participation by nonprofit corporations from other states—Requirements. A nonprofit corporation may participate in a joint self-insurance program covering property or liability risks with similar nonprofit corporations from other states if the program satisfies the following requirements:

(1) An ownership interest in the program is limited to some or all of the nonprofit corporations of this state and nonprofit corporations of other states that are provided insurance by the program;

(2) The nonprofit corporations of this state and other states shall elect a board of directors to manage the program, all of whom must be affiliated with one or more of the participating nonprofit corporations;

(3) The program must provide coverage through the delivery to each participating nonprofit corporation of one or more written policies affecting insurance of covered risks;

(4) The program must be financed, including the payment of premiums and the contribution of initial capital, in accordance with the plan of management and operation submitted to the state risk manager in accordance with this chapter;

(5) The financial statements of the program must be audited by a certified public accountant, and these audited financial statements must be delivered to the state risk manager not more than one hundred twenty days after the end of each fiscal year of the program;

(6) The investments of the program must be initiated only with financial institutions or broker-dealers, or both, doing business in those states in which participating nonprofit corporations are located, and these investments must be audited annually by the certified public accountants for the program;

(7) The treasurer of a multistate joint self-insurance program must be designated by resolution of the program and the treasurer must be located in the state of one of the participating entities; and

(8) The program must obtain approval from the state risk manager in accordance with this chapter and must remain in compliance with this chapter, unless exempt from application for reapproval, as granted under RCW 48.180.015. [2015 c 109 § 11.]

48.180.040 Approval or disapproval by state risk manager—Within one hundred twenty days—Risk manager's powers and duties—Program's obligations. (1) Within one hundred twenty days of receipt of a plan of management and operation, the state risk manager shall either approve or disapprove of the formation of the joint self-insurance program after reviewing the plan to determine whether the proposed program complies with this chapter and all rules adopted in accordance with this chapter.

(2) If the state risk manager denies a request for approval, the state risk manager shall specify in detail the reasons for denial and the manner in which the program fails to meet the requirements of this chapter or any rules adopted in accordance with this chapter.

(3) If the state risk manager determines that a joint self-insurance program covering property or liability risks is in violation of this chapter or is operating in an unsafe financial condition, the state risk manager may issue and serve upon the program an order to cease and desist from the violation or practice.

(a) The state risk manager shall deliver the order to the appropriate entity or entities directly or mail it to the appropriate entity or entities by certified mail with return receipt requested.

(b) If the program violates the order or has not taken steps to comply with the order after the expiration of twenty days after the cease and desist order has been received by the program, the program is deemed to be operating in violation of this chapter, and the state risk manager shall notify the attorney general of the violation.

(c) After hearing, or with the consent of a program governed under this chapter, and in addition to or in lieu of a continuation of the cease and desist order, the state risk manager may levy a fine upon the program in an amount not less than three hundred dollars and not more than ten thousand dollars. The order levying the fine must specify the period within which the fine must be fully paid. The period within which the fines must be paid must be not less than fifteen and not more than thirty days from the date of the order. Upon failure to pay the fine when due, the state risk manager shall request the attorney general to bring a civil action on the state risk manager's behalf to collect the fine. The state risk manager shall pay any fine collected to the state treasurer for deposit into the general fund.

(4) Each joint self-insurance program approved by the state risk manager shall annually file a report with the state risk manager providing:

(a) Details of any changes in the articles of incorporation, bylaws, charter, trust agreement, or other agreement among the participating nonprofit corporations;

(b) Copies of all the insurance coverage documents;

(c) A description of the program structure, including participants' retention, program retention, and excess insurance limits and attachment point;

(d) An actuarial analysis;

(e) A list of contractors and service providers;

(f) The financial and loss experience of the program; and

(g) Other information as required by rule of the state risk manager.

(5) A joint self-insurance program requiring the state risk manager's approval may not engage in an act or practice that in any respect significantly differs from the management and operation plan that formed the basis for the state risk manager's approval of the program unless the program first notifies the state risk manager in writing and obtains the state risk manager's approval. The state risk manager shall approve or disapprove the proposed change within sixty days of receipt of the notice. If the state risk manager denies a requested change, the state risk manager shall specify in detail the reasons for the denial and the manner in which the program would fail to meet the requirements of this chapter or any rules adopted in accordance with this chapter. [2015 c 109 § 12.]

48.180.045 Treasurer may be designated by resolution—Bond—Program's interest and earnings. (1) A joint self-insurance program may by resolution of the program designate a person having experience with investments or financial matters as treasurer of the program. The program must require a bond obtained from a surety company in an amount and under the terms and conditions that the program finds will protect against loss arising from mismanagement or malfeasance in investing and managing program funds. The program may pay the premium on the bond.

(2) All interest and earnings collected on joint self-insurance program funds belong to the program and must be deposited to the program's credit in the proper program account. [2015 c 109 § 13.]

48.180.050 Prohibition on receiving anything of value for services rendered. (1) An employee or official of a participating nonprofit corporation in a joint self-insurance program may not directly or indirectly receive anything of value for services rendered in connection with the operation and management of a self-insurance program other than the salary and benefits provided by his or her employer or the reimbursement of expenses reasonably incurred in furtherance of the operation or management of the program. An employee or official of a participating nonprofit corporation in a joint self-insurance program may not accept or solicit anything of value for personal benefit or for the benefit of others under circumstances in which it can be reasonably inferred that the employee's or official's independence of judgment is impaired with respect to the management and operation of the program.

(2) RCW 48.30.140, 48.30.150, and 48.30.157 apply to the use of insurance producers and surplus line brokers by a joint self-insurance program. [2015 c 109 § 14.]

48.180.055 Program exempt from certain taxes and fees. A joint self-insurance program approved in accordance with this chapter is exempt from insurance premium taxes, fees assessed under chapters 48.02, 48.32, and 48.32A RCW, business and occupation taxes imposed under chapter 82.04 RCW, and any assigned risk plan or joint underwriting association otherwise required by law. This section does not

apply to or provide exemptions for insurance companies issuing policies to cover program risks and third-party administrators or insurance producers serving the joint self-insurance program. [2015 c 109 § 15.]

48.180.060 Investigation fee—Use—Failure to pay.

(1) The state risk manager shall establish and charge an investigation fee in an amount necessary to cover the costs for the initial review and approval of a joint self-insurance program. The fee must accompany the initial submission of the plan of operation and management.

(2) The costs of subsequent reviews and investigations must be charged to the joint self-insurance program being reviewed or investigated in accordance with the actual time and expenses incurred in the review or investigation.

(3) Any program failing to remit its assessment when due is subject to denial of permission to operate or to a cease and desist order until the assessment is paid. [2015 c 109 § 16.]

48.180.065 Immunity from liability—Person who files, reports, or furnishes information—State risk manager and agents or employees.

(1) Any person who files, reports, or furnishes other information required under this title, required by the state risk manager under the authority granted under this title, or which is useful to the state risk manager in the administration of this title is immune from liability in any civil action or suit arising from the filing of any such report or furnishing such information to the state risk manager, unless actual malice, fraud, or bad faith is shown.

(2) The state risk manager and his or her agents and employees are immune from liability in any civil action or suit arising from the publication of any report or bulletin or from dissemination of information related to the official activities of the state risk manager unless actual malice, fraud, or bad faith is shown.

(3) The immunity granted under this section is in addition to any common law or statutory privilege or immunity enjoyed by such person. This section is not intended to abrogate or modify in any way such common law or statutory privilege or immunity. [2015 c 109 § 17.]

Chapter 48.185 RCW

ELECTRONIC NOTICES AND DOCUMENT DELIVERY

Sections

- 48.185.005 Delivery by electronic means authorized—Insurer requirements—Party consent—Definitions.
- 48.185.010 Certain property and casualty insurance information—May be mailed, delivered, or posted on website—Requirements to post on website.

48.185.005 Delivery by electronic means authorized—Insurer requirements—Party consent—Definitions. The definitions in this subsection apply throughout this chapter unless the context clearly requires otherwise.

(1)(a)(i) "Delivered by electronic means" includes:

(A) Delivery to an electronic mail address at which a party has consented to receive notices or documents; or

(B) Posting on an electronic network or site accessible via the internet, mobile application, computer, mobile device,

tablet, or any other electronic device, together with separate notice of the posting which shall be provided by electronic mail to the address at which the party has consented to receive notice or by any other delivery method that has been consented to by the party.

(ii) "Delivered by electronic means" does not include any communication between an insurer and an insurance producer relating to RCW 48.17.591 and 48.17.595.

(b) "Party" means any recipient of any notice or document required as part of an insurance transaction, including but not limited to an applicant, an insured, a policyholder, or an annuity contract holder.

(2) Subject to the requirements of this section, any notice to a party or any other document required under applicable law in an insurance transaction or that is to serve as evidence of insurance coverage may be delivered, stored, and presented by electronic means.

(3) Delivery of a notice or document in accordance with this section is the equivalent to any delivery method required under applicable law, including delivery by first-class mail; first-class mail, postage prepaid; certified mail; or registered mail.

(4) A notice or document may be delivered by an insurer to a party by electronic means under this section only if:

(a) The party has affirmatively consented to that method of delivery and has not withdrawn the consent;

(b) The party, before giving consent, has been provided with a clear and conspicuous statement informing the party of:

(i) The right the party has to withdraw consent to have a notice or document delivered by electronic means at any time, and any conditions or consequences imposed in the event consent is withdrawn;

(ii) The types of notices and documents to which the party's consent would apply;

(iii) The right of a party to have a notice or document in paper form; and

(iv) The procedures a party must follow to withdraw consent to have a notice or document delivered by electronic means and to update the party's electronic mail address;

(c) The party:

(i) Before giving consent, has been provided with a statement of the hardware and software requirements for access to and retention of notices or documents delivered by electronic means; and

(ii) Consents electronically, or confirms consent electronically, in a manner that reasonably demonstrates that the party can access information in the electronic form that will be used for notices or documents delivered by electronic means as to which the party has given consent; and

(d) After consent of the party is given, the insurer, in the event a change in the hardware or software requirements needed to access or retain a notice or document delivered by electronic means creates a material risk that the party will not be able to access or retain a subsequent notice or document to which the consent applies:

(i) Shall provide the party with a statement that describes:

(A) The revised hardware and software requirements for access to and retention of a notice or document delivered by electronic means; and

(B) The right of the party to withdraw consent without the imposition of any fee, condition, or consequence that was not disclosed at the time of initial consent; and

(ii) Complies with (b) of this subsection.

(5) This section does not affect requirements related to content or timing of any notice or document required under applicable law.

(6) If this title or applicable law requiring a notice or document to be provided to a party expressly requires verification or acknowledgment of receipt of the notice or document, the notice or document may be delivered by electronic means only if the method used provides for verification or acknowledgment of receipt.

(7) The legal effectiveness, validity, or enforceability of any contract or policy of insurance executed by a party may not be denied solely because of the failure to obtain electronic consent or confirmation of consent of the party in accordance with subsection (4)(c)(ii) of this section.

(8)(a) A withdrawal of consent by a party does not affect the legal effectiveness, validity, or enforceability of a notice or document delivered by electronic means to the party before the withdrawal of consent is effective.

(b) A withdrawal of consent by a party is effective within a reasonable period of time, not to exceed thirty days, after receipt of the withdrawal by the insurer.

(c) Failure by an insurer to comply with subsections (4)(d) and (10) of this section may be treated, at the election of the party, as a withdrawal of consent for purposes of this section.

(9) This section does not apply to a notice or document delivered by an insurer in an electronic form before July 24, 2015, to a party who, before that date, has consented to receive a notice or document in an electronic form otherwise allowed by law.

(10) If the consent of a party to receive certain notices or documents in an electronic form is on file with an insurer before July 24, 2015, and pursuant to this section, an insurer intends to deliver additional notices or documents to such party in an electronic form, then prior to delivering such additional notices or documents electronically, the insurer shall:

(a) Provide the party with a statement that describes:

(i) The notices or documents that shall be delivered by electronic means under this section that were not previously delivered electronically; and

(ii) The party's right to withdraw consent to have notices or documents delivered by electronic means, without the imposition of any condition or consequence that was not disclosed at the time of initial consent; and

(b) Comply with subsection (4)(b) of this section.

(11) An insurer shall deliver a notice or document by any other delivery method permitted by law other than electronic means if:

(a) The insurer attempts to deliver the notice or document by electronic means and has a reasonable basis for believing that the notice or document has not been received by the party; or

(b) The insurer becomes aware that the electronic mail address provided by the party is no longer valid.

(12) A producer shall not be subject to civil liability for any harm or injury that occurs as a result of a party's election to receive any notice or document by electronic means or by

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an insurer's failure to deliver a notice or document by electronic means.

(13) This section does not modify, limit, or supersede the provisions of the federal electronic signatures in global and national commerce act (E-SIGN), P.L. 106-229, as amended. [2019 c 132 § 5; 2017 c 307 § 1; 2015 c 263 § 1.]

48.185.010 Certain property and casualty insurance information—May be mailed, delivered, or posted on website—Requirements to post on website. (1) Notwithstanding any other provisions of this chapter, standard property and casualty insurance policy forms and endorsements that do not contain personally identifiable information may be mailed, delivered, or posted on the insurer's website. If the insurer elects to post insurance policy forms and endorsements on its website in lieu of mailing or delivering them to the insured, it must comply with all of the following conditions:

(a) The policy forms and endorsements must be accessible to the insured and the producer of record and remain that way for as long as the policy is in force;

(b) After the expiration of the policy, the insurer must archive its expired policy forms and endorsements for a period of six years or other period required by law, and make them available upon request;

(c) The policy forms and endorsements must be posted in a manner that enables the insured and producer of record to print and save the policy form and endorsements using programs or applications that are widely available on the internet and free to use;

(d) The insurer must provide the following information in, or simultaneous with, each declarations page provided at the time of issuance of the initial policy and any renewals of that policy:

(i) A description of the exact policy and endorsement forms purchased by the insured;

(ii) A description of the insured's right to receive, upon request and without charge, a paper copy of the policy and endorsements by mail;

(iii) The internet address where their policy and endorsements are posted;

(iv) The insurer, upon request and without charge, mails a paper copy of the insured's policy and endorsements to the insured; and

(v) Notice, in the manner in which the insurer customarily communicates with the insured, of any changes to the forms or endorsements, the insured's right to obtain, upon request and without charge, a paper copy of such forms or endorsements, and the internet address where such forms or endorsements are posted.

(2) Nothing in this section affects the timing or content of any disclosure or other document required to be provided or made available to any insured under applicable law. [2015 c 263 § 2.]

Chapter 48.190 RCW

PUBLIC BENEFIT HOSPITAL ENTITIES—JOINT SELF-INSURANCE PROGRAMS

Sections

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48.190.005 Intent. This chapter is intended to provide authority for two or more public benefit hospital entities to participate in a joint self-insurance program covering property or liability risks. This chapter provides public benefit hospital entities with the exclusive source of authority to jointly self-insure property and liability risks, jointly purchase insurance or reinsurance, and to contract for risk management, claims, and administrative services with other public benefit hospital entities, except as otherwise provided in this chapter. This chapter must be liberally construed to grant public benefit hospital entities maximum flexibility in jointly self-insuring to the extent the self-insurance programs are operated in a safe and sound manner. This chapter is intended to require prior approval for the establishment of every joint self-insurance program. In addition, this chapter is intended to require every joint self-insurance program for public benefit hospital entities established under this chapter to notify the state of the existence of the program and to comply with the regulatory and statutory standards governing the management and operation of the programs as provided in this chapter. This chapter is not intended to authorize or regulate self-insurance of unemployment compensation under chapter 50.44 RCW or industrial insurance under chapter 51.14 RCW. [2017 c 221 § 1.]

48.190.010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Hospital services" means clinically related (i.e., preventive, diagnostic, curative, rehabilitative, or palliative) services provided in a hospital setting.

(2) "Property and liability risks" include the risk of property damage or loss sustained by a public benefit hospital entity and the risk of claims arising from the tortious or negligent conduct or any error or omission of the entity, its officers, employees, agents, or volunteers as a result of which a claim may be made against the entity.

(3) "Public benefit hospital entity" means any of the following:

(a) A public hospital district organized under the laws of this state or another state and any agency or instrumentality of a public hospital district including, but not limited to, a legal entity created to conduct a joint self-insurance program for public hospital districts that is operating in accordance with chapter 48.62 RCW; or

(b) A nonprofit corporation, whether organized under the laws of this state or another state, that meets the following requirements:

(i) The nonprofit corporation operates one or more hospitals each of which is licensed for three hundred sixty or

fewer beds by the department of health pursuant to chapter 70.41 RCW; and

(ii) The nonprofit corporation is engaged in providing hospital services.

(4) "Self-insurance" means a formal program of advance funding and management of entity financial exposure to a risk of loss that is not transferred through the purchase of an insurance policy or contract.

(5) "State risk manager" means the risk manager of the office of risk management within the department of enterprise services. [2017 c 221 § 2.]

48.190.020 Formation—Powers—Service of process.

(1) The governing body of a public benefit hospital entity may join or form a self-insurance program together with one or more other public benefit hospital entities, and may jointly purchase insurance or reinsurance with one or more other public benefit hospital entities for property and liability risks only as permitted under this chapter. Public benefit hospital entities may contract for or hire personnel to provide risk management, claims, and administrative services in accordance with this chapter.

(2) The agreement to form a joint self-insurance program may include the organization of a separate legal or administrative entity with powers delegated to the entity.

(3) If provided for in the organizational documents, a joint self-insurance program may, in conformance with this chapter:

(a) Contract or otherwise provide for risk management and loss control services;

(b) Contract or otherwise provide legal counsel for the defense of claims and other legal services;

(c) Consult with the state insurance commissioner and the state risk manager;

(d) Jointly purchase insurance and reinsurance coverage in a form and amount as provided for in the organizational documents;

(e) Obligate the program's participants to pledge revenues or contribute money to secure the obligations or pay the expenses of the program, including the establishment of a reserve or fund for coverage; and

(f) Possess any other powers and perform all other functions reasonably necessary to carry out the purposes of this chapter.

(4) Every joint self-insurance program governed by this chapter must appoint the state risk manager as its attorney to receive service of, and upon whom must be served, all legal process issued against the program in this state upon causes of action arising in this state.

(a) Service upon the state risk manager as attorney constitutes service upon the program. Service upon joint self-insurance programs subject to this chapter may only occur by service upon the state risk manager. At the time of service, the plaintiff shall pay to the state risk manager a fee to be set by the state risk manager, taxable as costs in the action.

(b) With the initial filing for approval with the state risk manager, each joint self-insurance program must designate by name and address the person to whom the state risk manager must forward legal process that is served upon him or her. The joint self-insurance program may change this person by filing a new designation.

(c) The appointment of the state risk manager as attorney is irrevocable, binds any successor in interest or to the assets or liabilities of the joint self-insurance program, and remains in effect as long as there is in force in this state any contract made by the joint self-insurance program or liabilities or duties arising from the contract.

(d) The state risk manager shall keep a record of the day and hour of service upon him or her of all legal process. A copy of the process, by registered mail with return receipt requested, must be sent by the state risk manager to the person designated to receive legal process by the joint self-insurance program in its most recent designation filed with the state risk manager. Proceedings must not commence against the joint self-insurance program, and the program must not be required to appear, plead, or answer, until the expiration of forty days after the date of service upon the state risk manager. [2017 c 221 § 3.]

48.190.030 Applicability of chapter. This chapter does not apply to a public benefit hospital entity that:

(1) Individually self-insures for property and liability risks; or

(2) Participates in a risk pooling arrangement, including a risk retention group or a risk purchasing group, regulated under chapter 48.92 RCW, is a captive insurer authorized in its state of domicile, or participates in a local government risk pool formed under chapter 48.62 RCW. [2017 c 221 § 4.]

48.190.040 State risk manager—Rules. The state risk manager shall adopt rules governing the management and operation of joint self-insurance programs for public benefit hospital entities that cover property or liability risks. All rules must be appropriate for the type of program and class of risk covered. The state risk manager's rules must include:

(1) Standards for the management, operation, and solvency of joint self-insurance programs, including the necessity and frequency of actuarial analyses and claims audits;

(2) Standards for claims management procedures;

(3) Standards for contracts between joint self-insurance programs and private businesses, including standards for contracts between third-party administrators and programs; and

(4) Standards that preclude public hospital districts or other public entities participating in the joint self-insurance program from subsidizing, regardless of the form of subsidy, public benefit hospital entities that are not public hospital districts or public entities. These standards do not apply to the consideration attributable to the ownership interest of a public hospital district or other public entity in a separate legal or administrative entity organized with respect to the program. [2017 c 221 § 5.]

48.190.050 State risk manager—Approval of program creation—Required submissions. Before the establishment of a joint self-insurance program covering property or liability risks by public benefit hospital entities, the entities must obtain the approval of the state risk manager. The entities proposing the creation of a joint self-insurance program requiring prior approval shall submit a plan of management and operation to the state risk manager that provides at least the following information:

(1) The risk or risks to be covered, including any coverage definitions, terms, conditions, and limitations;

(2) The amount and method of funding the covered risks, including the initial capital and proposed rates and projected premiums;

(3) The proposed claim reserving practices;

(4) The proposed purchase and maintenance of insurance or reinsurance in excess of the amounts retained by the joint self-insurance program;

(5) The legal form of the program including, but not limited to, any articles of incorporation, bylaws, charter, or trust agreement or other agreement among the participating entities;

(6) The agreements with participants in the program defining the responsibilities and benefits of each participant and management;

(7) The proposed accounting, depositing, and investment practices of the program;

(8) The proposed time when actuarial analysis will be first conducted and the frequency of future actuarial analysis;

(9) A designation of the individual to whom service of process must be forwarded by the state risk manager on behalf of the program;

(10) All contracts between the program and private persons providing risk management, claims, or other administrative services;

(11) A professional analysis of the feasibility of the creation and maintenance of the program;

(12) A legal determination of the potential federal and state tax liabilities of the program; and

(13) Any other information required by rule of the state risk manager that is necessary to determine the probable financial and management success of the program or that is necessary to determine compliance with this chapter. [2017 c 221 § 6.]

48.190.060 State risk manager—Approval and denial of program creation—Violations of chapter—Reports.

(1) Within one hundred twenty days of receipt of a plan of management and operation, the state risk manager shall either approve or disapprove of the formation of the joint self-insurance program after reviewing the plan to determine whether the proposed program complies with this chapter and all rules adopted in accordance with this chapter.

(2) If the state risk manager denies a request for approval, the state risk manager shall specify in detail the reasons for denial and the manner in which the program fails to meet the requirements of this chapter or any rules adopted in accordance with this chapter.

(3) If the state risk manager determines that a joint self-insurance program covering property or liability risks is in violation of this chapter or is operating in an unsafe financial condition, the state risk manager may issue and serve upon the program an order to cease and desist from the violation or practice.

(a) The state risk manager shall deliver the order to the appropriate entity or entities directly or mail it to the appropriate entity or entities by certified mail with return receipt requested.

(b) If the program violates the order or has not taken steps to comply with the order after the expiration of twenty

days after the cease and desist order has been received by the program, the program is deemed to be operating in violation of this chapter, and the state risk manager shall notify the attorney general of the violation.

(c) After hearing or with the consent of a program governed under this chapter and in addition to or in lieu of a continuation of the cease and desist order, the state risk manager may levy a fine upon the program in an amount not less than three hundred dollars and not more than ten thousand dollars. The order levying the fine must specify the period within which the fine must be fully paid. The period within which the fine must be paid must not be less than fifteen and no more than thirty days from the date of the order. Upon failure to pay the fine when due, the state risk manager shall request the attorney general to bring a civil action on the state risk manager's behalf to collect the fine. The state risk manager shall pay any fine collected to the state treasurer for the account of the general fund.

(4) Each joint self-insurance program approved by the state risk manager shall annually file a report with the state risk manager providing:

(a) Details of any changes in the articles of incorporation, bylaws, charter, or trust agreement or other agreement among the participating public benefit hospital entities;

(b) Copies of all the insurance coverage documents;

(c) A description of the program structure, including participants' retention, program retention, and excess insurance limits and attachment point;

(d) An actuarial analysis;

(e) A list of contractors and service providers;

(f) The financial and loss experience of the program; and

(g) Other information as required by rule of the state risk manager.

(5) A joint self-insurance program requiring the state risk manager's approval may not engage in an act or practice that in any respect significantly differs from the management and operation plan that formed the basis for the state risk manager's approval of the program unless the program first notifies the state risk manager in writing and obtains the state risk manager's approval. The state risk manager shall approve or disapprove the proposed change within sixty days of receipt of the notice. If the state risk manager denies a requested change, the state risk manager shall specify in detail the reasons for the denial and the manner in which the program would fail to meet the requirements of this chapter or any rules adopted in accordance with this chapter. [2017 c 221 § 8.]

48.190.070 Participation with entities from other states. A public benefit hospital entity may participate in a joint self-insurance program covering property or liability risks with similar public benefit hospital entities from other states if the program satisfies the following requirements:

(1) An ownership interest in the program is limited to some or all of the public benefit hospital entities of this state and public benefit hospital entities of other states that are provided insurance by the program;

(2) The participating public benefit hospital entities of this state and other states shall elect a board of directors to manage the program, a majority of whom must be affiliated

with one or more of the participating public benefit hospital entities;

(3) The program must provide coverage through the delivery to each participating public benefit hospital entity of one or more written policies affecting insurance of covered risks;

(4) The program must be financed, including the payment of premiums and the contribution of initial capital, in accordance with the plan of management and operation submitted to the state risk manager in accordance with this chapter;

(5) The financial statements of the program must be audited annually by the certified public accountants for the program, and these audited financial statements must be delivered to the state risk manager not more than one hundred twenty days after the end of each fiscal year of the program;

(6) The investments of the program must be initiated only with financial institutions or broker-dealers, or both, doing business in those states in which participating public benefit hospital entities are located, and these investments must be audited annually by the certified public accountants for the program;

(7) The treasurer of a multistate joint self-insurance program must be designated by resolution of the program and the treasurer must be located in the state of one of the participating entities;

(8) The participating entities may have no contingent liabilities for covered claims, other than liabilities for unpaid premiums, retrospective premiums, or assessments, if assets of the program are insufficient to cover the program's liabilities; and

(9) The program must obtain approval from the state risk manager in accordance with this chapter and must remain in compliance with this chapter, except if provided otherwise under this section. [2017 c 221 § 7.]

48.190.080 Designation of treasurer—Interest and earnings. (1) A joint self-insurance program may by resolution of the program designate a person having experience with investments or financial matters as treasurer of the program. The program must require a bond obtained from a surety company in an amount and under the terms and conditions that the program finds will protect against loss arising from mismanagement or malfeasance in investing and managing program funds. The program may pay the premium on the bond.

(2) All interest and earnings collected on joint self-insurance program funds belong to the program and must be deposited to the program's credit in the proper program account. [2017 c 221 § 9.]

48.190.090 Receiving or soliciting anything of value—Inducement. (1) An employee or official of a participating public benefit hospital entity in a joint self-insurance program may not directly or indirectly receive anything of value for services rendered in connection with the operation and management of a self-insurance program other than the salary and benefits provided by his or her employer or the reimbursement of expenses reasonably incurred in furtherance of the operation or management of the program. An employee or official of a participating public benefit hospital

entity in a joint self-insurance program may not accept or solicit anything of value for personal benefit or for the benefit of others under circumstances in which it can be reasonably inferred that the employee's or official's independence of judgment is impaired with respect to the management and operation of the program.

(2) RCW 48.30.140, 48.30.150, and 48.30.157 apply to the use of insurance producers by a joint self-insurance program. [2017 c 221 § 10.]

48.190.100 Tax exemptions. A joint self-insurance program approved in accordance with this chapter is exempt from insurance premium taxes, fees assessed under chapter 48.02 RCW, chapters 48.32 and 48.32A RCW, business and occupation taxes imposed under chapter 82.04 RCW, and any assigned risk plan or joint underwriting association otherwise required by law. This section does not apply to, and no exemption is provided for, insurance companies issuing policies to cover program risks, and does not apply to or provide an exemption for third-party administrators or insurance producers serving the joint self-insurance program. [2017 c 221 § 11.]

48.190.110 Fees. (1) The state risk manager shall establish and charge an investigation fee in an amount necessary to cover the costs for the initial review and approval of a joint self-insurance program. The fee must accompany the initial submission of the plan of operation and management.

(2) The costs of subsequent reviews and investigations must be charged to the joint self-insurance program being reviewed or investigated in accordance with the actual time and expenses incurred in the review or investigation.

(3) Any program failing to remit its assessment when due is subject to denial of permission to operate or to a cease and desist order until the assessment is paid. [2017 c 221 § 12.]

48.190.120 Civil immunity—Filings and publications. (1) Any person who files reports or furnishes other information required under this title, required by the state risk manager under the authority granted under this title, or which is useful to the state risk manager in the administration of this title, is immune from liability in any civil action or suit arising from the filing of any such report or furnishing such information to the state risk manager, unless actual malice, fraud, or bad faith is shown.

(2) The state risk manager and his or her agents and employees are immune from liability in any civil action or suit arising from the publication of any report or bulletins or arising from dissemination of information related to the official activities of the state risk manager unless actual malice, fraud, or bad faith is shown.

(3) The immunity granted under this section is in addition to any common law or statutory privilege or immunity enjoyed by such person. This section is not intended to abrogate or modify in any way such common law or statutory privilege or immunity. [2017 c 221 § 13.]

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Chapter 48.195 RCW CORPORATE GOVERNANCE ANNUAL DISCLOSURE

Sections

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48.195.030	Responses to annual disclosure inquiries—Documentation and supporting information.
48.195.040	Documents, materials, and other information are confidential—Restricted use by commission—Restricted use in civil actions.
48.195.050	Retaining third-party consultants—Under direction and control of the commissioner—Written agreements and consent.
48.195.060	Failure to timely file—Penalties.
48.195.100	Rules.

48.195.005 Purpose—Application. (1) The purpose of this chapter is to:

(a) Provide the insurance commissioner a summary of an insurer or insurance group's corporate governance structure, policies, and practices to permit the commissioner to gain and maintain an understanding of the insurer's corporate governance framework;

(b) Outline the requirements for completing a corporate governance annual disclosure with the commissioner; and

(c) Provide for the confidential treatment of the corporate governance annual disclosure and related information that will contain confidential and sensitive information related to an insurer or insurance group's internal operations and proprietary and trade secret information which, if made public, could potentially cause the insurer or insurance group competitive harm or disadvantage.

(2) This chapter does not prescribe or impose corporate governance standards and internal procedures beyond that which is required under applicable corporate law. This chapter does not limit the commissioner's authority, or the rights or obligations of third parties, under chapter 48.03 RCW.

(3) This chapter applies to all insurers domiciled in this state. [2018 c 30 § 1.]

Effective date—2018 c 30: "(1) The first filing of the corporate governance annual disclosure is 2019.

(2) This act takes effect January 1, 2019." [2018 c 30 § 11.]

48.195.010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Commissioner" means the insurance commissioner of this state.

(2) "Corporate governance annual disclosure" means a confidential report filed by the insurer or insurance group under this chapter.

(3) "Insurance group" means those insurers and affiliates included within an insurance holding company system as defined in RCW 48.31B.005.

(4) "Insurer" has the same meaning as set forth in RCW 48.31B.005.

(5) "ORSA summary report" means the report filed under chapter 48.05A RCW. [2018 c 30 § 2.]

Effective date—2018 c 30: See note following RCW 48.195.005.

48.195.020 Annual disclosure—Lead state when insurer part of insurance group—Additional information

may be required. (1) An insurer, or the insurance group of which the insurer is a member, must, no later than June 1st of each calendar year, submit to the commissioner a corporate governance annual disclosure that contains the information described in RCW 48.195.030(2). If the insurer is a member of an insurance group, the insurer must submit the report required by this section to the commissioner of the lead state for the insurance group, under the laws of the lead state, as determined by the procedures outlined in the most recent financial analysis handbook adopted by the national association of insurance commissioners.

(2) The corporate governance annual disclosure must include a signature of the insurer or insurance group's chief executive officer or corporate secretary attesting to the best of the individual's belief and knowledge that the insurer has implemented the corporate governance practices and that a copy of the disclosure has been provided to the insurer's board of directors or the appropriate committee thereof.

(3) An insurer not required to submit a corporate governance annual disclosure under this section must do so upon the commissioner's request.

(4) For purposes of completing the corporate governance annual disclosure, the insurer or insurance group may provide information regarding corporate governance at either (a) the ultimate controlling parent level, (b) an intermediate holding company level, or (c) the individual legal entity level, or any combination of (a) through (c) of this subsection, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the corporate governance annual disclosure at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it must indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in the level of reporting.

(5) The review of the corporate governance annual disclosure and any additional requests for information shall be made through the lead state as determined by the procedure within the most recent financial analysis handbook referenced in subsection (1) of this section.

(6) Insurers providing information substantially similar to the information required by this chapter in other documents provided to the commissioner, including proxy statements filed in conjunction with form B requirements, or other state or federal filings provided to the commissioner are not required to duplicate that information in the corporate governance annual disclosure, but are only required to cross-reference the document in which the information is included. [2018 c 30 § 3.]

Effective date—2018 c 30: See note following RCW 48.195.005.

48.195.030 Responses to annual disclosure inquiries—Documentation and supporting information. (1) The insurer or insurance group has discretion over the responses to the corporate governance annual disclosure

inquiries, provided the corporate governance annual disclosure contains the material information necessary to permit the commissioner to gain an understanding of the insurer's or insurance group's corporate governance structure, policies, and practices. The commissioner may request additional information that he or she deems material and necessary to provide the commissioner with a clear understanding of the corporate governance policies, the reporting or information system, or controls implementing those policies.

(2) The corporate governance annual disclosure must be prepared consistent with the national association of insurance commissioners' corporate governance annual disclosure model rule which may be adopted by the commissioner. Documentation and supporting information must be maintained and made available upon examination or upon request of the commissioner. [2018 c 30 § 4.]

Effective date—2018 c 30: See note following RCW 48.195.005.

48.195.040 Documents, materials, and other information are confidential—Restricted use by commission—Restricted use in civil actions. (1) Documents, materials, or other information including the corporate governance annual disclosure, in the possession or control of the commissioner that are obtained by, created by, or disclosed to the commissioner or any other person under this chapter, are recognized by this state as being proprietary and to contain trade secrets.

All the documents, materials, or other information is confidential by law and privileged, is not subject to chapter 42.56 RCW, are not subject to subpoena, and are not subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer. This section does not require written consent of the insurer before the commissioner shares or receives confidential documents, materials, or other corporate governance annual disclosure related information under subsection (3) of this section to assist in the performance of the commissioner's regular duties.

(2) Neither the commissioner nor any person who received documents, materials, or other corporate governance annual disclosure related information, through examination or otherwise, while acting under the authority of the commissioner, or with whom the documents, materials, or other information are shared under this chapter are permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (1) of this section.

(3) In order to assist in the performance of the commissioner's regulatory duties, the commissioner:

(a) May, upon request, share documents, materials, or other corporate governance annual disclosure related information including confidential and privileged documents, materials, or information subject to subsection (1) of this section, including proprietary and trade secret documents and materials with other state, federal, and international financial regulatory agencies, including members of any supervisory college as defined in RCW 48.31B.037, with the national

association of insurance commissioners, and with third-party consultants under RCW 48.195.050, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the corporate governance annual disclosure related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality; and

(b) May receive documents, materials, and other corporate governance annual disclosure related information, including otherwise confidential and privileged documents, materials, or information, including proprietary and trade secret information or documents, from regulatory officials of other state, federal, and international financial regulatory agencies, including members of any supervisory college as defined in RCW 48.31B.037, and from the national association of insurance commissioners, and shall maintain as confidential or privileged any documents, materials, or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the documents, materials, or information.

(4) The sharing of information and documents by the commissioner under this chapter does not constitute a delegation of regulatory authority or rule making, and the commissioner is solely responsible for the administration, execution, and enforcement of this chapter.

(5) A waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade secret materials, or other corporate governance annual disclosure related information does not occur as a result of disclosure of the corporate governance annual disclosure related information or documents to the commissioner under this section or as a result of sharing as authorized in this chapter. [2018 c 30 § 5.]

Effective date—2018 c 30: See note following RCW 48.195.005.

48.195.050 Retaining third-party consultants—Under direction and control of the commissioner—Written agreements and consent. (1) The commissioner may retain at the insurer's expense, third-party consultants, including attorneys, actuaries, accountants, and other experts not otherwise part of the commissioner's staff as may be reasonably necessary to assist the commissioner in reviewing the corporate governance annual disclosure and related information or the insurer's compliance with this chapter.

(2) Any persons retained under subsection (1) of this section is under the direction and control of the commissioner and is acting in a purely advisory capacity.

(3) The national association of insurance commissioners and third-party consultants are subject to the same confidentiality standards and requirements as the commissioner.

(4) As part of the retention process, a third-party consultant must verify to the commissioner, with notice to the insurer, that it is free of a conflict of interest and that it has internal procedures in place to monitor compliance with a conflict and to comply with the confidentiality standards and requirements of this chapter.

(5) A written agreement with either the national association of insurance commissioners or a third-party consultant, or both, governing the sharing and use of information provided under this chapter must contain the following provisions and expressly require the written consent of the insurer

prior to making public information provided under this chapter:

(a) Specific procedures and protocols for maintaining the confidentiality and security of corporate governance annual disclosure related information shared with the national association of insurance commissioner or a third-party consultant under this chapter;

(b) Procedures and protocols for sharing by the national association of insurance commissioners only with other state regulators from states in which the insurance group has domiciled insurers. The agreement must provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the corporate governance annual disclosure related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality;

(c) A provision specifying that ownership of the corporate governance annual disclosure related information shared with the national association of insurance commissioners or a third-party consultant remains with the commissioner and the national association of insurance commissioners or third-party consultant's use of the information is subject to the direction of the commissioner;

(d) A provision that prohibits the national association of insurance commissioners or a third-party consultant from storing the information shared under this chapter in a permanent database after the underlying analysis is completed;

(e) A provision requiring the national association of insurance commissioners or a third-party consultant to provide prompt notice to the commissioner and to the insurer or insurance group regarding any subpoena, request for disclosure, or request for production of the insurer's corporate governance annual disclosure related information; and

(f) A requirement that the national association of insurance commissioners or a third-party consultant consent to intervention by an insurer in any judicial or administrative action in which the national association of insurance commissioners or a third-party consultant may be required to disclose confidential information about the insurer shared with the national association of insurance commissioners or third-party consultant under this chapter. [2018 c 30 § 6.]

Severability—2018 c 30 § 6: "If any provision of this chapter other than section 6 of this act, or its application to any person or circumstances is held invalid, the remainder of the chapter or the application of the provision to other persons or circumstances is not affected." [2018 c 30 § 10.]

Effective date—2018 c 30: See note following RCW 48.195.005.

48.195.060 Failure to timely file—Penalties. Any insurer failing, without just cause, to timely file the corporate governance annual disclosure as required by this chapter is required, after notice and hearing under chapters 48.04 and 34.05 RCW, to pay a penalty of five hundred dollars for each day's delay, to be recovered by the commissioner and the penalty must be paid to the general fund of this state. The maximum penalty under this section is one hundred thousand dollars. The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer. [2018 c 30 § 7.]

Effective date—2018 c 30: See note following RCW 48.195.005.

48.195.100 Rules. The commissioner may, under chapter 34.05 RCW, adopt rules to implement and administer this chapter, including the national association of insurance commissioners' corporate governance annual disclosure model rule. [2018 c 30 § 8.]

Effective date—2018 c 30: See note following RCW 48.195.005.

Chapter 48.200 RCW

HEALTH CARE BENEFIT MANAGERS

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48.200.900	Rule making—2020 c 240.
48.200.901	Effective date—2020 c 240.

48.200.010 Findings—Intent. (1) The legislature finds that growth in managed health care systems has shifted substantial authority over health care decisions from providers and patients to health carriers and health care benefit managers. Health care benefit managers acting as intermediaries between carriers, health care providers, and patients exercise broad discretion to affect health care services recommended and delivered by providers and the health care choices of patients. Regularly, these health care benefit managers are making health care decisions on behalf of carriers. However, unlike carriers, health care benefit managers are not currently regulated.

(2) Therefore, the legislature finds that it is in the best interest of the public to create a separate chapter in this title for health care benefit managers.

(3) The legislature intends to protect and promote the health, safety, and welfare of Washington residents by establishing standards for regulatory oversight of health care benefit managers. [2020 c 240 § 1.]

48.200.020 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Affiliate" or "affiliated employer" means a person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, another specified person.

(2) "Certification" has the same meaning as in RCW 48.43.005.

(3) "Employee benefits programs" means programs under both the public employees' benefits board established in RCW 41.05.055 and the school employees' benefits board established in RCW 41.05.740.

(4)(a) "Health care benefit manager" means a person or entity providing services to, or acting on behalf of, a health carrier or employee benefits programs, that directly or indirectly impacts the determination or utilization of benefits for, or patient access to, health care services, drugs, and supplies including, but not limited to:

(i) Prior authorization or preauthorization of benefits or care;

(ii) Certification of benefits or care;

(iii) Medical necessity determinations;

(iv) Utilization review;

(v) Benefit determinations;

(vi) Claims processing and repricing for services and procedures;

(vii) Outcome management;

(viii) Provider credentialing and recredentialing;

(ix) Payment or authorization of payment to providers and facilities for services or procedures;

(x) Dispute resolution, grievances, or appeals relating to determinations or utilization of benefits;

(xi) Provider network management; or

(xii) Disease management.

(b) "Health care benefit manager" includes, but is not limited to, health care benefit managers that specialize in specific types of health care benefit management such as pharmacy benefit managers, radiology benefit managers, laboratory benefit managers, and mental health benefit managers.

(c) "Health care benefit manager" does not include:

(i) Health care service contractors as defined in RCW 48.44.010;

(ii) Health maintenance organizations as defined in RCW 48.46.020;

(iii) Issuers as defined in RCW 48.01.053;

(iv) The public employees' benefits board established in RCW 41.05.055;

(v) The school employees' benefits board established in RCW 41.05.740;

(vi) Discount plans as defined in RCW 48.155.010;

(vii) Direct patient-provider primary care practices as defined in RCW 48.150.010;

(viii) An employer administering its employee benefit plan or the employee benefit plan of an affiliated employer under common management and control;

(ix) A union administering a benefit plan on behalf of its members;

(x) An insurance producer selling insurance or engaged in related activities within the scope of the producer's license;

(xi) A creditor acting on behalf of its debtors with respect to insurance, covering a debt between the creditor and its debtors;

(xii) A behavioral health administrative services organization or other county-managed entity that has been approved by the state health care authority to perform delegated functions on behalf of a carrier;

(xiii) A hospital licensed under chapter 70.41 RCW or ambulatory surgical facility licensed under chapter 70.230 RCW;

(xiv) The Robert Bree collaborative under chapter 70.250 RCW;

(xv) The health technology clinical committee established under RCW 70.14.090; or

(xvi) The prescription drug purchasing consortium established under RCW 70.14.060.

(5) "Health care provider" or "provider" has the same meaning as in RCW 48.43.005.

(6) "Health care service" has the same meaning as in RCW 48.43.005.

(7) "Health carrier" or "carrier" has the same meaning as in RCW 48.43.005.

(8) "Laboratory benefit manager" means a person or entity providing service to, or acting on behalf of, a health carrier, employee benefits programs, or another entity under contract with a carrier, that directly or indirectly impacts the determination or utilization of benefits for, or patient access to, health care services, drugs, and supplies relating to the use of clinical laboratory services and includes any requirement for a health care provider to submit a notification of an order for such services.

(9) "Mental health benefit manager" means a person or entity providing service to, or acting on behalf of, a health carrier, employee benefits programs, or another entity under contract with a carrier, that directly or indirectly impacts the determination of utilization of benefits for, or patient access to, health care services, drugs, and supplies relating to the use of mental health services and includes any requirement for a health care provider to submit a notification of an order for such services.

(10) "Network" means the group of participating providers, pharmacies, and suppliers providing health care services, drugs, or supplies to beneficiaries of a particular carrier or plan.

(11) "Person" includes, as applicable, natural persons, licensed health care providers, carriers, corporations, companies, trusts, unincorporated associations, and partnerships.

(12)(a) "Pharmacy benefit manager" means a person that contracts with pharmacies on behalf of an insurer, a third-party payor, or the prescription drug purchasing consortium established under RCW 70.14.060 to:

(i) Process claims for prescription drugs or medical supplies or provide retail network management for pharmacies or pharmacists;

(ii) Pay pharmacies or pharmacists for prescription drugs or medical supplies;

(iii) Negotiate rebates with manufacturers for drugs paid for or procured as described in this subsection;

(iv) Manage pharmacy networks; or

(v) Make credentialing determinations.

(b) "Pharmacy benefit manager" does not include a health care service contractor as defined in RCW 48.44.010.

(13)(a) "Radiology benefit manager" means any person or entity providing service to, or acting on behalf of, a health carrier, employee benefits programs, or another entity under contract with a carrier, that directly or indirectly impacts the determination or utilization of benefits for, or patient access to, the services of a licensed radiologist or to advanced diagnostic imaging services including, but not limited to:

(i) Processing claims for services and procedures performed by a licensed radiologist or advanced diagnostic imaging service provider; or

(ii) Providing payment or payment authorization to radiology clinics, radiologists, or advanced diagnostic imaging service providers for services or procedures.

(b) "Radiology benefit manager" does not include a health care service contractor as defined in RCW 48.44.010, a health maintenance organization as defined in RCW 48.46.020, or an issuer as defined in RCW 48.01.053.

(14) "Utilization review" has the same meaning as in RCW 48.43.005. [2020 c 240 § 2.]

48.200.030 Registration requirements—Application—Fees—Retention of transaction records. (1) To conduct business in this state, a health care benefit manager must register with the commissioner and annually renew the registration.

(2) To apply for registration under this section, a health care benefit manager must:

(a) Submit an application on forms and in a manner prescribed by the commissioner and verified by the applicant by affidavit or declaration under chapter 5.50 RCW. Applications must contain at least the following information:

(i) The identity of the health care benefit manager and of persons with any ownership or controlling interest in the applicant including relevant business licenses and tax identification numbers, and the identity of any entity that the health care benefit manager has a controlling interest in;

(ii) The business name, address, phone number, and contact person for the health care benefit manager;

(iii) Any areas of specialty such as pharmacy benefit management, radiology benefit management, laboratory benefit management, mental health benefit management, or other specialty; and

(iv) Any other information as the commissioner may reasonably require.

(b) Pay an initial registration fee and annual renewal registration fee as established in rule by the commissioner. The fees for each registration must be set by the commissioner in an amount that ensures the registration, renewal, and oversight activities are self-supporting. If one health care benefit manager has a contract with more than one carrier, the health care benefit manager must complete only one application providing the details necessary for each contract.

(3) All receipts from fees collected by the commissioner under this section must be deposited into the insurance commissioner's regulatory account created in RCW 48.02.190.

(4) Before approving an application for or renewal of a registration, the commissioner must find that the health care benefit manager:

(a) Has not committed any act that would result in denial, suspension, or revocation of a registration;

(b) Has paid the required fees; and

(c) Has the capacity to comply with, and has designated a person responsible for, compliance with state and federal laws.

(5) Any material change in the information provided to obtain or renew a registration must be filed with the commissioner within thirty days of the change.

(6) Every registered health care benefit manager must retain a record of all transactions completed for a period of not less than seven years from the date of their creation. All such records as to any particular transaction must be kept available and open to inspection by the commissioner during the seven years after the date of completion of such transaction. [2020 c 240 § 3.]

48.200.040 Contract requirements—Written agreement describing rights and responsibilities—Filing of contracts—Confidentiality. (1) A health care benefit manager may not provide health care benefit management services to a health carrier or employee benefits programs without a written agreement describing the rights and responsibilities of the parties conforming to the provisions of this chapter and any rules adopted by the commissioner to implement or enforce this chapter including rules governing contract content.

(2) A health care benefit manager must file with the commissioner in the form and manner prescribed by the commissioner, every benefit management contract and contract amendment between the health care benefit manager and a provider, pharmacy, pharmacy services administration organization, or other health care benefit manager, entered into directly or indirectly in support of a contract with a carrier or employee benefits programs, within thirty days following the effective date of the contract or contract amendment.

(3) Contracts filed under this section are confidential and not subject to public inspection under RCW 48.02.120(2), or public disclosure under chapter 42.56 RCW, if filed in accordance with the procedures for submitting confidential filings through the system for electronic rate and form filings and the general filing instructions as set forth by the commissioner. In the event the referenced filing fails to comply with the filing instructions setting forth the process to withhold the contract from public inspection, and the health care benefit manager indicates that the contract is to be withheld from public inspection, the commissioner must reject the filing and notify the health care benefit manager through the system for electronic rate and form filings to amend its filing to comply with the confidentiality filing instructions. [2020 c 240 § 4.]

48.200.050 Inquiries or complaints—Violations of chapter—Enforcement actions—Responsibility of carriers and programs for compliance. (1) Upon notifying a carrier or health care benefit manager of an inquiry or complaint filed with the commissioner pertaining to the conduct of a health care benefit manager identified in the inquiry or complaint, the commissioner must provide notice of the inquiry or complaint concurrently to the health care benefit manager and any carrier to which the inquiry or complaint pertains.

(2) Upon receipt of an inquiry from the commissioner, a health care benefit manager must provide to the commissioner within fifteen business days, in the form and manner required by the commissioner, a complete response to that inquiry including, but not limited to, providing a statement or testimony, producing its accounts, records, and files, responding to complaints, or responding to surveys and general requests. Failure to make a complete or timely response constitutes a violation of this chapter.

(3) Subject to chapter 48.04 RCW, if the commissioner finds that a health care benefit manager or any person responsible for the conduct of the health care benefit manager's affairs has:

(a) Violated any insurance law, or violated any rule, subpoena, or order of the commissioner or of another state's insurance commissioner;

(b) Failed to renew the health care benefit manager's registration;

(c) Failed to pay the registration or renewal fees;

(d) Provided incorrect, misleading, incomplete, or materially untrue information to the commissioner, to a carrier, or to a beneficiary;

(e) Used fraudulent, coercive, or dishonest practices, or demonstrated incompetence, or financial irresponsibility in this state or elsewhere; or

(f) Had a health care benefit manager registration, or its equivalent, denied, suspended, or revoked in any other state, province, district, or territory;

the commissioner may take any combination of the following actions against a health care benefit manager or any person responsible for the conduct of the health care benefit manager's affairs, other than an employee benefits program:

(i) Place on probation, suspend, revoke, or refuse to issue or renew the health care benefit manager's registration;

(ii) Issue a cease and desist order against the health care benefit manager and contracting carrier;

(iii) Fine the health care benefit manager up to five thousand dollars per violation, and the contracting carrier is subject to a fine for acts conducted under the contract;

(iv) Issue an order requiring corrective action against the health care benefit manager, the contracting carrier acting with the health care benefit manager, or both the health care benefit manager and the contracting carrier acting with the health care benefit manager; and

(v) Temporarily suspend the health care benefit manager's registration by an order served by mail or by personal service upon the health care benefit manager not less than three days prior to the suspension effective date. The order must contain a notice of revocation and include a finding that the public safety or welfare requires emergency action. A temporary suspension under this subsection (3)(f)(v) continues until proceedings for revocation are concluded.

(4) A stay of action is not available for actions the commissioner takes by cease and desist order, by order on hearing, or by temporary suspension.

(5)(a) Health carriers and employee benefits programs are responsible for the compliance of any person or organization acting directly or indirectly on behalf of or at the direction of the carrier or program, or acting pursuant to carrier or program standards or requirements concerning the coverage of, payment for, or provision of health care benefits, services, drugs, and supplies.

(b) A carrier or program contracting with a health care benefit manager is responsible for the health care benefit manager's violations of this chapter, including a health care benefit manager's failure to produce records requested or required by the commissioner.

(c) No carrier or program may offer as a defense to a violation of any provision of this chapter that the violation arose from the act or omission of a health care benefit manager, or

other person acting on behalf of or at the direction of the carrier or program, rather than from the direct act or omission of the carrier or program. [2020 c 240 § 5.]

PHARMACY BENEFIT MANAGERS

48.200.210 Definitions applicable to RCW 48.200.220 through 48.200.290. The definitions in this section apply throughout this section and RCW 48.200.220 through 48.200.290 unless the context clearly requires otherwise.

(1) "Audit" means an on-site or remote review of the records of a pharmacy by or on behalf of an entity.

(2) "Claim" means a request from a pharmacy or pharmacist to be reimbursed for the cost of filling or refilling a prescription for a drug or for providing a medical supply or service.

(3) "Clerical error" means a minor error:

(a) In the keeping, recording, or transcribing of records or documents or in the handling of electronic or hard copies of correspondence;

(b) That does not result in financial harm to an entity; and

(c) That does not involve dispensing an incorrect dose, amount, or type of medication, or dispensing a prescription drug to the wrong person.

(4) "Entity" includes:

(a) A pharmacy benefit manager;

(b) An insurer;

(c) A third-party payor;

(d) A state agency; or

(e) A person that represents or is employed by one of the entities described in this subsection.

(5) "Fraud" means knowingly and willfully executing or attempting to execute a scheme, in connection with the delivery of or payment for health care benefits, items, or services, that uses false or misleading pretenses, representations, or promises to obtain any money or property owned by or under the custody or control of any person.

(6) "Pharmacist" has the same meaning as in RCW 18.64.011.

(7) "Pharmacy" has the same meaning as in RCW 18.64.011.

(8) "Third-party payor" means a person licensed under RCW 48.39.005. [2020 c 240 § 10; 2014 c 213 § 3. Formerly RCW 19.340.020.]

48.200.220 Auditing of claims—Requirements—Prohibited practices. An entity that audits claims or an independent third party that contracts with an entity to audit claims:

(1) Must establish, in writing, a procedure for a pharmacy to appeal the entity's findings with respect to a claim and must provide a pharmacy with a notice regarding the procedure, in writing or electronically, prior to conducting an audit of the pharmacy's claims;

(2) May not conduct an audit of a claim more than twenty-four months after the date the claim was adjudicated by the entity;

(3) Must give at least fifteen days' advance written notice of an on-site audit to the pharmacy or corporate headquarters of the pharmacy;

(4) May not conduct an on-site audit during the first five days of any month without the pharmacy's consent;

(5) Must conduct the audit in consultation with a pharmacist who is licensed by this or another state if the audit involves clinical or professional judgment;

(6) May not conduct an on-site audit of more than two hundred fifty unique prescriptions of a pharmacy in any twelve-month period except in cases of alleged fraud;

(7) May not conduct more than one on-site audit of a pharmacy in any twelve-month period;

(8) Must audit each pharmacy under the same standards and parameters that the entity uses to audit other similarly situated pharmacies;

(9) Must pay any outstanding claims of a pharmacy no more than forty-five days after the earlier of the date all appeals are concluded or the date a final report is issued under RCW 48.200.260(3);

(10) May not include dispensing fees or interest in the amount of any overpayment assessed on a claim unless the overpaid claim was for a prescription that was not filled correctly;

(11) May not recoup costs associated with:

(a) Clerical errors; or

(b) Other errors that do not result in financial harm to the entity or a consumer; and

(12) May not charge a pharmacy for a denied or disputed claim until the audit and the appeals procedure established under subsection (1) of this section are final. [2020 c 240 § 11; 2014 c 213 § 4. Formerly RCW 19.340.040.]

48.200.230 Basis of finding of claim. An entity's finding that a claim was incorrectly presented or paid must be based on identified transactions and not based on probability sampling, extrapolation, or other means that project an error using the number of patients served who have a similar diagnosis or the number of similar prescriptions or refills for similar drugs. [2014 c 213 § 5. Formerly RCW 19.340.050.]

48.200.240 Contract with third party—Prohibited practices. An entity that contracts with an independent third party to conduct audits may not:

(1) Agree to compensate the independent third party based on a percentage of the amount of overpayments recovered; or

(2) Disclose information obtained during an audit except to the contracting entity, the pharmacy subject to the audit, or the holder of the policy or certificate of insurance that paid the claim. [2014 c 213 § 6. Formerly RCW 19.340.060.]

48.200.250 Evidence of validation of claim. For purposes of RCW 48.200.210 through 48.200.270, an entity, or an independent third party that contracts with an entity to conduct audits, must allow as evidence of validation of a claim:

(1) An electronic or physical copy of a valid prescription if the prescribed drug was, within fourteen days of the dispensing date:

(a) Picked up by the patient or the patient's designee;

(b) Delivered by the pharmacy to the patient; or

(c) Sent by the pharmacy to the patient using the United States postal service or other common carrier;

(2) Point of sale electronic register data showing purchase of the prescribed drug, medical supply, or service by the patient or the patient's designee; or

(3) Electronic records, including electronic beneficiary signature logs, electronically scanned and stored patient records maintained at or accessible to the audited pharmacy's central operations, and any other reasonably clear and accurate electronic documentation that corresponds to a claim. [2020 c 240 § 12; 2014 c 213 § 7. Formerly RCW 19.340.070.]

48.200.260 Preliminary audit report—Dispute or denial of claim—Final audit report—Recoupment of disputed funds. (1)(a) After conducting an audit, an entity must provide the pharmacy that is the subject of the audit with a preliminary report of the audit. The preliminary report must be received by the pharmacy no later than forty-five days after the date on which the audit was completed and must be sent:

(i) By mail or common carrier with a return receipt requested; or

(ii) Electronically with electronic receipt confirmation.

(b) An entity shall provide a pharmacy receiving a preliminary report under this subsection no fewer than forty-five days after receiving the report to contest the report or any findings in the report in accordance with the appeals procedure established under RCW 48.200.220(1) and must allow the submission of additional documentation in support of the claim. The entity shall consider a reasonable request for an extension of time to submit documentation to contest the report or any findings in the report.

(2) If an audit results in the dispute or denial of a claim, the entity conducting the audit shall allow the pharmacy to resubmit the claim using any commercially reasonable method, including facsimile, mail, or email.

(3) An entity must provide a pharmacy that is the subject of an audit with a final report of the audit no later than sixty days after the later of the date the preliminary report was received or the date the pharmacy contested the report using the appeals procedure established under RCW 48.200.220(1). The final report must include a final accounting of all moneys to be recovered by the entity.

(4) Recoupment of disputed funds from a pharmacy by an entity or repayment of funds to an entity by a pharmacy, unless otherwise agreed to by the entity and the pharmacy, shall occur after the audit and the appeals procedure established under RCW 48.200.220(1) are final. If the identified discrepancy for an individual audit exceeds forty thousand dollars, any future payments to the pharmacy may be withheld by the entity until the audit and the appeals procedure established under RCW 48.200.220(1) are final. [2020 c 240 § 13; 2014 c 213 § 8. Formerly RCW 19.340.080.]

48.200.270 Application. RCW 48.200.210 through 48.200.270 do not:

(1) Preclude an entity from instituting an action for fraud against a pharmacy;

(2) Apply to an audit of pharmacy records when fraud or other intentional and willful misrepresentation is indicated by physical review, review of claims data or statements, or other investigative methods; or

(3) Apply to a state agency that is conducting audits or a person that has contracted with a state agency to conduct audits of pharmacy records for prescription drugs paid for by the state medical assistance program. [2020 c 240 § 14; 2014 c 213 § 9. Formerly RCW 19.340.090.]

48.200.280 Predetermination of reimbursement costs—Appeals—Review by commissioner. (1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "List" means the list of drugs for which predetermined reimbursement costs have been established, such as a maximum allowable cost or maximum allowable cost list or any other benchmark prices utilized by the pharmacy benefit manager and must include the basis of the methodology and sources utilized to determine multisource generic drug reimbursement amounts.

(b) "Multiple source drug" means a therapeutically equivalent drug that is available from at least two manufacturers.

(c) "Multisource generic drug" means any covered outpatient prescription drug for which there is at least one other drug product that is rated as therapeutically equivalent under the food and drug administration's most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations;" is pharmaceutically equivalent or bioequivalent, as determined by the food and drug administration; and is sold or marketed in the state during the period.

(d) "Network pharmacy" means a retail drug outlet licensed as a pharmacy under RCW 18.64.043 that contracts with a pharmacy benefit manager.

(e) "Therapeutically equivalent" has the same meaning as in RCW 69.41.110.

(2) A pharmacy benefit manager:

(a) May not place a drug on a list unless there are at least two therapeutically equivalent multiple source drugs, or at least one generic drug available from only one manufacturer, generally available for purchase by network pharmacies from national or regional wholesalers;

(b) Shall ensure that all drugs on a list are readily available for purchase by pharmacies in this state from national or regional wholesalers that serve pharmacies in Washington;

(c) Shall ensure that all drugs on a list are not obsolete;

(d) Shall make available to each network pharmacy at the beginning of the term of a contract, and upon renewal of a contract, the sources utilized to determine the predetermined reimbursement costs for multisource generic drugs of the pharmacy benefit manager;

(e) Shall make a list available to a network pharmacy upon request in a format that is readily accessible to and usable by the network pharmacy;

(f) Shall update each list maintained by the pharmacy benefit manager every seven business days and make the updated lists, including all changes in the price of drugs, available to network pharmacies in a readily accessible and usable format;

(g) Shall ensure that dispensing fees are not included in the calculation of the predetermined reimbursement costs for multisource generic drugs;

(h) May not cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive, or misleading;

(i) May not charge a pharmacy a fee related to the adjudication of a claim, credentialing, participation, certification, accreditation, or enrollment in a network including, but not limited to, a fee for the receipt and processing of a pharmacy claim, for the development or management of claims processing services in a pharmacy benefit manager network, or for participating in a pharmacy benefit manager network;

(j) May not require accreditation standards inconsistent with or more stringent than accreditation standards established by a national accreditation organization;

(k) May not reimburse a pharmacy in the state an amount less than the amount the pharmacy benefit manager reimburses an affiliate for providing the same pharmacy services; and

(l) May not directly or indirectly retroactively deny or reduce a claim or aggregate of claims after the claim or aggregate of claims has been adjudicated, unless:

(i) The original claim was submitted fraudulently; or

(ii) The denial or reduction is the result of a pharmacy audit conducted in accordance with RCW 48.200.220.

(3) A pharmacy benefit manager must establish a process by which a network pharmacy may appeal its reimbursement for a drug subject to predetermined reimbursement costs for multisource generic drugs. A network pharmacy may appeal a predetermined reimbursement cost for a multisource generic drug if the reimbursement for the drug is less than the net amount that the network pharmacy paid to the supplier of the drug. An appeal requested under this section must be completed within thirty calendar days of the pharmacy submitting the appeal. If after thirty days the network pharmacy has not received the decision on the appeal from the pharmacy benefit manager, then the appeal is considered denied.

The pharmacy benefit manager shall uphold the appeal of a pharmacy with fewer than fifteen retail outlets, within the state of Washington, under its corporate umbrella if the pharmacy or pharmacist can demonstrate that it is unable to purchase a therapeutically equivalent interchangeable product from a supplier doing business in Washington at the pharmacy benefit manager's list price.

(4) A pharmacy benefit manager must provide as part of the appeals process established under subsection (3) of this section:

(a) A telephone number at which a network pharmacy may contact the pharmacy benefit manager and speak with an individual who is responsible for processing appeals; and

(b) If the appeal is denied, the reason for the denial and the national drug code of a drug that has been purchased by other network pharmacies located in Washington at a price that is equal to or less than the predetermined reimbursement cost for the multisource generic drug. A pharmacy with fifteen or more retail outlets, within the state of Washington, under its corporate umbrella may submit information to the commissioner about an appeal under subsection (3) of this section for purposes of information collection and analysis.

(5)(a) If an appeal is upheld under this section, the pharmacy benefit manager shall make a reasonable adjustment on a date no later than one day after the date of determination.

(b) If the request for an adjustment has come from a critical access pharmacy, as defined by the state health care authority by rule for purposes related to the prescription drug purchasing consortium established under RCW 70.14.060, the adjustment approved under (a) of this subsection shall apply only to critical access pharmacies.

(6) Beginning July 1, 2017, if a network pharmacy appeal to the pharmacy benefit manager is denied, or if the network pharmacy is unsatisfied with the outcome of the appeal, the pharmacy or pharmacist may dispute the decision and request review by the commissioner within thirty calendar days of receiving the decision.

(a) All relevant information from the parties may be presented to the commissioner, and the commissioner may enter an order directing the pharmacy benefit manager to make an adjustment to the disputed claim, deny the pharmacy appeal, or take other actions deemed fair and equitable. An appeal requested under this section must be completed within thirty calendar days of the request.

(b) Upon resolution of the dispute, the commissioner shall provide a copy of the decision to both parties within seven calendar days.

(c) The commissioner may authorize the office of administrative hearings, as provided in chapter 34.12 RCW, to conduct appeals under this subsection (6).

(d) A pharmacy benefit manager may not retaliate against a pharmacy for pursuing an appeal under this subsection (6).

(e) This subsection (6) applies only to a pharmacy with fewer than fifteen retail outlets, within the state of Washington, under its corporate umbrella.

(7) This section does not apply to the state medical assistance program. [2020 c 240 § 15; 2016 c 210 § 4; 2014 c 213 § 10. Formerly RCW 19.340.100.]

48.200.290 Enforcement—Disputes—Civil penalties.

(1) The commissioner shall have enforcement authority over this chapter and shall have authority to render a binding decision in any dispute between a pharmacy benefit manager, or third-party administrator of prescription drug benefits, and a pharmacy arising out of an appeal under RCW 48.200.280(6) regarding drug pricing and reimbursement.

(2) Any person, corporation, third-party administrator of prescription drug benefits, pharmacy benefit manager, or business entity which violates any provision of this chapter shall be subject to a civil penalty in the amount of one thousand dollars for each act in violation of this chapter or, if the violation was knowing and willful, a civil penalty of five thousand dollars for each violation of this chapter. [2020 c 240 § 16; 2016 c 210 § 2. Formerly RCW 19.340.110.]

48.200.900 Rule making—2020 c 240. The insurance commissioner may adopt any rules necessary to implement this act. [2020 c 240 § 20.]

48.200.901 Effective date—2020 c 240. Sections 1 through 19 of this act take effect January 1, 2022. [2020 c 240 § 23.]

Chapter 48.201 RCW
CAPTIVE INSURANCE

Sections

48.201.010	Findings—Intent—2021 c 281.
48.201.020	Definitions.
48.201.030	Eligible captive insurer—Registration.
48.201.040	Tax on premiums—Remittance.
48.201.050	Commissioner's enforcement authority.
48.201.060	Commissioner's rule-making authority.

48.201.010 Findings—Intent—2021 c 281. The legislature finds that creating a framework for Washington private entities and public institutions of higher education to manage their risks through captive insurers will facilitate the growth and safety of those entities and protect the public interest. The legislature further finds that captive insurance promotes prudent risk management and provides access to insurance and reinsurance markets that may not be available to these Washington entities otherwise. The legislature believes that encouraging the use of captive insurance will support those who rely upon the strength and stability of employers in this state.

The legislature does not intend by chapter 281, Laws of 2021 to make Washington a captive domicile state. Rather, the legislature is establishing a framework for registration by captive insurers that insure Washington-based entities and are licensed by the jurisdictions in which they are domiciled. [2021 c 281 § 1.]

Effective date—2021 c 281: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [May 12, 2021]." [2021 c 281 § 15.]

48.201.020 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Affiliate" means an entity directly or indirectly controlling, controlled by, or under common control with another entity, such as a parent or a subsidiary corporation. "Affiliate" also means any person that holds an insured interest because that person has or had an employment or sales contract with an insured person.

(2) "Captive owner" means one of the following:

(a) An entity that is organized under Title 23B, 24, or 25 RCW, or analogous provisions of the law of another state or territory; or

(b) A public institution of higher education.

(3) "Casualty insurance" has the same meaning as "general casualty insurance" as defined in RCW 48.11.070.

(4) "Control" means possession of the power to direct the management and policies of an entity through ownership of voting securities, by contract, or otherwise.

(5) "Eligible captive insurer" means an insurance company with the following characteristics:

(a) It is wholly or partially owned by a captive owner;

(b) It insures risks of the captive owner, the captive owner's other affiliates, or both;

(c) One or more of its insureds have their principal place of business in Washington;

(d) It has assets that exceed its liabilities by at least \$1,000,000 and has the ability to pay its debts as they come

due, both as verified by audited financial statements prepared by an independent certified accountant; and

(e) It is licensed as a captive insurer by the jurisdiction in which it is domiciled.

(6) "Property insurance" has the same meaning as in RCW 48.11.040.

(7) "Public institution of higher education" means an institution of higher education as defined in RCW 28B.10.016. [2021 c 281 § 2.]

Effective date—2021 c 281: See note following RCW 48.201.010.

48.201.030 Eligible captive insurer—Registration.

(1) Within 120 days after May 12, 2021, or, if later, within 120 days after first issuing a policy that covers Washington risks, an entity acting as an eligible captive insurer must register with the commissioner.

(2) The commissioner will approve an eligible captive insurer's registration if the commissioner determines that the eligible captive insurer has sufficiently demonstrated:

(a)(i) That its assets exceed its liabilities by at least \$1,000,000 and it has the ability to pay its debts as they come due, both as verified by audited financial statements prepared by an independent certified accountant; and

(ii) That it is in good standing in its jurisdiction of domicile; and

(b) The eligible captive insurer has paid a fee of \$2,500.

(3) The commissioner may request additional documentation and information if needed to show that these requirements have been met.

(4) The commissioner may deny registration for any eligible captive insurer that fails to meet the requirements in subsections (2) and (3) of this section.

(5) A registered captive insurer may renew its certificate of registration for successive periods of 12 months each by, for each period, meeting the requirements of subsections (2)(a) and (3) of this section and paying a renewal fee in an amount set by the commissioner not to exceed \$2,500.

(6) A registered eligible captive insurer may provide only property and casualty insurance and may provide such insurance to a captive owner, to the captive owner's other affiliates, or both. A registered eligible captive insurer may assume risks from other insurers as a reinsurer without regard to the limitations in the preceding sentence.

(7) A registered eligible captive insurer may insure risks of its affiliates and obtain or provide reinsurance for ceded or assumed risks insured in this state or elsewhere. [2021 c 281 § 3.]

Effective date—2021 c 281: See note following RCW 48.201.010.

48.201.040 Tax on premiums—Remittance.

(1) On or before the first day of March of each year, a registered eligible captive insurer must remit to the state treasurer through the commissioner a tax in the amount of two percent of the premiums, exclusive of returned premiums and sums collected to cover federal and state taxes and examination fees, for insurance directly procured by and provided to its parent or another affiliate for Washington risks during the preceding calendar year. The tax when collected must be credited to the general fund.

(2) For the purposes of this section, "Washington risks" means the share of risk covered by the premiums that is allo-

cable to this state, based on where the underlying risks are located or where the losses or injuries giving rise to covered claims arise. A registered eligible captive insurer may use any reasonable method of determining such an allocation, including actuarial analysis or use of a proxy such as sales, property value, or payroll. Whether paid directly or by reimbursement, neither the timing nor the nature of a captive insurer's payment may be deemed to reflect, create, or constitute Washington risks.

(3) The registered eligible captive insurer must share its methodology and relevant analysis in determining its allocation with the commissioner.

(4) A registered eligible captive insurer is not liable for premium tax on moneys received as a reinsurer or on insurance placed through a surplus lines broker or other intermediary that collects and remits premium tax.

(5) If a registered eligible captive insurer fails to remit the tax provided by this section by the last day of the month in which the tax becomes due, the registered eligible captive insurer must pay the tax and the penalties and interest provided in RCW 48.14.060. The tax may be collected by distraint, or the tax and fine may be recovered by an action instituted by the commissioner in any court of competent jurisdiction. Any fine collected by the commissioner must be paid to the state treasurer and credited to the general fund.

(6) Taxes on premiums are due under this section from an eligible captive insurer for any period after January 1, 2011, if not previously remitted to the commissioner, and further provided that all such taxes must be limited to an eligible captive insurer's Washington risks. Taxes due under this subsection for periods before July 1, 2021, are not subject to the penalties or interest provided in RCW 48.14.060. For periods beginning July 1, 2021, a registered eligible captive insurer is subject to the sanctions in subsection (5) of this section.

(7) Taxes on premiums may not be imposed on or collected from an eligible captive insurer affiliated with a public institution of higher education. [2021 c 281 § 4.]

Effective date—2021 c 281: See note following RCW 48.201.010.

48.201.050 Commissioner's enforcement authority.

(1) The commissioner is authorized to make use of any of the powers established under Title 48 RCW to enforce the laws of this state. This includes, but is not limited to, the commissioner's administrative authority to investigate, issue subpoenas, conduct depositions and hearings, issue orders, impose penalties, and seek injunctive relief. With regard to any investigation, administrative proceedings, or litigation, the commissioner can rely on the procedural law and regulations of the state. An eligible captive insurer that violates any provision of this chapter after its effective date will be subject to the fines and penalties applicable to authorized insurers generally, including revocation of its registration, suspension of registration, and refusal to renew registration.

(2) An eligible captive insurer that fails to register under chapter 281, Laws of 2021 is acting as an unlawful, unauthorized insurer and is subject to the fines and penalties applicable to unlawful, unauthorized insurers generally. [2021 c 281 § 5.]

Effective date—2021 c 281: See note following RCW 48.201.010.

48.201.060 Commissioner's rule-making authority.
The commissioner may adopt rules as necessary to implement chapter 281, Laws of 2021. [2021 c 281 § 6.]

Effective date—2021 c 281: See note following RCW 48.201.010.